Away towards the Asylum

Abandonment, Confinement and Subsistence in Psychiatric (De-)institutionalization in Romania

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Declaration

I hereby declare that no parts of the thesis have been accepted for any other degrees in any other institution. This thesis contains no material previously written and / or published by another person, except where appropriate acknowledgment is made in the form of bibliographical reference.

Leyla Safta-Zecheria, Budapest, 15.04.2018

Abstract

This dissertation explores the everyday role of psychiatric asylums, in order to understand how they could be reworked into less oppressive structures through psychiatric deinstitutionalization. The dissertation is built on one year of ethnographic fieldwork in northeast Romania around former and existing psychiatric institutions, as well as archival and library research and interviews with policy advocates and policymakers. I argue that despite the terrible part psychiatric asylums have played as places, where the mentally ill and disabled have been let die throughout modern history, asylums still are defended by both some of their inmates and their carers on the grounds that they offer the possibility for subsistence for those who understand themselves as abandoned by their nuclear families and in danger of becoming surplus populations to the needs of capital and the state. It is the quest for subsistence that makes people consent to their medicalization and their confinement. This is the case, since abandonment happens as a fracture in social relations, previous to the person coming to live in an asylum. But even in the absence of a desire to remain, asylums work to confine people to their premises through ableist narratives and in certain instances through actual violence. Exploring how subsistence, abandonment and confinement work to circumscribe people's aspirations, as well as looking at the everyday life of post-asylary alternatives, allowed me to develop the modalities of sense making approach, a novel understanding of how sense is being made in practice by extending both Dvora Yanow's ([2000] 2011) and Ian Hacking's (1982, 1991, 2012) conceptual work. Moreover, it allowed me to develop a new mode of policymaking. This modality of policymaking is grounded in the work of educator Paulo Freire and proposes moving the locus of decision making closer to the people that are affected by projects of deinstitutionalization, thus helping to develop a politics of hope that can inform policies. This thinking is also rooted in the need to overcome anthropological representations of abandonment, as a final and hopeless process (compare Biehl, 2005). Overcoming the temptation to reproduce the vernacularly dominant hopelessness of abandonment in scholarly thinking, can inform a politics of hope that can help rework processes of abandonment in practice, by de-normalizing the meaning structures that reinforce abandonment, as the dominant imaginary of economically autonomous nuclear families. Through this the dissertation seeks to contribute to the anthropology of biopolitics and

abandonment, to the methodological question of how to conduct ethnographic policy research, as well as to opening up possibilities for a Freirean modality of policymaking.

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During the time of writing this dissertation, I have been fortunate to experience one of the most affectionate and intellectually stimulating atmospheres that I ever thought possible. And this in a variety of places, academically and fieldwork wise. This makes thanking everyone involved a hard, if not impossible task, now when there is an official possibility to do so.

My supervisor, Viola Zentai, has offered kind and caring guidance from the very beginning. Her ability to see where I was going, even before I could develop an intuition of it and her capacity to read between the lines beyond what is actually there into what I mean to say has always amazed me. As has her intellectual and personal generosity as a mentor and friend. I hope that one day, I can be half the mentor she is to other people, who are trying to find their way. So much of her thinking has gone into this dissertation that to mention even a small part of it would risk putting her name on every third footnote.

My supervisory panel at CEU was a friendly and stimulating environment which made it easy to share even unbacked but important ideas to be developed. John Clarke, who from our very first encounter at the CEU Sociology and Social Anthropology Department, volunteered to become my "lifeboat" in my subsequent transitions between anthropology and policy studies, has lived up to his promise by being a stimulating and kind commentator to this day. I admire John's ability to encourage people and his perceiving sense of where an argument is going. Prem Rajaram Kumar, has helped into being much of the abstract thinking that has gone into this thesis and has helped me, as well as others of my friends and colleagues to navigate the boundaries between anthropology and political science. Prem's ability to parsimoniously render the mundane abstract and political remain an inspiration for my thinking to come.

The Doctoral School of Political Science, Public Policy and International Relations at CEU, has been a great interdisciplinary home, making me not feel out of place as an ethnographer and interpretive thinker. For this, I thank especially Xymena Kurowska, during whose class on political ethnography, I came to develop the stepping stones of the methodology that went into this project and Lea Sgier, whose perceiving and thorough remarks about analyzing and writing have helped me discipline and organize my thinking. Being a teaching assistant to Dvora Yanow at the CEU organized ECPR summer school was a great opportunity to develop my thinking about and challenge the boundaries between anthropology and policy studies. Receiving Dvora’s perceptive comments on an early draft of what later came to be part 3 of the dissertation, helped focus and organize my thinking. I also thank the Doctoral School for devising a supervisory system made out of panels and yearly conferences that have offered me a venue for structured exchanges that helped me not to get lost in the researching and writing process, as well as form the stepping stone to some future projects.

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This project was sparked quite spontaneously, while trying to find a collective research project in 2011 at the *Studienkolleg zu Berlin* with Alexander Brödner, Andreas Leidinger and Felix Förster. Although we have lost touch, our vivid conversations and research trips live on through this project.

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At the unconscious beginning of this project was definitely my mother's activity on behalf of humanitarian NGOs with children in children's houses in the early 1990s, which allowed me to understand the privileged context that I was raised in, early on. My family has also been a safe haven from my many research and writing related wanderings, providing me with an enviable safety net. My brother, Altan, has also been keen to understand what I try to do in my research and has been an invaluable support in the many frustrations of moving around across national boundaries. My late grandmother, Aneta Safta, who was an English teacher introduced me early on to the language that I have now come to write in.

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Notes on anonymization and translation

Throughout the thesis, I have anonymized the vast majority of informants by changing their names. Where there were personal details that I thought would make the person identifiable despite the changed name, I refrained from providing these details. In some, very few, cases, when I was confident that the person or institution would prefer to be named, or the naming was necessary in order to link the institutional context through documents, I have named the person or institution. In these cases, I have used the original name of the institution, but have mostly refrained from naming the people involved. I have not named any of my vulnerable research participants, nor any of the staff members I have interviewed by their real names. I have also changed the names of institutions or given them a generic name. This was the case for the "New Beginnings" Center and the psychiatric hospital in Never Neverland, and the Asylum and the Asklepion, where the location of the institution was also anonymized. A glossary of sites and people to serve as orientation to reading the dissertation has been included in the appendix, at the very end of the dissertation.

An extended version of this dissertation included the original language quotes in Romanian, German and French. I have removed the full quotes for parsimony reasons and due to the word limit, and have only retained original language formulation in brackets or footnotes, when a possible conflict of meaning between languages would impede the unambiguous understanding. A version including original language quotes can be obtained upon request.

Outline Overview

Introduction

In 2003 and the beginning of the year 2004 around one hundred people of the five hundred patients of the psychiatric hospital in Poiana Mare died[1]. Public outcry followed the exposure of this state of affairs by human rights NGOs[2]. Since many of the deaths were caused by malnutrition and hypothermia, this led to consistent improvements in living conditions within the hospital, as well as hospitals countrywide. There was also pressure to close such places that ran under the very popular label of psychiatric deinstitutionalization[3]. One year after the public exposure of these massive deaths, the Minister of Health scheduled the hospital to be closed[4]. Patients interviewed by a daily newspaper were vehemently against the closure, a man saying that if they would have wanted to close the hospital, this should have been done when they were dying of starvation and cold. A woman is quoted to ask: "if they close the hospital, what would they do with us?"[5] The people interviewed were against being exposed to starvation and cold, yet they did not fear that this would happen again within the hospital, but rather on the outside where they feared finding themselves abandoned with nowhere to go[6]. Through their implicit protest of deinstitutionalization, the to-

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[1] http://www.gds.ro/Local/2014-07-30/Dincolo+de+portile+inchise+ale+Spitalului+de+la+Poiana+Mare/ accessed on 22.09.2016

[2] AI Index EUR 39/002/2004, Denial of medical care/health concern, Patients at the Poiana Mare psychiatric hospital 20.02.2004, Public UA 71/04 Romania, available here https://www.google.at/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjsi8C6xpTSAhUCRhQKHQN_DFEQFggkMAA&url=https%3A%2F%2Fwww.amnesty.org%2Fdownload%2FDocuments%2F96000%2Feur390022004en.pdf&usg=AFQjCNFCDiaGsqr0xfoSR-Y3IdiZxJxrVw&cad=rja

[3] Most commonly psychiatric deinstitutionalization is understood as "the process of closure or downsizing of large psychiatric hospitals and the establishment of alternative services in the community" (see Chow and Priebe 2013). The situated meanings of this process will be explored in the dissertation.

[4] http://www2.gandul.info/reportaj/quot-de-ce-n-au-inchis-spitalul-cand-muream-de-foame-si-de-frig-quot-253565 accessed on 22.09.2016

[5] http://www2.gandul.info/reportaj/quot-de-ce-n-au-inchis-spitalul-cand-muream-de-foame-si-de-frig-quot-253565 accessed on 22.09.2016

[6] This stance was even for more surprising, since there is clear evidence of high numbers of unnatural deaths in the hospital as early as 1995 when in the seven months between the end of February and that of September, 65 people had died, at least 25 of them of severe malnutrition. See Council of Europe report 1998 Council of Europe *Rapport au Gouvernement de la Roumanie relative à la visite effectuée en Roumanie par le Comité européen pour la prevention de la torture et de peines ou traitements inhumains ou dégradants (CPT) en Roumanie du 24 septembre au 6 octobre 1995*, Strasbourg, 19.02.1998 , available at http://www.cpt.coe.int/documents/rom/1998-05-inf-fra-1.pdf accessed on 27.02.2013 Given the continuities in staff numbers from other hospitals that are most likely to have been similar for care staff that attended to the everyday needs of people, we can assume that the carers had witnessed these death rows unfold as they carried out their contradictory care work in the hospital. It was this work that they came to argue needed to be preserved in order for them not to become beggars.

be deinstitutionalized patients found themselves in line with many beliefs that deinstitutionalization leads to homelessness, furthers marginalization and ill health.

While these declarations were being made, the staff of the hospital was also protesting the planned closure by blocking the main road that passes in front of the hospital (Calafat- Bechet) with an ambulance (probably the hospital ambulance) carrying a banner, asking the famous anticorruption advocate and then Minister of Justice: “Mrs. Macovei[7], where are the human rights?” (right banner) [8].

Image 1, source: http://romanialibera.ro/galerie/cadrele-medicale-de-la-poiana-mare-au-blocat-drumul-calafat-bechet--20797/img/2 accessed on 24.06.2017

It is only apparently unthinkable and ironic that the staff of an institution where one fourth of the inmates in their care had died mostly of hunger and cold, deaths which they had most probably personally born witness to, would protest human rights infringements. At a closer look, the closure of the hospital was advocated on the basis of it as a place of human rights infringements, in the sense of the right to life of the patients whose deaths became symbolically spatialized and institutionalized in the hospital. The closure of

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[7] The presence of Monica Macovei as an addressee is not incidental and is most probably due to two things, one she was alongside the then minister of health, Eugen Nicolaescu, in charge of the hospital- since as a partly forensic psychiatric hospital Poiana Mare was under the double jurisdiction of the Ministries of Justice and Health and secondly, she was at that time an icon of the fight against corruption and here probably implicitly in favor of human rights.

[8] Press article from Romania Libera can be accessed here: http://romanialibera.ro/actualitate/fapt-divers/cadrele-medicale-de-la-poiana-mare-au-blocat-drumul-calafat-bechet--20797 accessed on 24.06.2017

the hospital was to put an end to the dying, much like the end of the Second World War put an end to the dying in concentration camps. Or so it was hinted at in the media coverage surrounding this and similar places at the time[9]. On the other hand, the closure was protested by the staff on the basis of an understanding of human rights as a social right, the right to work. A point which is visible on other protest banners that read: “we want to work, not beg” (“vrem să muncim, nu să cerșim”)[10], pointing to the fact that the impossibility of finding work, would bring the care and clinical workers into a position of dependency on the alms of the rest of society.

Image 02: http://romanialibera.ro/actualitate/fapt-divers/cadrele-medicale-de-la-poiana-mare-au-blocat-drumul-calafat-bechet--20797 accessed on 24.06.2017, “we want to work, not beg”, banner reads: “Nicoleascu [then Minister of Health] = the surgeon-hangman of hea[lth]”

Yet, this work that was defended as a social right by the workers was silently based on reproducing practices that led to letting people die. The hospital appeared to both endanger the lives of its inmates - as a place that

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[9] See for example Romania Libera *Poiana Mare Concentration Camp. Another 440 patients on the brink of death*, 23.02.2004 available at http://antidiscriminare.ro/pdf/PressArt.pdf , accessed on 09.02.2013, 12:09, as well as the entire press art collection of articles, unfortunately no longer available online at this time (13.7.2017)

[10] http://romanialibera.ro/actualitate/fapt-divers/cadrele-medicale-de-la-poiana-mare-au-blocat-drumul-calafat-bechet--20797 accessed on 24.06.2017

regularly became a place of death (in 1995 and 2003-2004), as well foster the lives of its workers and inmates who therefore successfully protested its closure. The hospital still exists and functions to this day[11], although living conditions have greatly improved since the scandal.[12]

From a Freirean perspective (Freire 2017, [1968/1974]), it is interesting to note that the oppression of the hospital workers in a peripheralized part of Romania (Dolj county where the hospital is located, is until today one of Romania's famously poor regions) in post-socialist neoliberal transition that made it unthinkable for them to find work anywhere else, made it imperative for them to reproduce this oppression to the fullest extent upon those more marginal, namely the inmates of the (then partly forensic) psychiatric hospital, endangering their right to life. Two categories of oppressed people would find themselves separately protesting the closure of a place that despite its horrible history, seemed to them to be worth defending.

The tension between politics that led to the unnatural deaths of too many people in state-administered, isolated institutions and the fears of deinstitutionalization as a change of this politics puzzled me. If psychiatric hospitals had been places of horror where people were locked up and left to die, how come people experiencing them as patients and care workers came to defend them against potential closure? What are the underlying dynamics that lead people to fear "the world outside" and do these fears materialize once such places are closed? This prompted me to investigate the relationship between asylums for those deemed mentally ill and biopolitics in Romania. What follows is my account of this relationship and how a policy story - that of deinstitutionalization cuts through this relationship making it visible and easier to study in practice. This allows for investigating both the way in which biopolitics operate in everyday lives in contexts of abandonment, as well as how policy is a deeply socially embedded process.

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[11] See for example the website of the hospital: http://www.spitalpoianamare.ro/ accessed on 24.06.2017

[12] http://www.gds.ro/Local/2014-07-30/Dincolo+de+portile+inchise+ale+Spitalului+de+la+Poiana+Mare/ accessed on 15.01.2018

The main title of the dissertation *Away Towards the Asylum* plays on the way in which state and other political infrastructural attempts (such as those of humanitarianism) to deinstitutionalize the system have eventually come to reproduce it. The normative ideals of overcoming asylary structures have often given rise to new or renamed asylary structures. Moreover, even everyday life attempts to overcome institutionalization by deinstitutionalizing certain people by taking them out of institutions and preparing them for an independent life have similarly ended back in institutions. The fact that asylums have come to resurface at the moment of their explicit demise (as will be visible in two of the genealogical chapters 2 and 7), doesn't mean that asylums are an unavoidable outcome of fatalistic social processes. To the contrary, they are embedded in everyday biopolitical (calculative, moral and affective) orders legitimizing trajectories of letting people, who appear to pertain to "less deserving" populations, die. Identifying how these processes work in everyday life allows thinking beyond returning to the asylum by developing a politics of hope (abandonment and hope will be explored throughout part 2 of the dissertation, chapters 4 - 6).

Abandonment, alongside confinement and subsistence are key notions to understanding the way in which the asylary system works and what it produces or more precisely what it solidifies. The concepts, alongside that of biopolitics as a calculative, moral and affective everyday process are key to the way in which I think about my research topic. That is why, I will introduce them, alongside the questions they open for the dissertation here at the very beginning.

The answers to the question posed here, as well as theoretical elaborations on each of the concepts run through the thesis. They cannot easily be located in one or two chapters. Moreover my theoretical thinking, just like my research operates rhizomatically (see chapter 1) - I explore topics and the theories that help me make sense of them where I find I can provide the thickest theorizing. This is a theoretical decision I have made since I believe that theories grounded in ethnographic explorations are more powerful.

Concepts and questions that run through the dissertation

On “being given to the state”: the politics of abandonment between and beyond nuclear families and the state

Institutionalization is understood as abandonment by the people affected by it. It is therefore not surprising that this emic category finds itself in ethnographic studies of life in places, where people considered mentally ill are brought, as that of Erving Goffman (1961) in Asylums and that of Joao Biehl (2005) in Vita. Yet, what I add to the ethnographic study of abandonment is the observation that abandonment is relational to what is considered the normal - social, namely the (nuclear) family. Abandonment therefore in the mental health system and broader social policy systems is understood by “the abandoned” being given to the state by their mothers (reflecting an almost universal gendered dimension of the family).

Moreover, abandonment in terms of being given to the state therefore creates the conditions of possibility for a state-based biopolitics that can be traced through total institutions for those deemed mentally ill, be they children or adults. As Goffman explains at the very beginning of his book on asylums (Goffman, 1961, pg. XIII): “A total institution is a place of work and residence where a great number of similarly situated people, cut off from the wider community for a considerable time, together lead an enclosed, formally administered round of life.” Total institutions are thus places of isolation, where a relatively homogenous population is brought together based on a defining feature.

The “state-ness” of total institutions means that both food, places to sleep and comfort come (to a great extent) from public resources and completely function as part of a policy system, making calculations appear explicit in everyday practices. Abandonment here allows me to see how processes of normalization and hierarchizing operate in an isolated setting, while constantly thinking through how this setting is being and could be transformed through novel practices of knowledge making and the policy practices that can emerge from here.

Confinement and Subsistence or “if I were to leave where would I go?”

As the protests surrounding the closing of Poiana Mare hospital and as many other instances from my fieldwork show, it is not always clear where and when abandonment is considered to take place. The politically relevant question is whether abandonment happens in the nuclear family and then the trajectory into the asylum is just a consequence of this process, or whether the asylum is the place, where the nuclear family (or the mother) abandons a person. Understanding when and where abandonment takes place is politically consequential since it opens up the space to ask how abandonment can be remade into something else and when and where can one start to rework the process of abandonment.

Moreover, if people feel abandoned in asylums, why do they continue inhabiting them? Put differently: how do people participate in what they perceive to be their own abandonment? Many of my conversation and interview partners in the most asylary of places would praise the freedom of the life on the outside. When I would ask why they do not leave, they would say they have nowhere to go. Having nowhere to go implied not having access to the things necessary to make a living “on the outside”, a home, a social network/ family, a job, enough money. In institutions at least, as one of my interview partners put it “the state gives me some hogwash”.

The question of biological survival being ensured, opened up the question of subsistence- how does one live in order to live up to one’s own imaginaries of being human? How does one live with the gendered sense of failure that comes with feeling abandoned- the failure as a daughter or mother, the failure as a provider and how does one live with the haunting of one’s failed or disappeared family? How do people live with and in the system? Sometimes the imaginary of being human would be haunted by the need and desire to resume one’s responsibilities or by a longing for freedom. Sometimes it would be connected to accepting one’s faith as abandoned or orphaned and making a living in asylums or in their deinstitutionalized afterlife. Yet, forms of subsistence were not the only reasons why people would not leave asylums. Some would plan to leave, but postpone their plans indefinitely because of their fear of being caught trying to leave and being violently punished.

When the work of the fear of not being able to subsist did not do the work of keeping a person in place, the actual work of violently confining the inmates to asylums would be done by the staff. Confinement thus operated to keep people in place and to keep the economy of such institutions going. This lead to a phenomenon that a German psychologist, who regularly came to Romania, called keeping people hostage for the salaries of the staff. Confinement thus works to solidify the work that the fear of not being able to subsist already does. As explained above, people themselves come to at least half-heartedly consent to their confinement through the pressure of families that due to their expected unproductivity or immorality desire their confinement and the resulting subsistence ensured by the state. Thus abandonment, subsistence and confinement (the building blocks of my subtitle) appear as the attributes of the system- this is both how the asylary system works and what it produces.

The Politics of Biopolitics

For a thicker understanding of what a less oppressive way of carrying out psychiatric deinstitutionalization could be about, it is central to understand practices of hierarchizing subjects that come to bear upon both the livelihood and in-extremis upon the life itself of the hierarchized subjects through different biopolitical interventions. Moreover, practices of hierarchizing subjects also bear upon the kind of life that subjects are enabled to live through dispersed, plural and anachronic processes of ‘conduct” which as Foucault pointed out “is one of the best aids for coming to terms with the specificity of power relations.” (Foucault 2000, pg. 341)

Initially, I saw these practices of hierarchizing and biopolitical interventions as something that would be reworked through psychiatric deinstitutionalization. But it soon became apparent that neither the past nor the present of biopolitics in Romania, as well as its trans- and supranational (read EU) ramifications, was as stable as a binary transition from one type of biopolitics to another would assume. Therefore, my project aims to link different biopolitical logics and practices and follow as they operate within and outside of institutions into the lives of people that are governed as mentally ill/disabled.

Exploring the politics of biopolitics in this setting means playing with the different meanings of (bio-) politics. Since Foucault's notion of biopolitics (1978, 2003 [1997]) is tied to the of enhancement of life through abstract calculation directed at populations, its existence has as a prerequisite a form of political power that can enact such an endeavor. My project takes the tension between the everyday abstractness of bio-power and the positioned lived experience of subjects that participate in its enactment. Politics here doubles biopolitics to stress that the everyday politics of people, do not automatically coincide with those of the calculative regime behind the abstract bio-power: they resist, enact, rework, as well as ignore biopolitical interventions that they are called to participate in. The subjects of the system are manifold, both in their numbers and in their positionalities. But irrespective of their positionalities, they do in complementary and contradictory ways reproduce as well as create their own biopolitical orders by enacting practices of hierarchizing others and themselves. It is this dimension of bio-power as part of lived life that I seek to explore: How do people share in the will to make subjects live or let them die?[13] Or less provocatively: how do people participate in enhancing others and their own lives? What are the practices of hierarchizing subjects and how do they work to divide and oppress their subjects? How could they be re-worked to enable solidarity as opposed to division among their subjects?

There is a fractured relationship between what Foucault has called biopolitics and what Didier Fassin, has termed the politics of life (2006, 2011). The nature of this relationship rests on the tension between the apparently abstract nature of biopolitics as something directed at populations and the practices by which life is given meaning and enhanced or not in everyday life. I do not see the politics of life and biopolitical calculations and interventions as two separate fields of inquiry, as Fassin's delimitation from Foucault would suggest. Rather than this, I seek to understand the contradictory and tense coexistence of biopolitical interventions and other forms of hierarchizing humanity (to borrow again from Fassin, 2012) in everyday life.

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[13] to appropriate Tania Li's approach to asking question in "The Will to Improve", where people shared in the will to improve: Li, 2007, pg. 4; see also see also Foucault, 1978, 2003 on biopolitics and Li, 2009 on making live and letting die;

Overview of the chapters

Although my investigation was much less neat with many conceptual and empirical ups and downs, I have managed to group what I have found into three main parts preceded by an introductory section and finalized by a conclusion. In the introductory section, apart from this short introduction, I have also included a chapter called the social life of the project (chapter 1), exploring how I have come to ask the questions I did and how they relate to the process of doing and writing research from the different positionalities from which I have explored my topic. This chapter is meant both as a reflection and as an example of how a policy story can be studied rhizomatically.

Part 1 is conceived broadly as a genealogy of present day modalities of sense making and infrastructures and the way in which they are imbued with biopolitical questions. I proceed by first introducing modalities of sense making as an approach to the ways in which knowledge is produced and enacted in everyday settings, as well as biopolitical orders. Then, in chapter 2, I go over to tracing the relationship between nuclear families and asylums into the history of the birth of religious asylums in the Romanian Principalities, up until the creation of the categories that govern the system today during the inter- and postwar years. In chapter 3, I explore four modalities of sense making that have shaped the relationship between asylums and biopolitics in Romania in the last thirty years: the humanitarian, the juridification of the past, the human rights and the experience based modalities of sense making all acted to create populations and make specific forms of action possible and desirable.

In part 2, I look at trans-local practices, practices that run throughout the system connecting different places in unexpected ways. The first chapter of this part (chapter 4) explores the two relevant policy systems that make institutionalization possible, the psychiatric and the disability system, in terms of their macro-infrastructural features. It looks at broad populations and their movements through the system, as well as at attempts to reform each of the systems and how they have so far been unsuccessful at replacing the asylum as the main care and treatment infrastructure. In chapter 5, I look at how subsistence is being sought with clinical means by investigating the oppressive and empowering entanglements between the biological and the social. In chapter 6, I look at the relationship between asylums and nuclear families in terms of its subjective perception as abandonment, as well as in terms of the trajectories that take both the “children”[14] and the “adults”[15] from their biological or social families or networks into asylums. By looking into these stories and similar anthropological framings of abandonment (for example Biehl, 2005), I try to go beyond the normalizing tendencies of insisting on abandonment as a hopeless state and open a space for hope as an exploration of the potentialities of the present (Massumi, 2002 and Freire, [1968/1970] 2005).

In part 3, I focus on one of the two populations previously introduced that of the “children” and look at the way in which a space of eternal childhood has emerged in lieu of a huge children’s neuropsychiatric hospital that once housed around 2000 children in a town of 8000 inhabitants at Romania’s border with Ukraine. In the first chapter of this part, chapter 7, I use insights from genealogy and ethnography to trace what the hospital meant as a place to the different people whose lives have been entangled with it. In chapter 8, I look at different biopolitical orders that have been enacted around the neuropsychiatric children’s hospital and the way in which they were reworked and resisted in everyday life. In chapter 9, I look at the way in which people considered “children” challenge the category of eternal childhood and aspire to become part of a different social order.

Finally, in the concluding part, in chapter 10, I introduce a way to work with the potentialities of the present against abandonment in crafting a Freirean approach to social policymaking. I conclude with short conclusions regarding asylums, abandonment and the potentialities of the present.

What the dissertation could bring

As a piece of interdisciplinary work, with the dissertation I aim to contribute to three disciplines in different ways. While I understand myself as a political or social anthropologist, I have equally been trained in policy analysis and feel confident in talking to critical and constructivist policy scholars. Moreover, my

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[14] People who have grown up in the system as a consequence of the pronatalist policies and the encouragement of institutionalization starting in the mid 1960s and early 1970s respectively

[15] People who have been abandoned later in life, into asylums, both populations will be explored at length in Part 2

ethnographic and policy analysis work has pointed me into a genealogical direction. Working with the complexities and epistemic asymmetries of the way in which the care of those considered mentally ill and disabled works today, I felt it was important to trace the emergence of the current care, treatment and confinement infrastructure and look at the discursive forces that have shaped it. As Foucault (1976) has pointed out, genealogies are about constituting an "insurrection of subjugated knowledges" (pg. 81) and establishing a "historical knowledge of struggles" (pg. 83). In this vein, I aim to trace the emergence of the present day system by looking at what had to disappear or be reworked in order for present practices within and surrounding the system to become possible.

As a policy PhD, the dissertation is an effort to rethink social policy (compare Lewis, Gewirtz and Clarke, 2000) and to make possible an expansion of the policy imaginary (see Lewis, 2000) governing both the making and the analysis of policies. To do this, my project places the policy story of deinstitutionalization beyond its immediate reach both genealogically, as well as socially and geographically. In terms of a methodology for studying policy, it seeks to expand Dvora Yanow's ([2000] 2011, Chapter 2) work on (policy related) interpretive communities by focusing the analysis on modalities of sense making as a conceptual device to capture meaning making as process and not as group identity. Moreover, by building on Marcus' ethnographic methodology (1995) and proposing a rhizomatic methodology for policy research, I propose new ways of choosing fieldsites as field sights - as places from where the researcher can see (and be seen).

I do not only want to contribute to policy analysis as a mostly theoretical field, but also to policy as a practical field in two ways. One way to contribute to this is by studying a concrete policy story that of deinstitutionalization. In this, I show that although apparently an innovative, straightforward and unitary process, deinstitutionalization is in practice a dispersed, unequal process, with older concepts that seek to be applied to new realities (not that new, born at the same time with modern psychiatry) and traveling across contexts like floating signifiers.

The second way in which I seek to contribute to policy as practice, is by developing a mode of policymaking derived from the work of educator Paulo Freire (1997 [1992] and 2017 [1968, 1974]) that would allow for crafting less oppressive policies within this field - proposing a more hopeful way of thinking and doing deinstitutionalization. This understanding of deinstitutionalization should not be focused on closing institutions and on uncritically "setting" people "free", but on overcoming confinement and ableist protection without leaving people abandoned or endangering their subsistence. It should allow for subsistence without oppressive subordination.

As an ethnography, it seeks to contribute to an emerging field that could be described as the anthropology of abandonment (see Biehl, 2004, 2005, Höjdestrand, 2009, Povinelli, 2011, Li, 2009, 2013) by investigating the complex relationships between people who are let die and those that let them die, as well as those who are made live and on what terms they are made live. I want to offer a thick ethnographic account of biopolitics by tracing the affective, moral and calculative reasoning behind biopolitical interventions, the dynamic processes of population making they require, as well as the way in which these abstract orders become enacted, rejected or reworked in the everyday life around (former) asylums for the mentally ill. Furthermore, the ethnography I offer looks at the complex entanglements between the biological and the political and contributes to work on the potential violence of selective make live interventions (compare Ticktin 2006, 2011 and Petryna 2002, 2004).

I also hope that people who have experienced the system from within as patients or inmates, its humiliations, but also its moments of affection and the refuge it sometimes offers can find my account interesting and familiar and that professionals active in the field can find in it things that tickle their curiosity.

Chapter 1: The Life of the Research Project

In this chapter, I explore the way in which I conducted my political ethnography of biopolitics and deinstitutionalization of services for the mentally ill and disabled in Romania. In a way, this is an account of what Edward Schatz (2009, pg. 14 -16) described as a monist political ethnography - where the claims to knowledge cannot be separated from the context of knowledge production and political refers to the way in which power plays out in ethnographic research projects.

I started this research project without knowing where it will led. In 2011, I was part of a small interdisciplinary student research group. We were to receive a small amount of funding to carry out an international comparative research project. There was no need for it to be particularly scientific, but we all had to find common ground despite coming from disciplines as far away as bionics and law. We had all read Foucault, and this is how we came to want to be interested in “madness”. After finding the broad topic, we settled on a comparison of mental health services in Finland, Germany and Romania. I came to organize a research visit to Bucharest to study mental health. Thus I came to get in touch with alternative service providers, the users’ organization Aripi and a number of progressive professionals.

At that time I was doing an MA in European Ethnology, more or less the German/ European equivalent to Social Anthropology, and at the institute at which I was studying there was a research group on social practices surrounding psychiatry. At that time, I was also struggling with anxiety and depression and was quite terrified at the idea of seeking professional help. It was around this time that I decided to write my MA dissertation about mental health in Romania - in a sense I wanted to observe a field I was reluctant to enter on either side of the multiple positionalities available in it - to create my own way of understanding mental illness and its treatment.

I initially wanted to write about how the “way of being” (Hacking, 2006) a user of psychiatry is being crafted through contacts with Western European NGOs, and surrounding community care centers. But since community care structures were mostly NGO based and at the time I intended to carry out my fieldwork (in

2012), there was a blockage of European Union structural funding, the main funding for such alternative services[16]. I was left with little conversation partners that found mild interest at best in my topic.

At that time I also came to read the human rights reports (most of which were either in French or in English) and come across the very high numbers of deaths in psychiatric hospitals. I came to follow the trail of documents and experts that led me to the founding of the National Center for Mental Health and the pressure during the EU accession process to ensure the respect for human rights. The un-natural and untimely deaths, as well as the humiliating living conditions documented in the reports (CPT, 1998, AI 2004 a, b) made me feel outraged and I considered something needed to be done about it. In a sense, through reading these reports I came to strongly identify with the human rights modality of sense making. I considered that whatever the concerns about self-determination, autonomy and opening a space of critique of psychiatry and of sharing of experience involved in the users' movement there were more pressing concerns, like the right to life of confined people. I later came to understand just how strongly these questions were entangled and how a person is first silenced, then let die. It is in this way that I started being interested in the relationship between biopolitics and psychiatric asylums.

I had long been interested in Brazil and had even lived there for a time, so I also started reading on the Brazilian mental health reform that appeared to be more far reaching than the Romanian one. I came to see that the alternatives to asylums can also involve violence and humiliation of users (Nunes & Torrente, 2009). The human rights reports released in the immediately preceding EU accession, suggested deinstitutionalization was the only way to fulfill the human rights of psychiatric inmates. I thus developed a more critical stance towards deinstitutionalization and came to ask myself different questions. Was the closing of hospitals and the setting up of alternative "community-based" services always a benign process? If not what were the continuities between "alternatives" and asylary systems?

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[16] http://www.fonduri-structurale.ro/stiri/9866/blocarea-de-fonduri-ue-pentru-romania-cum-sunt-afectati-beneficiarii-proiectelor accessed on 25.02.2018

It was about this time that I moved to the public policy department at CEU to start the PhD - and started asking questions related to the way in which deinstitutionalization worked as a policy. Central to orienting my inquiry was the question whether policy learning occurs in everyday settings where deinstitutionalization is carried out. Assuming that such a massive infrastructural processes as that of closing large hospitals and moving people "into the community" is likely to have noticeable impacts on people's lives, I came to ask myself how these were connected to policy related knowledge production processes.

Or put differently how do everyday struggles in spaces of psychiatric/ mental health care become incorporated into broader struggles related to policy and social recognition? In a sense I was interested in two things: the first was what does the policy of deinstitutionalization do to the surroundings and to the lives of people where and with whom it is being carried out? In this I followed Tania Li's (2005) call to look at what a policy does in everyday life and not whether it fails or not. Following Clarke et. al (2015) I was interested in how a policy gets assembled and translated in everyday life. On the other hand, I was also interested in whether and how the struggles I supposed arose surrounding deinstitutionalization were translated into policy or other forms of political knowledge - whether and how they were reassembled as policy relevant knowledge.

Studying policy ethnographically

In following deinstitutionalization as a policy to see what it does to the everyday life of its subjects made me face an important methodological question: how to study policy ethnographically? Ore more precisely: where to look for the richest field site? From Dvora Yanow (2014 pg. 146) I learned to think about mapping my research setting for "exposure to a variety of possible meanings/ interpretations within them [the settings] concerning matters of interest". I therefore set out to map the possible places (both geographically as locations and socially as stake holder positionalities) where people could think differently about deinstitutionalization, such as community care centers and psychiatric hospitals as the two spatial extremes. I also thought about expertize of the psy-professions and the positionality of being mentally ill and thought that it is likely for different positionalities to hold different views of deinstitutionalization, as well as have different ways of channeling their experience into policy relevant knowledge. Yet, something was still missing for the research question and the relationship with the fieldsites to be quite right.

Both during the previous research project, my MA thesis research, as well as early on during my PhD studies, I carried out interviews with people who had been active in drafting the mental health law and conceiving or working at the National Center for Mental Health care - the main agency relevant to mental health policy. Some of my interview partners pointed towards a very progressive team that worked around the Asklepion[17], a psychiatric hospital that had close ties to a foundation with broad mental health user involvement. I found a conference organized by the people from the Asklepion and secured my field entry.

At that point, although I knew much about how the policy process from psychiatry to mental health had worked, as well as had been to a number of community care centers, and NGO offices, I had never been on a psychiatric ward. And except for the horror stories, I had read in human rights reporting, I didn't know much about the everyday life of system and how policies were practiced. The team surrounding the hospital had long supported policy plans for deinstitutionalization and reform towards a mental health approach, and had enjoyed even international recognition due to this position.

Yet, when I reached the Asklepion with my questions surrounding deinstitutionalization, I was greeted with surprise and was repeatedly told my questions were best studied in a (neuropsychiatric or disability) social protection care setting or around a hospital for the chronically ill. The Asklepion, it was explained to me was an acute psychiatric hospital – stays normally did not exceed 13 days (at the time of my fieldwork in 2015, this was the case because of the funding structures that favored very short term commitments), whereas in centers for people with (neuropsychiatric) disabilities, people could spend their entire life. There was nothing to deinstitutionalize here.

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[17] I chose the name Asklepion for the acute psychiatric hospital, where conducted fieldwork in early 2015 January-April 2016, since it captured the dual/plural nature of the place as a space of both medical treatment and spiritual healing, much like the antic Greek temple to the god Asklepios. Both the town and the hospital were anonymized, due to the explicit request of the hospital management.

Especially the manager was concerned that similar to other previous researchers focused on mental health, I would lump the long term beds in asylums - like the centers for neuropsychiatric recovery and rehabilitation and acute and chronically ill psychiatric hospitals together and count the number of beds in this way. Her irritation was with a previous report, that had followed this logics and thus probably contradicted that Romania had less than the European average hospital beds - meaning that it could on the long term lead to advocating for a decrease in hospital bed numbers[18].

Yet, there was also something related to my new positionality. I sensed that conference and policy interactions were one thing, and challenging the knowledge monopoly of doctors acting as managers from unknowledgeable position of a social scientist was quite another. If openness to different approaches was what needed promotion on a national and international policy level, on the local level doctors still stressed their own monopoly on defining issues, while opening a space for other professional positionalities to contribute, but not reframe questions[19].

Despite the insistence to stress there was no link between the Asklepion and residential social protection institutions (asylums), I did witness two-three instances where people were referred to residential institutions, as well as an instance where a woman was suggested to go to a psychiatric hospital for the chronically mentally ill for a short stay - which I also took to mean that she could in the medium term also become an institutionalized person[20]. Sometimes, one of the doctors would pride himself of having arranged the institutionalization of a young woman of around eighteen years of age who had been hidden away from society completely and fed only with milk, a situation which made her look much like a six or seven year old child. She was now happy in a long term care institutions for the disabled[21].

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[18] Interestingly, her fears were not unfounded, since at the end of my stay at the Asklepion it was almost certain that the number of beds would decrease to half. The transformation as far as I am aware did occur with dire consequences for the hospital’s budget.

[19] This was by far one of the most progressive approaches to these questions, anyway, a point that needs to be stressed.

[20] I will explore these practices in a different chapter

[21] I did eventually meet the woman he had spoken of and she seemed indeed content with her life and her surroundings.

This is how I came to rethink how to go about choosing my next field site. Initially, I had wanted to map out a potentially diverse fieldsite setting, including community care centers in different cities, the Asklepion as a psychiatric hospital. I did not see these fieldsites as connected in any other way but through their relationship as places of potential difference to what deinstitutionalization could do to them or around them. Reaching the Asklepion and realizing that some (few) people take the Asklepion as a starting point on a path to institutionalization made me think I should proceed to follow this path.

It is thus that I returned to thinking through George Marcus' (1995) seminal essay on multi sited ethnography in which he argues that anthropologists had shifted from the "committed localism" of the conventional single fieldsite, contextualized in its relationships to what Wallerstein referred to as the world-system, to a multi-sited practice of following and tracing an issue as it moves through different sites. The different objects that he notes could be "followed" are: people, things (mainly in terms of commodities), metaphors (as well as signs, symbols), plots (stories and allegories), biographies (as life stories) and conflicts[22]. In the case I am presenting what I was following was at the beginning the policy stories of deinstitutionalization in different settings, but what I came to follow after arriving at the Asklepion was the trajectory of people that are institutionalized, deinstitutionalized and then sometimes institutionalized again - it is people's movements away towards the asylum - the phrase came to give the title of the dissertation as well.

Among the inspirations associated with multi-sited ethnography, Marcus cites Deleuze and Guatari's ([1987] 2005) rhizome. Marcus (1995, pg. 102) only mentions it in passing, but I came to explore this metaphor further by thinking about the implications of understanding the connections between field-sites not as a root-tree relationship, but as a rhizomatic one[23]. So far I had conceptualized policy analysis as a root-tree relationship: the policy as the root and what it does (its "impact" or "implementation process" as the tree). This understanding obscured the multiplicity of connections between the sites in which policy was

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[22] Marcus (1995), pg. 106-110; whether this practice was entirely new anthropology at the time of Marcus' writing is a matter for debate. Nevertheless, I draw on his observations initiating a trend in anthropology, as they are helpful in organizing my discussion of conceptualizing my field sites.

[23] See Deleuze & Guatari ([1987] 2005), Introduction : Rhizome

made, translated and assembled, and how these connections in themselves shaped dominant understandings of the policy itself that can better understood as rhizomatic connections. This understanding also helps to move away from a topography of power that is centered on the state into more complex and more twisted topologic representations (compare Allen, 2011).

I had thought about the rhizome as a potential organizing metaphor for my research practice before going to the field, but it was only in the field that I could let myself be abducted by branches of the rhizome and taken into new research contexts. This was due to my epistemic positionality as outside of the field of deinstitutionalization and came to shift, once I came to (re-) enter epistemically and geographically into the field through my first field-site.

Put differently: the extent and the ramifications of the rhizome were little visible to the me as a researcher at first and to a large extent still remain invisible. What I came to see once I had entered the field were glimpses of the rhizome and this through a process of transforming my objects of knowledge: people, documents and places became field-sites as I engaged them as a researcher, and treated them as heuristic devices to shed light on other (near-by) parts of the rhizome. From the Asklepion, I could see the psychiatric hospital for the mentally ill, as well as the asylary residential institutions were people came to spend their entire lives.

This transformation of perspective happened through the sense that was being made of other potential field-sites in the field-site. A field-site similar to a lamp shedding light, while being operated by me as a researcher can uncover only a limited horizon of knots in the rhizome. Inevitably, some parts of the rhizome as well as its full extension remain invisible, as they are outside of the reach of the field-site's meaning making processes, now turned field-sights (since they are connected with what and how can be seen) for me as a researcher.

Rhizomatic ethnographic policy research thus entailed for me a reflection of my own peripatetic positionality (compare Marcus, 1995) between field-sights, trying to show how my possibilities for knowledge construction were enhanced and limited by how people understood me and how I understood the field. I therefore, will continue the reflection with the positionalities I held during my stay at the Asklepion.

The Asklepion as a field-site/ sight and my positionality within it

I was very fortunate to start my fieldwork at the Asklepion. On the one hand, it was an inter-disciplinary setting with psychiatrists working alongside psychologists, social workers, occupational therapists, nurses, carers and even a priest and it was common for some users to be involved in ethical and other hospital wide committees. It allowed me to see how different modalities of sense making surrounding mental illness would play into the lives of people who were arranged as patients in the hospital.

Since there existed an exchange between the Asklepion, and the relatively small town and its surroundings were through the monthly community visits, as well as on the through the activity of foundation that worked closely with the hospital, I could obtain a limited peri-institutional understanding of the Asklepion and the complexity of issues surrounding acute psychiatric interventions.

Yet, my first fieldsite and its surroundings, also gave me a good opportunity to figure out how limiting my positionality can be. Upon arriving, I was urged by the manager to sign a volunteering agreement in order to make my stay in the hospital justifiable and legitimate. I agreed of course and was asked to also provide the manager with the interview guidelines I was planning to apply. I did not have any interview guidelines at the moment, but I thought that it could be a good opportunity to develop them, so I went along with her proposal.

Since I was not formerly introduced neither to the staff nor to the patients (as users were known in the hospital) I was at first mistaken for a recently admitted patient by the nurses and other members of the staff and as a member of the staff by the patients. This privileged identity as an-in-between-other did not last long though.

The fact that I was a PhD student, the Romanian *doctorand* which sounds intuitively very close to *doctoriță*, doctor-ess shaped my positionality. In the eyes of most, I came to be one of the university graduates staffing the hospital. This was also the case, because most employees had volunteered for months at the hospital, before being employed.

Upon giving me a walking tour through the hospital, the head nurse and trade union leader, remarked that there was an empty office, as one of the psychologists had left the hospital and suggested he give me the key. The office was on the second floor which was also the top floor where most socializing activities were being carried out - it was the floor where occupational therapists received people in what I came to regard as the living rooms of the hospital where the social workers organized group therapy meetings and where psychologists held individual therapy sessions.

It was on this floor, in an office previously used as a psychological cabinet that I carried out most of the interviews with users and some of the interviews with staff. It was in this way that people that had previously been admitted to the hospital and that had come here for counselling or therapy were now being invited in for an interview by me. This and the fact that an ethnographic interview (especially an open ended one), carried out in a psychiatric hospital is not perceivably different from a therapeutic first interview created the perception in most of my patients interviewees' minds that I must be a *therapist.* I tried to emphasize that I was not offering counselling services, that I was not trained as a psychologist and that I needed the interview for my PhD thesis, but all of this was to no avail, after talking about life situations, I would be asked to give advice on how to go about things. Although reluctant at first, I let myself be drawn into counselling in certain situations, yet stressing my lack of professional training[24]. An interview partner even insisted, I also talk to a man she thought she was falling in love with and later stressed that she would like to come again and talk in my office. After these experiences, I realized that having a questionnaire, however

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[24] Looking back on this episode I realize how much I had internalized the professionalizing discourse on care and social work.

open ended, would be very useful and I re-analyzed the one I had provided the management of the hospital with. This secured some clearer focus of the interview.

Nevertheless, weeks after I met one of the former patients of the hospital by chance, we were both hitch-hiking in a less crowded part of the county. When the driver briefly exited the car, I turned as I was sitting upfront and told her that I believe we know each other. She replied, “why yes, you are the lady I did therapy with in the hospital. Thank you. I am much better now. God and the medicines helped me get better”. The driver returned and it was too late to stress as I had done before that I am not a therapist. Similarly, when I once asked people to attend a focus group, one lady replied, she is here in a reserve (single room where you pay extra to book it) and came to the hospital more to rest. She doesn’t need “the group”, meaning she doesn’t need group therapy.

Being a volunteer, having my own office, having access to the keys to all rooms and being friends with some of the staff (due to the fact that their stays were longer in the hospital, as opposed to the users’), made me a perceived part of the staff. This probably influenced the way people would talk about their stay in the hospital, especially in focus groups they would all see their hospital stay as benefic, and their health as improving etc. Only towards the end of my stay in town, while spending more time at the greenhouses of the foundation, did I come to realize how a more critical stance can be developed and different kind of stories heard.

I realized that would I do the fieldwork in a hospital again, I would take the patients/ users and even the staff out for coffee or a cake in order to interview them or to the contrary, I would visit people in their rooms at their beds - a move I was reluctant to make, as I thought it might be disrespectful, but I later came to realize that it might have also been read as a sign of closeness. Decentering the hospital would have made understanding the hospital as a place structured by power relations more easily explicit.

In the beginning, I was also reluctant to interview patients, as they appeared to be on strong medication. I thought about whether it would be ethical to interview someone in such a vulnerable state, but soon after came to reframe my position regarding this question. There were several reasons for that: first, people who would regularly be committed to the hospital (as the vast majority of the users were) are likely to be taking psychoactive medicine for long periods of time. It would therefore be almost impossible to talk to users in a different state of mind. Yet, understanding how mental health policy works needs to include the views of its users - so I saw no easy way around this. What I did do, was always try to make my inquiry as understandable as possible. I also checked with the nurses before interviewing some of the people, since they were likely to be aware of special conditions. I was never told not to interview a specific person, but I was told to avoid interviewing in the hours following lunchtime, since then people are likely to have taken strong medication and some would require sleep. I therefore resolved to limit my inquiry to interviewing users in the morning and staff in the afternoon, when they were also more likely to be available.

Switching fieldsights

In switching, I took the advice that professionals active in the Asklepion had given me to look at the residential protection system for people with disabilities. This system was not officially part of the mental health system, since these centers ran as the social protection of the mentally ill - they were administered as spaces of care, not as spaced of treatment. Yet, they were also spaces of confinement as I was to learn.

After leaving both the hospital and the foundation, I embarked on a two week long continuous journey to visit the residential institutions for people with disabilities in the rest of the county[25]. These institutions are in relatively difficult to access rural areas and they cannot be visited without a previous approval from the central body with joint legal responsibility in the county capital, the General Directorate for Social Assistance and Child Protection (hereafter *Direcție*, Direcția Generală de Asistență Socială și Protecția Copilului). I obtained the permission for a total of almost two weeks, during weekdays.

Reaching these institutions (CRRNs and CRRPHs) was not at all trivial. I was renting an apartment in a town that was not the county capital. I don't drive, so I was dependent on some sort of public transportation. The public transportation connecting most of the villages around the five institutions in the rural area and

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[25] I have anonymized the county were most of these encounters took place, to make it easier to anonymize the research locations themselves.

one in the urban area left from the county capital and I had to take a bus to the county capital since no direct transportation existed between villages and small towns. I often got up as early as five a.m. in order to be able to arrive still during the morning in one of these places mostly by hitchhiking at least part of the way and would then have to make my way back in the evening. Not to mention the fact that such trips are expensive for local standards costing around the equivalent of ten euros to go and come back (with minimum wage at that time at around 200 euro). It is important to reflect on this experience, since probably for most people who have family members living in such a place and do not drive or own cars, this kind of journey is the only way in which they can visit them.

Once I would reach each one of the centers, I would generally be brought to the head of the institution and be invited in for coffee. In all but one case, I called one day in advance to announce my coming, so that the person was mostly informed. In case the information had not been received, I presented the written request that had been approved by the *Direcție*. Generally, the heads would be friendly at first, I could generally sense that I was being seen as a controller by some. Conversations would typically reach the point where the person would complain about either staff, lack of training opportunities, changes in the administrative structure or the like.

On the first day, I was received by a social worker who gave me the advice to try and talk to the residents after the main staff's working hours, because that´s when the residents will feel more at ease. It is when I will get to know them and they will tell me most as well. I tried to keep to this, whenever I felt I wouldn't be overstepping too many unwritten rules.

The visits went smoothly, with one notable exception. In the one center that was worst off, in the sense that it had once housed roughly 400 people and had now as part of the move towards deinstitutionalization been split into three smaller centers, the original one and two smaller, newer ones where "the better ones" (the more compliant ones) were moved. Those who remained, so the head, were no longer *recoverable*[26]. One of the three buildings of the institution was being renovated and therefore the residents were being crowded into the two other pavilions, this she mentioned was being done so that she wouldn't need to fire any of the employees. She also mentioned that it is good that the previous pavilion was closed, since it had really been like Ausschwitz (sic)[27] - she most probably meant that the unproductive were being left die there, a point which is confirmed but the county level statistics of death in the years between 2010-2015, over three hundred had died[28].

After this introduction, I asked to visit the premises (as I generally would), the psychologist to whom I was referred, was nevertheless a bit surprised about this and she asked a male colleague to come along with us. The men's ward was locked, we knocked and a carer came and unlocked the door. It was shower day and half naked men were all about. I felt horribly embarrassed, someone of the staff complained to one of the men that he was only wearing a towel. I said, it's my fault, I am the one who shouldn't be here now. The bedrooms as much as I could see them were overcrowded. The psychologist asked whether I would like to see some more, for embarrassment I said no. We came to the door and it was already locked, the carer came back and unlocked us. I couldn't help thinking that of all people there, the carer with the key was the least safe of all.

As my visit progressed, I asked to speak with some residents which did also happened. I was granted the doctor's room where I could talk to two ladies alone. As neither of them allowed me to record the conversation, I took notes. I asked to talk to a man as well, and went to the men´s pavilion where the door was again unlocked. From one of those who had stumbled out was a man, who resembled a boy. We changed

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[26] This was the first time that I met with the much criticized politics of naming people with disabilities unrecoverable, I have traced the emergence of this terminology in the first genealogy chapter - Chapter 2- and tied it to productivism (reducing people to resources, see Mladenov 2015) – the point was to separate the potentially productive from the potentially unproductive or unrecoverable for production who could be let die.

[27] A similar comparison about the old pavilion had been done by a nurse who had worked there and now worked somewhere else.

[28] http://www.crj.ro/pledoarie-pentru-demnitate/lagarele-de-langa-tine-infografice/ accessed on 25.02.2018; the population of institutionalized people in the county was at around 1000 residents, meaning that around one third had died in three years. Moreover, this particular asylum was the one where the most violent were brought - those who could not "integrate" in the other asylums.

rooms, since the doctor had come and ended up in a somewhat separated corner of the occupational therapy room. There, the young man allowed me to record the conversation. He told me that he had been beaten by the other men in the dormitory, something that given the circumstances was not surprising. And it was then that it happened. The head of the center came in furious and told me I was in breach of the rules[29] and I should be shown where the gate is. I went to her office where she continued to try and intimidate me. Apparently, she disapproved of me recording the interview and considered I would have to be made to leave, but underneath this was the concern for whether this information would reach the public. The fear for the reputation of the center superseded all curtesy and probably also all concern for the wellbeing of the residents. To her it was clear, I could only be an ambassador of the human rights modality of sense making and it was in this event that I myself also felt the closest I have ever felt to this mode of thought - I had discovered a residential center that truly looking like a concentration camp lager where the most vulnerable and violent of all disabled people would be let die.

Generally, I felt a strong unease with my role as a researcher in these institutions. In some conversations I would be asked, how I will help them. “Can you help me get out of here? How can I get out of here?” I would then ask questions about the person’s family, whether anyone there would take responsibility to take them home. Some stories of abandonment were so sad that I asked myself what right do I have to ask about this and rekindle such experience. I felt that because my hands were tied what immediate action was concerned, it was reckless to ask questions that went so deep into the person’s desires.

Yet, sometimes I would feel this lack of responsibility as something pleasant, as when I was asked whether I would take an old lady away and I could say no. The situation was that two women had been sharing a room for around 20 years, now the rules had been changed and the center changed into a Center for Recovery and Rehabilitation of People with Handicap. This went hand in hand with a new regulation that provided that all residents must be in the possession of a certificate certifying their handicap[30]. One of the old ladies

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[29] This hypothesis was confirmed by someone at the center in Suceava, yet I never obtained the clear reference why. (needs further checking)

[30] I explore the process that made the woman fear for her place in the asylum in a different chapter addressing “social cases”

did not have such a certificate and her transfer appeared imminent to all those there. The old lady, sharing the room with her asked me not to take her away. I was happy to be able to say that I can do no such thing. But could also not help her stay.

Shortly after, during a group discussion the old woman that had pleaded for her room mate's stay felt ill and had to be taken into her room. Later on in the evening I inquired about her and asked her how she was doing. As I asked about the reason why she felt ill, she said: "well you asked me how I came to live here? What could I do? Do you think I am here for nothing". Again I felt ruthless and reckless in my inquiry.

I think that the visits to these centers in the two weeks exposed to my own self, a paradox I had long hinted at. It is worth studying structures that cause suffering, that are oppressive and personal at the same time, but at what price? And how to do it, without running the risk of causing more suffering? And how to do it when all you offer is your account of how things go?

On the same note, weeks later, I was walking through Siret with one of the residents of the Long Term Chronically Ill Hospital, she told me about her family and that she misses them and asked. "Can you help me with that?". I honestly replied "Right now, no", although my mind was looking for solutions and what she exactly means (whether seeing them just shortly or going to live with them, as it had already happened before). She replied: "Yeah, I know. I know your kind. You come and ask questions, but you cannot help. Others have been here before you. That's why I know your kind. I even signed and nothing happened".

The question of how people had reached the asylums where they were residing got me on the one hand thinking what right I had to rekindle the experience of abandonment and the guilt that one feels as having failed socially and been put in such a place, a question that I explore in a chapter. At the same time, it also pointed me to a process that in the human rights modality of sense making is called "forced transfer" - the path that takes people into asylums, often without their knowledge of where they are going. I had been told by some people that they had come to the asylums through a psychiatric hospital for the chronically ill, so at a later point when I could arrange to visit the mentioned hospital, I did and could witness the practice myself, another point that I will explore later on in a chapter. The fact that my interviews in these places took me in many directions testifies to how rhizomatic the fieldwork process actually was.

At the Asklepion, I was told that in Siret there had been a lot of deinstitutionalization activities and that if I wanted to study this process that would be a good place to do it. I was told by a psychologist that in Siret, as opposed to the Asklepion, there was the history of a large psychiatric institutions and it would be interesting to see what had come of it.

Never Neverland and my positionalities within it

When I first visited Siret in the spring of 2015, I was given a tour by the manager of the psychiatric hospital that started at the *cazarmă,* a Habsburg military barracks that had during the most of state socialism and transition (from 1956 to 2001) housed the main building of the neuropsychiatric children's hospital. At the high time of its use at the beginning of the 1980s when the hospital celebrated its 25th anniversary the complex of the hospital was spread across the entire 8000 inhabitants town in sixteen different buildings and housed over 2000 child inmates. Siret was the largest of four capitals of abandonment, neuropsychiatric children's hospitals in Romania and children used to be brought to Siret at the age of three from everywhere in the country. Siret was the border town to Ukraine and was considered by most of the young people living and working there as a dead end. On my first evening out with my neighbors, they all jokingly asked who I had angered in Budapest to end up here.

During my time in Siret, I conducted innumerable interviews and informal conversations with people who grew up and some with people, who had worked at the hospital, as well as people who knew the hospital from its outside. I visited people, who were now living on their own or with their new families, in their homes after being invited or brought over by a friend of theirs, I listened to many life stories and problems. Yet, I was perceived by people quite uniformly, a point which I will discuss below.

Change started in Siret with a group of volunteers and a BBC reportage in the early 1990s about the terrible living conditions in the Neuropsychiatric Children Hospital. Therefore in the years to follow both many transnational journalists and volunteers came to Siret, some still keep coming. My positionality as a somewhat foreign outsider easily settled into the paths determined by these previous visitors, rearing similar expectations.

One day at the very beginning of my stay, I took my camera (which is quite biggish in size) and went to take a picture of the *cazarmă* (literary military barracks, but vernacular for the old building where the hospital was housed) as it was being demolished. As I was trying to get a better angle, I asked one of the workers which he would recommend and he took me to the other part of the building. As I was taking photographs he suggested I also take a picture of a man, who was just passing by. The man had stopped and was looking at us, especially at my camera. I asked him whether I can take a picture of him and as I was clicking the button, the worker said: "Yeah, you see he also grew up here, didn´t you?"

I asked, whether this was true and was met with a yes. Then I asked whether he would like to tell me more about his experience here over coffee. He agreed and we went somewhere downtown for a meal and coffee. He complained about the current state of affairs in the hospital that the current manager was "keeping them closed, they cannot go out as they want and he makes them work", I should make a scandal, bring the television and show what is happening. I said, I am not here to cause a scandal and he seemed disappointed. My camera probably was misleading. But the hospital manager himself had an attitude that ran along the same lines, my contract even stating that I should publicize in order to improve the living conditions of the residents. Also, many a time he stressed the importance and benefic effect that the scandals the hospital had been subject to had on improving the financial possibilities of the hospital. So a journalist-volunteer designated for a scandal or something along these lines was what I was expected to be. I say journalist volunteer because the first journalists were connected to volunteers directly, since they were engaged in humanitarian journalism. I also came to inhabit a second connected positionality - that of the volunteer.

In the former children's hospital and its follow-up the Chronically Ill Hospital, ever since there had been volunteers there had also been a divide between volunteers and employees. The volunteers considered the employees to be just sitting and waiting for their time to pass, whereas they came from far away to pass time with the residents. Volunteers often were more open to new situations, yet, interestingly the residents who had grown up with the current staff as their caretakers, only referred to staff, generally to infirmaries as "our mother" or sometimes even "our mothers". Similarly, to being mistaken for a patient or a member of the staff at the Asklepion, in Siret the divide was between a member of the staff and a volunteer. Yet, the volunteer option almost instantly settled in. This gave me the legitimacy to participate in the day to day life of the residents, and leeway also for interacting with the staff.

And yet being a volunteer somehow also meant being part of the staff. It meant not being one of the residents. Just after my arrival in Siret, I met with a foreign volunteer, who had come first in the nineties and adopted her daughter from the former hospital, briefly before foreign adoptions became outlawed. She had now returned to live in Siret. She told me that it is likely that the residents will not accept me as one of them, they will keep some distance. It took some time for her to be accepted, and it was easier since she feels, because of her daughter, they feel that she has accepted one of them and therefore she can accept them as well. In the little time I will spend in Siret, I might still remain foreign.

I came to feel, what she had told me soon after when I was passing by in the afternoon in a former half-way house (a center that was designed to prepare former residents of the hospital for an independent life), now integrated into the structures of the psychiatric hospital designed for those more able to live independently. I was passing time with the residents at the club, a sort of activity oriented living room and asked to go to the toilette, the residents exchanged glances and one was told, take her to staff. And indeed I was shown the way to the toilette designed for staff. Similarly, when once leaving on Friday, I was asked whether I would come again the next day. Another resident replied, she can't come, she's free tomorrow, it's Saturday. Oh.

Another episode at the same house, clarified to me what my perceived position actually was. The residents were having lunch. I went into the kitchen and asked the carer if there was anything I could help her with, she said no (mostly I got this answer in a very decisive tone, as if I would be trying to take their jobs away or stress that they cannot manage). She then asked me whether I would also like to have some soup. I replied that I would like to and she set my plate (full with the very best things in the soup, around five meatballs and tons of rice) and everything up in a corner in the kitchen and then went to see whether everything was alright in the dining room. I waited for her to come back and asked whether it is a problem, if I go eat in the dining room with the others. She replied, quite surprised that of course not, but that she had thought I would like to eat separately.

I went into the dining room and sat at one of the tables, and one of the women I had talked to more upon watching me eat, asked whether I don't eat bread. I said, generally I do, but now there is too much rice in the soup (I realized only my soup was this thick, not that of other residents). She thought a bit and said, "oh, maybe you don't have bread". I looked on the table, there were two baskets with loafs of bread, I said "there is bread, I will eat some later from here", but she went to the kitchen and offered me the same kind of bread, just separately, "you know in case you don't want to eat the same one as us". I remarked that that was not the reason and before she had a chance to hand me the bread, I took a loaf from the basket and said, "I will eat it with the second course" and asked her why she had brought the bread. She said, it will be here for all of us to eat. After thinking a bit, she added: "But you don't keep away from us, do you?"[31]. The breaking of bread together was a way of both making visible and transgressing the caste-like boundaries between residents on the one side, and staff on the other - like myself other volunteers appeared often to be caught in between these two fronts, no one ever being quite sure where to place them.

Another dividing line between the people of Siret was among the former residents of the hospital - some of which were referred to as "young people" and others as "the children". This is how chose to name Siret Never Neverland the previous inmates of the hospital were still referred to as "children" mostly around the new psychiatric hospital (the follow-up institution to the old one) and "(our) young people" in the "New

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[31] "Dar tu nu te ferești de noi, nu?"

Beginnings”[32]Center for Recovery and Rehabilitation for People with Handicap. This practice of discursive belittling and infantilization carried out so-matter-of-factly by even the most progressive professionals was directed at people, who were all older than 20 years of age, the vast majority also older than 30 years. Ironically, all except for two inmates of the psychiatric system - generically referred to as “children”, were over 42 years of age, since they had been at least 18 years old when the hospital was closed[33], whereas the “young people” were around ten years younger since roughly at the same time (starting 1998, but mostly after 2001) they were taken out of the hospital as young people (more or less around 12-18 years of age) to be given the chance to live in the community. The “young people” had had the chance of intense preparation for an independent life through a half-way house. The different gradation of infantilizing nominal politics therefore reflected the different opportunities to join mainstream society that the former inmate children have had. Needless to say that these attributes are partly internalized and that they have as a consequence not being taken seriously, few find the resources to challenge them.

Whereas at the beginning of my stay in Never Neverland, I did fieldwork mostly among the “children”, in the second part of my stay, I came to do fieldwork mostly among the “young people” of Never Neverland by volunteering at the Center for Recovery and Rehabilitation for People with Handicap “New Beginnings”. Similarly, to the other two volunteering opportunities I had had in the past in psychiatric institutions, I was yet again there as non-resident, non-staff, who at first glance was closer to the staff side of the discursive frontline. Yet, I think that this time I managed to at least keep my status as a privileged in between, if not to discursively switch sides. In the residential system (be it psychiatric or social protection) managed to be a friend, closer to the residents and politely distant from most of the staff.

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[32] The name has been changed, as almost all the names in this paper, as I could not obtain the permission for naming any of the institutions involved. I have tried with my practice of naming to convey either the metaphorical universe of the original name or of what I had observed in the place.

[33] Those under 18 years of age in 2001 when the hospital was closed were taken to other centers operating in a similar closed way. This led to dismantling brothers and sisters who only after many years on their one could find each other again. This not to mention the friendships between inmates and the motherly relations with some of the “women” carers that were dismantled by this move to enforce “human rights” onto a population that had not been previously consulted.

The motherly friend that comes and goes to the (less or more) dead end

“You should have chosen to do something else”, the administrator at the Center told me upon my first day as a volunteer at the center. “in this field, you will have no satisfaction”. The he went on to tell me that the lack of perspective of the people there is why it is so, “you just cannot get them to do what you say, no matter how many times you tell them”. And yet this ableist attitude did not color all of the staff, the people working in the place were divided into two groups the ones in the office and the ones working 12 hours every second day who cared for all the needs of one of the five houses of the center each. And in both types of activity you would have different nuances of ableism and challenges to ableism.

As I was neither spending all my time in the office, nor was I cooking (at times I also did this, but only together with some of the residents) on a regular basis and as there were other unwritten rules that I regularly disrupted, such as segregated eating, I was definitely not a member of the staff. Yet, I was also not sleeping there and definitely I did not know everyone ever since times immemorial (most of the residents had grown up together since the age of two or three), so I was in no case a “young person”. Funnily, of course I was more or less just as young as most of the young persons. Generally, a bit younger.

So, I was a friend. I came and spent the long boring days in the beautiful British built houses with British plugs that had once been built as protected housing for them to have a “normal” life as members of society, and now had become part of the state structure, since the “New Beginnings” Foundation had run out of funds and had “given them to the state”[34]. I would have long conversations about the ways in which each person saw their life and what dreams and wishes they had.

The pretty houses, in beautiful settings formed a better living standard than most regular working people had in Siret. And yet, most were not allowed to leave the premises on their own. But they could do so accompanied by me or by some of the more able residents. Many times when one of the residents would

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[34] A formulation used by both staff and residents to refer to both the care structures and the people that were “given back to the state”.

ask me whether I will take them out for a walk, I would say yes and would invite them over to my place at the other end of town. On the first visit to my place, I remember having counted how many we were several times and checked on how everyone was walking and whether we had lost no one. I realized I was behaving like staff, despite trying everything in my power not do so, I had internalized the securitizing discourse on care for people with disabilities so prevalent even in the most progressive places. And yet, I was one of the links most of the residents had to talking walks and being a guest in someone's home. I was one of the links to the worlds outside. To which the "young people" of Never Neverland anyhow had far more access than the vast majority of institutionalized people everywhere else.

The walks and the long conversations, as well as being perceived by many as friendly were the reasons why people became emotionally attached to me and me to them. Roughly one month after my volunteering time had ended and I had already left Siret and was living somewhere closer to my next fieldsite, I visited the "New Beginnings" center again. A woman (three years my senior) who I had come to be very close to in my time there said she missed me and she wanted to spend some time with me. During our conversation she kept embracing me. She told me that once I had come, after I left she cried. She cried because she missed me. "That was when you came with a notebook and asked the young people, what they wanted, how would they like to live. After that I missed you so much. Maybe it's because my mother died when I was only two, maybe because I grew up without a mother that I feel so close to you". Always when I would ask questions, even repetitive ones as I did many times, she enjoyed telling me about her life.

This alerted me again to the emotional and relational side of interviewing. Of course, I was interested in her life story and she was interested in telling it, but this process coupled with the time spent together to build trust creates a bond, the loss of which is hard to compensate for. Is it irresponsible to form such ties? I asked myself. Would I be her friend if she wouldn't be part of my research object? were questions that kept spinning in my mind and which I often came back to during my later stay at the Asylum.

I think the answer that I managed to find is that these are all false questions. I would have not chosen such a topic and such a fieldsite if I wouldn't have cared what people like Dorina thought. And as in any place some authentic mutual understanding emerges with certain people. I miss my friends from other places, I also miss her and my other friends in Never Neverland, be they residents, former inmates now living on their own or progressive professionals. We speak on the phone, text or keep track of each other on facebook just like with any other one of my friends[35].

My stay in Never Neverland also involved making friends from the former inmates outside of the hospital structures, mostly women working in the Wood Industry Factory very close by and living either in rented or foundation run protected housing places. As they were more free and considered more able to care for themselves because of their financial independence, we met in the evenings or at unconventional times during the day and would hang out. They knew about my research topic and told me many stories of their life both in the hospital and afterwards. Having come to know them gave me both courage and hope that things can change.

The friendly stranger at the Asylum

I ended my time in Never Neverland around November and moved on to volunteer at Romania’s largest residential institutions which I will call the Asylum. The institution itself is a Center for Neuropsychiatric Recovery and Rehabilitation. The place houses 400 people and employs around more or less 350. The most veteran of all residents had been there for over 40 years, the center has been around since the 1960s, but used to be much smaller. In deinstitutionalization plans, as the head of the center told me, it ranked among the first on the list, the government seeking to dismantle it soon. But as stories from a lot of employees confirmed there had been such threats before, but they never materialized. The hospital rather kept growing. Some say unofficially that it is the only one that still takes people in.

In terms of the administrative category it finds itself in, it is very similar to “New Beginnings”, yet, my experience with this place was much different. The endless sadness, the feeling of dead end and of real

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[35] Unfortunately, such statements still need to be made because of the sterile and caste-ist ableism I experienced in Siret, as well as in other places throughout the system, as well as outside of it in situations where people thinking of themselves as able-minded or -bodied would interact with people they considered not be so.

abandonment evoked to my mind João Biehl's account of the "zones of abandonement" strikingly described in Vita (2005). It was the dead end of many existences where people were left to die under the pretext of their un-recoverability or ironically of their recovery.

Siret although a small town was urban with the little pleasures of urban life, such as pizza places where one could also go out for a drink or a soft drink. It had a small park and a place to hang out in front of the mayoralty. All of these places were used by the residents of the center "New Beginnings", by some on their own, by some accompanied by me or someone else. Here there was no such thing and I remembered the words of a German friend who worked in an asylum for the elderly, "such a place in the midst of a forest" when describing such a center she had seen in Romania. Here there was the much praised peace and quiet of 19th century asylums and people's life remained circumscribed within the surface surrounded by the Asylum's fences.

"New Beginnings" also had something else, for a long time a number of residents worked at a farm in the town, others would occasionally go to work in the houses of people they knew. Their existence was therefore not so precarious and for as long as I stayed at the "New Beginnings" center I was never asked for money explicitly (despite of course being given the bill when going out for a soft drink or such things).

At the Asylum things worked in a different way, the minute I would pass the gate, the first person would ask me for money. Most of the residents that I wasn't especially close to did this on a regular basis. I became accustomed to keeping 50 bani coins (roughly 10 eurocents) in my pockets and passing them on to almost everyone who asked. This was enough to buy the person either a cigarette or a coffee from other people who had some (be it lower level staff or other residents that had a right to go to the store on the other side of the gate). This of course was the reflection of the precarized state the residents were in. Up to a certain amount roughly 600 RON (under 150 euros), the state would take 80% of the person's income for the board and lodge offered at the Asylum. Leaving them with very little spending money.

But money wasn't the only reason I would be surrounded by people the moment I would come through the gate, just as often as being asked for money sometimes by the same people, but mostly by others, I would be hugged, caressed or kissed on the cheek. Making it up to the office on the top floor of the main building often took roughly 15 minutes, spent being hugged, caressed or asked about what I had done over the last days. The feeling of emotional strain would follow me through the entire day and although I did not spend more than five or six hours a day at the Asylum, I couldn't get myself to do anything intellectual until late evening. The damp feeling of revolt and of helplessness followed me through the entire day and it took some time after leaving to get back to my old self.

I made close friends with a woman in her fifties and a man who turned thirty during the time I was there, and often when I was not out interviewing someone on the wards, I would come to relax with one of them, talking about their life here and before they came and telling them about myself. When the hour of departure came among the people I was closer with the younger man cried and wouldn't stop for many minutes on end. I felt guilty for leaving and wandered again whether what I was doing was right. The woman said she will miss talking to me, since it helped her think about her family. Maybe she will manage to escape this place and we will meet again outside, she said.

The same was said to me by another man I had gotten along with well during my stay there, he also added and despite his serious nature was visibly touched that he wishes me to have healthy children. A strange wish I thought, but then it was probably what he knew he could never have in the Asylum.

For the people there I was and still am a link to the outside world, a world that as the head of the institution put it "they no longer know much about". But which I told stories of. Weeks after leaving (and now two years after leaving still) I would still receive phone calls several times a week from residents from both the Asylum and Never Neverland. Just before Valentine's Day, I received a call from one of the younger women. She wanted to prepare a song for the Valentine's Day celebration at the Asylum and ask me to send her the lyrics of a song by Romanian folk rock singer, telling me that she had no one else to ask from.

There were different situation that confirmed people there had no one to ask a favor from. I was there over the Winter holidays, coming at the beginning of December and leaving at the beginning of January. As I always do, I also carried my phone with me. As people would see it, they would ask me to make phone calls to their families and I would give it to anyone who asked.

Some would call their families talk for a while and be hung up on, but others would not know who to talk to. In authentic dismay, they would point to the phone asking to talk to someone. I first said I would gladly hand it to them, if they had a phone number to call. But then I realized this was not what they wanted. Having someone to talk to on the outside was a sign of not being completely alone there, of being someone. So, I first asked my friends if they would agree to take phone calls from those asking to talk.

Among such phone friendships I facilitated was one between my partner and a woman who asked to speak to her mother. She had been abandoned as a child and had never come to know her. Despite me trying to explain that it’s not her mother and hearing the male voice of my partner (who was probably slightly younger than she was), she kept believing that she had spoken to her mother. These processes of communication were not linear, since the patterns these people asking to talk and having a quite pronounced intellectual disability used were different from my own and from that of either of my friends. But they were happy to speak on the phone to the strangers they had never met who would send small gifts that I would bring.

But using the phone was not that linear an experience either. On X-mas eve I came to the Asylum, I was one of the few people to come from the outside and in the upper elite ward where only women lived, I was there with no staff. The atmosphere was more pleasant, I brought some candy which we ate while talking and was again asked for my phone. I gave it to everyone who asked and witnessed some more or less abrupt final conversations between the residents and the family. One said the family told her they would come soon, the other got hang up on after asking “when are you coming to get me out of here?” and yet another hung up on her family upon hearing that they will only come the next day with her family rushing to come and comfort her.

It was a sad experience which few days after turned into a humiliating experience. The “boss of the group”[36], the nurse on the ward asked me to come to the kitchen, closed the door and almost shouted at me that she had warned me before about giving the phone to people on her ward (which was true but upon the words of one of the women inmates: “this is what you come to when you’re locked here. You come to beg for a phone and be denied it”, I had decided to ignore this absurd request in the future). That I think I am doing them good, but I am not, since one of the women I gave the phone to had run away after calling her family and that the family had complained to her - to the nurse. The other woman’s family rushed over on X-mas Eve, because I had given her the phone and they saw that she was distressed. Her family is really close to the doctor, they will surely complain to him as well. And then in a threatening tone that then they might go even higher. I asked what is the basis from which they complain. As far as I know, they have a right to communicate and I am fulfilling it with my own means. How can families complain?

It was easier for me to resist bowing the head in such situations, since I did not depend on a salary from the institution. But what made me close the subject without any conclusion (because of someone else coming in) and not repeating the conversation again was due to the fact that this woman could limit my access to the ward and all the people who inhabited it including my friends. Yet, what happens to people who do the same and work there? What are their options in such situations?

This episode made many things clear to me about the dehumanization of the staff, their reluctance to see institutionalized people as people, and their support for their abandoning families. It also made clear to me that change from below in such an institution is almost impossible, because of the humiliations you endure as either institutionalized person or any other kind of person who rejects this dehumanization. Finding it in your powers to restrict an access to a phone on X-mas Eve without bothering to come tells a more gruesome tale of what it means to have a care profession in such a place.

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[36] “Șefă de grupă” was the designation for the head nurse of a ward.

But it is not that people working in these places are less people than those working elsewhere, it is about the kind of working conditions that an asylum of four hundred residents considered mentally ill, held in the middle of the woods creates. For example at the very beginning of my stay, I was warned about Arzoaica, a woman with short hair and heavily built who was considered violent. I was told that when she sees a young woman like myself, she will try to come close and when I stretch out my hand to her, she will hit me out of the blue. I was told that she was strong enough to knock me down. The first days I went up and down the stairs to the social workers office in fear of violence. I had often heard that large asylums where places of violence, but now the fear of violence had a name to me. It was Arzoaica.

A few days into my stay, I went out around lunch time to speak on the phone. I was in the hospital courtyard, just between the adult building and the dining hall. A woman came close to me and caressed me, while I was trying to continue my conversation on the phone. I asked her permission to continue my conversation, but it didn’t seem to work, so I ended my phone call abruptly and continued interacting with her. She was now interested in my earrings examining them. Then another woman came and called on her to come and join her, the name she used to call her was Arzoaica. It was thus that I met the woman who became my first personalized myth of violence.

This did not mean that all violence was preventable, but that sometimes moving around in fear might provoke more violence than stopping to understand what the person actually wants. Another time, though I was asked for money by a man. He was expecting I give him one of the 50 bani coins, I would hand out to anyone when asked. But I happened to have run out of coins, I told him I don’t have money with me now, but would gladly give him some next time. He them lifted his arm to, so as to threaten to hit me. And in an instant everyone around us, started looking the other way or walking faster. Someone farther away shouted, let her be. And I rummaged through my pockets and found a few 10 bani (much less than 5 eurocents) coins, which I knew had been there, but I was reluctant to offer initially since I thought he might be offended by the meager amount. He took the change, said thank you and moved on, but the situation might have gone in a different way.

Living with the fear of violence, made many of the employees either lock themselves up in their office - I was also assigned to the social workers office and used it mostly to leave my stuff or talk to staff. I avoided to work there, since I preferred interviewing people in their rooms, living with the busy-ness of the wards and the fear of violence. The only precaution I took was to remain in the wards that were considered somewhat less dangerous than the adult male ward which was a male-only area. I did enter the ward on a visit, but I did not continue going there to talk to people in their bedrooms, as they did in the other cases. This is why some of the information I have about people occupying the adult wards is richer when it comes to women than men.

The ethics of doing research with institutionalized people

Another question that puzzled me throughout my visits to different asylums and Never Neverland was the question of how to develop an ethics of my research project without reproducing the power relations involved in relationships of legal guardianship. People under legal interdiction are assigned a legal guardian[37]. In the case in which, the person who is deemed legally unfit does not have relatives or other people who would accept to be legal guardians, the a public institution or the institution ensuring person's protection (including private institution) can be assigned guardianship (see law 448/2006, art. 25, paragraph 4[38]). In practice this means that the head of an (social protection or psychiatric) institution is appointed legal guardian. Ensuring that I do not enter exploitative relations with the people, I did fieldwork with, thus would mean by generally accepted ethical standards that I ask permission for the interview from the heads of the institutions. I did do this in practice each time I would start fieldwork in a new institution, but in my view this practice of asking for permission from the head of the institution reproduced the power relations that my project set out to challenge. So alongside asking for the head of the institution's approval, I also asked for individual approval from people, as well as tried to clarify my positionality (as a person doing research

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[37] On legal guardianship and mental and intellectual disability, see Pascu, Ionescu & Paunescu (2011), available here http://www.crj.ro/wp-content/uploads/docs/Tutela%20protectie%20sau%20obstacol%20%een%20calea%20integrarii%20persoanelor%20cu%20dizabilitati%20integrale.pdf accessed on 29.03.2018

[38] Available here http://www.dreptonline.ro/legislatie/lege_protectia_persoane_handicap_448_2006_rep_2008.php accessed on 29.03.2018

for writing a book, when PhD wasn't an understandable concept) to everyone I did research with, including those where I assumed had limited legal capacities.

Non-geographic fieldsites

The archive, the library and their silencing artifacts

After the ethnographic field stay, I spent several weeks doing archival and library research (in the National Archives Bucharest, focusing on the Ministry of Labor, Health and Social Protection archives period 1948-1952, and in the relevant county level branch of the National Archives; as well as the University Library in Bucharest) to dig into the discursive and political forces that shaped the creation and perpetuation of closed residential institutions for people with disabilities. This allowed to try the origins of the way in which the care and confinement system operates today, and look at how these have shifted across time and space. Yet, it also revealed to me the limitations of what I could discover in documents and books already produced about the mentally ill and disabled. Since the artifacts of modalities of sense making dealing with mental illness were imbued with the process of silencing the mentally ill that had its infrastructural translation in the asylum as a care, confinement and occasionally let die institution (see genealogy chapter). It was impossible to reconstruct by something other than guesswork, what people thought of the categories of their treatment and confinement in different times. I am sure that a more gifted historian would have found both a way of letting these documents speak about the everyday life of asylums, as well as discover traces that more easily uncover these silences lies. Yet, what I was able to do was think between genealogically tracing modalities of biopolitical sense making as they operated through the care and treatment infrastructures and ethnographically generating data about how people live these discursive structures nowadays (in 2015).

Interviewing policy makers and advocates

Parallel to archives and fieldwork, I also conducted interviews with policy-oriented people throughout Romania engaged in advocacy related to disability and mental health policies. If the mental health interviews helped me identify the first fieldsite/ sight, the disability advocacy emerged as an important site/sight for my research after having been to the field.

In the mental health advocacy groups, I was often regarded as a weirdly positioned very young person and came to feel rather deficient and lacking in medical language - as one my interview partners, a psychiatry professor put it after an interview when I asked him whether he had any questions: “what are you, a psychologist?” - somehow exploring the final frontier of his discursive boundaries. Yet, in the disability field I felt much more at home, since many of the policy makers or advocates, had similar professional backgrounds to my own.

In the mental health setting, it appeared to me necessary to take on a clinical view in order to say something pertinent, a move I was very reluctant to do. There are several reasons for that, firstly, I think due to my lack of training I would make a lousy clinician, since I wouldn’t know what exactly to look for. Secondly, as I try to show throughout my dissertation many issues have been medicalized and clinicized when some of their aspects are more easily looked at through a social lens (whatever exactly this could mean) and it is this that I can more readily offer. In the disability approach on the other hand, the de-medicalization of disability was already on its way, leaving room for different epistemologies of the social to emerge and re-shape the modalities of sense making dominant in the field. In this way, I could feel more at home in the discursive landscape surrounding disability than that surrounding mental illness.

Writing as a way of asking questions

Although I had felt I had had a clear idea where the research was going, while keeping an open mind during the research process, it wasn’t until sitting down at my desk that I could make sense of it more coherently. The idea of making biopolitics one of the main focuses of the dissertation, came out of struggling to understand both the systematic letting die of disabled and mentally ill subjects, as well as the shady-grey practices of challenging these biopolitical regimes in everyday life. A further focus on abandonment had been with me during the research process, but I only managed to overcome the temptation to explain everything that happened in the care and confinement system once I sat down and thought about the moments that challenges such an approach. In a sense processes of conceptual abduction continued during the writing phase, pushing me to form new rhizomatic connections of intertextuality between my fieldnotes, interview materials, archives, academic books and articles as well as memories. In a sense each concept I was tempted to engage with, itself turned into a field-sight, a place from which I could re-engage epistemically with my material generating new ways of asking questions and thinking about my experiences.

Political ethnography and policy relevant knowledge

Having gone through the way in which my positionality and my limited and evolving ability to ask questions and explore them has shaped the data I was able to generate and the findings I was able to formulate can I still claim to produce policy relevant knowledge? My answer to this is that all knowledge is partial and produced from a certain positionality which is more or less transparent to those at receiving end. As Donna Haraway (1988, pg. 581) has stressed it "feminist objectivity" equals a project of situated knowledges that make "connections and unexpected openings" possible (ibid., pg. 590). The stake of my project, as that of Donna Haraway is to make collective action possible through connecting particularities. A point I will return to in the conclusion.

Part 1: A genealogy of modalities of sense making and biopolitical infrastructures surrounding mental illness in Romania

Introductory section: Biopolitics and modalities of sense making

Biopolitics and the politics of life

My starting point for the inquiry into biopolitics is Foucault's concept of bio-power as "what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life" (Foucault, 1978, pg. 143). Yet going beyond Foucault, I link explicit calculations regarding the fostering of life and the way in which life is best fostered to affective regimes that enable, dis-able, challenge and re-work calculative biopolitical orders in both abstract and everyday - practice related terms. In this I seek to link Foucault's understanding of biopolitics as something resting on the biological abstraction of life with a calculative purpose to Fassin's understanding of the politics of life (2011, pg. 189f.) as bringing the substance of life as "existence and living" back into the center of inquiry surrounding the everyday politics of life between the social and the biological[39].

I claim that abstracted forms of biopolitical reasoning are not necessarily merely calculative, but that they have an affective side which is centered on establishing the value of certain lives from a specific moral standpoint. By "moral", I mean something akin Fassin's (2015, pg. X-XI) use of the word in the preface to the edited volume "At the heart of the state" in which he sees "moral subjectivities" as the site where "values" and "affects" play out in the "government of populations". Nevertheless, I go one step further in asserting that moral orders are part of biopolitical calculations, affects shape what is constructed as a legitimate form of intervention even beyond the everyday lives of implementing the government of populations - they penetrate the making of interventions through the creation of legitimate or deserving populations. Such moral biopolitical orders (and not just everyday practices) are most visible in humanitarian actions centered on the alleviation of the suffering of deserving subjects. But they are also visible in the representational regimes governing human rights advocacy which is centered on a

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[39] In this Fassin (2011, pg. 190-191) interestingly builds on Adriana Petryna and Joao Biehl's work, authors that have been highly influential in the thinking that has gone into this thesis as well.

comparatively calculative presupposition that of fundamental individualized legal equality in terms of rights.

These affective biopolitical regimes of intervention are entangled with other more calculative modalities of making sense - one medicalizing psychiatric/mental health centered on treatment and the defectologist/disability one centered on integrating people into production thus equalizing their status. Neither modality of sense making is purely affective nor calculative, rather than this calculative and affective logics penetrate all modalities of sense making.

In *The History of Sexuality* (1978, pg. 139f) when discussing the two forms that "power over life takes", Foucault distinguished between anatomo-politics centered on "the body as a machine" and biopolitics that operate through regulatory controls of the population. He treated these two instances of power over life together, since both reproduced the capitalist relations that had rendered them possible and both gave rise to practices of social hierarchization and segregation. (compare Foucault 1978, pg. 141) Since biopolitics as Foucault describes it was based on practices of normalization centered on the realization of basic needs and the realization of human potential as "a plenitude of the possible" (pg. 145), it engulfed a paradox of relationships between equality and inequality that is at the core of the operation of normalizing powers. As sociologist Bruce Curtis (2002, pg. 510) building on Foucault's work on populations put it "normalizing judgement implied authoritative categorization and hence the construction of populations", while at the same time, populations are dependent on establishing a "practical equivalence among subjects, objects or events." (Curtis, 2002, pg. 508) Subjects in populations are both equivalent with each other and different in respect to mostly statistically based analytical distinctions that also serve as the basis of biopolitical intervention (compare Curtis 2002, pg. 508). In short, biopolitics is built on a tense cohabitation of homogenizing and individualizing forces that hierarchize forms of abstracted life and work back into the lived lives of individuals as disciplining and regulatory forces that emerge on the basis of different forms of normalizing power. This power is always entangled with the question of the legitimacy of the norm on which the generation of the normalizing abstraction is based.

In the dissertation through genealogical reasoning, I want to show that norms upon which biopolitical interventions regarding the mentally ill were carried out, were made possible by what I call modalities of sense making. I will first clarify the concept and then move on to exploring the emergence of the present-day system.

From styles of scientific reasoning to modalities of sense making

As a philosopher of science, Ian Hacking developed the concept of “styles of reasoning” (Hacking, 1982, 1991, 2012) or what he later (2012) also termed “ways of finding out” (2012, pg. 599) to account for scientific modes of inquiry as self-authenticating modes of knowledge production. I find Hacking’s idea which he developed building on historian of science Alistair Crombie’s work fascinating. Yet, for it to be useful in thinking through the connection between biopolitical orders and the way in which the politics of bio-politics play out in everyday life, it is necessary to bend this concept beyond what it was designed to account for. In the following, I plan to take this concept out of the realm of the scientific, paralleling my move of taking biopolitics out of the realm of the purely calculative.

I take Hacking’s idea that reasoning comes as an active embodied process involving thinking and doing (compare Hacking, 2012, pg.600) and extend it beyond the reach of the philosophy of science into the realm of the development of biopolitical projects and the emergence of biopolitical practices in different political infrastructures surrounding mental illness in Romania. Given that Hacking’s concept was not developed to account for non-scientific modes of reasoning as well as for reasoning in everyday practices in contexts where not the generation of knowledge, but the reproduction of life is in the center of activity, I have developed the concept of modalities of sense making to account for the differences that arise from my take of his concept.

This is also necessary since bending Hacking’s concept would be contrary to Hacking’s original intentions. As Martin Kusch after a careful analysis of Hacking’s work on “styles of reasoning” notes, Hacking was very careful to delimit the “styles of reasoning” from humanistic and moral reasoning, the reasons for this delimitation varied over time in his thinking - but mostly related to the fact that they are not self-stabilizing or only insufficiently so (compare Kusch 2010, pg. 162-163). Furthermore, Kusch (2010) also stressed that Hacking has been very careful to not stray too far from Crombie's original set of six styles scientific of reasoning characteristic of European sciences. (see Kusch, 2010, pg. 159)[40].

Modalities of sense making as opposed to styles of reasoning describe meaning making processes not as processes of inquiry, as "ways of finding out" something new in the scientific sense of the word, but in terms of practical everyday forms of knowing, including not only the production of "facts" but their affective connotations. The everyday in this sense is not limited to contexts in which biopolitical orders enter, but also context in which they are produced. I argue that biopolitical orders are both calculative and affective - meaning that they build on calculations, as much as they do on emotions - from their very emergence as scientifically based political plans. Nevertheless, modalities of sense making also self-authenticate – in the sense Hacking described as producing the criteria for their own validation. And just like "styles of reasoning", they also allow statements to achieve or lack "truthfulness" value.

To clarify this point: in connecting the everyday practices in spaces where biopolitical orders make themselves visible and their production as affective-scientific regimes, I bend James Elwick's (2012) interpretation of Hacking's "styles of reasoning" as "conditions of possibility". In his careful reading of Hacking, Elwick looks at how certain styles of reasoning are necessary but not sufficient conditions for statements to gain validity (compare Elwick, 2012). Once a style of reasoning has disappeared, all the statements made possible by it become incomprehensible (see Eliwck 2012, pg. 619-620). The implications of Elwick's philosophical-historical thinking for modalities of sense making means that in order for certain biopolitical orders and practices to emerge, a certain modality of sense making is necessary, once this modality of sense making loses importance, so does the biopolitical order it sustains. Yet, the modality of

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[40] Since my inquiry is not centered on analyzing the anatomy of the production of scientific knowledge from a philosophy of science perspective, I will not dwell on the six styles that Hacking appropriates from Crombie, but focus on developing different modalities of sense making, which will have little in common with the original typology put forward by Crombie.

sense making itself does not need to be fully stable (is there such a thing?), rather than this it is re-invented, re-worked and contradicted in practice - since everyday practices are much messier than an analytical philosophy of science approach would suggest. Through this, I conceive of modalities of sense making as fully embedded in everyday social orders. In this, I distance myself again from Hacking who sees “styles of reasoning” as stable and after the initial stabilization independent of the social order (compare Kusch’s critique of Hacking, 2010, especially pg.169f on the relationship between “styles” and social order).

From interpretive communities to modalities of sense making

Another important source of inspiration for the modalities of sense making approach has been Dvora Yanow’s work on “interpretive communities” or “communities of meaning or practice”: “groups of people who share a view of a policy issue under analysis” (see Yanow, [2000] 2011, Chapter 2, pg. 5/15, electronic version). In this, Yanow understands “community” as referring to “people who share an interpretation of policy or implementing agency artifacts, without necessarily sharing the geographic basis that is the historical origin of the term”. (ibid, pg. 7/15)

“Interpretive communities” are different from what Haas (1990) has described as epistemic communities, since they do not aim to influence policies, rather than this they are affected by policies once codified and implemented. Yanow’s ([2000–2011) approach is explicitly set in the everyday lives of people that use “services” established as a consequence of policies. Yanow (ibid., pg. 11/15) locates the point of departure for ethnographically identifying such communities by “looking for people spending time or working together in the same organizational area or having similar training, or he might simply look for people who read the same newspaper”. The gained familiarity allows the policy researcher-analyst to see the different perspectives of the communities affected by policies, allowing her to identify the overlapping and communalities and define borders between interpretive communities (ibid.) .

Mostly because her research helps to bridge the formalized language of policies with the life worlds of people, I have learned very much from Yanow’s approach to doing policy research. Nevertheless, I part ways in emphasis when it comes to doing policy-research - this is why I feel it is necessary to delimit my take on modalities of sense making from her description of interpretive communities.

Firstly, as explained above, I derive from Hacking a preference for looking at the “style of reasoning” or at the modality in which sense is being made in practice - this means that a person can make sense of a situation in two, three or several modalities of sense making at the same time. A modality of sense making might be entangled with another one, in a single sentence. It is possible, following Yanow, to capture these messy processes through looking at “communities” as well and stressing that people can belong to multiple communities at the same time. Yet, there is a further question that is not as easy to answer. Is a relatively shared way of looking at a policy problem enough to create the feeling of mutually belonging to a group among the members of “interpretative communities” or do we as researchers need to ascribe a group identity in order to describe an epistemic relationship? Modalities of sense making allows me to foreground epistemic positionalities and look at their consequences in terms of what they make possible in terms of interventions. Furthermore, modalities of sense making do not only operate while policies work into people’s lives, they also work into policies making certain kinds of interventions possible.

Modalities of sense making and political infrastructures

As explained above by building on Elwick (2012), modalities of sense making are conditions of possibility for knowledge production to occur. But how does the resulting knowledge become bio-political? How do political projects become imbued with the biopolitical reasoning characteristic of each modality of sense making?

My argument here is that modalities of sense making do not only become biopolitical through being translated into state policies, although the state through-out the modern period remained the main imaginary for crafting biopolitical interventions. Modalities of sense making also enable different biopolitical interventions by becoming part of other transnational political imaginaries, such as those of humanitarianism. Furthermore, modalities of sense making also shape what happens in everyday life through practices considered legitimate and moral by day-to-day people who act as carers, doctors, inmates or patients. In this I follow, Painter's understanding of the state as a collective imaginary (see Painter, 2006), adding to it an investigation into other mobilizing political imaginaries such as those of religious communities and humanity. I explore how these imaginaries enable different processes of homogenization and individualization of subjects that lead to the crafting of populations for biopolitical interventions.

In the following, I will explore the ways in which modalities of sense making and biopolitical reasoning enabled practices of care and confinement of those mentally ill and disabled (as well as the fore-runner concepts that were used in what is now Romania).

Chapter 2: Genealogy of Population Making and Biopolitics: The growth of asylums for the care and confinement of the mentally ill and disabled

This chapter explores the most dominant modalities of sense making and the way in which they shaped biopolitical interventions surrounding mental illness and mental disability from the emergence of modern state forms in the Romanian principalities to state socialism. This period covers the time in which asylary/ residential care of the mentally ill and disabled became incorporated into the state. In this, I want to clarify how abstract calculations and affective orders surrounding the mentally ill in Romania shifted over time and how the present way of asking questions has become possible. In this, I look at which forms of "subjugated knowledges" (Foucault, 1976, pg. 81) have become undistinguishably incorporated into the scientific order of modernizing aspirations.

I do not assume modalities of sense making and corresponding affective and calculative orders to have determined everyday life and subjectification practices to a full extent, rather than this I see them conditions of possibility for what happened and happens in everyday life.

Urban spatial control of surplus populations

The history of disability and madness in what is now Romania starts with the *"calicie"*, the neighborhoods that housed the *"calic[41]"* population: the mad, the disabled, the crippled and those dependent on "begging" in order to subsist- in short all that were excluded from the regular practices of bread winning as surplus without becoming robbers or thieves. The *Calicie* was an Oriental style autonomous neighborhood

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[41] To avoid confusion: *calic* is the name of the subject position, whereas *calicie* is the name of the space as a type of neighborhood, where such subjects were settled through political acts on behalf of the rulers.

(*mahala*), which existed in Bucharest from the 15th century to the late 17th century[42] (see Majuru, [2003] 2016, especially pg.69).

The *Calicie* neighborhoods were highly regulated and anyone who wanted to settle needed to be recognized by local *calic* leaders as a *calic* or *mișel* (Majuru, [2003] 2016, pg.75). The internal population of the neighborhood was subdivided into groups according to the characteristics of the population and each group (such as the alienated, the crippled or those struck by the plague had their own leadership from among themselves) (compare Majuru, [2003] 2016, pg. 74).

The comings and goings of the *calici* were highly regulated. They were not allowed to enter the city walls[43] unsupervised (Majuru, [2003] 2016, pg.65). Even the occupation of asking for alms characteristic of the *calici* was regulated. They were allowed to ask for money alms in designated spaces and times, especially during holy holidays, when they were allowed to cross the bridge into the city proper[44]. The occupation was so highly regulated that the *calici* even had their own guild (compare Majuru, [2003] 2016, pg. 75).

The protection and regulation the inhabitants received came directly from the ruler (*domn*) and the space of the neighborhood settlements was on land belonging directly to the ruler (Majuru, [2003] 2016, pg.68-69), while the practice of asking for alms was regulated religiously by the *Mitropolie*, the governing of the Orthodox church and involved among other rules the prohibition of worsening one's wounds to induce pity which was considered deceitful. (see Majuru, [2003] 2016, pg.77)

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[42] In the first part of the genealogical account, I will focus on Bucharest as the central city of Wallachia, later together with Iași it was one of the two central cities of the United Romanian Principalities and the Romanian Kingdom, as well as later capital of Romania. This focus on the capital city excludes many other possible focuses (including the history of mental illness in Transylvania before the incorporation into Romania in 1918), but also helps to focus the inquiry around the relationship between urban space modernization, the modernization of medicine and state making.

[43] A Calicie was always outside the city walls. (Majuru, [2003] 2016, pg.65)

[44] In Bucharest, the *Calicie* was placed right across the Dâmbovița (Bucharest's main river) from the ruler's court- almost perfectly coinciding with today's Rahova- Ferentari, the notoriously stigmatized neighborhood (Majuru, [2003], 2016).

The *Calicie* as a social form was both a form of urban exclusion and inclusion. The *calici* were part of the city and could govern their own matters to a certain extent, yet, they were free to do so by taking on subgroup identities that most likely were both stigmatizing and inciting of pity. The effort to make them subsist was not based on specific calculations, but rather they depended on the pity that each *calic* individually would incite in other urban inhabitants at regulated times and in regulated spaces and thus was based on a humanitarian-religious modality of sense making.

In 1650 the protection of this population passed from a political to a religious problem, since they were placed under the protection of the church, the domains on which they had settled, already pushed to the outskirts of the growing city were then dissolved and distributed to high office boyars. (Majuru, [2003] 2016, especially pg.69) By the 18th century, the guild of *calici* is lost as a category for regulation, making this form of subsistence disappear (compare Majuru, [2003] 2016).

The issue of dangerousness is no longer massified and attributed to all inhabitants of the *Calicie,* nor is political protection offered to all inhabitants anymore. The dangerously mentally ill are separated from the others taken into confinement in monasteries in the mountains (compare Majuru, [2003] 2016, especially pg. 218), while a religiously argued infrastructure of healing develops. Yet, the monastic asylums never fully manage to assimilate the ever-growing population that resulted from the eradication of the *Calicie* neighborhoods, therefore contributing later on to the creation of psychiatric asylums. (compare Majuru, [2003] 2016, especially pg. 218)

The emergence of biopolitics: nuclear families and monastery-prisons

By the 18th century, the nuclear family was already conceived of as a self-sustaining economic unit (Vintilă-Ghițulescu, 2011 [2004], pg. 352). From the family people would be sent to monastic asylums, if the economic sustainability of the unit would be endangered. For example, the importance of the economic sustainability of the nuclear family was so central that divorce would only be granted if the economic sustainability of the family would be endangered (see Vintilă-Ghițulescu, 2011 [2004], pg. 362).

Yet, although the monastery-prison appeared as a place of care, it was also one of organized abandonment. Monasteries, hospitals and asylums around churches, where places were those people, whose everyday presence in the neighborhoods, could be a nuisance to the public order of cities were locked away. These were the “the blind and the limp”, but also the “cripples, the vagabond, the ill, the mad, beggars and syphilitic people” (see Vintilă-Ghițulescu, 2015, see pg. 389). This process was declared to have a philanthropic reasoning behind it, but would sometimes imply bringing people there, just to “let them die”. A contemporary critic, the head doctor of Bucharest, criticized that philanthropy would need to imply more than founding asylums, actually also maintaining them. (see Caracaș quoted in Vintilă-Ghițulescu, 2015, pg. 389).

It is at this time that the biopolitical relationship between nuclear families and asylums first emerged. The monastic model of care and confinement of the mentally ill, then was uncritically inherited by the psychiatric system. It is in the name of the economic sustainability of the family and each members’ role in this that individual family members can be invalidated as mentally ill, the responsibility for furthering the person’s life thus is transferred to a religious body through requesting monastic confinement.

The putting together of the two elements, illness and monastery, appears somewhat awkward from today’s perspective since it means thinking a confinement oriented religious modality of sense making together with a scientifically informed psychiatric one. Yet, at that time the boundaries between illness and spell[45] were not clearly drawn (see Vintilă-Ghițulescu, 2015, pg. 402). The mad were considered in that time to be “cursed” people. Thus “hospital-prisons”[46] were established around churches containing icons, believed to have miraculous healing powers for the mad and the hopelessly infirm. The “spring of healing” was to work its magic in these spaces. (see Vintilă-Ghițulescu, 2015, pg. 391-392)

The religious logic of healing started from the assumption that mental illness was brought about by evil powers and only a divine intervention could cure it (Dinu, 2017, vol. II, pg. 161). The mentally ill were

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[45] *“boală și vrajă”*

[46] “*spitale-închisoare*”

considered to be unaware of what was right or good for them and thus the relatives or public authorities would bring them into monastic confinement (see Dinu, 2017, vol. II, pg. 161-162). Doctors were not present in these places initially since the healing was considered a religious or more precisely divine matter and not a medical one. The healing process itself consisted of taking the demons out through exorcism and the mediation of holy icons, for example that of Mary. (compare Dinu, 2017, vol. II, pg. 162)

Yet, monasteries were only a last resort for ill abandoned people. Few people were actually taken into the monasteries, since if they were taken in as ill people the monks had to carefully prove that the commitment was necessary and that they were truly ill and need healing through the "holy icon" (compare Dinu, 2017, vol. II, pg.162). Those people that are divorced on the accounts of their illness related lack of productivity, for example had to be taken back by their original families, who were asked to agree to the divorce. As Constanța Vintilă-Ghițulescu argues (2011 [2004], pg. 364), this was practiced since they were expected to provide for the person after the divorce. Neither the political *domnie* (feudal ruling institution), nor the religious monasteries took responsibility for the care of the divorced person (see Vintilă-Ghițulescu 2011 [2004], pg. 364).

Those who were confined to monastic asylums, nevertheless, brought financial advantages to the caring monks, since the (Phanariot[47]) political rulers would send gifts for the burning of candles at the holy icon (see Dinu, 2017 about the Sărindar monastery in Bucharest, vol. II, pg.162). This established a proto-psychiatric relationship that linked confinement and care to the compensation of the carer and the funding of the infrastructure through the state - the infrastructural commodification of care thus first appeared in monasteries.

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[47] Istanbul based Greek families of Orthodox religion from which rulers of the Romanian principalities with Ottoman support would be selected from the early 18th century up until the 1820s.

The religious logic of healing also went beyond the limited space available within the walls of monasteries. There were home visits, where monks would bring reproductions of the holy icon with them into the homes of people, who needed healing but could not be taken to a monastic asylum (see Dinu, 2017, vol. II, pg.163).

Basically, what had once been framed as *calicie*, as a political problem solved through intervention into urban space, became a religious problem that led to the regulation of nuclear families as productive units and the creation of asylums for disciplining the ever-growing numbers of outliers, now seen as “having had their mind taken by the devil”. This went hand in hand with the banning of people, who were unlikely to subsist in normalized ordinary economic relations from the city. The problem of their subsistence being on the one hand domesticized through the responsabilization of families or exiled in total monastic institutions with little communication with the outside world, where they risked being let die. This led to a de-urbanization of the problem of subsistence through the religious framing of the problem, which coincided with urban transformations initiated by political rulers in Bucharest (compare Majuru [2003] 2016, pg.69), which lead to the disappearance of closed protective spaces (the *calicie*). This de-urbanization and its corresponding structures, the family and the asylum, was later inherited by the medical psychiatric modality of sense making.

What also emerged as part of the monastic model was the political discrediting of the mentally ill as demonic and mindless. Whereas during the time of the *calicie*-neighborhoods there was a political order which incorporated representatives of the *calici* themselves, there was no such structure in the religious order. The mad(wo)man was a discredited figure on the grounds of spells and illness. A way of looking at a subject, which on the one hand provides the hope for an individual transcending of the condition of illness through healing, as opposed to being a “*calic*” as an apparently unescapable category. On the other side, it also meant that at least for the time in which someone inhabited the position of the demonically ill-needing-healing their voice was annihilated through a full loss of credibility. It was on the basis of the loss of credibility of the mentally ill and the silencing this involved that a psychiatric modality of sense making could find acceptance in the 19th century Romanian principalities.

The statization and scientification of knowledge production and infrastructure

The "privileges" of the *calici* had been abolished by the mid 18th century (compare Majuru [2003] 2016, pg.77) and the small number of monastic asylums was not enough to confine the growing surplus populations who continued to be seen as socially dangerous. The idea of surveillance of these populations was thus carried into the 19th century (compare Majuru [2003] 2016, pg. 218).

The 1830s as the time of the Organic Legislation[48] went hand in hand with an increase in channeling matters through the state infrastructure. Put differently, what Joe Painter (2006) termed "the state" as "the imagined source of central political authority for a national territory" (Painter 2006, pg.758), emerged through the practices of governing and establishing of state infrastructure that were made possible by the Organic Legislation. The transformation in the legitimacy of a new political imaginary that of the state, made possible the intensification of the presence of a medical psychiatric modality of sense making within the monastic infrastructure of care.

The invention of the state as a new imaginary for understanding the political, was connected to a new secularized way of understanding the legitimacy of knowledge production and everyday practices. This came hand in hand with a geography of knowledge production and aspirations that was oriented towards the universities of Western Europe and a political imaginary connected to Europe as a political ideal[49].

Medicine was one of the practice producing knowledge systems that was unavailable to local practitioners, since as a knowledge system it was tied to medical universities which did not exist in the Romanian Principalities until the late second half of the 19th century (see Bărbulescu, 2015, pg. 15). Thus until 1875, all medical doctors had studied abroad (see Bărbulescu, 2015, pg. 309).

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[48] The Organic Legislation released in 1830 were the first comprehensive state making set of rules to be active in both Romanian Principalities (see Hitchins, 2014), pg. 287ff.

[49] Political historian Keith Hitchins argues that "Europe" or "the West" was either "a model to be followed or rejected, but never ignored" (see Hitchins, 2014, pg. 311), meaning that the idea of Europe haunted the political imaginary of the intellectual elite of the time.

Medical knowledge was a recognized form of knowledge which strived to obtain control over local healing practitioners. Put differently, the inclusion of medicine as an imagined issue of state, empowered those doctors who had studied in Germany, Austria and France to become gatekeepers and rule-setters in the practices of healing (see Bărbulescu, 2015). Practices of healing were challenged by a modality of sense making centered on curing through treatment - a different language that aspired to be scientific and modern. Vernacular healing practices started being regulated through the state by doctors (Bărbulescu 2015, pg. 308).

The statization of healing practices had an important European dimension connected to the aspirations of state-making in the 19th century. Therefore, in terms of driving processes of statization, doctors with degrees from European universities enjoyed a special legitimacy (compare Bărbulescu 2015, pg.300ff). The doctors drew their legitimacy from universities and especially from the academics they had studied with at the respective universities pointing to the existence of an epistemic community in Peter M. Haas' terms (1989)[50] that emerged during this time and influenced the homogenization of psychiatry related statization practices in Europe and in what came to be called the peripheries of Europe.

However important the struggle between the empiricists and the doctors was not the only defining struggle out of which modern Romanian psychiatry emerged. In the bottom line, both empiricists and doctors aimed to heal minds through reworking bodies with the aid of different substances. What they differed in was the way in which knowledge achieved validity and who could be a legitimate holder of knowledge: whereas empiricists understood knowledge as practice, the doctors emerged on the basis of knowledge as theory validated by Western European universities (compare Bărbulescu 2015, especially pg. 281fff). The other main struggle of the 19th century, although also constructed around healing was between the medical and the religious modality of sense making. While the religious modality of sense making did not develop a framing of the body as ill, it rested on an understanding of mental illness as a punishment for the sins of

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[50] I will return to what epistemic communities and how they operated later in the chapter.

oneself or one’s ancestors (see Miloșescu, 2010). The main site of this struggle was the asylum at Mărcuța, near Bucharest.

Mărcuța - the central site of struggle between the religious and the medical framing of mental illness

The asylum at Mărcuța functioned from 1835 when it was established as an asylum for mad(wo)men, the infirm and „beggars” with only nine beds to 1923 when the nine hundred fifty bed hospital for the alienated was closed and its patients moved to the modern psychiatric asylum that had just been opened (see Miloșescu, 2010)[51]. The space of the asylum was nevertheless used (most probably) continuously until today when next to the monastery of Mărcuța one finds a school for special education.

The growth in numbers of admissions parallels the process of urban Westernization (Majuru ([2003]2016, compare pg.8 and 218). Medicalization of mental illness thus parallels urban Westernization - the asylum and the city center both emerge as different sites of modernization with its aspirations of (scientific) classification and ordering. Yet, at the time of the establishment of Mărcuța it is hard to conceive that anyone could imagine the dimension it was to take and its importance in the later psychiatric, since it was always considered an improvisation and an improper unsystematic asylum which kept growing (see for example Obregia, quoted in Parhon 1910, pg. 52, as well as Parhon, 1910, Miloticiu, 1895, pg. 121).

Mărcuța as a site allows for chronicling the struggles between a religious philanthropic approach to surplus populations (“beggars”) in which the mentally ill were considered an insignificant category to the medicalization of the condition of “madness” and thus the rendering irrelevant and invisible of the economic

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[51] The numbers were apparently deceiving since the place often came to house a number of people double the number of beds (Miloșescu, 2010, pg. 54 and 55, Parhon 1910, pg. 52).

forces that worked to co-produce madness. This struggle was visible throughout the early-mid nineteenth century[52].

The building of the asylum at Mărcuța had previously housed a Lazaret for the confinement of plague and cholera victims (Miloșescu, 2010, pg.37ff), and an asylum for the poor probably since the 18th century (Miloșescu, 2010, pg. 49). It was transformed into an Asylum for the Mad(wo)men somewhere between 1830 and 1840. This transformation was preceded by the movement of mad people[53] from Wallachian monastery-prisons to the hermitage[54] of Malamuc[55] where "beggars" were also interned (Miloșescu, 2010, especially pg. 18). This trans-institutional asylary migration of people based on their belonging to the category of "mad(wo)men" was done by the order of the then ruler. The move was part of a mutating political order driven by aspirations of statitzation which most probably made little sense to the people who were thus pushed around according to their classification.

This medical classificatory logic went hand in hand with plans to re-organize monastic incomes in an effort to establish uniformity and transparency in the legalistic impulse that characterized the 1830s as the time of the Organic Legislation (see Samarian, 1940, pg.173/174). This move that went had in hand with creating a Central Agency for administering all of the income of monasteries that were administered locally (Samarian, 1940, pg. 174). So, the specialization within a monastic infrastructure on a particular kind of pre-established mad subject (despite the fact that they were brought together with other categories of subjects) became a function of the central state's involvement in and reshaping of church affairs and infrastructures.

The mad as a separate category of intervention is thus a form of what Timothy Mitchell (2006 [1999]) has called "the state effect". In describing the "state effect", Mitchell referred to the historical conceptual

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[52] The transformation of Mărcuța from an asylum for mad(wo)men to an institute for the alienated throughout the 19th and early 20th centur was chronicled by doctor and medical historian Pantelimon Miloșescu (2010) on whose work I draw extensively in the following.

[53] *smintiți*

[54] *schit*

[55] The name "Malamuc" still survives through its derivate *balamuc*, which is synonymous with mad chaos and is used both in a derogatory, as well as friendly-funny way in everyday language. Others trace the origin of the word Malamuc from *a balamuți*/ which apparently in that time meant to talk gibberish, thus testifying that the monastery was re-named once mad people were brought there (see Vintilă-Ghițulescu, 2015, pg. 394)

separation between the state and the social or in Mitchell's words "the phenomenon we name "the state" arises from techniques that enable mundane material practices to take on the appearance of an abstract nonmaterial form" (see Mitchell (2006 [1999], pg. 170), that of the state. Mitchell insists on historicizing the imaginary coherence of the state that allows for practices to take on this nonmaterial form. Yet, although careful to stress the historic separation between state, society and economy, he ignores religion as an imaginary sphere that previous to the state made possible the emergence of an abstraction of practices from the mundane. Put differently religious asylums show that there was a "church" or "god" effect, before there was a "state effect".

Returning to Mărcuța: its emergence is linked with the assertion of the state as an imagined actor which was connected with the celebration of the Organic Legislation as the cornerstone of the "modern" Romanian states. Yet, asylums as legitimate places for the mad were already based on the rendering abstract of mundane practices of confinement. The previous abstraction took on the language provided by the religious modality of sense making. With the emergence of the state effect, confinement started taking on the abstracting language provided by the scientific psychiatric modality of sense making.

Mărcuța housed "beggars", "the infirm" and the "mad", categories that were considered separate, yet, they shared the same infrastructure with no initial effort of infrastructural separation (compare Miloșescu, 2010, especially page 22). People rendered beggars - those people rendered surplus by the organization of production and subsistence, as well as being located outside traditional networks of support and care would find themselves together with those considered "mad" and "infirm". Similar to monastic asylums, we can suppose that the asylum at Mărcuța worked to ensure the subsistence of those who were not supported by their families, while the state worked to responsibilize families for the care of unproductive family members (compare Vintilă-Ghițulescu, 2015, pg. 388).

Mărcuța soon became a place of horrors where people would be exposed to violence, since only the „furiously" mad would be sent there (Miloșescu, 2010, pg. 24-25). Yet, even though Mărcuța was a special place of confinement, violent treatment within monastic asylums was not atypical, reportedly involving inmates being treated like animals and left to hunger to quiet them down (Miloșescu, 2010, pg.78 about Mânăstirea Neamțului).

Mărcuța was run under different administrations which shifted between the *Eforia Spitalelor* - the medical governing body and *Departamentul Credinței* - the Department of Faith, the religious governing body and the *Ministerul Dinăuntru,* presumably the Ministry of Interior (see Gomoiu, 1940, pg. 166ff. and Miloșescu, 2010). These shifts testify to the unclear nature of Mărcuța as a religious or medical establishment and also to the yet unclear framing of madness as a medical-state/religious-philanthropic issue. Yet, all these departments were administrative bodies pertaining to the state, testifying to the government of the mentally ill through the emerging state effect. Nevertheless, a clear tendency is distinguishable: the medical logic kept growing in importance in the organization of the asylum based on medical categories[56], as well as through the impressive growth in numbers of committed people based on medical categories of madness[57].

The statization of the care of the mentally ill and the emergence of a psychiatric epistemic community

As outlined above Mărcuța as a site was strongly entangled with the process of statization of care for the mentally ill in its transition from the religious to the psychiatric modality of sense making. Yet, the process of statization itself mutated during the second half of the 19th century. In political history, this period is known as the period of the small unification between Wallachia and Moldavia (1859) and the creation of common political institutions, culminating in independence from the Ottoman Empire (1877-1878) and the introduction of the monarchy (1866-1881) - it is a time of state-making, modernization and Europeanization as Westernization. From the perspective of this chapter, it is the time of the solidification of what Mitchell

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[56] A point that I will explore at length in the next section.

[57] Although "beggars" and "mad(wo)men" were considered separate categories from the very beginning, sometimes being classified as "powerless"/ "incapable" (*neputincioși*) and mad (*smintiți*), with a growing number of mad(wo)men and a decreasing number of powerless people (see Miloșescu, 2010, pg. 57 and 58), the mad(wo)men and the infirm were physically only separated after A.I. Cuza, the then ruler of the country visited the hospital in 1860 (Miloșescu, 2010, pg. 57) - making again the link between "scientific" classifications, distribution of hospital populations and the increasing power of the state visible.

(2006 [1999]) called the "state-effect". This happened through processes of what Painter (2006, pg. 758) has called statization as "the intensification of the symbolic presence of the state across all kinds of social practices and relations". When speaking of mental illness, statization meant the increase in power of a psychiatric epistemic community (Hass 1989) that through the newly developing imaginary of the state established partial dominance in inscribing its understanding of mental illness and its treatment infrastructurally.

According to Haas (1989, pg. 384) an epistemic community describes "a specific [transnational] community of experts sharing a belief in a common set of cause-and-effect relationships as well as common values to which policies governing these relationships will be applied." The psychiatric epistemic community that emerged at the same time with other practices of statization in the second half of the 19th century (starting around 1860) up until after the First World War was centered on creating a psychiatric treatment system based modernizing aspirations. Its members shared a similar form of expertize, they were graduates of studies in medicine. Thus, they held an acquired belief in the need to render scientific the treatment of the alienated on the basis of elaborate classifications translated into adequate infrastructures.

The first generation of this epistemic community had as its most prominent member Alexandru Șutzu. Șutzu studied medicine in Athens and then in Paris (see Toma, pg.20) and was professionally active in Bucharest, and as well as partially by Alexandru Brăescu who studied in Iași and Paris and was later active in Iași (see Toma, Majuru &Buda, 2006, pg. 554). The second generation consisted of Alexandru Obregia and Constantin Parhon who both studied medicine in Bucharest and then went for specializations in Western European clinics[58]. Whereas Șutzu was professionally and politically active in the last four decades of the 19th century and the first decade of the 20th century, coinciding more or less with his time as head of Mărcuța from 1867 to 1909 (see Toma, Majuru& Buda, 2006, pg. 559f), Brăescu was active from 1895 to 1919. As psychiatrists, Obregia and Parhon were professionally and politically active starting from the 1890s up until

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[58] See Toma &Majuru, 2006, pg. 558 (for Obregia) and BZI (2014) available at https://cultural.bzi.ro/povestea-lui-constantin-ion-parhon-10788 accessed on 21.01.2018 (for Parhon)

the interwar years[59]. Whereas Șutzu and Obregia were based mainly in Bucharest at Mărcuța, Parhon also taught at the University in Iași, despite also being active in Bucharest and Brăescu was only active in Iași. The four men all held important positions within the state executive infrastructure, but even before holding such positions they publicized their views on what should be done to improve the treatment and care of the mentally ill.

Șutzu was the first identifiable advocate of regulating the situation of the "alienated" through the *Law on the Alienated* in 1894 (Royal Decree no 4090/ 10.12.1894, see Toma, 2008, pg. 165). His argument in favor of a law was publicized in a speech he held ten years previous to the decree (see Șutzu, 1884), testifying to his advocacy activities. The law created the „alienated" as a special legal subject. Șutzu argued that the need to regulate alienation was based on the desire to help the "miserable alienated" by guaranteeing a "humane treatment", "individual freedom", once they are released from treatment facilities and their "private property" (see Șutzu, 1884, pg. 28).

The argument in favor of governing the "alienated" as such is thus connected to affective reasoning centered on pity - which is signaled by the word "miserable"[60]. "Moreover, the state is imagined as a guarantor of the already existing property of those committed against potential exploitative ambitions of the family, and not as a provider of subsistence. Alienated institutes, as the one at Mărcuța need to treat the person and not become a permanent home. The medicalization of madness, the legal protection of the alienated and the secularization of monastic spaces appear as mutually constitutive processes mediated by the epistemic community of doctors, especially Șutzu[61], in the late 19th century.

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[59] Parhon continued to be politically and professionally active throughout the next decades, mostly as an endocrinologist, as well as prominent state socialist statesman of the early years, but my account only focuses on his activity as part of the psychiatric epistemic community. Brăescu does not fit neatly into the generational framework, since his advocacy activities are closer to the second, whereas his profile is closer to the first generation.

[60] "*nenorociții alienați*"

[61] That today there are a couple of names of important men doctors to stand for these epistemic communities is connected with the glorification of heroic doctors still around in medicine today (see for example busts of doctors in hospital gardens or in ward corridors) including that of Obregia in the psychiatric hospital that carries his name.

Whereas the first generation was concerned with rendering vernacular an imaginary of alienation the creation of which legitimized the statization of treatment in a medical-psychiatric way, the second generation was focused on its infrastructural translation into two modern psychiatric hospitals, the one near Bucharest (now called Obregia) and Socola (near Iași).

The politics of psychiatry: what was mental illness and why did it keep growing?

The asylum in Mărcuța had grown from an official population of nine alienated people in 1837 to one of 950 by 1919 (see Miloșescu, 2010, pg. 54). A medical commentator at the end of the 19th century, L. Iarchi (1884, quoted in Miloșescu, 2010, pg. 54) attributed this growth in numbers to the fact that "the government had grown more seriously interested in the protection of the alienated and the people saw that madness is an illness like any other illness and run to the asylums, instead of going to have them looked at, at monasteries"[62]. The growing numbers of confined people attested the power medicalization of madness[63] and the statization of care and treatment I have described above.

Alexandru Șutzu saw the growing numbers as an effect of people's understanding of mental illness as somatic illness. Therefore, people had come to also understand the role of the doctor as the only competent agent to treat such an illness making monasteries with their prayers and church services[64] and the old hags doing charms and disenchantments[65] redundant (Șutzu, 1884, pg.29). Through this Șutzu chronicled the gradual replacement of the religious modality of sense making and the practices it had made possible with a medical one which made new practices possible.

Yet, he also identified an affective reason for the increase in numbers: the decrease in the sentiments of shame[66] that had existed in all families and caused the alienated to be locked up in the room farthest away

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[62] "În ospiciul Mărcuța – scria doctorul Leon Iarchi în 1884 - numărul alienaților a crescut și acest lucru se explică prin faptul că guvernul a început a se interesa mai serios de ocrotirea alienaților iar poporul a văzut că nebunia este o boală ca toate boalele și aleargă la ospiciu, în oc de a-i căuta pe la mânăstiri." (Miloșescu, 2010, pg. 54)

[63] on the medicalization of madness in Romania, compare Toma (2008)

[64] *maslu*

[65] *descântece*

[66] *rușine*

or the cellar - which allegedly was replaced by a "a more noble feeling of *humanity"* (see Șutzu, 1884, pg.29). This implied that the asylum despite the terrible death rates and the horrible living conditions was perceived by its head as a more humane place, one of curing. What Șutzu chronicles here is something quite different but connected to the previous point: with the emergence of a staticized medical infrastructure, the biopolitical cornerstones of the monastic regime (the family and the asylum) and their relationship could be reworked. An asylum oriented towards treatment was therefore replacing the asylums oriented towards healing and appeared as the better, more forward-looking cases. That this image was fairly distorted in its day, as it is today, is fairly obvious and connected to the next point:

Șutzu also saw the increase of the asylum population as inevitable, independent of the two previous points, since statistically of the 100 alienated that would enter the hospital in one year only 25 are cured and around 15 die[67], in between them was an open space for people leaving uncured or staying on in the hospital. Amounting to an annual increase of the hospital population, independent of an increase in mental alienation (Șutzu, 1884, pg.29-30).

Șutzu saw the increase of the population of the alienated, also as caused by the increase in general paralysis (later discovered to be tertiary syphilis) which he attributed to the alcoholism of Romanian peasants hung on addictive foreign wines (Șutzu, 1884, pg.30). He also this process as connected to a social transformation that led to an over-use of the brain, because no one knows their place in society anymore, due to the possibilities and risks of social mobility emerging in the modern Romanian social and political order and the emerging all-encompassing politicization of society:

"The general formula for everyone today is: we live and we fight for getting ahead. Behold the purpose and aim of everyone.

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[67] It was probably easier in the time of Șutzu's writing to account publicly for the death of mentally ill people, since it had not yet been discovered that general paralysis/ later known as tertiary syphilis had manifestations similar with the mental illness categories of the time, but in time did prove lethal. Mental illness therefore could have been considered a lethal illness.

We work to get ahead and to get ahead we push all our cerebral activity to an exaggerated effort, that led to a diffuse congestion of the brains which is the anatamo-pathological cause of general paralysis. We all wish to get ahead and that is due to the democratic spirit, the democratic morals, that for some time have entered our countries' social mechanism. Before, in our old society, cerebral activity was unnoticeable, because our wishes and aspirations were more modest. Before, a boyar would aspire to die a boyar. A craftsman aspired for him and his child to remain a craftsman. A landlord from the countryside, lived on his domains, raised his children and aspired to die on his domains. The gypsy, it was well-known, had no consolation sweeter than that he will die in his master's courtyard. Today these morals have changed. In the turbulent times that we find ourselves we all strive to get ahead." (Șutzu, 1884, pg. 30-31)

Șutzu came from a Phanariot family that ruled in both Moldova and Wallachia during the Phanariot regime (Toma, 2008). His nostalgia for a proper order of society where everyone knew his place, can be read as the nostalgia for the political order of the later Ottoman Empire that granted his family great discretionary power as rulers. His nostalgia was for power that would not necessarily be connected with expertise, but with standing. Thus, his family history helps to chronicle the way in which state power shifted from rulers based on Ottoman backing to those based on professional expertise acquired in Western Europe and the continuities of maintaining power within a ruling family that access to resources had made possible.

Obregia held another opinion on the socio-political origins of mental illness: „The increase of the number of ill people in the asylum, proves that here among us [Romanian nationals] as everywhere, the fight for prosperity and subsistence produces more and more victims" (Obregia, 1905, pg.7). Obregia was not as apologetic about knowing one's place in society and the late Ottoman political order as Șutzu was and his intervention fits neatly into a re-framing of the presumed causes of mental illness that Parhon (1910, pg.9) notes as the "ever hardening struggle for existence [subsistence]", as well as the growth of "syphilis, malaria and alcoholism". Parhon as opposed to Șutzu was far from being in anyway nostalgic for the previous political order, since he was from early on a leftist (founder in 1919 of the Laboring Party, a short-lived leftist party) and later supporter of the communist party during its time in illegality, as well as during early state socialism (compare Biz, 2014). His understanding of madness therefore is fully coherent with his understanding of politics.

The theories on the origins of mental illness are purely speculative and tell us more about the politics of the doctors and their sociological understanding of the world around them than about actual scientific treatment models. Whereas the state was first staffed with offspring of ruling families, since they were the ones who could afford acquiring the new necessary expertise, as the academic process was democratized so were the subject positions held within the small epistemic community. The politics of psychiatrists were entangled with their understanding of modernization, society and mental illness and were similar in reasoning to those of sociologists[68]. Yet, as opposed to sociology that was also emerging as a discipline at that time, psychiatry also could legitimately use bodily interventions to "treat" the minds brought to alienation by society's transformations through bodily treatments, such as balneo-theraphy (bathing therapy) and its likes. How this worked is visible in the following:

This social mobility and resulting mental alienation, Șutzu saw as connected to civilization in a political way, since on the one hand the complexity of the financial and economic operations, the colossal companies and industrial plants which put "the cerebral system of an ever-growing number of people into continuous movement" and on the other hand, "in a civilized and democratic country we see those political and social struggles, that other times interrupted and periodical, have now become continuous and permanent, rocking deeply societies and as the waves of the sea that widen and broaden tend to comprise in their circle those indifferent and even the boys from our school benches." (Șutzu, 1884, pg. 31)

Politicization appeared to Șutzu as the root of the increase in alienation and therefore in the need for bigger asylums which were justifiable on the basis that they offered a more humane treatment than those offered by strictly monastic asylums. The connection between social mobility and general paralysis appears

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[68] The similarity of psychiatry with other human (and social) sciences has been noticed by others as well, most notably Ian Hacking (2006, pg. 293).

hallucinating, once it has been proven that the actual bio-chemical cause of the condition described by Șutzu was a sexually transmittable disease.

Biopolitical ambitions and classifications

Based on political beliefs about people's place in society and the role of the state in this imaginary, psychiatry was equipped with bio-chemical technologies to transform bodies. Although the origins of mental illness were described sociologically, the technologies for their mending were individualized. The population of the alienated was produced based on scientific classifications, but the treatment intervention was conceived as acting onto the individual, at the best the isolated individual separated from the sickening family environment (see Șutzu, 1872, pg.100).

The perfecting of these transformative technologies went hand in hand with the aspirations for a modern asylum based on a discipline oriented medical modality of sense making. For this, first the existing infrastructure which had been inherited from the monastic model, had to be challenged and a new one based on scientific classifications developed. Șutzu described Mărcuța before his mandate as „a place of terror and repulsion for our society" and „the saddest refuge an infirm or an alienated could find", creating for himself a reputation similar to the one held by Pinel in France of setting the mentally ill free of their chains[69]. The legacy of salvaging the mentally ill of their ill faith at the hands of religion and society was taken up by the next generation of the epistemic community and framed in a more scientifically precise biopolitical language.

Obregia documented the death rate for the two decades around the turn of the century 1890-1910, proving that it would sometimes reach 20-23%[70], proportional to the accumulation of large numbers of ill people and the decrepitude of buildings. Obregia linked the high death rates with the deficient hygienic conditions,

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[69] A point which is later taken up by Parhon who pointed to the fact that in 1841 the asylum housed 35 alienated (people) and had that year bought ten chains with padlocks and twelve straight-jackets (see Parhon, 1910, pg.10).

[70] The better years would reach a mortality of 11-12%, whereas in the West it is around 6-9%. (see Obregia quoted in Parhon, 1910, pg.54

as well as with the location of the hospital. This was due to the asylum's proximity to a cemetery where Bucharest's cholera victims and other people who had died of infectious diseases had been buried[71] (Obregia, 1905). The concern for housing ever-growing asylum populations hygienically, and thereby preventing their premature death by acting biopolitically, went hand in hand with a desire to systematize, classify and distribute the resulting sub-populations in an adequate way.

The very high percentages of deaths brought both Parhon (1910) and Obregia (1905, pg. 11-12) to conclude that there was a direct correlation between lack of investment in buildings and the high number of deaths among patients, or in Obregia's wording: "[the correlation between investment in buildings and the high numbers of deaths] This is new proof of the well-established fact that for treating the alienated the worth of the building intervenes with a much higher force than in all other categories of ill people. Take an improvised asylum, cramped, run-down, the alienated cannot be isolated, nor can they be well assigned to places and distributed, nor can they be defended from disease and epidemics that spreads faster than anywhere else; dysentery, typhoid, erysipelas and on top of all this tuberculosis, the main killer[72] in all asylums, but especially in the over-populated ones. At Mărcuța malaria is also added. All make curing take longer, or impede it altogether or even take away many of our ill people in full process of curing their psychosis" (Obregia, 1905, pg.10-11).

The point about systematizing the asylum and distributing people according to categories and in a second step spatially hierarchizing the categories of asylum inmates was framed as a measure of humanizing the services towards the mentally ill and protecting them from the biopolitical consequences of asylums that endangered their lives. Yet, it was not the asylum itself that was being challenged, but its lack of systematicity, as well as its geographic position in a life-threatening place. Thus, change was requested by the Obregia through the creation of a modern asylum at the outskirts of Bucharest (see Obregia, 1910, 1905).

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[71] Interestingly, the asylum at Mărcuța existed and functioned at the time when the cholera victims were buried in its immediate proximity pointing to the deadly nature of the state`s biopolitical intervention towards the inmates at Mărcuța.

[72] *secerătoare*

Obregia's measures were building on Şutzu's who was well known for replacing the cells, breaking the chains and putting an end of violence and intimidation once he had entered the hospital in 1866[73]. Ironically, the years of burial of the cholera victims in the immediate vicinity of the asylum (1863-1866, see Obregia 1905, pg. 9) coincided with the acclaimed transformation of the treatment conditions at Mărcuța. The simultaneity of the advent of the heroic figure of the enlightened doctor and the consequences of the burial of cholera victims points to the contradictory nature of the biopolitical shift that occurred with the advent of modern psychiatric aspirations.

What Şutzu, Obregia and Parhon shared was a medical impetus to salvage and liberate the ill that went hand in hand with the building of larger and more systematic asylums. The asylums were thought of as places of needed isolation and treatment, as well as securing society's security needs.

The systematization and distribution of the mentally ill: psychiatric science and its infrastructural translation

The ambition to separate, classify and adequately isolate different classes of ill people within the asylum as an institution coincided with its statization and with its medicalization as an institution. After Mărcuța came to be increasingly penetrated by a medical modality of sense making in the second half of the 19th century[74], the adequate separation of the mentally ill became a priority - a point which becomes enshrined in Mărcuța´s topography (Şutzu 1870 quoted in Miloșescu 2010, pg. 73):

The wards were subdivided into two main wards for women and men, as well as sub-divisions of wards which housed specific populations based on whether they were recovering or chronic patients and whether

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[73] see Miloșescu, 2010, pg. 60 building on literature from the 1870s reprinted in the 1970s, see also Toma, 2008, pg.20. It is impossible not to notice that the imagery associated with Şutzu was built on that of the French psychiatrist Phillipe Pinel (1745-1826) who is popularly credited with freeing the mad people from their chains- and still gives his name to many associations and community care centers working within frameworks of deinstitutionalization today/ he is also popularly known as the founder of modern psychiatry- pointing to a genealogical move allowing Şutzu to appear as a local Pinel.

[74] Coinciding with Şutzu´s time as head of the institution (after 1867)

they were agitated or retired[75]. Interestingly there was also a special ward for “noblewomen” and apparently no such ward for “noblemen”[76] (see Șutzu 1870 quoted in Miloșescu 2010, pg. 73). It is remarkable from Șutzu’s description that the rooms and spaces were larger and with more light for those considered to be recovering and the “noblewomen”[77], as well as smaller for those chronically ill or agitated - who were probably considered undeserving of such privilege. Those considered to be recovering also had the opportunity to learn a craft - thus testifying to a projection of future integration into productive processes (see Miloșescu 2010, pg. 73). Much of this quite improvised organization of the asylum and its tidy presentation by the medical head reveals that the question of (in)curability or chronicity of illness had its infrastructural translation in Mărcuța at the time of its medicalization.

From the topographic description of the Mărcuța asylum, it becomes obvious that the desired humanization of the treatment of the “alienated” must have operated selectively by hierarchizing the subjects and attributing to them a space that they were allowed to inhabit. It is in this context that on the basis of broad clinical prognostics (and interestingly not diagnosis) related to the expected future of the person that the infrastructure at Mărcuța was organized. Given the documented over-crowdedness of the asylum it is safe to hypothesize that the resources must have been distributed towards the rehabilitation of those considered to be recovering or noblewomen thus distributing the burden of the inhuman living conditions on those considered chronically ill. Biopolitically speaking, those recovering were made live, while the others were let die.

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[75] The category retired although resonating with present day categories of invalidity based retirement, probably meant something else in that time. Yet, until now I could not make out exactly what it meant.

[76] This might have been the case, since Șutzu is also famous for founding the first private alienated clinic, the “Caritatea” Institute.

[77] It is hard to grasp the exact meaning the phrase must have held in southern Romania at that time, since as opposed to Transylvania there was no routed tradition of nobility in Walachia, it is also striking that there was no noblemen section

Obregia developed his plan for the central asylum near Bucharest at the time of his activity at Mărcuța (see Obregia 1910). It was projected to house one thousand mentally ill people (see Obregia, 1910, pg.5). It was to be by far Romania's largest asylum and take over the population housed at Mărcuța. A regulation from 1892 gave way to building two asylums in what is now known as the Old Kingdom (Romania as made up of Wallachia and Moldavia), one near Bucharest and one near Iași (see Obregia, 1910, pg. 3, Memoriul, 1895[78]). Yet, the law only started being implemented through the advocacy practices of academically affiliated doctors at that time.

Two distinguishable groups were active in the policy advocacy practices related to establishing the two scientific psychiatric asylums: a group of doctors from the medical faculty in Iași, and a group surrounding Obregia and Parhon in Bucharest. Their activities appear as the continuation of the psychiatric epistemic community's activities, since their explicit and separately (meaning in Iași and in Bucharest) promoted aims were directed at influencing state *policy.* Their aim was to bring about infrastructural transformations of asylary care and academic psychiatric training through the state funded construction of scientific asylums. Through this they continued the statization of care and treatment infrastructures for the mentally ill and disabled and the creation of a modern scientific state infrastructure. Yet, they were the first who aimed at transforming the infrastructure through the executive and not legislative vehicles of the state - meaning that per se they appear as the first policy advocates in this field.

Obregia submitted a report to the Ministry of Internal Affairs in 1905 arguing for the construction of a central national asylum in the vicinity of Bucharest, titled: *Report addressed to the Minister of Internal affairs by the head doctor of the asylum of Mărcuța regarding the urgent necessity of building a central*

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[78] Memoriul 1895 is my abbreviation for the much longer Memoriul Facultăței de Medicină din Iași adresat domnului Ministru al Instrucției publice relativ la clădirea unui Institut de Alienați la Tîrgul-Ocna (1895) a document submitted by the faculty of medicine at Iași University to the Minister of Education requesting the psychiatric asylum to be built near Iași and not at Tîrgu Ocna as apparently there had been a change of plans as to where to build the asylum, which was in the end built near Iași at Socola, a former monastery sugested by the memorandum.

asylum for the alienated near Bucharest (1905)[79]. The concept Obregia had in mind included the possibility of having a partially open system of treatment after the example of Geel in Belgium (Obregia, 1905, pg. 13ff.), called alienated family colonies[80]. This meant placing certain "alienated" people in peasant families that should care for them and where they should also work around a "large central systematic asylum" (Obregia, 1905, pg. 14).

Again, practices of hierarchizing were at the core of the project: the "dangerous and acute" should be kept within the hospital, whereas the "more suitable" are placed in "open door" system[81] with open pavilions and are "freed" for agricultural labor. If problems were to arise, the ill person would be returned to the asylum and on a weekly basis would receive medical visits and a bath on the premises of the asylum (Obregia, 1905, pg. 14-15). Șutzu, too, had mentioned the open system.

Both Obregia (1905) and Șutzu (quoted and analyzed in Toma, 2008, pg. 172 based on 1869) were distrustful of completely open systems and saw them as potential auxiliaries to the asylary system. Both argued for rigorous medical control of the care practices of families which would receive in their care the mentally ill and a rigorous selection of the ill people that should be allowed this freedom increasing measure.[82]

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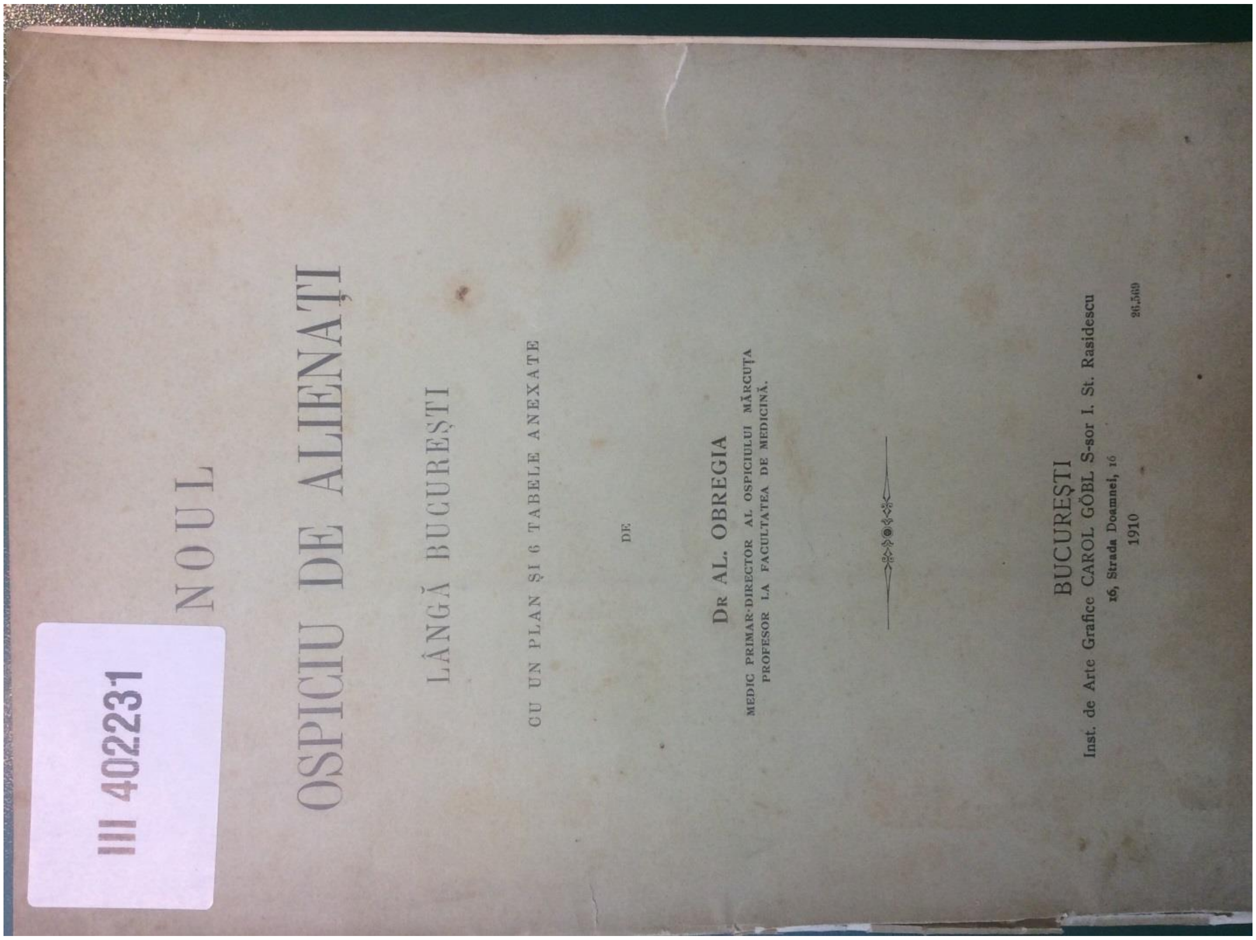
[79] Obregia Alexandru (1905) *Raport adresat domnului ministru de interne de către medicul director al ospiciului Mărcuța relativ la necesitatea urgentă a clădirii unui ospiciu central de alienați lângă București*

[80] *colonii familiale de alienați*

[81] the original is in English, as the system is English and still referenced today

[82] The system they proposed resembled very much what community psychiatry was later to be defined as, since it brought together the question of saving costs with the question of re-integrating the mentally ill into society and production. I am unaware whether the system was ever practiced once the Central Asylum was opened in 1923.



NOUL

OSPICIU DE ALIENAȚI

LÂNGĂ BUCUREȘTI

CU UN PLAN ȘI 6 TABELE ANEXATE

DE

Dr AL. OBREGIA

MEDIC PRIMAR-DIRECTOR AL OSPICIULUI MĂRCUȚA
PROFESOR LA FACULTATEA DE MEDICINĂ.

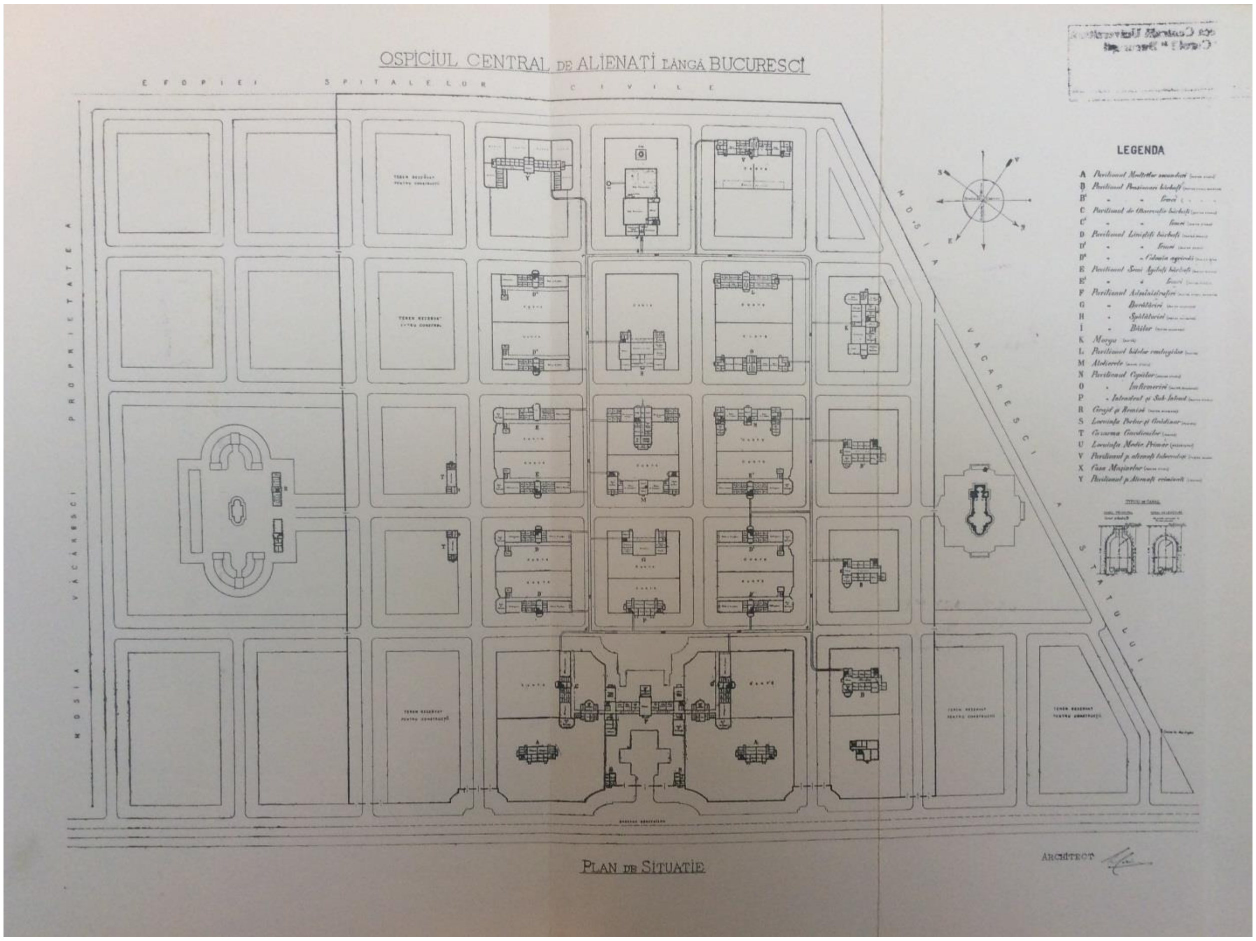
BUCUREȘTI
Inst. de Arte Grafice CAROL GÖBL S-sor I. St. Rasidescu
16, Strada Doamnei, 16
1910

26.569

Cover of the first policy paper, including its translation into concrete state policy, BCU, Bucharest

Returning to Obregia's policy advocacy activity, one can say the report (1905) supporting the construction of the asylum was a success. One year after the first submission, the then Minister of Internal Affairs G.G. Cantacuzino and Obregia submitted a similar report to the Council of Ministers (the then government), together with a law that gave way to the construction of the asylum (see Cantacuzino & Obregia, 1906, as well as *Lege pentru clădirea unui ospiciu de alienați lângă București*, 1906). The documentation also pinned down the means to be used in the process. The law was passed in 1906 and the building process started in 1908, yet was only completed in 1921 after World War I (Prelipceanu, 20004).

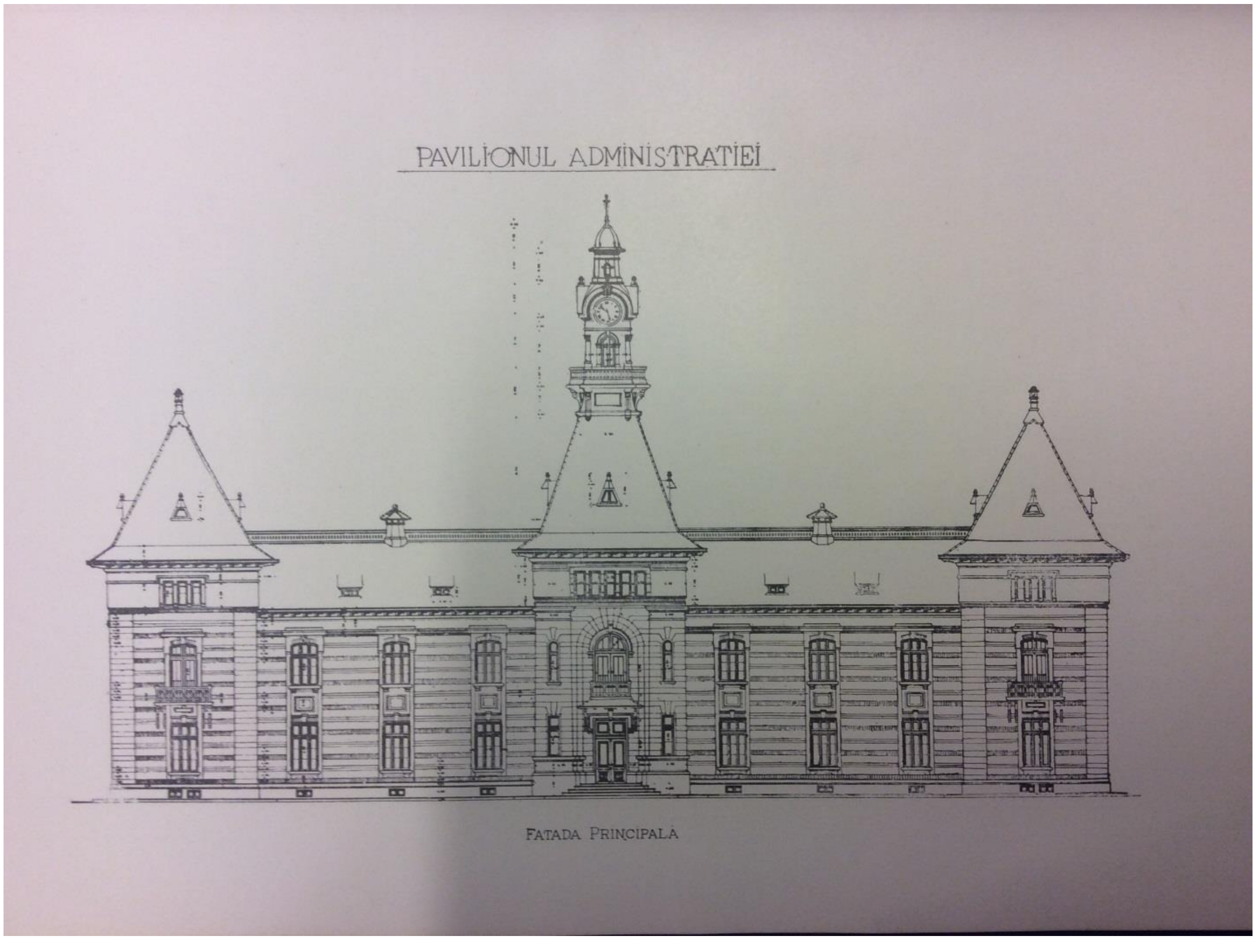
The plan of the hospital can be seen below (copied from Obregia, 1910).



The central asylum for the alienated next to Bucharest from Obregia, 1910

F is the administrative pavilion and contains the panopticon tower, see Obregia 1905 pg. 29-30

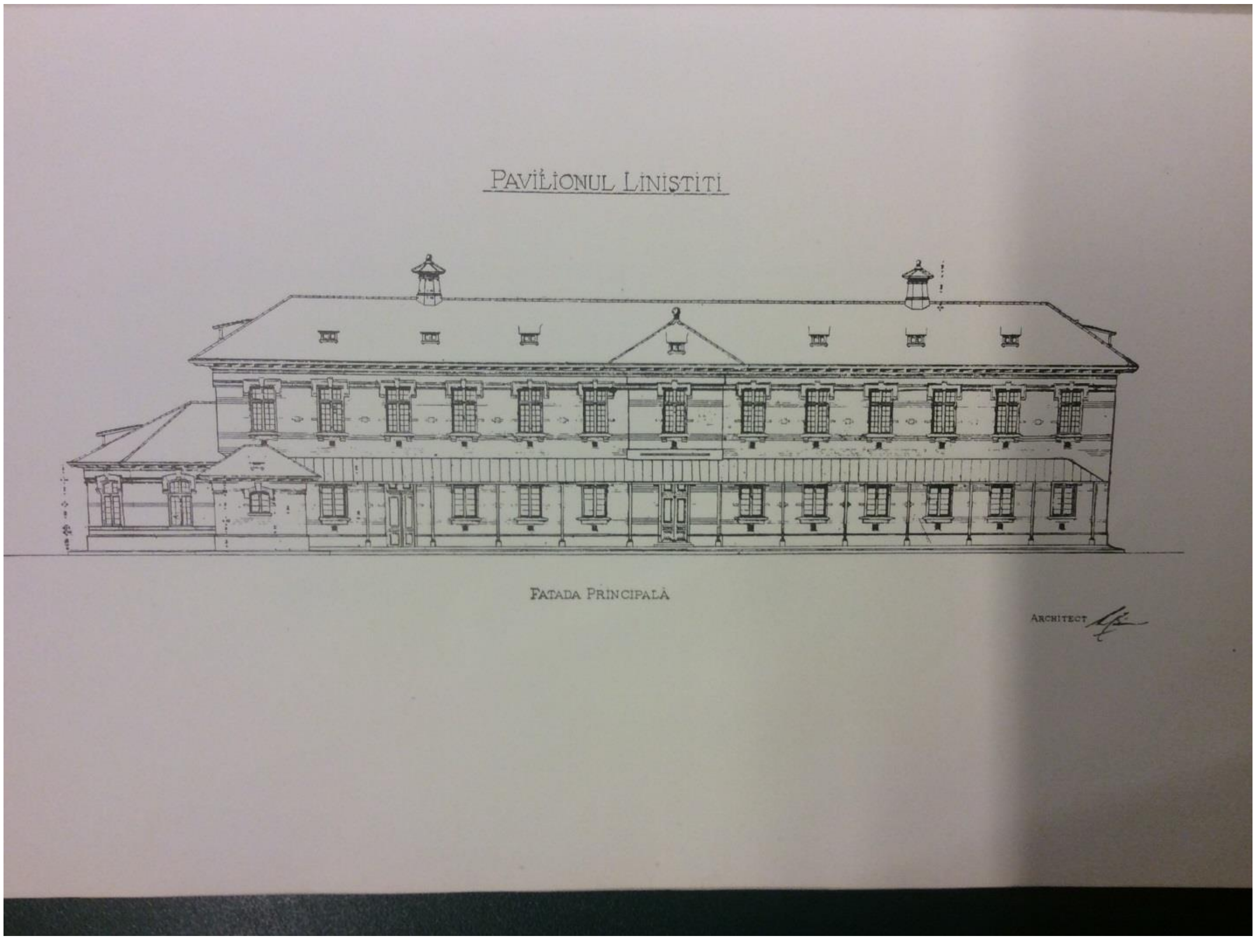
The plan of the hospital above was put into practice and together with its almost contemporarily established counterpart in Iași, Socola, (opened in 1905) still is one of the main and definitely largest psychiatric hospitals in Romania. The plan mirrored well the ambitions of systematization and medical control that characterized the entire endeavor - the pavilions were designed symmetrically to avoid the extra costs a further aestheticization that would bring the environment closer to a regular urban setting and further away from an asylary one would have involved (see Obregia, 1910, pg. 29). The buildings were designated for different groups of ill people, thus extending and making more recognizable the classificatory ambitions already practiced by Șutzu at Mărcuța and all were placed in such a way as to be visible from the clock tower placed in the center of the administrative building (F on the map) which was to be used by the staff to control the asylary population both in temporal terms, since the clock in the tower moved the clocks in the rooms of the asylum through an electric mechanism, as well as spatial terms, since the tower formed an observatory with a round balcony that could allow the surveillance of the entire asylum, since all the pavilions were placed in such a way as to allow for the visual radius from the tower to reach every building (see Obregia 1910, pg. 29-30).



The Panopticon at the Central Hospital in the administrative pavilion, the clock tower ensured both the uniformity of time in the asylum since it defined the rhythm of all the clocks in the rooms on the wards and the spatial surveillance since all the other buildings were placed so as to be visible from the tower. Picture from Obregia 1910

The central axis is made up of buildings of general interest, kitchen, workshops (iron molding, locksmith, wood, shoe-making), the baths for hydrotherapy, as well as electrotherapy, the washroom and wardrobe, and the very end the machine hall, since it produces smoke and coal dust (pg. 30). The other buildings were comprised of twelve pavilions for the ill people. For the “quiet ill people” the plan reserved places closer to the front part of the asylum, for “the agitated” it reserved the places closer to the baths, the rooms of which were especially split into smaller ones to allow for the agitation of one not to spread to the others (pg. 31). Each pavilion having two floors, the upper one reserved for quiet patients, having fewer isolation and bathing facilities (pg. 31), whereas the lower floor foresaw smaller rooms, dedicated “to the more sickly” with more isolation rooms and baths (pg. 32).

Most probably the classification and separation of the mentally ill in the newly planned asylum was more complex and sophisticated than the short description provided in the publication by Obregia, since from the pictures at the end, we again find a pavilion of the retired[83], showing that much of the classificatory practices of Mărcuța had been integrated into the new asylary structure.



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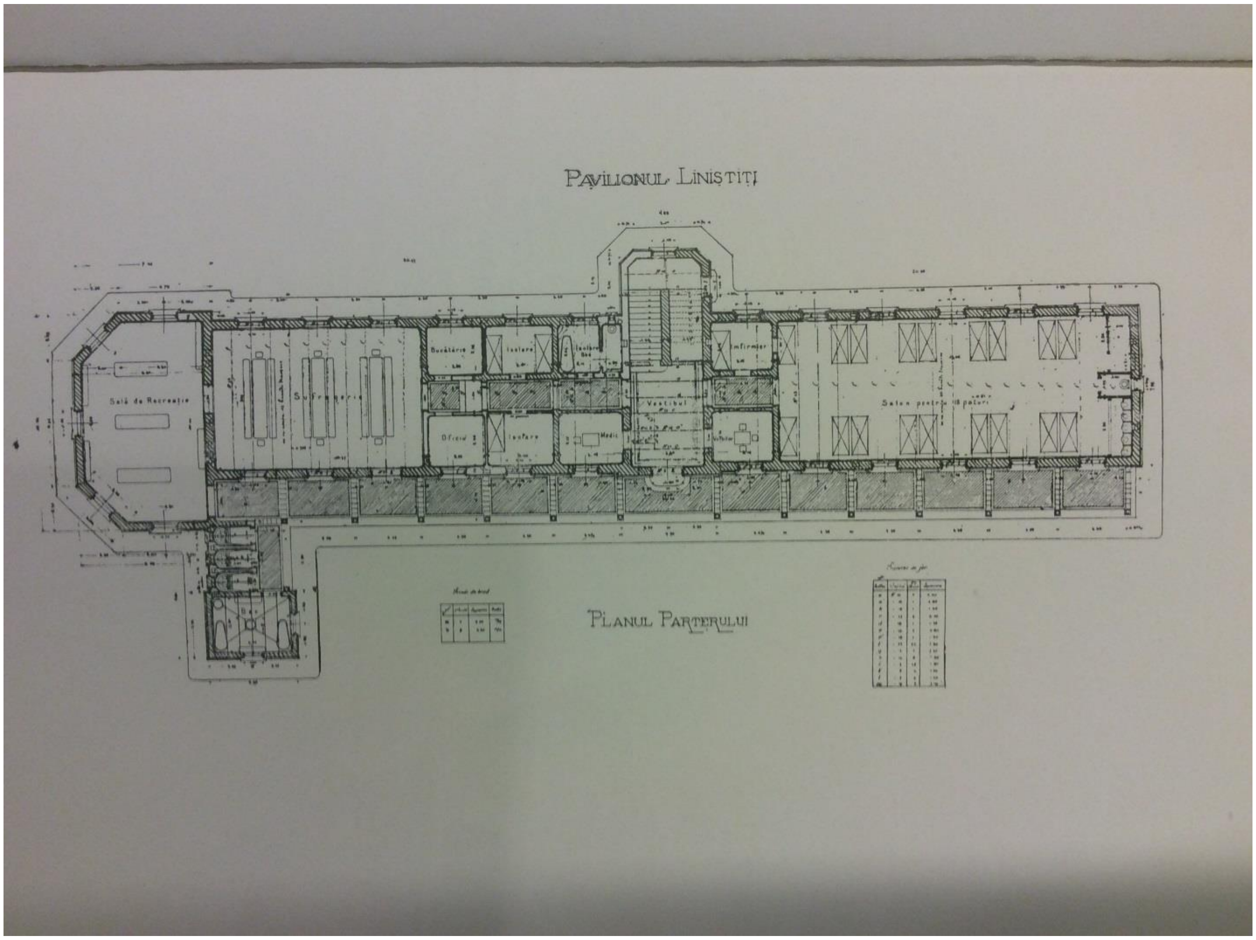
[83] *pensionarilor*

The pavilion of the quiet ones, façade, Obregia 1910



The pavilion of the quiet ones, plan of the interior, Obregia 1910

What did this systematization mean for the mentally ill that had by now been pushed around from the premises of the Mărcuța asylum into new tidy buildings and had come to be classified in precise categories depending on how they were likely to behave in the new infrastructure? As the silences in the policy documentation show most likely they had at best been informed about the new whereabouts and their rules and had little possibility to imagine in advance the disciplinary potential of this new panopticon-infrastructure the spatiality of which was one of hierarchical control which was designed to turn the patient into "the principle of his own subjection" through the fact that he is made constantly aware of being visible and individualized (compare Foucault, [1975] 1995, especially pg. 234).

Inheriting from Mărcuța, what Foucault called "the rituals of exclusion" ([1975] 1995, especially pg. 227) built on the binary distinction normal/alienated and on the desire to create on the outside a "pure community". Obregia's Central Asylum was designed to spatialize disciplinary mechanisms aiming to render the process of treatment more efficient and thus returning the alienated to the community, once efficiently disciplined. Yet, this return as we see in his description of the "open system" had to still be subjected to a panopticon-like surveillance, tying the alienated person to the surroundings of the hospital.

If Mărcuța can be read as a place of "compact, swarming, howling masses" (Foucault, [1975] 1995, pg. 230), Șutzu's classificatory ambitions culminating in Obregia's panopticon architecture aimed to avoid these and to substitute an architecture of massification through one that individualizes confinement (compare ibid). Similar to Foucault's description of the panopticon, the Central Asylum worked to abolish the crowd, as the locus of "multiple exchanges" and "individualities merging together", making possible the emergence of separated individualities that the architecture was conceived to discipline (compare ibid). Yet, while the object of power is individualized, power itself is automatized and disindividualized, as it becomes a function of space (compare ibid., pg. 232).

The ambitions of this project appear total, but it is unlikely that their implementation was successful in establishing full disciplinary dominance over the people confined to the hospital. As Erving Goffman described any total institution gives rise to an underlife of its inmates separate from the ambitions of staff (compare Goffman 1961). Moreover, Obregia's was only a partial panopticon, ensuring the surveillance of the wards as buildings and not of the individuals within the wards, leaving much leeway for spontaneous developments of the everyday life. Moreover, today although the grounds of the hospital correspond to those erected at the beginning of the 20th century, I have not met anyone that was aware of the panopticon-like features of the tower at the main entrance.

Nevertheless, it is not incidental that the establishment of the panopticon-based topography of the Central Asylum was the peak of the activity of the first epistemic community of psychiatrists that were empowered by the state and empowered the state to transform itself through medicalization into a modern state - since as Foucault pointed out: “Panopticon is the general principle of a new “political anatomy” whose object and end are not the relations of sovereignty but the relations of discipline” ([1975] 1995, pg. 238). The epistemic community’s scientific use of power, thus legitimized the broadening of state intervention into the lives of people through giving the mandate to enhance life, a discipline oriented structure that maximized the control of the psychiatrists over the inmates, and through this of the state over the unwanted.

Yet, the modernizing ambitions of enhancing life remained the domain of aspirations despite their infrastructural translation. Although the classificatory ambitions and their biopolitical motivation went hand in hand as the cornerstones of the psychiatric modality of sense making, they did not in fact guarantee an enhancement of life. The biopolitical question of the mentally ill being let die in asylums was carried into the modernized infrastructure of scientific asylums, as we learn from Parhon. He complained that in 1918 Socola’s[84] inmates were not being given enough food for even the most basic needs, there was no treatment in the hospital and hygienic conditions were deficient (Parhon, 1919, pg. 527)[85]. Parhon testified to having addressed the issue personally by arguing that the administration of the asylum be turned over to a sanitary -medical- directorate and concluded that thus the problem had been solved by 1919. His solution to the problem of letting people die was a more thorough medicalization.

Parhon (1919) also criticized that public authorities did not allow enough leeway for doctors in committing patients and that this caused many, especially poor people, to be denied admission to the hospital. When public authorities did bring the alienated in, often they bore signs of violence. He added that for each act of resistance the mentally ill would be beaten during transportation, sometimes their wrists tied with so much

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[84] The Socola hospital (near Iași) had been established in 1905 as one of the two modern psychiatric hospitals of pre-war Romania.

[85] In 1919 Parhon was writing for the newly founded famous sociologist Dimitrie Gusti’s publication *Arhiva pentru Ştiință și Reformă Socială*.

force that the wounds would carry on showing weeks after their commitment to hospitals. Against such state of affairs, Parhon argued that the judiciary should impose to the executive powers a more humane treatment of the "poor" mentally ill.

Parhon saw further possible improvements in the development of vaster therapeutic mechanisms such as the possibilities of having bathing therapies in asylums, reaching up to even permanent bathing. He tied the misgiving of such a lack of possibilities to the fact that generally bathing was little available in the hospitals Socola and Mărcuța[86], making an implicit link between deficient hygienic conditions that probably endangered the health and life of people to the lack of therapies that were extremely violent.

It is not difficult to notice that Parhon was very agile in detecting violence and abuse against the mentally ill, everywhere but in fully medicalized modern asylum-like structures[87]. What is fascinating, nevertheless, is the epistemic blindness to the violence of medical treatments, combined with the keen observation of those committed by police authorities, families and the economic organization of society[88]. The figure of the "alienated" remains a faceless member of an ever-extending population group who belongs in the asylum for treatment purposes[89]. The "alienated" once treated and cured, Parhon resumes attributing non-therapeutic needs and desires of the alienated to find work and recognition in society. Therefore, in this new infrastructure and mode of knowledge production which rested on a modernizing psychiatric gaze the homogenous population of the alienated is produced, upon this population psychiatrists intervene to cure

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[86] The article is written briefly before the transfer of the patients from Mărcuța to the Central Asylum near Bucharest

[87] Of course, such settings did not fully exist at the time, and as the ethnographic part will show, still do not exist.

[88] Parhon also argues that families' financial interests pushed asylums to readmit the cured mentally ill and that the authorities were cooperative in this, a problem which he considered needed more awareness (see pg. 531). Interestingly, he also criticized that "the reputation of being alienated" (*reputația de alienat*) - what we would now after Erving Goffman (1963) call stigma - would cause them problems in getting employment once healed and released from the asylum, despite having the necessary abilities and skills needed for labor (see pg. 530).

[89] Parhon saw among other things that not enough alienated were being interned in the asylums compared to statistical evidence of their numbers throughout the country and that the procedure of commitment was too bureaucratic, meaning that the doctors opinion did not suffice, the only ones who could commit the mentally ill to asylums being public authorities (see pg. 528). This meant that sometimes especially poor patients would need to be returned to places far - far away, because families had not filled out the necessary forms. He argued for an empowerment of the doctors in committing patients when they considered fit, although he did see that this should not be permanent since "Society" through the legal framework "should offer guarantees to the mentally ill when it comes to their commitment to hospitals and their classification among the alienated" (pg. 528).

the subjects and states to put in place the infrastructure necessary for such cure - once a subject leaves the conceptual realm of alienation through being cured, a new individualized path is available.

A modality of sense making based on social solidarity and the emergence of social policy

The interwar years did not only bring about the infrastructural translation of the medical psychiatric modality of sense making in modern psychiatric asylums[90], but also of an imaginary of social solidarity channeled through that of the state into the development of social policy centered social sheltering. Social sheltering[91] or social assistance[92], as well as health came to be a territory of systematic interventions after the First World War (see Răducanu [1930]). As we learn from *Enciclopedia României* (hereafter ER)[93], the rendering of social assistance as a matter of state involved what now could be read as an affective shift from pity[94] as a driver of charity to the less "noble"[95] motive of social solidarity[96] which served not primarily the "alleviation of the suffering of some [people]"[97], but the "satisfaction of general interest"[98] (see ER, pg. 519).

This general interest as pointed out by Eugen Botez[99] (Botez, [1930]) was mainly about regulating and coordinating the activity of private actors, as well as creating "own organizations and settlements in those branches of assistance where private [actors] cannot act usefully" (pg. 232). The directorate headed by Botez aimed to ensure: the protection of (1) children, (2) the infirm, (3) the needy elderly, as well as the fight (4)

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[90] Bucharest, Socola, as well as those that were incorporated into the new territoriality of Romania after the First World War

[91] *ocrotire socială*

[92] *asistență socială*

[93] ER is the comprehensive work documenting the Romanian state and social developments up until 1938, edited by Dimitrie Gusti (2000 [1938]),

[94] *milă*

[95] *nobil*

[96] *solidaritate socială*

[97] *alinarea suferinței unora*

[98] *satisfacerea interesului general*

[99] Botez, Eugen (Jean Bart) [probably 1930], Jean Bart was the founding head of Social Assistance, a function which he carried out between 1921 and 1931 within the structures of the Ministry of Labor, Health and Social Protection (see Paul Cernat's Chronology of Jean Bart's life as part of the foreword to the 2010 Biblioteca pentru Toți edition of Bart's most famous novel *Europolis*.) Therefore, Bart's views on the system can be considered authoritative as a voice speaking for the ministry-led establishment of the system.

against beggary and vagabondage, (5) social illnesses and the control of (6) philanthropic societies and (7) of the implementation of the law for the appeal to public charity. (Botez, [1930], pg. 232)

Basically, this meant that whereas assistance could be provided in a non-staticized setting for those aimed to be "protected", the way in which this was to be provided was to be controlled by the state. Thus, the imaginary of the state was one of a controlling instance and not primarily one of providing care.

The situation looked differently for those groups of people whose activities and thus subject positions were considered harmful and thus in need of being fought against[100] - like beggary and vagabondage. In this case, Botez writes that: "[in the] the fight against beggary, private initiative cannot bring any utility, to the contrary sometimes beggary is even encouraged. It has been rightly said that alms, charity are an endless barrel. The difficulty is in knowing who is to be helped and who has made of beggary a profession" (Botez, [1930], pg. 238-39). It is here that a staticized order comes to oppose a humanitarian one, the imaginary of social solidarity is conjured to oppose humanitarian philanthropy. The regulation of receiving alms that was the cornerstone of the *calicie* is fundamentally challenged on exactly the grounds of its establishment - its Oriental flair.

Botez identified "beggary" as a problem, since it primarily caused disturbances of the public order, as well as "gave a degrading and *Oriental* aspect to our cities" (Botez, [1930], pg. 238, my emphasis). This causing the author embarrassment, since with great horror he notes: "In American magazines reproductions of photographs showing the types of beggars from the Capital of Great Romania have appeared" (Botez, [1930], pg. 238). Interestingly, Botez does not see a connection between unemployment and beggary, stating explicitly that as opposed to other countries, this was not the case in Romania, since the population was mostly rural and that there were no crises of overproduction, unemployment "just starting to arise in Transylvania" (pg. 239). Therefore, he saw the solution in repressive re-educating measures and in the

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[100] *combătut*

proper selection of those to be subjected to this, since the great causes of beggary were: “ignorance, illness and alcoholism”[101] (pg. 239).

In the fight against “beggary”, Botez notes that a great success had been obtained nowhere else but at Mărcuța that had been turned into a correction facility for minors to reeducate and protect them against a future of beggary and prison, after the transfer of mentally ill to Obregia’s Central Asylum. The correction facility apparently had a capacity of between 350 and 400 minors (around 1930) and despite the lack of specialized leadership staff, Botez notes “wonderful results” (pg.240) in one of the first such project in the Old Kingdom, Transylvania having had two such facilities before the establishment of the directorate within the ministry.

At Mărcuța we can again follow-up a central transformation for the genealogy of mental illness and disability: the emergence of re-education facilities for those considered “defective” and most significantly “morally defective”, a concept with some weight at that time. The mad had been turned into alienated and moved into the disciplining facilities of the Central Asylum. Yet, those who were not “alienated” were turned again into “beggars”, in a new way, now being exposed to specific (if not professionalized) disciplining processes.

By the 1930s the category “defective” found its way into official state language, as new plans for the directorate for sheltering[102] were being crafted. It was to be made up of four different services, one of which was especially dedicated to the service of “defectives”[103] which involved a (1) medical-pedagogic section, (2) another section involving the sheltering of the alienated and a third one (3) aiming at mental hygiene and eugenics (Botez, [1930], pg. 253-254). Whereas the medical-pedagogic section involved medical-pedagogic schooling, as well as sections for the sheltering of the blind and the deaf-mute, the (2) sheltering of the alienated involved on the one hand hospitals for the alienated and on the other hand work colonies

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[101] *ignoranța, boala și alcoolismul*

[102] *direcția ocrotirii*

[103] *serviciul defectivilor*

and asylums. The section (3) mental hygiene and eugenics involved keeping an evidence of the defective and carrying out studies and counseling.

Here we see that the ministry of labor and social sheltering with its occasional mergers with the ministry of health came to produce and reproduce a new meta-category destined for sheltering that of the "defective" which incorporated the smaller category of the "alienated". The category of the "defective" emerged as a proto-designation for what later will come to be handicap and disability. It was built on the re-drawing of conceptual borders surrounding the loci of the impediments experienced by the disabled subject in the society where he or she lives. The "defective" appears as a category in need of sheltering, as well as hospitalization. Its existence entitles data to be collected on this population through the channels of the state. While the imaginary of the state and its relationship with the genetic future of its national population, allows for a soft eugenic[104] function to emerge through counselling practices on the reproductive consequences of being "defective"[105].

Probably, some of these changes were due to the incorporation of Transylvania and its productivity centered social protection practices into the Romanian state after the First World War. As we learn from Botez the "mentally abnormal"[106] were cared for in medical-pedagogic establishments that included workshops for professionalization, in Cluj, Ineu (both in Transylvania), as well as in Mărcuța (near București) (see pg. 236). The re-education involved yet again the rendering productive of the mentally abnormal as a corrective to their condition as defective.

Since Botez writes this around 1930, it is clear that Mărcuța continued to function as an establishment for the alienated, but no longer a hospital psychiatric one, but a medical-pedagogic one, relevant not primarily

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[104] Whether these plans were carried out or not is unclear to me, so I incline to think they were never carried out. Nevertheless, a stronger eugenic function of the state was vividly debated during the interwar years relating to the eurgenic sterilization of the mentally ill (see Turda, 2009).

[105] Interestingly, the word "defectiv" has dissapeared from contemporany Romanian language in the nuance it had held at the time when Botez wrote this text. Yet, it has remained as a grammar notion that describes words that do not have all possible functions. (See dexonline, here https://dexonline.ro/definitie/defectiv accessed on 23.12.2017) Most probably this was the nuance of the word at that time as well, just that it referred to people who do not posses all the neccessary functions.

[106] *anormalii mintali*

to matters of health, but to matters of social protection, sheltering and re-education - ideas that given the localization of the two other such establishments most probably entered the Romanian socio-political landscape from Transylvania - thus enabling an infrastructural continuity at Mărcuța which customarily silenced by the psychiatric historiography which reads Mărcuță only as the forerunner to the Central Asylum, later known as the Central Hospital, now Obregia hospital.

The interwar years are therefore the years that allow for both mergers and separations of the treatment, the re-education and the support for those people considered mentally ill, as well as the creation of new meta-categories such as "defective" and specific categories such as the mentally abnormal and the chronically mentally ill to emerge. The continuity of housing the mentally abnormal and beggars, as well as their confinement in such spaces as Mărcuța, went parallel with state-led standardization of the care practices of philanthropic agents and the statization of certain confinement oriented re-education regimes that were aimed at fighting "beggary" and "vagabondage". This transformation was guided by the partial replacement of charity and pity as affective motives for the alleviation of suffering to the ensuring of the public interest through a system based on solidarity. Yet, the contradictions of this system were built into the categories of intervention which ranged from protection - a concept with a strong built in power-asymmetry - to confinement and control - proving that solidarity was conceived of not as primarily with the vulnerable subjects targeted by these measures, but with public order and the clean look of the city streets.

Productivism, processes of partial dialectics and their infrastructural translations: Separating the alienated from their residual populations

When the population of the alienated was transferred from Mărcuța to the newly founded central psychiatric asylum around 1923, it is likely that a population of mentally disabled people were left behind, as well as other non-medical residual categories. Mărcuța at the end of the 1920s housed the mentally abnormal (Botez, [1930], pg. 236). (Part of?) the settlement comes to bear the name “Principele Nicolae” (with 350-400 Botez 1930 pg. 240, later 500 places[107], Enciclopedia României , hereafter ER [1938], 2000) and we find news of its functioning as a closed settlement for the education of children who “because of their physical or psychical defects cannot be placed with raising [foster] parents within the Sheltering Centers” (see ER, [1938] 2000 pg. 530). These come to remain in the settlement temporarily or until they will have learned a profession (see ER, [1938] 2000 pg. 530) – meaning that until they will have been rendered productive.

The question of the continuity of the infrastructure of Mărcuța as the settlement “Principele Nicolae” (Botez, 1930, ER, [1938] 2000) must have been strongly entangled with its biopolitical geography as a place where people were let die, abandoned by scientific psychiatry due to the dangers it posed on the life of its curable patients[108].

Although scientific psychiatry claimed an interest in the enhancement of life and the treatment - medical normalization - of the alienated. This was infrastructurally reflected in the fact that by 1938 psychiatric hospitals in Romania had a total capacity of 5695 beds (out of the total of 24696 hospital beds in Romania at that time, an impressive percentage) in 16 mental and nervous illness hospitals in the entire country. (see ER, 1938 [2000], pg.506). Yet, modern psychiatry was not as interested in the abnormal or the mentally disabled[109] which remained behind in the now publicly stigmatized and still biopolitically threatening residual infrastructure, just like other relative surplus populations, the “beggars” and “vagabonds”. These newly emerging residual populations, now (at least partially) separated from the curable or treatable

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[107] It is interesting to note the growing numbers of official beds in the “principele Nicolae” settlement. It is possible that actually the whole range of previous beds continued in use for different categories of non-medically treatable people and that the diverging numbers reflect the different purposes of this settlement.

[108] It is very telling that I could not encounter any elaboration on how a place abandoned for reasons of causing people premature death was then re-assigned to house a facility of re-education. Nor could I until now find any information on how the biopolitical consequences of its geography were overcome in the years of its functioning, but I suspect there must have been systematic hygienic measures taken at some later point.

[109] “*debili*”

alienated, remained in the left behind infrastructure that was re-destined for their (re-) education as productive subjects.

The psychiatrically produced category of prospective curability and its partial dialectic of non-curability, produced the category of (1) defectives that could be educated for production and thus rendered independent of state care, as well as (2) the category of the chronically mental [illy ill] (see ER, pg. 506).

What the (1) defectives are concerned: their medicalized condition would remain unaltered but the educative process would empower them to re-enter society after having spent time in closed settlements in dubious places (such as the former grounds of Mărcuța). This category was reflected the emergence of a new productivist category of sense making that was translated into the social assistance system for “defectives” which involved placing blind, deaf-mute and mentally abnormal children into state care until the age when they can provide for themselves (ER, pg. 525). During this time, they received both theoretical and practical instruction provided to them by the Ministry of Health in specialized settlements. The children who are proven to not be educable were to be transferred to specialized asylums for the “un-educable” [110] (see ER, pg. 525), and thus in a new partial dialectic process another category emerged.

In other words, the category of non-curable, but educable too came to have a partially dialectic residual category that of un-educable subjects: people who would now be describes as severely mentally disabled[111]. This category described people that due to their condition were “not capable of any kind of labor”, testifying to the productivist nature of the modality of sense making that had given rise to them. The “un-educable” were housed in the only settlement for the un-educable at Târgu Mureș, in Transylvania, a place that had sixty beds (see ER, [1938] 2000, pg. 532).

What the (2) chronically mental [illy ill] are concerned, they were housed in special colonies, as the one described by Cahane (1932) at Dicio-Sân-Mărtin, as well as others at Balotești-Ilfov and Râul-Vadului-

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[110] *needucabilii*

[111] In the clinical terminology of the time, these subjects were called with names which later came to become popular derogatory terms: the idiots and imbeciles

Sibiu (see ER, pg. 506). The system of colonies for the chronically mentally ill which most probably had significant similarities with the asylums, but a permanent character, geared to minimizing the burden on both the family and the state of the chronically alienated were being built throughout the country by 1938.

The category of chronically mentally ill immediately after its emergence and infrastructural translation gained a biopolitical importance that went beyond the letting die of populations in asylums (be they monastic or modern). Although never translated into specific policies the 1930s brought about a debate surrounding the eugenic sterilization of the chronically mentally ill (see Turda, 2009 for an overview). The most extreme position within this debate was held by a psychiatrist from Dicio-Sân-Mărtin, an open-door alienated colony project[112] in Transylvania that came to be part of Romania after the first world war.

Mareș Cahane argued in favor of the eugenic sterilization of mentally ill for economic reasons, stating that caring for multiple generations of alienated people was an undue strain on state budgets (see Cahane, 1932, pg. 200). The obvious economic arguments, so Cahane, posed a new problem: namely once the alienated come to be living together with peasant families in the open-door system, how to avoid their "caco-genic" genes from spreading through procreation? We learn from his text that ad-hoc solutions found by doctors included avoiding releasing young patients into the colony by keeping them in the hospital (compare also Cahane, 1935). Cahane (1932, 1935) makes an effort to show that eugenic sterilization was a due, albeit recognizably "violent" and "uncivilized" balance between protecting the genetic future of the nation and giving the alienated the possibility to return to society.

Cahane's efforts led him to propose a motion to be passed by the 11th Congress of the Society for Neurology, Psychiatry, Psychology and Endocrinology supporting the eugenic sterilization of the chronically alienated

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[112] See Cahane (1932, 1935); This project had had a thunder-development even more impressive than that of Mărcuța, starting with 39 mentally ill people in 1905, and none committed to the hospital, the settlement reached its peak in 1914 with almost one thousand mentally ill people in family placement (972) and another 132 in the central hospital (Cahane 1932, pg. 201). The war caused the colony to decrease in size and no new people were brought to the place, which by 1930 (now part of enlarged Romania) had come to host only 190 in the central hospital and 129 in the colony. It was this that caused it to be called the "Geel of the Orient", being thus a realization of the plans associated with the building of modern asylums.

(see Cahane, 1932, 1935 and Turda, 2009)[113]. The motion although signed by the likes of Parhon and Leon Baliff, was never submitted to the ministry of health, nor made public (Turda 2009). This mostly due to the fact that the position was perceived as extreme for its day, probably also by its signatories. (compare Turda 2009)

Nevertheless, this short incursion into eugenics and psychiatry shows that the biopolitical signification of "alienation" was not limited to the alienated as a socio-biological subject, but also to her potential descendants. This did not remain in the sphere ideological debates surrounding the role of the state in the genetic future of the nation. As Cahane (1932) mentions, Parhon had carried out the sterilizations of mentally ill patients in Romania. This was researched by historian Marius Turda who found that they most likely had been the first such cases and that there is unfortunately no archival trace of these practice that has resurfaced to date (2009, pg. 89).

In short, the partial infrastructural and discursive separations between the curable, the educable and the abnormal un-educable defective, as well as the non-curably chronically mentally ill are at least as old as the extended staticized system of treatment and care of the interwar years, yet, it will mature into a full-blown distinction with further severe biopolitical consequences during the later period of state socialism. The difference between the two categories of (1) defectives and (2) chronically mentally ill lay in their relationship to psychiatric matters: whereas defectives that were considered educable were those intellectually disabled that needed guidance and not primarily treatment in order to be rendered productive, those alienated that were placed in colonies such as that at Dicio-Sân-Mărtin were considered mainly mentally ill, yet, not curably so, making their placement under a coordinated psychiatric gaze and an organized family based productive environment surrounding the hospital the permanent desired form of

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[113] The text of the motion is reproduced in Cahane 1932, pg. 546, as well as partially in Turda 2009, pg. 88 and reads: "Members of the 11th Congress of the Society for Neurology, Psychiatry, Psychology and Endocrinology, taking into consideration that due to the insufficient number of beds in the hospitals for mental illness, a number of chronically mentally ill people are left to walk freely in society or are placed in family colonies we ask the Minister of Health [starting here the translation has been taken from Turda, 2009, pg. 88] to accept as a prophylactic measure the sterilization of the hereditarily feeble-minded by X-rays or vasectomy. This sterilization could be performed only on patients who have been interned for at least five years in a mental hospital and only after the advice of a commission of specialists and the consent of the family [have been obtained]."

avoiding long term hospitalization due to its high costs for the state. Interestingly, both categories albeit differently were created in relation to the process of rendering the subject productive through educational or medical-social means. This went hand in hand with the processes of urban and technical modernization that had become common place at that time.

Intensified statization and extending the interwar system: postwar care of the mentally ill and disabled

The main analytical distinctions between the mentally ill and the mentally disabled, as well as the institutions were already in place by the beginning of the second world war and were inherited by the postwar state socialist system. The institutional building blocks of the system were not challenged during early state socialism. To the contrary, in this time the system came to be extended on a massive scale.

What the psychiatric infrastructure was concerned, according to psychiatry professor Mircea Lăzărescu (2006, pg.1), the years between 1955-1965 saw the establishing of 80% of the country's psychiatric hospitals that were still functioning in the 2000s. The buildings were not built especially for these purposes (ibid.)[114], and were most probably mansions that had belonged to noblemen and boyars that had been nationalized during the early years of socialism. Moreover, 1960-1975 saw the founding of 80% of the psychiatric wards in general hospitals (Lăzărescu 2006, pg.1). By the 1970s thus, the hospital centric infrastructure still in use today had been set-up, a step followed then by a relatively timid attempt to install community care services starting 1975 under the name of Laboratories of Mental Health[115] (ibid.). The psychiatric modality of sense making centered on treatment became generalized, but so did the separation of the curable from the un-curable or more precisely chronically mentally ill. The chronically mentally ill would be taken out of the medical treatment infrastructure into hospital homes[116] which later came to be places of death.

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[114] The only buildings built especially for this purpose originate in the 19th and 20th century (Lăzărescu, 2006), like those of Socola and Obregia.

[115] *Laboratoare de sănătate mentală*

[116] cămine spital

The social sheltering infrastructure was also extended at this time. It was here that a central emphasis on rendering productive was entangled with the increased importance of the meaning awarded to the imaginary of the state as a collective actor (compare Painter, 2006). This increased importance of the state meant the substitution of the interwar regulation of philanthropic activities through the state by an enacting of social assistance directly by the state and was connected to the furthering of the interest of the oppressed masses. A report on social assistance from 1950 stated "[during the previous regime] social assistance was organized to a very little extent by the State and to a very large extent by private societies (philanthropic or charity) that were also serving the exploitative interests of the bourgeois class." This transformation was based on the rendering productive of the "deficient" subjects. This was to be done by an increased emphasis on rendering the "deficient" productive and thus free of being "dependent on the alms of propertied classes"[117]. Yet, although the emphasis was on solidarity and not charity, as well as the rendering productive as a possibility for equitable inclusion into production, the system remained an asylary one.

The tense cohabitation between treating and rendering productive as means to inclusion, as well as confinement in order to protect the order or purity of the outside community remained the cornerstones of the now enlarged and generalized system. Pushing people around based on classifications seemed to increase with the growing number of institutions, since now *centre de triaj*, also appear selecting and sending people from everywhere in the country to everywhere else based on their classifications. At the same time, the asylary institutions seem to have played a central role in the political economy of labor during state socialism and after - they were built in isolated places not only to hide the "deficient" and the "chronically mentally ill" from the sight of mainstream society, but also in order to provide places of work to people in underdeveloped regions of the country[118]. It is in this system that the neuropsychiatric children's hospital of Siret is established in 1956, a point that I will explore at length in part 3. It is also in this system that the Asylum is established in 1962.

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[117] MMSOS 9/1950, ANIC Bucuresti pg.140-142, Referat approved by L. Rădăceanu, 16.01.1950

[118] A point which was stated clearly by the head of the former children's hospital in Siret in conversation we had, as well as by a human rights activist during our interview.

Moreover, it is this system that became over-populated in the aftermath of Ceaușescu's pronatalist policies (decree 770/1966), and the encouragement of institutionalizing disabled and poor children that followed law 3/1970 (see also Jinga, 2011). It is also in this system that overcrowding led again to letting people die. And it is in this system that transnational humanitarian volunteers came to challenge the system of solidarity in the name of charity in the 1990s.

Conclusion

Asylums as cornerstones of a biopolitical order that involved both an injunction to make the mentally ill live, as well as the potentiality to passively or actively let them die emerged as one of two cornerstones of a religiously designed biopolitical order. Based on a religious modality of sense making centered on healing, the first asylums offered both a continuity and a break with Ottoman urban spatialities destined for marginal populations, *calici*. At the same time, they were entangled with the political meaning attributed to nuclear families as self-sustaining economic units - only when the family would fail, would the asylum become an option for (not) furthering the life, as well disciplining the mentally ill subject. This modality of sense making broke with the pre-modern urban organizations by introducing a structural form of silencing the mentally ill subject, as a "cursed", "sinful" subject who is unware of herself.

The double biopolitical nature of asylums and their nature as places of isolation from "sickening" families was carried through into the modern psychiatric system together with the injunction to heal the mentally ill subject. Yet psychiatry did not use the language of healing[119], but of curing[120] which it shared with empiricist practical healers. Yet, psychiatry as an academic medical discipline taught in Western European universities grew to monopolize the credibility in the domain of statization. As a scientific and Occidental discipline, it drew on a narrative of Europeanization that what as the core of late 19th century state-making practices.

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[119] *tămăduire*

[120] *vindecare*

Thus, modern psychiatry as a modality of sense making came to imbue the imaginary of the state, transforming it by empowering it against the religious-philanthropic modality of sense making.

Despite taking over most of the vernacular practices of the religious modality of sense making and the empiricist modality of healing, psychiatry with its modernizing ambitions came to innovate in terms of analytically separating its subjects - it individualized the masses of confined people in monasteries and sought to choose those who can be normalized through bio-chemical, as well as disciplining treatments. Its practices of hierarchization and classification of subjects came to be spatialized in the two modern asylums that exist until today. Yet, its ambitions to further life through these classifications were soon after their creation invalidated.

Yet, psychiatry's individualizing force created the conditions of possibility for a new process of massification to occur. The idea that there are different kinds of treatable and thus normalizable subjects co-produced its dialectic opposite - those who are mentally ill, but not curable - the chronically alienated or mentally ill. The emergence of this category furthered the creation of new asylums during the interwar years that were connected with ambitions not to confine the population of alienated, but to control them. The emergence of this category also made possible the emergence of a eugenic debate regarding the sterilization of this population. The imaginary of the biopolitical future of the nation came to be entangled with the infrastructurally translated stigmatization of those considered un-treatable by medicine.

However, influential psychiatric reasoning grew entangled with a new powerful way of asking questions that similarly characteristic of modernizing aspirations: the need to render subjects productive, so as to render them economically sustainable and independent of their nuclear families. Although this reasoning can be traced well into the 19th century emerging more or less at the same time with psychiatry's classificatory ambitions, it grew influential during the early interwar years with the creation of the ministry of labor and social affairs after the first world war. The language of "deficiency" was strongly tied to a productivist modality of sense making that sought to create educational disciplining technologies adequate to certain types of deficiencies, including so-called moral ones.

The productivist modality of sense making dominated social policy imaginaries, by rendering the question of making someone productive a matter of the state[121]. Yet, this injunction to render productive the "deficient" also created a dialectic relationship between the category of educable and un-educable subjects with an injunction to separate the first from the second. This resulting dichotomy was in turn also infrastructurally translated leading to the emergence of asylums for those who are deficient and un-educable, a further residual category that escaped both medicine and education's disciplining technologies.

The care and treatment of those who are curable and educable, was be seen as a matter of private interest or philanthropy, only to be regulated by the state up until the inter-war years. The notion of social solidarity as a main driver of statization was translated into an increased governing and thus standardizing of philanthropic and humanitarian practices during the interwar years. At the same time the increased statization of previously religious and humanitarian matters, came to be expressed in state disciplining facilities for those considered "morally deficient", such as re-education facilities for "beggars", "vagabonds", etc.

These distinctions, notions and institutions were in place by the end of the interwar years and were inherited by early state socialism. While rejecting humanitarianism as a valid modality of sense making, state socialist social policy planning resolved to intensify processes of statization by replacing philanthropic with state infrastructures. Although more strongly emphasizing the need to render productive the "deficients", state socialism did not challenge the notions it inherited from interwar social and medical policy making - thus it came to extend on a massive scale an infrastructure which had been previously put in place. The double nature of asylums as places of contradictory biopolitics, involving both letting die and making live, was inherited into this system; as was its dialectic relationship with nuclear families as autonomous economic subsistence units.

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[121] It is not incidental that the ministry of labor is the same as that of social protection ever since its founding and that the ministry of health is sometimes merged with and sometimes separate from these two - since the rendering productive appears the main goal of social protection and assistance.

It is this infrastructure and its everyday life that I will explore in other chapters of the dissertation.

Chapter 3: Biopolitical advocacy in and after transition: the humanitarian, the human rights and the experience based modalities of sense making

In this chapter, I will explore four modalities of sense making that are operating in Romania in the present time. Two of them that have been central to transforming the biopolitical landscape of asylums during transition, the trans-national humanitarian and the human rights modality of sense making. The other two modalities of sense making can be read as very recent counter-points to the two main biopolitical modalities of sense making. The judicialization of the biopolitical past of state socialism is a counter-point to humanitarianism (as relief of the suffering of victims), which centers on the perpetrators of processes of letting disabled child die and seeks to make their punishment possible. A fourth modality of sense making has been emerging for some time, but it is now close to coming to maturity - the experience based advocacy. Focusing on life trajectories of people from institutions, the experience-based modality of sense making enables a re-politicize of stories similar to those that circulate in the human rights modality of sense making. I will trace each of these modalities of sense making genealogically and look at how humanitarianism and human rights modalities of sense making construct their populations and who are those left out by these constructions. While presenting these dominant modalities of sense making, I will also introduce the way in which how each is reworked by another less dominant modality of sense making that of judicialization for humanitarianism and the experience based one for human rights.

Both the humanitarian and the human rights modalities of sense making work with an asymmetry between the ones about which knowledge is produced and those which need to attain this knowledge. NGOs come to mediate an epistemic asymmetry between those who receive humanitarian aid or those who are victims of human rights infringements and the publics that need to learn about and act upon it. The humanitarian modality of sense making mobilizes direct action through humanitarian aid in a global market of morality. The mobilization of transnational aid to foster the lives of victims turns into a staticized search for the perpetrators of letting disabled children die in state institutions during state socialism, as the Romanian state tries to clean itself of its “Communist” past.

The human rights modality of sense making operates through getting publics to pressure the state or other institutional political actors (such as the European Union). As a counterpoint, a fourth modality of sense making aims to change the way in which the life of (formerly) confined people is fostered through an experience based account. This modality of sense making allows for a thicker complexity that leads to the development of more sophisticated, and at the same time inclusive political strategies and tactics. It is nevertheless, therefore, harder to replicate and expand.

Seeing only “tiny kids in cots”: the making of the population for transnational humanitarian action

A group of doctors who ran an evangelical charity in Britain, started coming to Romania at the beginning of the 1980s, but stopped soon after due to an experience of political intimidation. They only resumed sending goods around Xmas of 1989, the famous execution date of the Ceaușescu couple and only returned to Romania in the spring of 1990. At that time they asked an official at the ministry of health where they can help with medicines, they had received through a grant from a mental handicap organization in Britain and were referred to the neuropsychiatric children hospital in Siret.

Upon entering the hospital building, they saw the kids in cots, all dressed in uniformed rags and some standing straight in lines or tied to benches. It was clear that the hospital did not have enough staff and almost no medicine, so they started to send in both. One of my interview partners also remembered that she had photographed the tiny children in cots, just took slides of pictures. Upon her return to Romania one year later, she shared the photos with the children themselves and was impressed that the children recognized each other - she could only see "tiny kids in cots"[122]. How did she and numerous other humanitarian volunteers come to see only "kids in cots"?

The image above seems to fit the description of the volunteer, although it is unlikely that it is the photo she took. By googling "Romanian orphans" it is one of the first photographs that come up - having been shared widely it is unclear what the original source of the picture was[123]. What made this picture so powerful, so as to keep being shared so many years (some of the shares came from the early 2010s) after most probably the children in the picture have long grown up - is that it captured this same sense of suffering children in cots. The trope that legitimized mass humanitarian action by Western European and North American volunteers around Romanian "orphanages" in the 1990s. It was through these visual artifacts - such photographs of children in cots that the population of "Romanian orphans" was created[124].

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[122] Interview Siret, May 2015

[123] https://timnovate.wordpress.com/2011/12/31/resilience-the-case-of-the-romanian-orphans/ I have it from here (accessed on 17.02.2018), which appears to be a blog about self-betterment introducing one of the statistical results about the attained normality or adopted previously institutionalized Romanian children, but the picture can also be found on a conservative blog discrediting communism and other places.

[124] In many cases, these places were not "orphanages", since the "children" were not orphans- given the numbers of at least about 100.000 institutionalized children (Morrison 2004, pg. 168) in a country of 20 million, it must have taken

As also noted in the introductory section to this part, the creation of a "'population' is dependent, in its first instance, on the establishment of practical equivalence among subjects, objects or events" (Curtis, 2002). Basically, what happened through the production and circulation of this picture and the corresponding imagery was the creation of the homogenous image of the Romanian orphan living – or more precisely being let die - in a cot in an orphanage. That in most cases, these children were not orphans is invisible and irrelevant in this modality of sense making. As is the complexity of the actual conditions that brought the children to total institutions.

There appear to be no relationships among the children and except suffering and the possibility of relief there appear to not have been any other concerns and activities surrounding the child – the child in the picture became what Liisa Malkki (1996) called a "speechless emissary" - the "ahistorical, universal, humanitarian subject" (see pg. 378). The child in the picture was the "speechless emissary" of "Romanian orphans".

The creation of this population made possible the activation of aid flows in the global market of suffering (see Clifford, 2002). Yet, the imaginary and population somehow emerged simultaneously with the incipient incorporation into this global market of morality. Or put differently, the volunteers did not produce such pictures only to be sure that they could "pitch" the situation of "Romanian orphans" to potential donors. As the interview shows, the volunteers initially actually saw only children in cots devoid of all social connections or else why would they be impressed when they found out that children recognized each other? Their way of seeing the massification brought about by the uniformizing tendencies of state socialism in total institutions for children travelled into the global imagery of "Romanian orphans". Put differently, in order for transnational humanitarian aid to become a mass practice as it did in Romania around orphanages in the 1990s, a population deserving of such mobilization by Western standards needed to be created. Yet,

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a war to produce such numbers- but this was not the case. Rather than this it was the combined effect of pronatalist and pro-institutionalization policies carried out in the late 1960s and early 1970s, which I explore at length elsewhere in the dissertation.

the exact features it came to take were up to the way in which the early humanitarian volunteers, as the group I interviewed were, interpreted the situation into which they literally “landed”.

The population of “Romanian orphans” made possible a transnational reworking of the biopolitical functioning of total institutions for disabled children in Romania. Humanitarianism addressed mainly the places where the “unrecoverable” children were held, since they were the most precarious. Such a place was the hospital-home for unrecoverable children at Cighid. Cighid was located very close to a national border - in this case the Romanian-Hungarian border and the hospital was placed in a building with a previous life - the hunting castle of the Hungarian count Tisza[125].

Cighid was exposed to the Western world as a place of death by a German (Spiegel TV and der Spiegel) documentary[126]. A revisit from 2015 of a documentary filmed in 1995 speaks openly about the state biopolitics of letting “unrecoverable” children die during the Ceaușescu era. The documentary is introduced as follows:

“The „unrecoverables“ - this is what those children, who according to state standards did not deserve (were not worth) living, used to be called in the times of the Romanian dictator Ceaușescu. They were systematically let die in Cighid, a children’s home, in the Western part of Romania. The images of horror that SPIEGEL TV and DER SPIEGEL showed shortly after the fall of the dictator, awoke international participation. Donation-money saved the lives of many children. SPIEGEL TV visited the children five years later again. “[127]

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[125] Info available here http://adevarul.ro/locale/oradea/castelul-cighid-lagarul-copiilor-handicap-putea-cumparat-consiliul-judetean-bihor-1_562a8cb2f5eaafab2cf87071/index.html accessed on 17.02.2018

[126] see http://www.spiegel.de/video/vor-20-jahren-die-verlorenen-kinder-von-cighid-video-1561943.html and http://www.spiegel.de/video/rumaenien-das-zweite-leben-der-kinder-von-cighid-video-1168115.html and http://www.spiegel.de/video/25-jahre-spiegel-tv-die-kinder-von-cighid-video-1270517.html all accessed on 17.02.2018, also online is the written journalistic document http://magazin.spiegel.de/EpubDelivery/spiegel/pdf/13499656 accessed on 17.02.2018

[127] See http://www.spiegel.de/video/vor-20-jahren-die-verlorenen-kinder-von-cighid-video-1561943.html accessed on 17.02.2018

The story of Cighid continued being narrated in terms of the re-making of a place of death that Romanian journalists referred to as a concentration or extermination camp[128]. The written Spiegel documentary nevertheless, explicitly differentiated between "Auschwitz" (the way in which the neighbors allegedly referred to Cighid) and Cighid: " […]but Cighid ist not and was not an "Ausschwitz". In Cighid the killing-taboo is still formally respected. Cighid is the name that euthanasia through living conditions bears."[129] Cighid as a place of let-die was therefore documented in the journalistic piece in 1990, including the numbers of deaths in the two years the institution operated (1987-1989, formerly it had been an adult total institution) - 54 children, who died in 1988 and 62 in 1989 (ibid., pg. 202) from causes such as malnutrition and pneumonia.

Judicial reckoning with the biopolitical past – as reversed humanitarianism

The comparison to concentration camps and the thickness of the documentation of the biopolitical practices surrounding Cighid by the German journalists were maybe two of the reasons, why Cighid came to be included in a penal trial initiated in 2017 by the Institute for the Research of the Crimes of Communism and the Memory of the Romanian Exile[130]. The trial was opened for "inhuman treatments", a practice that according to the researchers had been illegalized by the penal code in 1968[131]. The research institution has the prerogative to notify the general prosecutor's office about crimes committed by/ during communism.

The practice of merging a judicialized reckoning with the past based on historical sources collected through a humanitarian modality of sense making embedded in the trial that has just begun with the press conference on the international children's day 2017 (1st of June) points to two things. On the one hand, the Romanian

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[128] A national TV (ProTv) documentary titled The children's lager, *Lagărul copiilor* from 2012, available here https://www.youtube.com/watch?v=XpxdKkYUlio (part 1) accessed on 17.02.2018, as well as *Mărturii exclusive din Cighid, lagărul de exiertminare a copiilor din România* https://observator.tv/social/marturii-din-cighid-lagarul-de-exterminare-a-copiilor-din-romania-211992.html accessed on 17.02.2018

[129] See documentary here http://magazin.spiegel.de/EpubDelivery/spiegel/pdf/13499656 accessed on 17.02.2018 , Spiegel 13/1990, pg. 195

[130] https://revista22.ro/70263175/iiccmer-a-depus-o-plngere-penal-pentru-moartea-a-771-de-copii-n-trei-cmine-spital.html accessed on 17.02.2018

[131] http://stiri.tvr.ro/copii-tortura--i---i-lasa--i-sa-moara-in-comunism--povestea-lui-izidor--orfanul-care-a-scapat-din-caminul-spital-de-la-sighet_818381_video.html#view accessed on 17.02.2018

state has taken over the reckoning with the past from the humanitarian modality of sense making[132] - or put differently the judgement of the past has been staticized through being judicialized. Judicialization thus become a new modality of statization[133]. On the other hand, what started out as helping the needy suffering children by transnational volunteers, has now become a question of punishing the actors of this biopolitical regime in the name of judging "Communism" - in which judging is meant literally, as the head of the research institute explained:

"The number of victims is hard to estimate. We came up with 10.000. there are more than 10.000 victims of the system, not of people. This is the first complaint regarding systematic crimes and systematic has three dimensions. On the one hand, the administrative, there are people that concretely were guilty for what happened, professionally, doctors and other professions that did not do their job completely and political, since these institutions were under political control".[134] Although the head stresses that the problem was systematic and not personalized, the people who will be judged for it primarily were those carrying out the policies of let die that have appeared to be systematic throughout the country. What is interesting to note here is that the fact that the policy of letting "unrecoverable" disabled children die was never official state policy, despite the complex web of selection criteria and hierachization practices with clear biopolitical consequences that the trial is uncovering. This unofficial, yet systematic structure in which "unrecoverables" were let die, made possible the emergence of this complex judicialization. Since people were acting on behalf of the state against the state laws, they are today punishable under those laws. Yet, the need to attribute to them (the administrators, carers, doctors, politicians acting on behalf of the system) punishment

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[132] The press file was filled with documents supplied by or produced by international humanitarian volunteers-journalists from the early 1990s, see https://www.iiccr.ro/wp-content/uploads/2017/06/2.-Cighid-print.pdf and http://www.iiccr.ro/sesizare-penala-privind-tratamentele-neomenoase-perioada-comunista-in-caminele-spital/ accessed on 17.02.2018 The head of IICMER- the Research Institute, Radu Preda, also stressing that the three institutions (of the 26 chosen to be investigated) were chosen because they had been covered by the foreign press, immediately after 1989.

[133] I thank John Clarke for pointing me to the conceptual relationship of judicialization as a modality of statization out..

[134] available here https://revista22.ro/70263175/iiccmer-a-depus-o-plngere-penal-pentru-moartea-a-771-de-copii-n-trei-cmine-spital.html accessed on 17.02.2018

is necessary in order to end transition and allow for a “new” “clean” Romanian state to emerge by re-inventing itself.

This need to clean the state acts through identifying guilty people - perpetrators – and seeking to punish them judicially. Through their punishment, the actions of letting children die lose their legitimacy, while the state on behalf of which these biopolitical practices were carried out becomes legitimate and is thus freed from its biopolitical past. It is interesting to note how this modality of sense making was made possible by humanitarian reporting that sought to show the plight of the victims of “Communist” biopolitics – establishing an open dialectic. If there are victims that need help, there must also be perpetrators. The dialectic thus strives for completeness through this recently emerging modality of sense making.

Human rights modality of sense making

Biopolitical changes and the human rights modality of sense making

The first connection between psychiatry and human rights monitoring came about around the 1970s, when Amnesty International (hereafter AI) (1979) showed concerns about political prisoners in psychiatric facilities in several countries in Eastern Europe, including Romania. These practices were also documented and challenged by a psychiatrized activist for free trade unions and human rights, Vasile Paraschiv (see Parschiv 2005). Although the first encounter between psychiatry and human rights in Romania was in this context, it is a very limited biopolitical encounter since it does not concern the fostering of lives of all the people in closed institutions for the mentally ill, but only those who are there for “political”, thus wrongful reasons.

The emphasis from Cold War logics stressing the individual dissident’s destiny at the hands of a totalitarian state and the corresponding early AI activity centered on political and civil rights of prisoners of conscience are transcended when Romania joins the Council of Europe in 1993[135]. The Council of Europe’s monitoring

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[135] https://www.coe.int/en/web/portal/romania accessed on 19.02.2018

body, the Committee for the Prevention of Torture and Inhuman and Degrading Treatment (hereafter CPT), similarly to AI is focused on "preventing ill-treatment of persons deprived of their liberty in Europe"[136].

The CPT started visiting places where people were deprived of their liberty in Romania in 1995, but only published its first report in 1998[137]. This was due to the policy of protecting human rights inherent in the practices of the CPT - which involved not entering into conflict with the states by publicly criticizing them, or in the words of the CPT 1998 report: : "The task of the CPT is not to publicly criticizes the states, but to assist them in the search for ways and means to enforce a "sanitary belt" that separates the acceptable treatment or behavior from the unacceptable treatment or behavior."[138] Through this the CPT positions itself as an aid to the state in identifying practices that "the state" as a "European state" (part of the Council of Europe) could not want to see continued, but that somehow happened despite the "state's" best intentions.

What the CPT found on its first visit to Romania at Poiana Mare hospital were twenty five cases in six months of death by starvation, as well as an in total death rate of sixty one people in six months of the five hundred people committed (end of February to September 1995) (see CPT, 1998, pg. 78). As the protocol with the Romanian government went, a biopolitics embodied by the hospital did not cause a scandal. Rather than this, a subsequent visit by the CPT in Poiana Mare in 1999 (report published in 2003[139]), noting improvements in the living conditions (CPT, 2003, pg. 84) and in nutrition, although noting that the served meals still contained 30% less calories than necessary (ibid., pg. 85)[140].

The CPT practices that clearly must have reminded the monitors of the humanitarian crisis surrounding institutions for the disabled children that had just been in the headlines, a few years previous to 1995. The inmates at Poiana Mare, although like the children of Cighid, were dying avoidable deaths in total institutions - yet, at that point in the 1990s they did not become the subjects of prime time documentaries

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[136] https://www.coe.int/en/web/cpt/about-the-cpt accessed on 19.02.2018

[137] See page with all the reports of the CPT here https://www.coe.int/en/web/cpt/romania accessed on 19.02.2018

[138] CPT, 1998, pg. 9, report (only French version) available here https://rm.coe.int/16806979e2 accessed on 19.02.2018

[139] https://rm.coe.int/16806979e4 accessed on 19.02.2018

[140] The CPT continues reporting on psychiatric hospitals until today .The last report was published in 2015 about a visit in 2014 and is available here https://rm.coe.int/1680697a4a accessed on 19.02.2018

and there were no flows of humanitarian volunteers coming to rebuilt the hospital. Rather than this, the Romanian state mobilized some resources and partly and temporarily mended the situation, only for Poiana Mare to re-emerge as a place of death in the 2000s[141].

This has to do with the circulation of knowledge characteristic of the Council of Europe monitoring activities, yet, at the same time there is something related to what the humanitarian modality of sense making does not capture that becomes visible when thinking of the deaths at Poiana Mare. Poiana Mare at that time was still a partly forensic psychiatric hospital - so people who had committed criminal offenses and had been considered legally irresponsible due to mental illness were held there. Moreover, the hospital was exclusively one for mentally adults. Despite the dying going on, it was not easy to present to the "world", meaning Western publics, the plight of these people - who appeared neither innocent, nor helpless. They thus did not easily qualify for becoming what Liisa Malkki (1996) described as "speechless emissaries". They did not qualify for the affective mobilization behind humanitarian biopolitical interventions - thus they could only be legitimate subjects of another modality of sense making and its biopolitical order - in this case that of human rights.

The human rights modality of sense making, in the form it took after the end of the Cold War, operated through the state and not despite it. Therefore, the human rights reporting practices did not need to mobilize spectators of suffering (Chouliaraki, 2006) to act directly. What needed to be done in order for change to emerge was to notify "states", meaning officials acting on behalf of the state as a collective imaginary. The CPT constructed its population, not on the basis of suffering, but by building on their conditions as people "deprived of liberty" - meaning that people, who would find themselves in the spatial confines of closed spaces run by the state.

Through this the initial modality of sense making built into AI's 1979 report is both reproduced and challenged. The concern is still with detained people, but not just with those "unjustly" psychiatrized, but

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[141] Interestingly, it is very possible that by the time the CPT published its report in 2003 in French, Poiana Mare had returned to being a place of let-die, see AI 2004 a,b.

with all who are subjected to inhuman and degrading living conditions and treatment. Thus the human rights modality of sense making is broadened. Yet, at the same time when it is broadened, it is also refocused and restricted, since it comes to tightly regulate the circulation of knowledge it produces in order to maintain cordial relationships with the "state". Through this the "public" is no longer an addressee, at least not a main one for this human rights activity. Another important epistemological restriction of this form of human rights practice was that it was limited to very few places, visited once every three years. Generally, visits would be rarely repeated in the same place and then generally not more than once. This created the possibility for temporarily replacing a let-die biopolitical order, but not fundamentally reworking it.

The human rights modality of sense making comes to be yet again transformed in the advent of Romania's EU accession negotiations which also facilitated the return of AI as a central actor in this field. In 2003 and 2004 AI carried out monitoring visits to six psychiatric hospitals throughout Romania, as well as compiled information from different sources (in a relatively un-transparent way). In May 2004 AI released a memorandum to the Romanian government presenting the situation it had observed in psychiatric hospitals as representative of the entire system and urged the government to immediately take measures in the direction of deinstitutionalization (AI, 2004b).

Although AI had started its monitoring visits in late 2003, the spark that made the human rights discourse thoroughly enter the public discourse came from a visit to one of few forensic psychiatric hospitals in Romania, that of Poiana Mare in early 2004. AI found that at least seventeen people had died in the two winter months preceding the visit (January, February)[142], apparently from malnutrition and hypothermia and that eighty four people committed to the hospital had died under similar circumstances the previous year. Press reports speak even of one hundred people that had died in two years (from a capacity of about 500 beds)[143].

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[142] Amnesty International AI Index EUR 39/002/2004

[143] http://www.9am.ro/stiri-revista-presei/Actualitate/32628/Genocidul-Poiana-Mare.html and http://www.gds.ro/Actualitate/2006-11-13/Lobby+pentru+Spitalul+Poiana+Mare/ accessed on 30.11.

The statement issued by AI (2004a), as well as statements issued by a newly founded Romanian NGO that still carries out monitoring visits to psychiatric facilities quickly travelled into press articles of the time, sparking horror. Titles included: “desperate situation of the patients from Poiana Mare” , as well as comparisons of Poiana Mare with a “concentration camp”, comparisons of other hospitals/ recovery centers with gulag camps, as well as an accusation of “genocide”[144].

What the report (AI, 2004a) and the subsequent memorandum (AI, 2004b) brought about was a structural transformation of the human rights modality of sense making. What remained constant was that the modality of sense making was still centered on detention centers (including psychiatric hospitals and institutions) and aimed at ensuring the basic rights of the confined, especially the right to life. It still targeted changes that operated through the state. Yet, it also opened an epistemological space where the legitimate knowledge production about total institutions needed to be something external to the state that had to be done by independent monitors: NGOs and journalists.

Moreover, the Romanian state was no longer trusted to make the necessary biopolitical changes without external pressure. The memorandum was released at a very timely moment, since EU accession was to follow in 2007 and one of the central Copenhagen Criteria that had to be fulfilled before accession was to be completed, was to ensure the presence of stable institutions ensuring among other things the respect for human rights[145].

Now, EU accession was promoting human rights through psychiatry to end dying and thus inaugurate an era of civilization - the Romanian “mentally ill” were becoming European citizens and thus their lives had to be performatively protected through their inclusion in the pre-accession monitoring process. The re-drawl of boundaries of European citizenship, thus led to a claim of making the most excluded of future European citizens live. Yet, just as “speechless emissaries” could not be produced out of just anyone who was dying,

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[144] See PressArt related to Poiana Mare, no longer online (available upon request).

[145] See Copenhagen criteria political criteria, available here http://europa.eu/legislation_summaries/glossary/accession_criteria_copenhague_en.htm accessed on 29.11.2014

neither could the people whose lives needed fostering by (state) intervention. At the time of the first pre-accession monitoring report to include psychiatric hospitals as places of great human rights concern[146] in 2005, people were already known to drown at the borders of Europe, trying to cross the Mediterranean into the Italian Island of Lampedusa[147].

The biopolitical border nevertheless did shift to include at least to a certain extent the mentally ill in Romanian asylums through this construction of an inclusive European population, who is entitled to have its life fostered. The human rights modality of sense making had become both enforced institutionally through the pre-accession monitoring process, while being mediated professionally at the National Center for Mental Health, as well as had become inclusive of the entire population of the people confined in psychiatric institutions. Yet, this high-time of the human rights modality of sense making ended with Romania's accession to the European Union and the end of the pre-accession monitoring process. The human rights modality of sense making thus had to re-invent itself for a local audience - and this was most clearly visible in a recent campaign.

"Sign the petition and free them from the lagers."

Throughout 2015 the Center for Legal Resources, the human rights NGO that had exposed the high number deaths at Poiana Mare hospital in 2004, ran a campaign that aimed to show the lives of people that lived in social protection residential institutions and to change these lives by proposing legal changes under the motto: "Sign the petition and free them from the lagers". Also, emblematically captured in the logo representing three uniform figures whose heads are joined by a key chain, the key is in red and hints at the possibility of the figures being freed by the recipient of the image signing the petition.

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[146] European Commission, *Romania 2005 Comprehensive Monitoring Report*, Brussels, 25.10.2005 available at http://ec.europa.eu/enlargement/archives/pdf/key_documents/2005/sec1354_cmr_master_ro_college_en.pdf , accessed on 18.02.2013

[147] AI (2005) available here https://www.amnesty.org/download/Documents/84000/eur300082005en.pdf accessed on 16.03.2018

The text of the petition itself was much milder than the slogan would suggest, asking for the creation of an independent human rights monitoring body that should be government funded and prevent abuses occurring in the centers (see text of the petition, accessed on 05.06.2017). Interestingly, although the text spoke of freeing people from lagers, it was apparent that their presence in such places was rather necessary for the functioning of the mechanism. The law **L303/2015** establishing the monitoring mechanism was approved and the monitoring body was swiftly staffed by the person who had coordinated the campaign, proving the campaign to be at least a partial success in policy terms.

The NGO's request was one of statization of its own activity. Yet, the statization was not completely successful since the activist soon after resigned. The resignation was reportedly caused by the efforts to institutionally block the actual functioning of the monitoring mechanism[148].

The petition was part of a larger public information campaign that consisted of an exhibition, with photos showing the everyday life of institutions designed to be shown at NGO fairs in Romania's larger cities. The setting for the exhibition was a cage where the photos were exposed. In the center of the cage lay a metal bed with no mattress which showed the alleged living conditions in the centers.

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[148] See a letter of protest against the resignation signed by a number of NGOs active in the field disability and human rights fields, see http://romanialibera.ro/index.php/actualitate/eveniment/scrisoare-deschisa-impotriva-demisiei-demisia-georgianei-pascu--care-candidase-pentru-functia-de-presedinte-a-consiliului-de-monitorizare-a-implementarii-conventiei-privind-drepturile-persoanelor-cu-dizabilitati-423502 accessed on 08.03.2018

Source: http://www.fotostefan.ro/lagarele-de-langa-tine-expozitie-foto-in-pasajul-universitatii-din-bucuresti/ accessed on 05.06.2017

The campaign also consisted of a video that explained the condition of people in institutions to the middle-class NGO fair visitors that I have translated below:

“No one ever held me in their arms when I was little.
As you were walking hand in hand with your mother,
I was rocking myself at the edge of a bed.
When I received the toys that had been so dear to you.
I threw them a long look and I hid in a corner.
I didn’t know how to play with them,
since no one had ever told me how to do it.
I grew up in the lagers from next door to you
without getting to know any of the beauties of your world.
In the hell from here, I learned that a beating is a piece of heaven.
The only school I went to is that of survival.

While you were walking hand in hand with your loved one,
I was rocking myself on the edge of another bed.
My hand was not caressed by another hand,
but by a leather belt that dug into my flesh.
Tied with the chain to the bed, I dreamt of your world.
A world in which I could live alongside you.

I grew old.
While you walk hand in hand with your grandchildren,
I cover my eyes or stare blankly at the world I never got to know
and that didn’t want to get to know me.
I have only one journey left to make.
The one that leads to the cemetery.
My pit will be dug by those like me.
No, no one will cry for me.
Another beneficiary has died.

I live in the lagers from next door to you and I am all alone in the world.
Help me to get out and have a home that is mine.”[149]

The text was accompanied by a series of images that illustrated the institutionalized person’s faith.

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[149] my translation from the *Lăgerele de lângă tine* campaign, video available here https://www.youtube.com/watch?v=4OsPeRI3tME accessed on 05.06.2017, posted on 10.12.2014 marking most probably the beginning of the campaign, images from the original video

Image 1: printscreen campaign video “Lagărele de lângă tine”, caption reads “I was small” 0:16

Image 2: printscreen campaign video “Lagărele de lângă tine”, 0:46, caption reads: “I grew up”

Image 3: Printscreen campaign video "Lagărele de lângă tine", 1:07, caption reads: a beneficiary

Image 4, printscreen campaign video "Lagărele de lângă tine", 1:15

While reading or listening to the text, one could get the impression that the text is a first-person narrative taken down by a reporter – yet the process of its production is more complex. As I learned in an interview with the campaign manager and professional human rights activist[150], the text had been written by the communication expert of the team, himself a writer, who had been impressed by the life of people with disabilities locked away in centers. The account is therefore a substitution of the confined disabled subject's

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[150] Interview May 2016

voice by that of the writer-communication expert. The impersonation is a form of disguised ventriloquism, the NGO speaks but what it says is hidden in a first-person account - it speaks through the mouth of the institutionalized person. Yet, what is most problematic is that this ventriloquism results in a fundamental othering that is the axis of the entire account: "while you were", "I was" - constructing a fundamental disabled other, living in a world without social relations (with those like himself) who needs salvation through the middle-class watcher that is prompted to act by among other things signing the petition. The disabled confined subject's aspirations are those of joining an essentialized other in the privileged and perfect world outside the walls: "Tied with the chain to the bed, I dreamt of your world. / A world in which I could live alongside you." The "you" can be any "you", but not another institutionalized person. There are no social relationships between people in institutions, no friendship, no sex and no own imaginary, just a longing for a banal, yet, successful existence in a non-institutional setting. The spectator of such suffering (compare Chouliaraki 2006) receives the ethical impulse to act and the action is then mediated into the complex process of the statization of the NGOs activity in the name of freeing people from institutions.

The campaign video catches well the dichotomy inside-outside felt and talked about by many of my interview partners within asylums. The word "lager" even having been used by some of them. Yet, it disregards the enormous complexity of the everyday life and social relations of asylary spaces and institutionalized people. Through this it risks creating a universalized victim that cannot act, only the middle-class recipient of the message can act in the name of their essentialized aspirations. Through this solidarity is both enabled (through the awareness of suffering happening in institutions) and disabled through the essentialized othering that makes an equal relationship between urban middle-class recipient of the message and the confined disabled subject impossible to imagine. Action is distributed to the middle class recipient alone. Why do institutionalized people not get a chance to sign the petition?[151]

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[151] This of course is a complicated question to ask given the intensity of power relations in institutions and the fact that you cannot break these power relations with the means of day to day civic activism. A person signing a petition with the word "lager" on it and continuing to live in an institution would be vulnerable to all sorts of abuse, but the question of how to include the voices of those who are silenced by the power mechanisms that activism seeks to counter remains an important one that cannot be easily answered from the complex ventriloquism of the video.

The return to appealing to the public was made possible and rendered necessary by the pre-accession monitoring coming to an end and losing its power of infrastructural transformation, due to the fact that institutionalized people came to be and are no longer becoming European citizens. Yet, the return to the public also involved re-inventing the aesthetic relationship with the presentation of findings of human rights monitoring - an aesthetization of infringements and of suffering. The epistemic asymmetry of humanitarianism thus finds its way into the production and circulation of knowledge built on a human rights modality of sense making. Yet, although directed at the public and built on a campaign of postcards the goal was again action through the state with the NGO seeking a form of incorporation of its previous practices into the state infrastructure.

I will now turn to another modality of sense making that operates with a different understanding of where the possibility for meaningful action and interpretation is located - namely, the experience based modality of sense making.

Experience based modality of sense making

The involvement of users in psychiatry, as well as of disabled people’s advocacy in thinking through service provision and the transformation of their narrative into broader political claims has been around at least since the beginning of the 1990s, I will not focus on these activities here. Rather than this I will focus on a graphic novel called “Becoming Eli” authored by illustrator Dan Ungureanu after long conversations with the books main character and co-president of a self-advocacy group called “something to say”, Eli (39 years old).

Extract from the book “Becoming Eli” by Dan Ungureanu, available here http://www.danungureanu.com/becoming-eli.html accessed on 16.03.2018

The book tells the story of Eli, as a story of becoming, from the child abandoned at birth, to becoming a self-advocate for the rights of people with disabilities and deinstitutionalization, who lives on her own. The story goes through her growing up in an orphanage, meeting her mother, then moving on to a vocational school and being again transferred to an asylum. From there she is helped by a friend to find a job and a place to stay in a nearby city, from she moves to Timișoara and starts living in a group home, founding a self-advocates association and fighting for the rights of people with disabilities, the establishment of group homes and the closure of institutions.

The book is political, while being personal at the same time. Small details of everyday life are interwoven with the political commitment of the protagonist. The words used (in the Romanian version) are those likely to have been used by Eli when talking about her past. We learn from the book that Eli used to be called Veta during her time in institutions. That she had been abandoned at birth, but that she did meet her mother after she had waited for some time and that she was surprised of how old her mother was. Among the staff, there is a teacher who shows her how to celebrate her birthday for the first time, but there are also carers who steal the presents brought to the orphanage by foreigners wishing the children merry xmas. The violence of both carers and other children or later young people is portrayed, alongside the friendships, separated by transfers to other institutions. A committee visited and the humiliation entailed is also recalled, showing how Eli (then Veta) was made to undress when appearing in front of the committee, the committee then deciding on her transfer without asking her. The attempt to organize a group trip to Bucharest in order to complain about the way they were being treated in the institution, makes them land right back at the asylum, with only one of the group making it to Bucharest, complaining and nothing at all changing in their everyday lives.

Extract from the book “Becoming Eli” by Dan Ungureanu, available here http://www.danungureanu.com/becoming-eli.html accessed on 16.03.2018

Until this point, the graphic novel addresses a life history similar to the one presented in the human rights campaign video. The protagonist is abandoned at birth, then grows up in institutions, experiencing violence and then waits for her death. But the account is thicker and more complex even up to this point.

Yet, the turning point in the graphic novel happens when Eli is told by a friend that she has found a job for her and a place to stay. Then Eli runs away by asking permission to leave the institution for a day from one of the carers and never comes back. She then starts on a path that has now made her become part of the European Platform for Self-Advocates (EPSA) board, and to a politically active life. But even this turning point is not narrated in a teleological way, Eli talks about the moments of hesitation and of thinking about returning to institutions. Towards the end of the book she is shown saying: “There were times when I thought about returning to the institution, because I knew my way around there…whereas life outside of it was something completely new.” (Ungureanu, 2017, no page numbers)

The hesitations and regrets make a book about a topic of such complexity more credible and less tacky. But most importantly the novel allows for the readers to locate agency somewhere else than in ourselves as intended viewers, but in Eli and in other people in Eli’s situation. It allows us to feel respect and compassion and not pity, and thus empowers us to act politically in a less condescending way. Since it opens a space of criticism towards institutions that epistemologically allows for the institutionalized to voice their suffering, but also their politics, their courage and their ownership of their lives without impeding solidarization or reifying the positionality of the character.

Moreover, what makes the graphic novel and the experience based modality of sense making different from the recent human rights video is that it tried to re-focus the processes of identification. Roxana Damaschin-Țecu as a board member of the Something to day association writing in the afterword for the book, underlined this point: “This novel reveals how Eli’s life was and is, trying to break barriers between us and them. Anyone of us could have been Eli, and we should all get to know Eli. What is happening behind the walls, under the guise of the state’s care towards the abandoned ones, is our business too. We should all plea that no one is still locked in institutions, after finding out how life there looks like.” (Damaschin-Țecu, 2017 in Ungureanu, 2017).

Yet, the emergence of the possibility for identification doesn’t mean equivalence of experience, nor does it mean that the epistemological asymmetries of any process of communication are gone. When I once talked to Eli about whether she had read the book, she said she will have to look at it again with her support person to fully understand - meaning that even though it is her story, understanding the way it has been mediated requires a collective effort which can be done in collaboration.

Interestingly, there is no talk of being let die or made live through the institutions, rather than this the key question addressed throughout the book seems to be “What kind of life should be fostered in which way?”

Modalities of sense making, biopolitics and the fostering of life

In this chapter, I have introduced different modalities of sense making that sought the fostering of life of institutionalized people in and around post-socialist transition. I have looked at the way in which each of the modalities of sense making (humanitarianism, judicialization of the past, human rights and experience based) constructs its populations and reveals its blind spots and how it distributes who can and should act. In the humanitarian modality of sense making “speechless emissaries”, the “Romanian orphans” emerged as a population deserving of transnational aid flows in the global market of morality. Their victimhood later was brought in a dialectical relationship to the need to establish who were the perpetrators of their suffering, opening a space for the state to clean itself by accusing those who has acted on its behalf.

The human rights modality of sense making allows for its subjects to be more diverse, but to be caught in the process of becoming European, as a form of showing how people from the margins of Europe are coming to belong to humanity by becoming European citizens. Once the aspiring Europeaness became a concluded formality, the human rights modality of sense making came to produce images for a new audience - the Romanian middle classes - in this the trope of the “speechless emissaries” was transformed into ventriloquized emissaries. The suffering institutionalized subject came to be put on show to perform the opinions of the human rights monitors. Yet, a counterpoint also arose through the experience based modality of sense making and its techniques of aesthetization - opening up a space of thinking political action and potentiality differently.

It is not that people no longer die in institutions - the numbers provided by the Center for Legal Resources (the human rights NGO) are alarming of the 25.000 in state residential institutions, more than 4000 have died between 2010 and 2015[152]. Although, I could convince myself that many people are brought to asylums to die, since they have nowhere else to go and are either terminally ill or have an age related mental illness, such as Alzheimer. The figures are proof, that life needs to be fostered in a brute biopolitical way, while at the same time the question for which kind of life is the life fostered needs to be explored. Overcoming confinement and objectivation and overcoming a murderous biopolitical regime need to go hand in hand.

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[152] http://www.crj.ro/pledoarie-pentru-demnitate/lagarele-de-langa-tine-infografice/ accessed on 20.02.2018

Part 2: Trans-local dynamics

Introductory section: policy systems, categories and trajectories

This part of the dissertation looks into dynamics that operate beyond and across sites. In the first chapter of the part, I set the stage for the two other chapters, by looking at the policy systems that govern the everyday lives of people considered mentally ill and disabled - namely the psychiatric and disability systems and attempts to reform them. In the following two chapters, I look at two different dynamics that operate throughout the system, inscribing trajectories into the lives of people. The first is the question of seeking subsistence with clinical means - people trying to access benefits and asylary care, which I explore in Chapter 5. In chapter 6, I look at how having come to live in asylums is perceived as feeling “abandoned”, an experience which is connected with a sense of gendered failure - especially one’s failed womanhood. Abandonment appears as a normalizing way of asking questions, in praise of the nuclear family which needs to be transcended in order for a politics of hope and potentiality to emerge.

Chapter 4: Away Towards the Asylum: an introduction to maintaining and changing the system from within

This chapter provides an overview over the treatment, care and confinement infrastructure for people considered mentally ill and disabled and the attempts to reform it from within, in order to do two things. On the one hand the chapter sets the scene for the other two chapters in this part, dealing with trans-local practices thus describing the infrastructure in which people are moved from one place to another. On the other hand, it allows to show how reforms to transform the system, have tended to reproduce asylary structures. I will argue that the reproduction of asylums is partly caused by the artificial separation of the similarly functioning chronic mental illness and mental and psychic disability infrastructures. This leads to concrete situations where a person is to be taken out of one system, only to be brought to another. I argue that this practical reality should be incorporated into the practices of governing the system, if asylums are to be transcended. On the other hand, the perpetual return to asylums is also caused by what has been called the passive social function of these centers, as places where those whose subsistence is endangered and who lack social networks come to live. Efforts to reform either system have done little to change these processes.

I will start by giving an account of the two main policy systems that are involved in the processes of treatment, care and confinement – the psychiatric/mental health and the handicap/disability systems - and the overlap and tensions that exist between them. Then I will analyze efforts to reform them separately, first efforts to introduce a mental health approach into psychiatry and second efforts to introduce an alternative approach to the care of people with disabilities, and show where they have fallen short of their own expectations.

Two policy systems - how they are governed separately and entangled in practice

I was doing ethnographic fieldwork in Siret around the former neuropsychiatric children's hospital, when in June 2015 Rovana Plumb, the minister of labor, declared that all residential centers for people with disabilities should be closed by 2020[153]. Among the many conversations I had after this moment, I also talked to an employee of the psychiatric hospital for the chronically mentally ill in Siret. Funded from different state funds, the hospital was not to be affected by the plans of sudden deinstitutionalization[154], so that the employee jokingly said: “we just need to hold on until 2020, then we will surely have many residents with these plans”. As we discussed it, the possibility that a new larger hospital (quite similar to the old huge children’s hospital that was existed in the same town) would emerge to cater for this population so often moved from one institution to another without being asked, appeared more and more plausible.

Deinstitutionalization plans were not aimed at enlarging residential institutions that catered for the same population framed as “mentally ill” and not as “mentally disabled”[155]. They were explicitly aimed at integrating people into the “family”[156]. Yet, as the employee and myself knew, families for most people in residential centers are biological realities and social aspirations, the ties having been severed long ago through a process felt as “abandonment” and described as “being given to the state”, by those living in such places. Nevertheless, the policy language of deinstitutionalization implied the family as an undisputable locus of care[157], ignorant of the everyday social reality of both institutionalized people and their biological families.

Yet, the existence of two separate policy systems is not the only obstacle to thinking beyond asylums. Moving away from asylums is often coded by both policy-makers and people in asylums (be they residents

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[153] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 31.01.2018

[154] By sudden deinstitutionalization, I mean the radical unprepared closing of asylary spaces in a very short time and with no preparations for the life of the inmates after the asylum.

[155] The medicalization of intellectual disability worked through the now outdated label of *oligofrenie,* a psychiatric diagnosis corresponding to intellectual disability. Now, although most people who fall under this category no longer should be hospitalized, de facto they are through associated diagnosis such as behavioral disorders, etc. The other way around people who suffer from mental illness, can access the administrative category of psychic disability which is tied to the incapacity to work and the need for care of people with mental illness. This makes possible the institutionalization and long term hospitalization of people in either system and thus a reframing of their conditions with a similar infrastructural outcome.

[156] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 31.01.2018

[157] This implies women as domestic laborers, a rather paradoxical declaration to be made by a woman social democrat minister.

or employees) in both policy systems as a move back to the family, a point which is connected with ideas of reworking “abandonment” under labels such as the “right to family life”. Similarly, the question of subsistence is another important driver of movements towards institutionalization, which I begin to explore in this chapter on a macro-level through reports and return to in the next chapter addressing explicitly subsistence.

The psychiatric system

It has nowadays become fashionable to call the psychiatric system, the mental health care system. I too started out in this way and if now I returned to calling the system “psychiatric”, it is because I believe it has not yet become a mental health care system. The main difference is that the psychiatric modality of sense making still monopolizes the way in which the system is constructed, leaving little room for other epistemologies (such as human rights, psychological, spiritual-religious, social etc.) to contribute on their own terms to forging and transforming the system.

This is visible in the institutions that deal with mental illness that are comprised of two kinds of psychiatric treatment facilities: psychiatric hospitals (8107 beds in 39 units)[158] and psychiatric wards in general hospitals (7709 beds/ unknown number of units) (see MHE, 2018, pg. 151). Two thirds of the total of around 16000 beds are being used for acute patients and the remainder for those chronically ill (see Sfetcu 2017 quoted in MHE, 2018, pg. 151)[159]. Besides the hospital centric ones, there are also individual psychiatric and psychological practices that can partly be funded by public funds in the national health insurance system. Furthermore, there are also 52 out-patient mental health centers (see MHE, 2017, pg. 152). These centers nevertheless are often incorporated completely into hospital structures, as I could observe during my fieldwork. There are also services that employ the label mental health and try to stray away from the

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[158] The size of psychiatric hospitals ranges between 50 and 1250 beds. (see MHE, 2018, pg. 151)

[159] I have not yet being able to find a differentiated account of how many of the chronically ill beds are actually are practically life-long commitments, but it is possible that a significant amount of the around 5000 beds for the chronically ill are. This might also be the case, even if statistically this is not visible, since a common informal practice at the time of my fieldwork was to release and re-admit people who didn’t have where to go after the maximum stay of around three weeks. Therefore, the people would actually never leave the hospital but would appear to leave and return shortly after.

hospital-centric logics of the psychiatric system, these are generally run by NGOs, most prominently, the Estuar foundation[160] that also enter into public-private partnerships with county level social protection institutions. The services they provide are day-care center activities, as well as a very limited number of protected housing opportunities that have been booked out with the same people for years. It is thus impossible to receive a bed in such a structure as a newcomer.

The disability system

It is estimated that about 8% of people considered mentally and psychically disabled in Romania live in residential institutions (see MHE, 2017), yet most of the people living in residential institutions are considered to be either mentally or psychically disabled (see ANPD, 2017[161]). Of the 17998 adults, who were institutionalized in residential institutions under the ministry of labor, 13829 were people with either psychic (3660) or mental (10169) disabilities. As I could observe during my fieldwork, people with different kinds of disabilities are often held in one center and the name and function of the center is often changed in order to represent more closely its inhabitants or in order to be included into a superior category of funding. The second process often goes hand in hand with a stigmatization of the inmates as mentally ill, due to the fact that neuropsychiatric recovery centers receive the largest amounts of funding[162]. That is probably also why they are the most common form of residential service. These institutions although very similar in size and populations they cater to, to the psychiatric hospitals for the (very) long term chronically mentally ill are administered under the ministry of labor and social protection[163] by county level directorates for the social assistance and child protection.

There are 407 residential institutions (see ANPD III/2017, pg. 18) in Romania today, of which 69 centers for neuropsychiatric recovery and rehabilitation catering for 6098 people - the institutions closest to

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[160] http://www.estuar.org accessed on 31.01.2018

[161] Data compiled from ANPD, III/2017 and ANPD Nr. Persoane handicap trim. III, both available here http://anpd.gov.ro/web/transparenta/statistici/trimestriale/ accessed on 31.01.2018 I have used the most recent data for this overview and not the one available for 2015, the time of my fieldwork. Yet, the variations in numbers are minimal.

[162] These changes often also effect the inmates who are pushed from one center to another after such a transformation, in order for their diagnoses to fit the newly crafted profile of teh center.

[163] Presently called the ministry of labor and social justice.

psychiatric hospitals for the chronically ill. The Asylum where I spent part of my fieldwork is such an institution. There are also 73 centers for disabled persons recovery and rehabilitation, who cater for 3160 residents. The “New Beginnings”[164] center in Siret where I spent another part of my fieldwork being one of them. The national disability statistics (ANPD III/2017) also show that there are 123 sheltered housing facilities[165], catering for 943 people that also run under the label of residential institutions, and that there also exist non-residential services such as day care centers, but in total they do not cater for more than 2163 people in the entire country. The statistical data shows that the state social protection system is still largely a residential - read asylum-like - one.

Moreover, statistics carried out by the Bucharest based Institute for Public Policy (IPP) on the implementation of the CRPD[166] in Romania (IPP, 2015[167], pg. 18) showed that the main reason for leaving the residential social protection system is death (76%) and it is increasing as a main reason (in 2013 it was “only” 70%[168]), reintegration into the family follows with a thin 16%. The other reasons include 6% transfer into centers in other counties - meaning that de facto people remain in the system. Moreover, the main reasons why people become institutionalized are the need for care (33%) and the fact that the person cannot ensure their socio-medical needs (18%), but the lack of family (12%), the impossibility to handle one’s household (12%), the lack of housing (10%) and the lack of income (6%) are also significant reasons for institutionalization - put together these purely subsistence related reasons come close to reaching 50% of all cases of institutionalization. Moreover, the IPP (2015) also documented that the number of people, who as children had been part of the child protection system and after 18 years of age go into the closed residential system is on the rise (see IPP, 2015, pg.18).

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[164] Name changed

[165] Unfortunately most of these institutions are smaller scale residential institutions catering to 10-30 people in a highly confining environment (compare MHE, 2017).

[166] Convention for the Rights of People with Disabilities

[167] Available here http://www.ipp.ro/wp-content/uploads/2016/02/Conventia-onu-5.pdf accessed on 31.01.2018

[168] See also for 2012, report from IPP 2013 http://www.ipp.ro/raport-de-monitorizare-a-stadiului-de-pregatire-a-romaniei-pentru-aplicarea-conventiei-onu-privind-drepturile-persoanelor-cu-dizabilitati-editia-a-iii-a/ accessed on 31.01.2018 Here the number of people who had left the system by death was 67% showing a clear increase in the percentage of people leaving the system in this way and thus for the fact that the system is getting ever more closed.

As is apparent from the above, the statistics concerning people with disabilities and their residential care are far more differentiated and elaborate than for the psychiatric system. They give a picture of trans-institutionalization, as well as the way in which the system acts as a dead end for those people, who lack a care infrastructure and the means for subsistence. Especially when family networks are also missing, these people risk spending their entire lives literally until death in institutions. This is probably why, as the human rights NGO, the Center for Legal Resources, has documented from the 25000 children and young people that had been living in institutions in the timespan between 2010 and 2015, around 5000 died[169] . Moreover, it is very telling that there are no reasons documented of people leaving the system to live on their own with other networks of support. This way of leaving the system is most probably hidden under the 2% other reasons[170] (see IPP, 2015, pg. 18).

Although there is no similarly thick statistical data on the psychiatric system for the chronically ill, it is likely that the reasons why people end up in such places and how they leave them are similar. Nevertheless, the psychiatric system is thus rendered invisible as a closed infrastructure for the care and confinement of the mentally ill, risking literally to take the place of the social protection system if this is to be radically reformed, exactly because of this rendering invisible[171]. Thus in order for deinstitutionalization of social

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[169] http://www.crj.ro/pledoarie-pentru-demnitate/lagarele-de-langa-tine-infografice/ accessed on 26.02.2018

[170] I assume this to be the case, since I know of people who have left the system without going to either the family or another center. Some of the very few such stories will be discussed in the other ethnographic chapters.

[171] Another infrastructure with structural similarities with the psychiatric and the disability ones, but with more pronounced features is of that forensic psychiatry, where closed hospitals serve as places of explicit confinement of those people who are considered to have committed a criminal offense without having the capacity to having aware of it on the grounds of mental illness related lack of decision capacity at the moment of the deed. During my visit to such a place and during policy meetings organized surrounding the question of reforming these hospitals at the parliament and elsewhere in Bucharest, I have come to notice that “social cases” (see Friedman 2009) also exist in the forensic system. Meaning that people are not released despite having recovered their capacity to discern, because of the lack of a support system understood explicitly as family. I will not go into this question here since it would mean going through a fully different legal and sociological repertoire. Nevertheless, when practices of dismissing people from forensic hospitals are being reworked (due for example to blatant overcrowding),this immediately puts pressure on the two other closed systems that cater for the mentally ill. I witnessed one such episode during my fieldwork when a man who during a psychotic episode had killed his mother, was many years later released from a forensic hospital. I met with his sister who was already looking for a closed center for people with disabilities, where he could be cared for. He also as an intermediary solution, first came to one of the psychiatric hospitals for the chronically ill. This system too needs to be considered when reforming the disability and mental illness related systems.

services to not mean enlargement of similar psychiatric closed infrastructures, these two policy systems need to be viewed together when conceiving the reform.

In my many interviews with people involved in crafting policies, as well as people trying to influence them in both the psychiatric/ mental health, as well as disability related advocacy groups, I have noticed a strong segregation of advocacy activity. Generally, NGOs or individual actors would either be active surrounding one policy system or another, or would at times focus their attention on one of the two systems that were governing their activity - one using the language of illness and the other that of disability.   There have been attempts to establish inter-ministerial coordination in this field. Most notably an inter-sectoral coordination committee for mental health established in 2006, that reportedly only met very few times[172]. But the issues and advocacy infrastructures and languages remained distinct[173].

The differences between the two systems

Although strikingly similar in the respect that I am interested in in this dissertation, the two systems are nevertheless distinct in several respects that derive from the fundamental difference between the modalities of sense making underpinning them. In the psychiatric system the dominant modality of sense making is still a medical one based on a model of illness and treatment - in which the body of the person is acted upon medically in order to determine changes in the mind[174]. The medical infrastructure is therefore oriented towards treatment and has doctors as its main actors and hospitals as its main sites. Acute psychiatric hospitals are most emblematic for the psychiatric logic - since they assume that mental illness can be a passing affliction that they are put in place to fix, whereas hospitals for the chronically ill assume that the illness and the person are hopelessly bound together. That is why the acute system in some places even takes

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[172] See https://www.curierulnational.ro/Specializat/2006-01-07/Comitet+pentru+Sanatatea+Mintala accessed on 01.02.2018

[173] Also the privileged voices of each system remained distinct with the deaf-mute and blind being key interlocutors on policy making ever since state socialist times on behalf of disabled people, and NGO service providers being more vocal than disabled people themselves (Interviews with two disability advocacy people in 2016). The mental health landscape although counting with one/ two users organizations and several NGOs active in the field, the policymaking itself is still dominated by psychiatrists of which very few are even mildly open to non-medical perspectives.

[174] I have traced the distinction between a psychiatric modality of sense making and a productivist disability oriented modality of sense making in the genealogy chapter.

on a mental health approach, with inter-disciplinary teams that allow for a more open reading of the person through different modalities of sense making (religious, social, psychological) to become spatialized in the acute hospital. Hospitals for the chronically ill do not rely as heavily on a treatment model, but rather aim at indeterminate care, since the illness is what causes the person to be formally excluded from the economic and social order of the world "outside". It is here that the psychiatric system comes to resemble the disability social protection system with its asylary structures.

The social protection system is built on a disability model that still is haunted by the dichotomy recoverable/ unrecoverable. Categories that from their onset had been tied to potential or lack thereof for a person to become a productive member of society[175]. The asylums that were built as *cămine-spital* (hospital-homes) during state socialism were conceived of as places where those with no hope to become productive would be both cared for and let die. The relationship to productivity is also seen in such infrastructural translations as integration centers through occupational therapy[176]. Moreover, psychiatrists and other doctors were absent from these institutions. Even in neuropsychiatric institutions, psychiatrists would almost never be found, treatment would be prescribed by psychiatrists in the towns close by these asylums.

Asylums as infrastructures are activated when families fail to perform their biopolitical function. Yet, the trajectory from the "family" as a locus of care and a provider of subsistence and the asylum generally goes through other state institutions, most notably the child protection system and acute psychiatric care. These trajectories are generally understood and felt by the people who are pushed through them in terms of a process of abandonment which I explore in the following two chapters, especially in chapter 6.

Two populations and their trajectories of institutionalization/ hospitalization

When I first arrived at the Asylum in May 2015, a neuropsychiatric center for recovery and rehabilitation, I was introduced to the two populations inhabiting it[177]. One building was taken up by the "copii" ("the

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[175] See genealogy chapter

[176] see ANPD III/2017, English translation there is misleading

[177] I will return to the two populations and their spatialization in the next chapter.

children”), people who although adults had grown up in the “system”, either in orphanages or in institutions for disabled children (such as the neuropsychiatric children’s hospital in Siret). The other building was taken up by the “schizophrenics”, the adults who despite having psychiatrically speaking different diagnosis, had had a social life previous to becoming institutionalized at the Asylum. These two populations were distinguishable from each other by their lives previous to coming to the Asylum, but this criteria was relevant enough to award them different spaces at the Asylum. What a person had been previously to coming to the Asylum was relevant to earn them a different kind of respect, some even being addressed with polite You by the care staff, the fact that they had graduated from several universities being a story often narrated to show that the place wasn’t just one for poor people, but truly for the mentally ill. The “adults” building had been thoroughly renovated more recently than that of the “children” . Yet, informally the “children’s” building was considered to be more safe from violence.

Yet, these two populations although most clearly spatialized at the Asylum, were representative of the inmates throughout the system in both psychiatric hospitals and residential social protection institutions. Such categories as children from previous institutions, did not just haunt the spatialization and entitlements at the Asylum, they also informed the statistics of progressive policy NGOs. One such study showed that the number of children from the protection system coming directly into residential centers upon reaching the age of 18 is on the rise(see IPP, 2015, pg. 18), reflecting the growth of the population of “children” throughout the system.

While the numbers of “children” are growing in the system, a human rights monitor noticed that the number of people coming from psychiatric hospitals started declining after 2007. Before that each time, she would visit an institution on a monitoring visit there would be new people, who had come through the psychiatric hospital, generally from children institutions. At the time of our interview in 2016, children institutions were being renamed once the children would become adults, without even changing the furniture - thus adults would end up sleeping in the very small cots they had grown up in. But, even in situations when mentally ill people would risk becoming homeless, psychiatric hospitals would not have where to refer them to, since the ties to the social protection system had been severed. Thus what the activist called “forced transfers” from psychiatric hospitals to residential institutions had been stopped.

The activist gave an example of a recent situation she had been through involving two brothers, both having been diagnosed with schizophrenia. They had been living with their parents in a flat in Bucharest. Upon the death of the parents, they remained alone with nothing to eat and no money. They ended up burning the furniture to heat the apartment and attacking people on the street for a bit of bread or money. The neighbors started calling the police, social workers and also notified her. She brought the brothers to Obregia psychiatric hospital where she thought it would be their only chance to keep warm in winter. From there, although she had expected them to be transferred to one of the residential institutions, a social worker from the hospital called a remaining family member to take them in, threating that otherwise they will land on the streets. In the end, the local social protection directorate appointed another social worker, who managed to obtain retirement benefits and all the necessary papers for the two brothers and organized them to be taken into a service network in another city[178]. The episode shows how the population of the “adults” stopped being admitted to a system that is starting to become closed on both ends: both admissions and releases.

Yet, the people who find themselves in such places are still there and have often come to be there on the grounds of what the human rights activist referred to as “forced transfers from psychiatric hospitals to centers for adults”, since the people do not voice their agreement to be placed in such places. These processes were (and to a certain smaller extent still are) based on trajectories or pathways between institutions that have become solidified over time and that rest on a fundamental asymmetry of knowledge between those professionals who activated by the family and on the basis of their expertise decide the placement of a person in such a center and the person, who becomes just the object of the knowledge generated by others, codified in files that determine where they are sent. The asymmetry of knowledge is built upon the silencing of a person as mentally ill or disabled, the genealogy of which I have explored in chapter two.

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[178] Interview human rights activist, 2016

But these trajectories often do not end when a person is institutionalized, since once in the residential system (especially the social protection disability one[179]) the person can be transferred within a county several times depending on whether she is part of the "mai cuminți", the better, more well-behaved ones or whether she appears to be violent. In the county where I did my field research, the population of the centers was hierarchized according to this. Institutionalized people also request to be transferred and sometimes are also heard.

When I went to one of the nicest centers with excellent living conditions, I could witness the preparation of such a transfer. On my trip to the different houses that made up the residential institutions, I was taken aback by the language used by the psychologist, a young woman in her late twenties, who was showing me around to describe the people she was introducing me to. On one instance, she referred to a man, Andrei, by saying he is not "cuminte", a word used to describe children that are well behaved in terms of not being naughty[180], then she went on to tell me that Andrei has bipolar disorder, as well as behavioral disorder. This two-fold objectification in infantilizing and clinical terms was not only discursive, as it had an administrative consequence – the man was to be sent to another more confining and more secluded institution. Andrei himself did not protest this decision, rather than this, he kept repeating that his "file is on the role" ("dosarul meu e pe rol"), apparently quite glad that he will soon go somewhere else. At that time, I had already visited the institution where he was going to be sent and knew that it would be much more depressing and confining than the place where we were currently in.

In other cases even deinstitutionalization NGOs would be said to have transferred people to one of the less well-off centers, like the one partially compared to a lager by one of its former and one of its current employees. The reason given for the transfer was that the person could not adapt to integrating in society.

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[179] I am not aware whether this is a practice in the psychiatric system, I would incline to say it is not, but that it sometimes happens that people in psychiatric hospitals are transferred to social protection institutions and then transferred again between social protection institutions.

[180] The word "cuminte" compares interestingly to the word used by Foucault (1975) at the very beginning of his section on discipline in "Discipline and Punish", namely "docile": "A body is docile that may be subjected, used, transformed and improved." (pg. 136)

In other instances, the “better ones” would be transferred to new smaller centers that had been established through European structural funding as part of the process of deinstitutionalization. Very well furnished and much smaller in size, the places nevertheless were often more confining than places like the Asylum where no one could keep track of who was where on the grounds of the old boyar’s mansion. Deinstitutionalization read as creating smaller institutions enhanced the possibility for surveillance, which caused some people to request being transferred back to the Asylum, especially on the grounds of having more sexual freedom.

The trans-institutional transfers, as well as the annual meeting of people with disabilities organized at the mall in the capital of the county to which many of the people in the centers would come created a community that spanned across residential institutions where I would sometimes meet people I had met in one institution again in another or would be asked who I had met in this or that place when mentioning I had been there.

These practices of hierarchization of the inmate population through transfers allowed for a segregated invisible order to emerge, in which some would be exposed to much more violence than others, while some lived in very comfortable conditions enjoying far more liberty than others. Nominally, the services were the same but the differences between places were huge - and not in a linear way. The largest place was not the most confining, nor was it the most violent. Nor were the smaller places necessarily more welcoming. The individual histories of each of the places, as previous elderly homes or previously rehabilitation centers for alcoholics or hospitals for the chronically mentally ill, still bore upon the categories based on which some of the people had been brought to the place initially. When the service category and the name of the place would change, so would the profile of the newcomers, often causing conflicts with those residents that had been living in the place for longer.

Alternatives to the care provided by the two systems

Alternatives to the asylary system for long term care have been around for a long time, although they have never covered the entire population of the mentally ill or of the mentally disabled. For some this has meant institutionalization in asylums or psychiatric hospitals, while for others it has meant feeling hopeless or abandoned or as one of my interview partners named the practice “institutionalized in the family” - meaning being locked in the family apartment and cared in a confining way by a family member[181], to name only the worse consequences of this lack of alternatives.

As opposed to fundamental challenges of the system biopolitically, as those posed by the humanitarian and human rights modalities of sense making, explored in the previous chapter, the alternatives explored here attempted to transform the system and its services from within or more exactly from its margins without rejecting the fundamentals of either modality of sense making.

Introducing a mental health approach to the psychiatric system

In the psychiatric modality of sense making, mental health emerged as a more encompassing epistemology than the psychiatric one that could act to equalize treatment relationships between users and doctors, as well as between doctors and other professions involved in the clinical care or treatment of the user. Yet, mental health still rested on the binary distinction health-illness, which it tried to water down without fully dissolving it, a point that made possible the coexistence of a series of professions but also their subordination to the psychiatric gaze. This is visible in the 20 year anniversary publication of the NGO Romanian League for Mental Health (2011), one of the main promoters of a mental health approach in the Romanian landscape. The head of the League, a psychiatrist, Bogdana Tudorache (2011, pg. 8) notes that the founding documents of the League attested that “mental health is more than the absence of psychic disorder and distress, because it involves the development of the inner, relational and social life in accordance to individual and collective desiderates.” Yet, a few pages later another psychiatrist, the late Radu Mihăilescu quotes a treaty on mental health from 2000 which he apparently co-elaborated with a team of three psychiatrists saying: “Writing about mental health psychiatrists make their voice heard. Can they come out in the agora? We *think they are obliged to do it, it is their duty to do it*, but with the wisdom, moderation and ability that the coordinates of their profession impose on them” (Tratat de Sănătate Mintală, Prefață, pg. 10, quoted in Mihăilescu, 2011,

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[181] Interview and conversation at the national agency for people with disabilities, ANPD

pg. 11, emphasis in original). So, it is mental health not as a modality of sense making, but a forum that allows psychiatrists to have a voice on broader social questions, especially those regarding the desirable collective and individual life forms - yet, again like in the late 19th and early 20th century psychiatrists re-affirm their competence and their indispensability as speakers on social issues, in a time where bodily treatments tied to modern pharmacotherapies had become more and more common. Mental health thus never appears to have become a modality of sense making per se, but a broadening of the psychiatric gaze and its credibility.

Community care

Another point stressed within questions of developing a mental health approach to services was the locus of care away from the asylum into the community. Alternatives to asylary care started being built as early as the mid 1970s and early 1980s under the somewhat awkward label of Laboratories for Mental Health (see Lăzărescu, 2006, pg. 1). The laboratories for mental health care were designed to allow for the psychiatric modality of sense making to be rendered one of many, as well as the setting of care and treatment to become localized based on the socialist health policy of making treatment available to people (compare Lăzărescu, 2006, pg. 1f). The laboratories for mental health functioned in close cooperation with dispensaries that included "sheltering sisters" on their staff, a form of medical social worker that would be integrated into psychiatric work as well (see Lăzărescu, 2006, pg. 2). The laboratories themselves included among their staff members: psychiatrists, psychologists, defectologists and speech therapists and were organized around county hospitals (meaning generally in county capitals) (see Lăzărescu, 2006, pg. 3).

The laboratories of mental health and the cooperation with social workers surrounding dispensaries appear as the first community care structures during state socialism. Nevertheless, during transition they become fully incorporated into hospital structures in 1996 (through law 276/1996), as funding decreased for mental health structures (Ciumăgeanu& Katschnig, 2009) and thus the structures lose their community care focus. As psychiatry professor Lăzărescu (2011, pg. 22) notes the community care structures never regained their previous extent after this move, not even after reform had become one of the pre-requisites of joining the

European Union. Yet, Lăzărescu also notes that what changed was the atmosphere in the 1990s and the extent of the project of mental health: “The bet was for the promotion of a psychically sanogenic [conductive of health] life, in the realization of which the entire community needed to be involved; the political and cultural factors, mass media, the police, the churches and the prime minister”. (Lăzărescu 2011, pg. 22)

At the same time, transition also brought about a series of transnational humanitarian cooperation partnerships, which led to the establishment of in 1993 of the first NGO based community care structures, such as those provided by the Estuar Foundation[182]. The services included community care centers in cities and towns around the country (around seven in total at the high time of its activity) and a very limited number of protected housing opportunities. Another community care pilot center was established in the late 1990s/ early 2000s and called the Trepte center, it had diagnostic profile focusing only on users with the experience of schizophrenia. Yet, in order to ensure the continuous running of the center it was placed inside the large Obregia hospital. The idea was to create the center as a best practice that would travel beyond its current location, but this did not happen[183].

Mental health law, policy and practice

A leading psychiatrist of the generation that promoted the mental health law (487/2002[184]) referred to it as the first law to regulate mental illness since the Regulations on the Law on the Alienated (1896)(see Mihăilescu, 2011, pg. 14)[185], meaning it was the first document to pass through a legislative body. This was not entirely the case since many of the infrastructural changes in between had been built on legislative documents. Rather than this the fact that the law’s creation was compared with Șutzu’s advocacy activities is part of the glorifying modernizing tropes of the psychiatric modality of sense making, while at the same time stressing how transition from state socialism was as big of a break with the past as the transition into

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[182] On the services currently oferred by the Estuar foundation: http://www.estuar.org/afla-mai-multe-despre-fundatia-estuar/misiunea-obiectivele-si-activitatea-fundatiei-estuar accessed on 27.02.2018

[183] Interview with psychiatrist at the Trepte center.

[184] Recently, republished in 2012 with some modifications, available here http://www.dreptonline.ro/legislatie/legea_sanatatii_mintale.php accessed on 27.02.2018

[185] The context of its genesis was discussed in the first genealogy chapter.

the modern state form. Similarly, Mihăilescu (2011, pg. 14) stresses that adopting the law filled a legislative void that needed filling, since it was part of the *aqui communitaire* the package of laws that Romania needed to adopt prior to becoming a member of the European Union. Yet, again modernizing psychiatry and European modernity seem to go together discursively.

A crucial discursive change takes place on a legislative level, since the subjects of this law are no longer referred to as "the mentally ill [people]" (bolnav psihic), but by the less stigmatizing label of "person with mental/psychic disorders" ("persona cu tulburări psihice/mintale") (ibid.). While at the same time introducing, provisions for involuntary treatment (see Mihăilescu, 2011, pg.14). Conceived exclusively by psychiatrists the law on mental health care, thus, ignored the existence of a huge social protection system that dealt with the mentally disabled and thus only regulated the psychiatric system. Moreover, the emphasis on community care being stated in the initial (2002) variant of the law so strongly, made it almost un-applicable since it was too far away from the everyday realities of psychiatric treatment, or at least this is how some of the reform psychiatrists explained their disappointment at the failure of the implementation of the law in conversations and interviews.

The human rights crisis, European Union accession and the National Center for Mental Health

Soon after the law on mental health was passed in 2002, Amnesty International (2004a,b) and the Center for Legal Resources exposed the high number of deaths in the Poiana Mare hospital, pushing for deinstitutionalization of mental health services to be put on the agenda for European Union accession under the rubric of ensuring human rights.

Although the law, on mental health had been passed this had changed virtually nothing in terms of practices of care and treatment in this field, especially since the regulations regarding its application had not been passed by the time of the scandal. The scandal added to the urgency of developing the application regulations that together with a plan for action for reform in mental health were developed in 2005 and early 2006. The human rights modality of sense making thus made it possible for a relatively young group of progressive mental health professionals (psychiatrists and psychologists) to create a National Center for Mental Health (Centrul Național de Sănătate Mintală) (hereafter NCMH) that operated by promoting a relatively fundamental change of the system from an asylary psychiatric one to one based on a broad mental health understanding. The NCMH was created in August 2006, and lasted under this staffing until the entire team resigned in protest of the funding cuts that the center experienced once Romania joined the European Union in April 2008. The sense of urgency of human rights protection and mental health reform disappeared, without having brought about major changes. The center was recreated eventually, considerably understaffed, as well as less willing to transform the system, as many professionals and users involved in advocacy eventually noticed.

Yet, it is worth stopping for a while to look at the Action Plan for Implementing the Reform in Mental Health of the Ministry of Health [2005/2006][186] since it is the most comprehensive reform project for mental health services developed to date. The document is fifty pages long, and combines assessments from needs to budgeting, to punctual planning of interventions[187]. The cornerstones of the reform were the Community Mental Health Centers that were to cater for sectors, geographic areas that correspond to inhabitant populations ranging from 100.000 - 150.000 people (see pg. 13). Moreover, places that had large psychiatric hospitals like Obregia Hospital in Bucharest with over 1000 beds should spatially separate patient admissions according to sectors and wards - meaning de facto that people should be committed together with their neighbors with whom they if necessary continue meeting in community mental health care centers. Community mental health care centers were to revive the laboratories for mental health care and in many cases, the only move that was actually carried out was to rename the laboratories to centers. The

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[186] The document is called Tudorache B, Ghenea, D, Ciumageanu, M., Teodorescu, R., Chira, D, Duportal, I, Tudose, C., Costache L, Marcu, G, Oancea, C. and Dobrescu I. [2005/2006]- Planul de acțiune pentru implementarea reformei în sănătate mintală a Ministerului Sănătății I was given the document by one of my interview partners, and have not been able to find its equivalent posted online. The dating is based on other documents and information about the process of creating the document from my interview partners some of which were involved in the drafting of the document.

[187] The very comprehensive nature of the report allows to identify some potential inaccuracies, the number of people with mental disorders in residential institutions is estimated at over 100.000 people (pg.1) which judging by the number nowadays that are just over 10.000 people with mental disorders, it is very little likely that over 10 years ago the number was twice as high.

community mental health centers also should coordinate with protected housing opportunities that should be organized around them in the same geographic areas and have at least 50 places (around 140 community mental health centers throughout the country), with each person receiving a room, and potentially sharing a flat with up to 3-4 people in a similar age range. Therapeutic services and social work services should be offered by the community mental health center (pg. 19). Equalizing the knowledge relationship with users of psychiatry, as significant holders of knowledge was also part of the action plan, since their inclusion considered desirable in the management of hospitals and services (se pg. 11 and pg. 24). Despite its complexities the plan was never carried out as was outlined, although a number of trainings and improvements to hospital infrastructures (also part of the plan) were realized. The project sought to reorganize old structures, transform them from within, as well as develop new alternative structures. This meant that resources were necessary for carrying out the plans, since no resources could be saved in the first place, while the community care based system was expanding. After the block resignation from the NCMH[188], and the onset of the economic crisis around 2009-2010, such ambitions became unrealistic for the new leadership of the NCMH, then turned into the National Center for Mental Health and the Fight against Drugs[189].

Other alternative projects, such as the community care centers established as pilot projects, also came to face difficulties leading up to the closure of some of these services, as well as the transformation to a more hospital-centric approach of other services. All in all the decade post EU-accession saw an increase in the importance of the hospital and the asylum as places of treatment and care.

Nevertheless, during this time ad-hoc informal deinstitutionalizing projects. On one of my visits to a larger psychiatric hospital, I was brought to two protected housing flats. The flats were funded through a very

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[188] Realitatea.net: *Demisie in bloc la Centrul National de Sanatate Mintala*, 26.03.2008, available at http://www.realitatea.net/demisie-in-bloc-la-centrul-national-de-sanatate-mintala_164081.html , accessed on 14.02.2013

[189] The reframing of the purpose to include the fight against drugs, while governing a pharmaceutically dominated psychiatric infrastructure is a fascinating form of biological regulation that circumscribes the boundaries of who is entitled to decide what psychoactive substance should be used by whom. The official website of the NCMH is available here http://www.cnsm.org.ro accessed on 27.02.2018

small NGO of motivated professionals, and housed four women, who were working occasionally and informally. Yet, officially the women were still hospitalized in the psychiatric facility, since their income was insufficient for maintaining a full home infrastructure. Moreover, some of them still required support with their basic daily activities, such as cooking, which was done on the premises of the psychiatric facility. The women would then take the food and bring it home with them.

The interesting part of this legally grey project was that it allowed for a flexible system, where support was given when needed and asked for, making the residents happy with the service they were receiving. Yet, the lack of legal guarantee of such projects makes them invisible to policymakers, as well as vulnerable to being closed down anytime when they become visible. It is not that alternatives are not being sought or lived in practice, but rather that until the legal framework changes to empower such initiatives, they will continue to remain invisible policy-wise.

Changing practices and infrastructures of care for the disabled

Deinstitutionalization of the services for adult people with disabilities has not been a policy priority until recently. This is probably the case because deinstitutionalization has become a major issue in social and social-medical services either through transnational humanitarian NGOs and through EU accession pressure which in both cases focused almost entirely on the deinstitutionalization of "orphanages", meaning of residential institutions for children[190]. Alternatively, the question of deinstitutionalization appeared in the pre-accession monitoring process as a human rights issue in the psychiatric system[191].

The institutionalized adults with disabilities in the social protection system remained invisible to these ways of asking questions, until their confinement to institutions could be framed as an infringement of their human rights with Romania's signing of the UN Convention for the Rights of People with Disabilities (hereafter

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[190] The way in which this process evolved as a process of uncritical modernization is described by Negoita (2010)

[191] Discussed in the previous chapter.

CRPD), with Article 19 explicitly stating the commitment to make life in the community possible for people with disabilities by creating appropriate services[192]. Romania ratified the CRPD in 2011[193].

Nevertheless, the formal right of people with disabilities to live in the community did not result in immediate measures for people with disabilities to live in the community, rather than this it provided the leverage for advocates of community services to enter a dialogue with the social protection system. As an advocate for deinstitutionalization put it, it established a possible consensus for transformation: "I avoid getting into opinion conflicts, I rather try to work towards consensual agreement, let's get to a minimum consensus, for example the we have the UN Convention regarding the Rights of People with Disabilities that speaks clearly of deinstitutionalization, of independent living and if it's a law, to me and to you, as well, let's start from here". Yet, this possible consensus has not yet given rise to appropriate services. As the IPP (2015) has mapped out an increase in the number of residential institutions (with more than 20 inhabitants) and the number of community care alternative have grown between 2010 and 2014 (see IPP, 2015, pg. 19). It was in this context that Rovana Plumb, the minister of labor in 2015, what appeared to be out of the blue proclaimed the closure of all around 350 residential institutions and the return to family and community[194].

What the legal framework set out by the CRPD did do was create the possibility for other projects to emerge, on the one hand innovative social services with a residential component run by the NGO Proact that encourages people with mental disability to leave the system and works to help them become deinstitutionalized and included in society using state funds[195]. In their activity, they emphasize the right of the person to self-determination, as well as the need to actively promote inclusion (as opposed to assuming it would happen if a person left the residential system).

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[192] See Article 19 here https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-19-living-independently-and-being-included-in-the-community.html accessed on 27.02.2018
[193] http://fra.europa.eu/en/theme/people-disabilities/ratified-crpd accessed on 27.02.2018
[194] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 27.02.2018
[195] http://proactsuport.ro/ro/acasa/#cefacem accessed on 27.02.2018

Another practice that has become more legitimate with the CRPD is self-advocacy of disabled people. Although this practice had been around for a very long time in the Romanian political landscape, since the blind and the deaf-mute had special organizational privileges that allowed them to be heard during state socialism and which translated in a series of professional integration measures during that time[196]. This resulted in an asymmetry of resources and a general difference in opinion between these two categories and the other disability categories, like intellectual and psychic disability[197] .

Yet, recently this has come to change through the work of the Ceva de Spus (Something to Say) Association in Timișoara that promoted the self-representation of people with disabilities, irrespective of disability[198]. Bridging the asymmetry of knowledge about their rights between intellectually disabled people and their advocates, as well as other experts has been one of the projects carried out by the NGO, which resulted in a work called "our rights for our understanding", which explains the CRPD provisions in an understandable and friendly language[199]. This is characteristic of the way in which the association works using the work of support persons to mediate and translate at policy meetings for people with intellectual disabilities, making their actual and effective participation possible.

Alongside these moves there have also been recent moves of pressure from the European Commission to establish the exact number of people to be deinstitutionalized by 2020[200], this was supposed to be part of a strategy that should have been released in 2013/2014, but only came to be released much later in September 2016 - the seven years for implementation thus shrank to three years and the goals diminished considerably. The goals at the moment are to move 300 adults with disabilities out of institutions, to establish seventy five new protected houses, seventy six new day centers and eight new respite/crises centers will be established

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[196] Interview with a disability policy make/ consultant, 2016

[197] ibid.

[198] One of its projects being the release of the book "Becoming Eli" analyzed in the previous chapter.

[199] Available here Our right to our understanding http://www.cevadespus.ro/docs/drepturile-noastre-pe-intelesul-nostru-CDS.pdf

[200] Interview policy maker/ social service consultant, 2016

by 2020[201]. The provisions did not specify any difference in kind of disability regarding this process[202]. The original project, according to my interview partner was targeted at around 700 or 800 people of the around 17000 people in residential institutions[203].

Concluding remarks

This chapter was conceived as an overview chapter, setting the stage for the two more situated and ethnographic chapters to follow in this part. In this, I have provided an overview of both the psychiatric/ mental health and the disability system, their asylary features and the way in which attempts to reform them have eventually returned at the asylum. I have shown that projects of deinstitutionalization, so long they remain focused on only one of the systems, risk reproducing the logics they set out to counter. Moreover, I have shown that the questions of abandonment (in terms of lack of social networks) and subsistence (in terms of lack of economic means to make living) push a vast number of people into institutions, while institutions themselves are becoming more and more closed as an infrastructure. The chapter has ended with some hopeful developments within the everyday life of a psychiatric facility and informal deinstitutionalization, as well as with hopeful developments from within the disability field that have been made possible by Romania's adoption of the CRPD.

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[201] see National Strategy for People with Disabilities, "A barrier-free society for people with disabilities" MHE, 2017, pg. 154; the bill was passed during the Cioloș government an dis available here http://anpd.gov.ro/web/wp-content/uploads/2016/09/MO-nr-737Bis-din-22-septembrie-2016.pdf accessed on 27.02.2018

[202] MHE, 2017, pg. 154

[203] Interview policy maker/ social service consultant, 2016

Chapter 5: The Politics of Seeking Subsistence with Clinical Means

In this chapter, I will explore the contradictions of processes of fostering lives through accessing welfare benefits and/ or asylary clinical infrastructures to ensure one's subsistence. Similar to Adriana Petryna's (2002, 2004) work on biological citizenship and the aftermath of Chernobyl in Ukraine, especially her depiction of people trying to access welfare benefits by making claims on the Chernobyl derived biological consequences for their bodies and Miriam Ticktin's work (2006, 2011) on the question of how lack of biological integrity becomes a desirable state as it enables sans papier people in France to gain political recognition[204], this chapter is an exploration of the entanglements between the biological and the political, in terms of making claims to one's right to subsist. I try to enrich these accounts with the question of what happens when the illness chosen to be performed for purpose of political inclusion is mental illness. What are the bio-chemical consequences of these performances for the mind-bodies of the people involved in this performance and how are these entangled with the social and political consequences of the stigmatization that goes hand in hand with having been diagnosed as mentally ill?

In my exploration, Jack Friedman's work (2009) on "social cases", people who become psychiatrically institutionalized because they are perceived by their physicians as "too poor" to survive outside clinical settings in transition Romania has been very helpful in finding a starting point. Nevertheless, his description is missing a thick account of how the people psychiatrized to escape poverty reflect on their condition[205] and thus misses the potential to problematize these and similar practices, and to explore both their empowering and their humiliating, oppressive consequences. Furthermore, practices of psychiatrizing people to escape dire poverty are not limited to long term hospitalization, as his work would suggest, but also exist in open clinical settings (such as acute psychiatric hospitals and private practices) where people gather the documents necessary for invalidity related benefits. Moreover, the present moment indicates that

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[204] Another similar process to what I am describing in this chapter is the shift from unemployment to sickness benefits in Britain (see Beatty and Forthergill, 2005) - a shift, which has affected mostly post-industrial regions, where sickness may conceal "hidden unemployment" (see pg. 837).

[205] There is an incursion into how people feel about their lives, but not about the diagnostic process in his article.

the practices of seeking social and economic rights with clinical means might have been a phenomenon specific to the transition from state socialism to neoliberal capitalism. This is suggested by the fact that legislation passed during the economic crisis in 2010 is putting an end to practices of subverting clinical categories by juridicializing these practices. Courts are thus called to be clinical: to decide who is the truly mentally ill and where she belongs.

Two instances of seeking subsistence with clinical means

In the following, I will explore two instances of seeking subsistence with clinical means and the current challenges each form is facing. I will conclude by looking at how although these practices have been challenged their humiliating consequences have not been put aside, rather than this they have been reproduced through the processes challenging them.

The first instance takes place in an open clinical infrastructure. I describe the contradictions involved in ensuring one's subsistence through retiring on the grounds of mental illness related invalidity. The challenge this practice is currently facing is the juridical incrimination of those who appear to have subverted clinical categories. Or put differently, motivated by legislation passed during the economic crisis (law 119/2010), the anti-corruption agency (DNA) has started putting professionals who have bent the rules of clinical diagnosis for ensuring people's benefits to trial. In this challenge, the financial damage brought to state funds and not the people's right to subsistence was foregrounded, leaving people most likely poorer, but nonetheless humiliated.

The second instance is set in the closed asylary infrastructure and is centred on people who anthropologist Jack Friedman (2009) in reproducing a vernacular term described as "social cases". In this part, I look at the care and confinement infrastructure and how people who want to leave it cannot for they do not know where to go from there. The major challenges faced by the reproduction of this infrastructure are twofold. On the one hand, the discursive challenges brought forward by the human rights discourse among other things, through an exhibition campaign called "the Lagers from Next Door", portraying asylums as concentration camps. This challenge is representational and is based on a form of orientalising the institutionalized disabled subject, thus perpetuating forms of othering that can be perceived as humiliating. The second major challenge to the asylary practice of seeking subsistence is that of sudden deinstitutionalization, which would endanger the livelihoods or at least the everyday life of both inmates and lower level care staff. Both challenges rest on approaches that ignore the salience of subsistence and thus do little to empower them.

The open clinical infrastructure: Invalidity retirement as a subversive key to subsistence

I met Mrs. Costin – a woman in her fifties – in the emergency ward of an acute psychiatric hospital. I was taken aback by her reaction when I had entered together with the psychiatrists carrying out a daily visit to the ward. Upon seeing the psychiatrist, a young man, she told him in a nervous voice that she will not stay there any longer. Even threatening to go on hunger strike if held, she added that the doctor and the other psychiatrists of the hospital had destroyed her life. She did consent to remaining in the hospital and I later interviewed her in private. In the interview, she told me that she regretted the initial step in the late 1990s on the path of psychiatric treatment and retirement - had she not made this step, she would have left abroad, the alternative strategy for subsisting for both patients and staff in northeast Romania. Mrs. Costin saw her label as a mentally ill person as enabling her family to discredit her and to avoid changing things: “you are crazy, you are crazy, they say this to avoid solving problems”.

As I later talked to a social worker and a psychologist about her, they linked her story with retiring after the loss of her job due to the closure of her workplace. They added that, at home, she lived through conjugal violence, to which she responded by defending herself. It was this defence apparently that the psychiatrist individualized as her violent behaviour, the reason for her commitment to the hospital. Thus, her husband was legitimized in calling the police to bring her to the hospital. Her diagnosis enabled her to retire on the basis of mental illness, but it also enabled her to be discredited. Her experience of violence thus became individualized and striped of its relationality and linked to mental illness rather than patriarchy.

The discrediting wasn't the only change that the path of psychiatrization had brought to her life, since the psychiatric diagnosis that had given her access to welfare benefits and to treatment, which she admitted she had once long before seen as beneficial, had come to enable a bio-chemical infrastructure of pharmaceuticals to silence her: "all are useless, the pills they give you. You feel like crawling, isn't this humiliation?"[206] When we discussed mental illness and her commitment to the hospital, she said: "Most have the same problem, it's not the problem of a mentally ill person. Someone should answer to me some day what is a mentally ill person? You haven't done a thing but you don't know how to split the cash to get them dressed [probably a child or children], I think that's mental illness."[207]

When I tell this story, most clinically trained people want to know what her diagnosis was and if I think she was just a *pensionită* (a person retired on the basis of mental illness, generally through faking the symptoms). My point is not to identify whether or not Mrs. Costin was truly mentally ill or truly entitled to the label of being mentally ill, but to explore how this label worked into her everyday life enabling violence and humiliation, as well as subsistence and how she made sense of it as relating directly to the lack of money, in which clinical support and oppression are entangled with the ensuring of basic subsistence.

This relationship between subsistence and diagnosis was also explained to me by Andreea, a young psychologist, also involved in evaluating people for retirement related paper work. She explained that once a person with schizophrenia has regained their health, it is most reasonable to maintain the diagnosis: "if their Global Assessment Functioning (which is tied to their symptoms) score passes 50, they lose their handicap retirement benefits, meaning they lose their only income and have no alternatives. So, if rehabilitation is a success, we condemn them and then they might have an autolytic (suicide) attempt. (…) if anyone does regain health, I am paid to keep them ill and they are paid to stay ill". She added that in her practice people who would fake a diagnosis would regularly come and simulate symptoms - saying that they

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[206] Interview February 2015

[207] Interview February 2015

do not sleep at night etc.: “the state helped them with a medical diagnosis, so that they do not starve and we maintain this system”, “we even commit people to the hospital during winter, because they do not have firewood or their heating oven is not working, they can heat up a little.”

Andreea was aware of the social and economic function she was pushed into reproducing and its biopolitical importance: “Health and the social should be separated: measures against poverty, first, since I don’t think it is normal that I have to hit a person with a diagnosis to make him live. (…) I know people who want to work, they want to escape these categories, they are fed up with the system, with us (professionals), with humiliations. They have nowhere to go and they see themselves pushed into accepting this situation [and the label] that doesn’t even describe them.”[208] Her colleague Matei, also a psychologist, had a different theory - she reported, in his take professionals should not fake diagnosis, they should cut the benefits and then people will organize and pressure the system. Andreea did not believe this to be possible, “I say, I would be condemning them, in the Nazi times I would have declared everyone [who was Jewish] German, I would have put my hand through fire saying that everyone is German.”[209]

The interview with Andreea pointed to the biopolitical importance of the welfare benefits that were tied to maintaining an administrative diagnostic reality imbued with humiliation and stigmatization, in order to make it possible for people to survive in the absence of jobs that would accept the work of (formerly) mentally ill people[210].

I also interviewed her colleague, Matei[211], who refused the practice of subverting clinical categories to ensure people’s access to benefits. He explained that he rejects such practices, since it leads to stigmatizing and disrespecting the person perpetuating marginalization. As a “social case”, a person gets pushed around with no one bothering to see what other than economic problems they have. He gave the example of a

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[208] Interview January 2015

[209] Interview January 2015

[210] She tied the impossibility to work also to the fact that family doctors, generally medical practicioners would refuse to issue certificates attesting that a person is fit to work, if a person had had a psychiatric diagnosis. Some jobs require such certificates.

[211] Interview March 2015

person, who had contracted syphilis and had reached tertiary stage with cognitive degradation with the family still trying to obtain retirement on the basis of intellectual disability. To Matei, the problem with faking diagnosis was that the person's condition was reduced to the potential generation of welfare benefits for the family - the person's clinical condition was turned into a financial possibility. He gave the example of an old man, he had been asked to evaluate, who was pushed around to an asylum and he died shortly after. Had the family not put so much pressure on the system, maybe his medical condition would have been discovered.

Interestingly, both Andreea and Matei spoke of the biopolitical importance of the administratively required evaluation process as a possibility to make live or prevent the death of the people they interacted with. Whereas they shared a desire to foster the lives of the people, they met with professionally, they had opposite tactics in doing this in everyday life and saw the importance of clinical diagnosis in opposite ways. Yet, both recognized how it sometimes was a matter of life and death and how clinical diagnosis meant a trajectory of humiliation and human degradation, as well as an access to subsistence.

Clinical courts: Juridical challenges to the subversion of clinical administrative categories

This fragile equilibrium in which humiliation, bio-chemical oppression and subsistence grew entangled, did not remain unchallenged on the side of the state - especially during the economic crises around 2010 and then peaking since 2016 after a series of scandals erupted.

The first took place in Arad and was related to the participation of people as patients in clinical trials. Apparently, the head of the psychiatric ward in Arad had included in clinical trials a series of people who did not suffer from mental illness but needed to prove that they had been committed to a psychiatric hospital in order to obtain or maintain their welfare benefits. These people were fictionally committed to the hospital and registered in clinical trials, while the medical trainees and nurses were pushed to modify the files to fit the necessary diagnosis for incorporation into clinical trials. This appeared to be a very lucrative business - since both the patients and pharmaceutical companies contributed through informal and formal payments, until the practice was revealed and the doctor was put on trial[212]. Here, the fragile equilibrium between retirement for subsistence is shown from the other side - that of professionals who choose to exploit the vulnerability of the persons depending on this income to subsist (or in some cases seeing this as an opportunity to have an extra income while working abroad).

The conditions of possibility for this fragile equilibrium to be challenged had been established during the high-time of the economic crisis in 2010, through the passing of a new law regarding retirement[213] that involved the possibility to check the validity of all retirement benefits granted on the basis of invalidity (this includes mental illness) and provided for the punishment of those, both professionals and patients, who had contributed to unlawfully obtaining the benefits. The law also directly affected a mixed group of professionals from Cluj, who in 2017 were convicted because of unlawfully providing people with fake diagnoses attesting that they were mentally ill in order for them to become entitled to retirement benefits in the years 2008/2009. This event marked a fracture in the possibilities for seeking subsistence with clinical mean, since courts were deciding to see this as a fraudulent practice on behalf of the professionals that participated in it.

The challenge to this empowering and humiliating practice of subsistence came from the anti-corruption body and was quantified in financial amounts of damage and assessed at 514.000 RON (roughly more than 100.000 euro)[214]. The trial had been initiated by the widely mediatized directorate against corruption (DNA), Romania's central anti-corruption agency. The psychiatrist involved defended himself saying that the certificates he had issued were based on his conclusions regarding the patients, since they had been the ones simulating mental illness[215]. Yet, irrespective of his defense, he was convicted to three years suspended

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[212] http://www.aradon.ro/seful-sectiei-de-psihiatrie-la-audieri-facea-experimente-pe-pacientii-internati/1649354 accessed on 05.01.2018

[213] law 119/2010, especially art.6, paragraph 3, available here https://www.avocatnet.ro/articol_20180/Legea-nr-119-2010-privind-stabilirea-unor-masuri-in-domeniul-pensiilor.html accessed on 05.01.2018

[214] through the facilitation of 17 retirement entitlements over a period of two years.

[215] http://gazetadecluj.ro/psihiatrul-clujean-radu-ciurea-condamnat-la-trei-ani-pentru-adeverinte-false/ accessed on 05.01.2018. Expertise committees asses the person's claim to retirement on the basis of invalidity by analysing files produced by experts, as well as by interviewing the applicants. The visit to the committee also involves long humiliating ques see https://www.ziardecluj.ro/coada-neputintei-zilnic-zeci-de-oameni-asteapta-ore-sir-sa-si-primeasca-certificatul-de-handicap accessed on 08.02.2018

sentence: a sentence likely to stop the practice, rather than punish the offender. At the same time, the recipients themselves appear not to have been punished. But I might not have learned such details due to the fact that patients are rarely as high-profile as doctors and therefore their convictions do not make it into newspaper headlines. What I did learn in subsequent visits to the field that some people in similar situations had been stripped of their benefits.

Therefore, the most serious challenge to the way in which subsistence is sought with clinical means is a judicial-legal one: in which courts come to behave like clinicians seeking to diagnose who the truly entitled benefit recipients and thus the mentally ill are. It is interesting to note that doctors are accused by courts of not being clinically precise enough and people are accused of not being mentally ill enough.

What the scandal in Cluj also revealed was a network based around a humanitarian association where in exchange for 50 RON (ten euro) a month, people were instructed on how to proceed in gaining access to welfare benefits through simulating mental illness. This financialized setting shows the complexity of financial transfers revolving around these practices. Yet more interestingly, through tapped phone recordings and interviews with evaluation committees, a performative order of mental illness was also revealed: people were encouraged to tie metal wires with cans to their legs, walk bare foot during winter and go to evaluation visits soaked in urine, as well as being given tranquilizers when going to expertize committees[216]**.**

When the trial was initiated, the people heading the association started to intimidate the alleged patients to convince them not to testify or stand trial. Even more, they would harass both the administrative evaluation body members (from the social assistance directorate) and the alleged mentally ill. The alleged pretenders were followed around by the heads of the association and passer-bys and neighbours were told that the

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[216] http://gazetadecluj.ro/psihiatrul-clujean-radu-ciurea-condamnat-la-trei-ani-pentru-adeverinte-false/ accessed on 05.01.2018

"mentally ill" people had broken their windows or committed other similar offenses.[217] These moves were obviously meant to discredit the mentally ill pretenders socially, and thus testify to the actual reality of their mental illness. That these performative practices were humiliating and stigmatizing is fairly obvious. What is more interesting is that their humiliating nature and the impreciseness and social nature of mental illness become more obvious and more important through the judicialization of the question of mental illness. Thus, the judicialization of the question of social rights with clinical means led in an indirect way to more oppression towards those seeking subsistence.

The question of why people would participate in fraud for such meager sums, accepting to perform humiliating postures was never asked. To my best knowledge, subsistence was never made a topic explicitly in the thin press debate. Yet, clearly, as a relatively late consequence of subtle austerity measures, this practice of using clinical means to ensure subsistence is scheduled to come to an end without the underlying question of subsistence being addressed. The challenge to this practice thus misses out on becoming truly empowering to those most affected by the humiliating and oppressive side of this practice.

I will now turn to the question of seeking subsistence with clinical means in the second proposed setting - the asylary one, as well as the challenges it is exposed to through human rights aesthetization practices and plans of sudden deinstitutionalization.

"Social cases" and care and confinement in an asylary space

The Asylum was founded in 1962 and was the first hospital-home (cămin spital) in the county[218]. As such it was housed in an old nationalized boyar's mansion to which a new building was added in the 1990s, probably through sponsorships of transnational humanitarian organizations. At the time of my fieldwork it

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[217] http://gazetadecluj.ro/psihiatrul-clujean-radu-ciurea-condamnat-la-trei-ani-pentru-adeverinte-false/ accessed on 05.01.2018

[218] Hospital-homes were the care homes for those considered unrecoverable during the state socialist regime. After a series of purely cosmetic name changes they are now called centers for recovery and rehabilitation.

housed around four hundred people and more than three hundred people were employed there, making it one of Romania’s largest asylums.

One of the first people I met in the village was a retired carer from the Asylum, as I asked whether it was true that so many people died being locked up in the asylum during state socialism, she explained “many were dying but not as many as requests for places from everywhere in the country”. I asked what it was like to work in such a place and she said that the “ill people were very mean” (“bolnavii erau foarte răi”), “so mean that we had to keep them chained to the ankles, or else they would run away”. As our conversation topic changed to the death of two of her children, a daughter at a quite young age, I could see the affective difference between mourning a family member and registering an inmate’s death, who it appeared was already socially dead[219] at the time they came to live at the Asylum.

The intense dying had stopped or grown less intense at the asylum or at least, I could not find any evidence of it, yet, the biopolitical past of the place as a place where the unrecoverable would be let die still haunted the atmosphere and the staff-inmate relations at the Asylum. So, too, did the practices of keeping people confined and the fear of the inmates running away.

Confinement was a practice that had no apparent legal backing - although both staff and inmates did not take the contractual relationships that were renewed annually very seriously, they did at least in theory codify the care relationship as a voluntary one on both sides. Nevertheless, if a person would choose to leave - which would automatically be termed a runaway - the carer on duty would be responsible to find the person and bring them back to the center on their own expense. [220]

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[219] Here I use João Biehl’s (2005) formulation from Vita, “socially dead”, yet I add that this social death is relational, the inmates were socially dead to the caretaker that did not feel the need to mourn them.

[220] I tried to find the legal backing for this very wide spread practice that I encountered in all centers for recovery and rehabilitation for people with disabilities that I visited- the only legal framework I found was the law governing public order (!) law 61/1991 which in its current form (last modified in 2016) still includes the ban of leaving a dangerous mentally ill person who had been entrusted in your care unsupervised and not notifying the sanitary or police organs in case the person has escaped. See http://www.euroavocatura.ro/legislatie/1229/Legea_61_1991,_Actualizata_2016,_pentru_sanctionarea_faptelor_de_i

For all these reasons, this could be a terrible place. Yet, at the very beginning of my ethnographic stay at the Asylum in December 2015, I was greeted with the opposite reaction on the side of an inmate. As I was leaving the main building together with a social worker called Ana, an employee of the Asylum, a visibly nervous and excited young man joined us. He told Ana that he had been informed he's the first on the list to be sent away since he was still young and can found a family. "They don't know what they are pushing me to do if they send me away from here", he continued. His words were intriguing, since it was the contrary of what I expected to hear from a person confined to the Asylum.

One of the first testimonies I was confronted with was one of attachment to the Asylum and resistance to being sent away. I never came across the man quoted above again or if I did, I did not recognize him among the many faces I encountered every day, so that my impression of his politics remained limited to this one encounter, under the gaze of the staff. Yet, his politics were not unique, even more common was their symmetrical opposite: people who wanted to leave, but found that they couldn't for reasons other than their own confinement.

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ncalcare_a_unor_norme_de_convietuire_sociala,_a_ordinii_si_linistii_publice accessed on 05.01.2018) Dangerous is not defined, so as it being applied nowadays it includes virtually anyone who finds themselves in such a center.

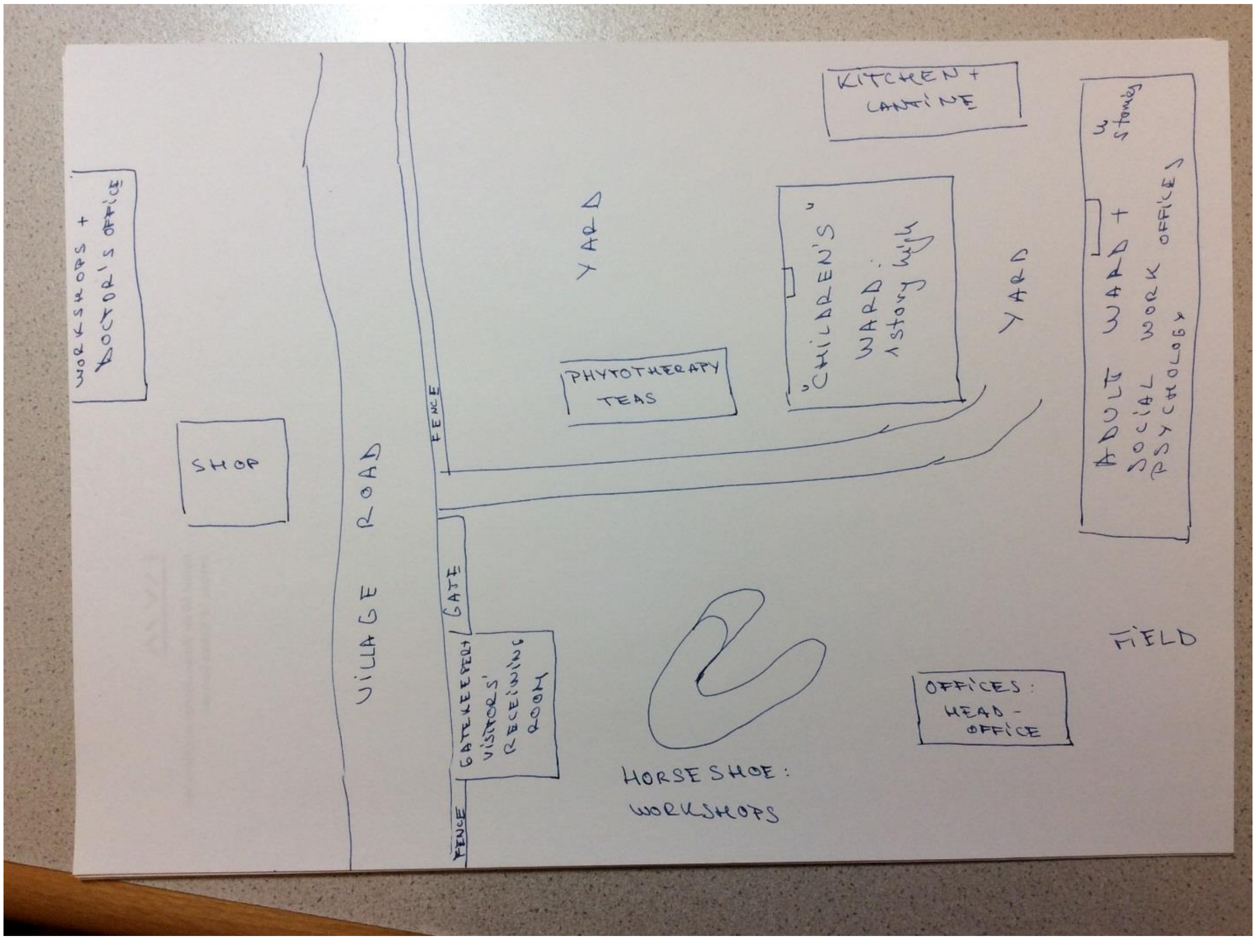

Image 1: Map of the Asylum in 2016

My first visit to the Asylum was in late spring, so that when I was there people could move freely around through the large courtyard of the former boyar's estate. The first man that caught my attention was urinating in full sight in the middle of the courtyard of the institution that immediately invoked in my mind the image of a Latin American punishment colony - the place appeared to be far away from any of the everyday social relations and conventions I was used to and people appeared to be sitting off some sort of punishment in were likely to never leave the busy hustle that appeared to be going on in the large yard of the institution.

I was shown around by Elena, a social worker, who explained to me the lay of the land and the populations living at the center[221]. On the one side are the people, "who come here from the family and we keep in touch with their families, generally they do not take their medication, destroy objects, try to set things on fire, threaten, enter into conflicts with other inhabitants. On the other, there are people, who come from other centers, and we don't know their family. Either they are abandoned or they come through a psychiatric hospital." Through abandoned, she meant that they had grown up in a foster home or orphanage and had been abandoned while in infancy*: "de mici"* and that they are generally people with "mental debility", as well as "major behavioral disorders" - meaning that they were children who grew up as the institutionalized generation called *decreței* (literary decree children - after the decree 770/1966 that inaugurated Ceaușescu's pronatalist policies)[222] and who bore the consequences of a closed understaffed orphanage system.

Elena also gave me a tour through the layout of the grounds showing how the two wards were instances of these two different sociological categories: "the children", she stressed again "were mostly abandoned at birth, they used to be children, now the ward "has adultized"[223], but we still call them children (*copii)*" [224]. It is noteworthy that for the social worker it was relevant that the ward had come of age and not the people inhabiting it, as they were somehow part of the ward itself. The formulation sounds as shaky in Romanian as it does in English. The words "having adultized" does not exist in Romanian either, but it is emblematic of what I describe in Never Neverland to be the eternal childhood of institutionalized people - here they are denied coming of age or maturing – formulations that exist in Romanian. Nevertheless, a word is invented especially for the "adultization" of "children" that describes the drawbacks of adulthood such as somatic illness but not the modified condition of consciousness, called maturity which allows to person to make their decisions and act autonomously. The other ward, the "adult" one was where the "schizophrenics" lived.

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[221] The image at the beginning of this section is a map of the Asylum that I drew to show how the different populations were spatialized at the Asylum. The lay of the land coincided with the two population groups residing at the Asylum.

[222] The word *decreței* is used to describe anyone who was born after the decree, irrespective of growing in an institution or not. Yet, since as I have shown in another chapter and as Jinga, 2011 also pointed out, legislation in the 1970s led to massive institutionalization of children, families being encouraged to entrust especially the disabled little ones to state care.

[223] "secția s-a adultizat"

[224] Adult children who grew up in the system, generally in the very same place where as grown-ups they are referred to as children by the staff. This form of discursive infantilization is common throughout the system.

“Schizophrenics” or “with schizophrenia” and “adults” were used relatively interchangeably to refer to the population of the larger ward, although of course many people of different clinical conditions and categories inhabited the ward. Yet, the vast majority was not from within the orphanage system – meaning that they were not “children”.

“If I were to leave where would I go?”

Most conversations that I had with inmates of the Asylum when we were together without staff being around, often reached the point when the person would tell me that they would prefer a life “in freedom” (“în libertate”). This would be followed by me asking, “why don’t you leave?” and the person answering: “but if I were to leave where would I go?”.

For example, once I discussed with Irina (a woman in her mid-fifties), the prospect of her deinstitutionalization, of which she appeared to be very critical: “Now I don’t even want to go home. They said the social cases would be leaving now. Now that we have a workshop where we can make some dough now we should leave? What should I do at home? There’s no land of milk and honey waiting for me. What should I do there with spade and shovel and no money? The thought of going home frightens me, it’s not like in Ceaușescu’s times that I could work in my father’s workshop, he died and I couldn’t find work anymore. […] I don’t want to be kicked out, thrown somewhere, it is convenient for me to stay here, I am a social case, it is harder to put up with the madmen but I conform to the laws governing.” Irina’s take on her confinement was one in which she preferred to enjoy the newly found occasional privileges of making money and not think of the beyond of the institutional as a desirable place, since she could not imagine herself finding employment, but at best would find herself working the land. She stressed her status as a “social case”, since it gave her the possibility to distinguish herself from the “madmen”, the regulars of the asylum. Yet, on another occasion, she told me she was pleased to have obtained a handicap certificate that entitled her to staying on at the Asylum.

The necessity to convert her status from that of a “social case” to that of a “handicapped person” reflects the tightening of clinical categories of entitlement to having one’s livelihood secured even through confinement and mirrors the judicialization of mental illness happening outside Asylums as well, explored in the first part of this chapter. During my time at the Asylum, the administrators were concerned about the tightening of regulations regarding whose stay can be funded on the basis of which clinical-administrative criteria; they feared financial controls would impose on individual managers the payment of the stays of those non-rightfully clinically entitled to their stay at the Asylum. This also pushed a different definition of "social cases" to become influential. As the head of the Asylum explained, "social cases, they are ill, but we do not have the offset of the illness [documented], or the family does not help us [with finding the files] or they are older and there are no files, no offset of the illness, no handicap certificate, so they are considered social cases and need to go home. I don't know what will come of them".[225]

Mrs. Laura was another woman in her fifties, whom I often talked to. She had been brought to the Asylum by her mother after becoming a widow and not being able to make ends meet in raising her two sons. She was critical both of her confinement at the Asylum, which she described as the state having taken everything from her and giving her hogwash in return - which she said was still better than the economic situation of her sons: "They suffer the most. At least the state gives me some hogwash [lături] to eat here. They don't get anything from anyone." Yet, she was also critical of being deinstitutionalized. I had asked her what she thought about the plan to establish houses for the inmates to be moved into somewhere close by the Asylum. Mrs. Laura replied: "I should go there and live and have a home, while my children struggle to survive? I'd rather stay here". I guessed that she meant staying there was not luxury but punishment, whereas staying at a house would mean escaping poverty, which her sons obviously had not yet done. At the same time, she often thought of leaving. In the five years that she had been at the Asylum, she repeatedly asked to be released and was repeatedly told that the family must come to request her release and sign that they will provide for her: a common practice with no legal backing, other than the law on public order 61/1991. She fantasized about moving in the countryside in the south with her mother-in-law and growing her own food

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[225] Interview with the head of the Asylum, January 2016

to survive or selling-off one of the houses her family owned and opening a bakery. Each time we would talk there would be a new such story of what she could do to subsist outside the Asylum and not be a burden on anyone's shoulders. She also considered running away, but never tried it: "They look for me with the police, if I leave. If not, I would have been long gone by now, but I don't want to hurt anyone. Otherwise I would have run away long ago." Not wanting to hurt anyone was connected to the carer's obligation to go on searching for the runaway inmates on their own costs. Two years after my initial stay, I revisited the Asylum and also talked to Mrs. Laura, who was still considering running away, but felt that she would be violently treated if this were to happen, so she continued staying.

"Where they take me, that's where I go"

Whether they knew where they could go or not ,the "adult" people at the Asylum all asked themselves the question: "Where would I go?", if they considered leaving. Yet, the "children" did not seriously consider such questions. Ioan, a man who turned thirty during my time at the Asylum, had grown up in closed institutions. As a child (as many other children with disabilities throughout Romania) he had grown up at Siret, from where the break-up of the huge hospital-orphanage in 2001 made him go to a different center. The next center, which was specialized on children and more sophisticated in its approach was the place where he felt most comfortable, yet, from there he was again taken to the Asylum when he turned eighteen. He belonged to the "children", although the reason he came to live at the "children's" ward was that he had reached administrative adulthood. We often talked about his life and what he thought of the Asylum and from his complaints I learned both about beatings within the hospital or other practices that bothered him in his surroundings. Yet, when I asked where he would like to live, he never provided me with a concrete answer. What he did say when I insisted was: "Where they take me, that's where I go". Although critical of the details of his confinement at the Asylum, he could not think beyond it. He had internalized the trajectory of being pushed around by social workers all his life and it had come to shape his horizons. It wasn't that he was not longing for a different kind of life, but that it epistemologically appeared inaccessible, not even to his imagination.

Challenges to the Care and Confinement Infrastructure: sudden deinstitutionalization and re-inventing the family

In 2015, the Center for Legal Resources, a human rights NGO ran the campaign the Lagers from Next Door, a campaign that presented the everyday life of “lagers” – meaning residential institutions for people with disabilities through an itinerant photo exhibition to be shown at NGO fairs and in city centers throughout the country. The campaign also included a petition that people were encouraged to sign under the motto “Sign the petition and free them from the lagers”, yet at a closer look the petition asked for an independent government funded body to emerge in order to continue the human rights monitoring activities the NGO had been doing for many years in closed residential institutions[226].

At more or less the same time with the campaign in June 2015, the then Minister of Labor and Social Protection, Rovana Plumb, declared at an international conference that all the centers for people with disability in Romania should no longer be funded and therefore be closed by 2020, the 17.000 people living there would be given into the care of the family through using European (Union) funding in the beginning.[227] As an explanation of the decision she noted: “Today we mark taking the responsibility of a high quality structural reform that is centered on the person with disabilities. More precisely, we pass from principles that have functioned so far, those that use institutions and systems to modern European policies that use new principles such as community, care and normality.”[228]

Hence a paradox arises when thinking between the human rights discourse and the ministerial one: the head of the Ministry administering closed residential institutions praises their functioning and plans their sudden closing, whereas the human rights NGO presents them as concentration camps and prescribes their monitoring and not their closure. The positional irony reveals that the biggest challenge to the practice of

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[226] I have analyzed the campaign elsewhere in the dissertation, that is why I only briefly mention it here.

[227] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 05.06.2017

[228] Rovana Plumb quoted in http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 05.06.2017

seeking subsistence with clinical means comes from within the system itself, since it can suddenly stop the financial reproduction of the entire biopolitical equilibrium by moving the locus of dependency from the state sponsored institutions to the "family" as an imaginary idealized space of non-commodified care.

The bitter irony of this project becomes ever more visible when the meaning of "family" in the proposals for change in the name of people with disabilities is analyzed: As the two trajectories into the asylary system have shown and as I have explored in other chapters as well, people reach the system after having been "abandoned" and perceive their stay in residential institutions as "having been abandoned here". Abandonment in this sense is always relational to the family, primarily the "mother", a point that I will explore at length in another chapter. For the "children" (those born and abandoned as a consequence of pronatalist policies, like Ioan), families exist either as imaginary spaces of an idealized existence (much like the life of the middle-class other in the human rights video) or as biological categories. For the "adults", families are perceived as the agents of abandonment and as those that refuse to take them back home. What characterizes the stay at the Asylum of people from both populations is precisely the enactment of a continuous process of being abandoned, that cannot be re-worked by a ministerial order to have them "re-integrated" into the family. The seizure in care relations having been solidified through the person's institutionalized abandonment, it is difficult to imagine what kind of policy alchemy could convert the process of abandonment into one of care.

If carried out such a project of sudden deinstitutionalization (a process that as far as I know has not started yet) would risk furthering, and not undoing, abandonment - thereby posing a serious challenge to this oppressive practice of seeking social rights with clinical means that doubles the subtler ones of trying to figure out who is truly entitled to being confined.

Conclusion: de-clinicization and re-politicization of the question of social and economic rights post transition

In the present chapter I explored how subsistence is e sought with clinical means in both the open psychiatric infrastructure through invalidity retirement on the grounds of mental illness and within the closed residential institutions through half-heartedly conceding to one's asylary confinement. Thus clinical solutions come to be enacted to solve the socio-economic problems of transition, as well as the biographical consequences of the pronatalist policies of the late 1960s and early 1970s. Where clinical solutions were found to economic problems the people who came to make use of them as patients or inmates described their experience in terms of humiliation, despite often seeing it as the only or a better solution than others to their situation.

Practices of seeking subsistence with clinical means appear to be disappearing due to the main challenge posed by the judicialization of mental illness – or more precisely the judicialization of the question of mental illness related entitlement to invalidity welfare benefits. These emerging practices seek to identify where money is being misspent and punish those who have subverted the categories allowing for entitlements. Although a challenge to the practice of seeking subsistence with clinical means, these practices do not lead to the empowerment of those subjected to clinical categories for administrative purposes. Rather than this, through ignoring the underlying question of securing subsistence, that motivates people to enter such humiliating performances and such asymmetrical relationships as those characteristic of subverting mental illness diagnostic categories, the challenges to these practices risk solidifying processes of social and economic abandonment. Through this, judicializing approaches institute a punitive and objectifying way of looking at "social cases" and the "mentally ill".

The discursive challenges coming from human rights advocacy practices, similarly builds on a form of objectifying disabled residents, orientalising them by turning them into a fundamental other of their middle-class audiences that are called upon to save them from a life in confinement. Finally, ad-hoc sudden deinstitutionalization, similar to judicialization, risks reproducing abandonment on a massive scale, ignoring the aspirations and desires of the confined, as well as the ways in which they have come to live in asylums.

A way forward would not run through objectification and judicialization of these questions, but through the de-clinicization of the underlying question of subsistence. This question should be repoliticized together with the people (previously) subjected to clinical categories as a question of social and economic rights. I will explore what this could look like in the chapter on Freirean social policy making.

Chapter 6: Abandonment, asylums and nuclear families

Many of the people, I have talked to in asylums considered themselves to be abandoned there. They linked abandonment to being "given to the state" by the mother, as the implicit legitimate provider of care. This understanding of abandonment carries both nostalgia and indignation towards the mother as the agent of abandonment and is political in an oppressive way, since it reproduces both a patriarchal and a productivist understanding of the nuclear family as an autonomous care and economic unit where care ideally should be non-commodified and thus not recognized as labor. Through this institutionalized people's nostalgia appears in line with declarative state policies that at the time of my fieldwork threatened to suddenly dissolve the entire residential care system for people with disabilities in favor of a return to the "family" as the implicit locus of care[229].

Yet, what is most fascinating is that affective perceptions of abandonment do not only remain vernacular, they also travel into scholarly thought giving rise to a recently established branch of anthropological thinking on abandonment that could be called the anthropology of abandonment (see Biehl, 2004, 2005, Höjdestrand, 2009, Povinelli, 2011, Li, 2009, 2013)[230]. What is meant by abandonment, nevertheless, differs in terms of whether the biopolitics of abandonment refers to the way in which populations are systematically being let die (see Li, 2009, Povinelli, 2011, Biehl, 2004, 2005,) due to their relationship with dominant economic, political and social structures. The terms of exclusion and thus of abandonment in contemporary society appear as the prospective lack of productivity of a population. This is described at the level of surplus populations relative to the needs of capital, whose life is not enhanced (Li, 2009), excluded minorities that now need to integrate into a late liberal economic order in order to be recognized politically and made live (Povinelli, 2011) or abandoned individuals understood as "ex-humans" like Catarina (Biehl's ethnography's

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[229] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 08.02.2018

[230] Although the authors might disagree on whether they pertain to the same conversation or not.

protagonist) who was abandoned by her family at the infirmary at Vita, after the breakdown of her marriage and since her disability cause her to become an economic burden on the family (see Biehl , 2004, 2005).

As Biehl's (2005) ethnography shows letting die is not always perceived as a biopolitical macro-process, it is also investigated in its relational and processual functionings. It is here that abandonment appears as a mediated relationship between the abandoned and her close ones (compare Höjdestrand, 2009, especially chapter 4 and Biehl, 2004, 2005 where the close ones are almost exclusively reduced to the nuclear and extended family). Yet, abandonment is nevertheless perceived as that what happens to those who become unwanted and unproductive or economically unsustainable.

In the following, I seek to contribute to investigating this relationship between abandonment and nuclear families through looking at how people describe the processes of being abandoned at asylums. Looking into the different populations that I have already introduced, the "children" and "adults" and how they emerge as those "given to the state" or "locked up" by their mothers, reveals the implicit patriarchal expectation of the mother as an unconditional care provider. Abandonment takes places when she becomes unable to fulfil this task due to the break-down or non-realization of a nuclear family. Thus people are given to the state as a masculinized provider that should ensure both their disciplining to conform with gendered norms and their subsistence.

The possibilities for these practices of abandonment to emerge come from the expansion of the social and medical assistance infrastructure during state socialism as a network of places that both were mandated to make people live, as well as functioned as places where people were let die[231]. In a further analytical step, I point forward by criticizing both the vernacular nostalgia surrounding abandonment, as well as its academic translations. Recognizing that seeing former families as a privileged locus of care is both romantic and naïve, at best, while being patriarchal and overtly dangerous to people's lives and physical integrity at worse, does not mean to justify the asylary confinement of abandoned people. People whose nuclear families have

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[231] A point that I explore throughout the thesis.

broken down or have come to be oppressive and unbearable or have not (yet) taken shape. Rather than this, I propose to think forward through the potentialities of the present, crafting an infrastructure that is neither asylary nor patriarchal and that could offer people a safe space. Such projects could be incorporated in a progressive way of doing deinstitutionalization that I will describe in another chapter.

In the following, I will look at the way in which understandings of being abandoned haunt both populations in and after asylums - the "children" and the "adults. First I elaborate on how abandonment is understood among the "children"[232], how it was made possible by a set of late socialist policies and what kind of imaginaries of nuclear families connected to abandonment haunt the everyday life of asylums and their afterlife - the quest for finding one's family and the disappointment often connected with this endeavor once successful. In a next step, I look at the population of "adults"[233] and how some of them understand abandonment as a gendered failure connected to memories of broken down nuclear families and failed possibilities to subsist on the outside. Furthermore, I connect the feeling of abandonment that "adults" in asylums feel to the trajectory of silencing most of them have experienced in order to reach the Asylum. From a different angle I continue by looking into the way in which abandonment is not tied to asylums, it makes itself visible and sometimes even turns lethal in open clinical infrastructures. Finally, I conclude by pointing forward to how a politics of hope could re-frame the dialectics of abandonment between nuclear families and asylums.

Abandoning the "children"

I will start out by re-telling some of the stories of abandonment as told by the "children" of Siret[234]. Then, I will look into the structural reasons that had made the emergence of such stories possible by looking into the pronatalist policies of the late 1960s, as well as the pro-institutionalization policies of the early 1970s. In a next step, I will look into imaginaries of families that haunt Never Neverland as a capital of

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[232] Adult people still living in or around residential institutions for the mentally disabled that were institutionalized immediately following birth or during infancy

[233] People abandoned in asylary structures later on in life

[234] As I explore in part 2, Siret was a recognized capital of abandonment, since disabled children from everywhere in Romania were brought there. At its peak during state socialism it must have housed around 2000 children.

abandonment - since these imaginaries and the social realities they bring about are highly relevant for re-thinking the relationship between nuclear families and asylums.

Ionel, now in his thirties and his sister Antoaneta, now in her twenties, were abandoned in the courtyard of the old hospital's main building[235] by their mother as small children, Ionel spontaneously remembered once when we were hanging out at the center for recovery and rehabilitation. His mother had allegedly said: "I'm going. But you stay here. We will see later… ". Ionel had a powerful story, since he could trace the exact moment of his abandonment in the conscious part of his childhood, recalling being physically brought to the hospital together with his sister. This episode is most likely to have happened in the 1980s or early 1990s - times of austerity or harsh capitalist restructuring.

Most people, who lived in Never Neverland at the time of my fieldwork in 2015 and had grown up at the hospital couldn't remember the exact moment of their abandonment. Elena a woman in her mid-twenties remembered that her mother abandoned her when she was two years old because the woman saw that her daughter couldn`t walk and since she lived in a house in the countryside and didn't have a toilette inside the house, only outside in the backyard, there was no way to offer Elena good living conditions. Elena recalled this with great emotional difficulty during our interview and most likely it was a reconstruction of this initial moment of abandonment by her mother, since the two women had not lost contact. After giving her up "to the state", her mother tracked Elena administratively and continued to visit her albeit rarely both at the hospital, as well as in all the follow-up projects where Elena came to live. These visits were still allegedly going on at the time of my fieldwork.

Others struggled to re-construct this initial moment differently, as Ștefan a then twenty-eight-year-old man with no visible disability did, who asked to see his file and discovered that his mother had declared that he had been dropped on the ground and that this caused him to be unable to move his legs. He was a bit over

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[235] at the *cazarmă*, as the main building was called after the Habsburg military barracks it used to house

one year old at that time and was abandoned together with his two older brothers, both of which grew up at a regular orphanage. It was probably this story that his mother told to make his abandonment, alongside his brothers possible for reasons that I will return to shortly. Later, he met his mother, who he was introduced to by a Catholic priest and she told him that it was his father's drinking that made her ask for a divorce, give her sons to the state and entrust her daughter to her parents to be raised, while she went to a large city in search for work. The dissolution of the family, thus had different effects on each of the children, since they all came to access and be brought up in different support structures - state and extended family.

Many of the people, I came to meet in Siret had no memory of the exact moment of their abandonment, yet all that could, had their strategies for finding out how this had happened and the lack of memory of the initial moment, did not impede the embitterment and the feeling of having been betrayed. As Andreea, another woman in her thirties from Never Neverland, once said: "you tell mothers not to abandon their children, so that they don't grow up in orphanages. Look at this beautiful girl," she pointed at her friend Manu. "How could her mother abandon her when she was small and keep that slut, her sister, at home?"

Pronatalist policies and the encouraging of institutionalization

These reconstructed personal narratives of abandonment, connected either to disabilities or poverty or to both were most often framed as the actions of mothers giving their children to the state. Often those that could ask themselves what happened asked "why did my mother give me to the state?". "The state" as the collective destination of abandoned children, emerged out of a policy context that favored state administered separation of children from their biological families and led to a mushrooming and overcrowding of total institutions (compare Jinga, 2011).

After the issuing of the decree 770/1966[236] the cornerstone of pronatalist policies prohibiting almost all forms of abortion in the context where birth control was inaccessible, the capacity of the children's neuropsychiatric hospital from Siret went up to 1200 beds, but reports speak of up to 2000 children that are

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[236] http://www.legex.ro/Decretul-770-1966-363.aspx accessed on 25.11.2016

likely to have been hosted there at a time. The neuropsychiatric children's hospital in Siret was most likely Romania's largest total institution for children[237], in a state system that came to encourage both the birth of unwanted children and their separation from biological families[238].

The pronatalist decree was followed by a law that further encouraged biological mothers or families to entrust children's care and education to closed state institutions. The law 3/1970 regulated the protection of minors including their institutionalization in either orphanages or institutions for "deficient" children, if "their parents are deceased, unknown or in any other situation that leads to the institution of tutelage, *if they do not have goods or other own material means* or there are no people that were or can be obliged to provide for them" or if the child is "deficient", *"their physical, moral intellectual or health condition is endangered within the family*" or "they had committed deeds that would be considered penal, but they are not answerable for them or they are exposed to committing such deeds or whose behavior contributes to the spread of vices or immoral habits among other minors"[239] (my emphasis). Although the categories of institutions suggested to provide for these categorized children vary slightly, it is telling that a single piece of legislation regulated all their destinies[240].

The law makes visible that state policy actively encouraged poor people to entrust their children to the care of the state, as well as gave the state the right to intervene in milieus that it could in advance label dangerous or immoral putting other children on a path of separation from their families. These policies came in a context of ensuring people's right to work and gender equality by integrating as many family members as possible into the workforce and unburdening families of caring for disabled children (compare Milea, 2004, pg 38 and Popescu, 2012 pg. 52). Paired with insufficient funding this led to a mushrooming of the category

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[237] https://www.monitorulsv.ro/Reportaj/2014-06-16/Aruncati-in-fostul-orfelinat-de-la-Siret-de-propriile-familii-peste-100-de-adulti-copii-au-invatat-sa-traiasca accessed on 26.11.2016

[238] The location of Siret at the border to Ukraine, the very end of national territory was not incidental, as other large total institutions would find themselves in similarly peripheral and secluded places.

[239] http://www.legex.ro/Legea-3-1970-445.aspx accessed on 24.11.2016, the law also mentions family placements as the first measure to be taken in certain cases, yet, unfortunately there is very little known about how this practice worked during state socialism.

[240] Interestingly this law does not specifically mention neuropsychiatric children hospitals, although my fieldwork material suggests the fact that they were in practice terms part of this infrastructure. I will continue to look for the exact piece of legislation that allowed for these places to operate.

of “irrecoverable” as it came to be applied to many children, since it “appeared reasonable that, in order to take the burden off the parents’ shoulders, such cases should be given priority to hospitalization” (Milea, 2004, pg. 28). This was probably the reason why, Ștefan’s mother must have lied about his incapacity to move his legs (unlike Elena, Ștefan had no difficulty walking) - adding a solid reason to her already firm decision to abandon her child alongside two of his siblings, ensuring he will be taken into the state infrastructure. The decision itself being motivated by the breakdown of their nuclear family due to her husband’s drinking.

These pieces of legislation, as well as the general worsening of economic conditions in Romania through - out the 1980s led to the overcrowding of an unprepared and underfunded infrastructure and to a generation of children that became famous internationally in the 1990s as children brought up in inhuman conditions in state institutions or “Ceaușescu’s children”[241]. It was with these children that by the time of my fieldwork were adults with ages ranging from late twenties to early forties that I carried out a large part of my fieldwork. But how had they come to Siret? Or put differently how was Siret as an infrastructure connected to the processes of giving children to the state?

Children abandoned in hospitals at birth would either directly be adopted by childless couples as if they were their biological parents[242] or would go on trajectories to cradles, *leagăne* where they would spend the first three years of their life, from there they would be transferred either to orphanages or hospital homes or neuropsychiatric children hospitals, as the one in Siret[243]. Since Siret was the largest institution for children with neuropsychiatric “deficiencies” in Romania and since it was one of only four such institutions in the entire country and the other three were located in the center and north west of the country (Râul Vadului, Lugoj and later Pâclișa) (compare Milea 2004, pg. 41), Siret brought together children abandoned in

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[241] I have analyzed one of the media representations that contributed to this discourse in the previous chapter

[242] I am indebted to an informal conversation with neonatologist for this point

[243] Siret was most likely the largest such institution in Romania pointing to the fact that Siret was central to the processes of abandonment of children in the entire country. Compare https://www.monitorulsv.ro/Reportaj/2015-03-17/Orfelinatul-Groazei-din-Siret-dispare-caramida-cu-caramida accessed on 26.11.2016 and Milea, 2004, pg. 41. That is why Siret was a central stop on the trajectories of abandoned children everywhere in Romania.

maternities as far away as Bucharest (500 km) or Târgu Mureș (300km). This process of geographic segregation solidified the process of abandonment, making distances very hard to travel even for those most committed parents that would have wanted to see their children again after giving them into the care of the state. This was even more telling, since children considered "deficient", especially severely "deficient" ones were deemed by both state discourse and certain families to be cared for better in specialized institutions, like the one in Siret. The chronic underfunding of the system also leading to a mushrooming of both the labels "deficient" and "irrecoverable" (compare Jinga, 2011, Milea, 2004 pg. 37-38) and implicitly the potential pushing of any abandoned child into the confining dynamics of such places as the hospital in Siret where many were likely to be let die. National in terms of its reach, the zone of abandonment that the old hospital in Siret represented might have disappeared but it gave way to a space that I called Never Neverland where the once children would actively be governed by logics mostly outside of their reach[244].

Biological Families, Imaginaries of Families and Abandonment

"I am grateful to my mother that she gave me away, who knows what it would have been like, if I wouldn't have been given away, I wouldn't have the life I have now. I wouldn't have had such a nice house, a job and a husband. When I went to my mother's, I came back with lice and full of boils." Mădălina a thirty-year-old woman, who worked in the wood industry and lived with her husband in foundation protected housing[245], was exceptional in her recollection of both her time at the *cazarmă*, which she regarded as better than living on the streets and in her assessment of her abandonment, which she saw as a chance for upward social mobility. She also said, she did not like to be in her mother's house, because of the living conditions there. The poverty of her biological family - embodied by the figure of her mother - was only escapable to her through the institutional biography, which brought her to post-institutional success - as opposed to most others in town, abandonment for Mădălina wasn't tragedy, but fulfillment.

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[244] A point that I will return to in the chapters focusing on Never Neverland

[245] As will be apparent from the part of the dissertation dealing with Never Neverland, a number of transnational foundations were active in deinstitutionalizing people in Siret. Mădălina's trajectory being one of the few that did not lead back into the state infrastructure after EU-accession, a point I will return to in a chapter in its own right.

When recalling how she had found her mother, Mădălina said she had gotten an address from the social worker and it was Manu, who wrote a small letter from the special education boarding school where they were sharing a room and two days later her mother arrived at the door. Manu's mother had also come to the door before and at the time of my fieldwork would even invite her to Bucharest to spend her holidays there and she would spend three weeks, sometimes even a month in Bucharest each year. When we met in Bucharest, Manu told me about an argument with her mother that ended with her saying the words: "don't you tell me how to live my life, since you weren't up to raising me" .

The plurality of forms of separation that led children into the hospital is reflected in its memory: some remember it as an orphanage, it was thus that it was scandalized by the BBC, who called it "(the) Romanian orphanage" and it later came to be remembered as the "orphanage of horrors" in much of local and national press and TV. But it was also a neuropsychiatric children's hospital, as its name suggests, as well as the memories from both staff and inmate children confirm some recovery activities were carried out within the hospital[246]. Also, popularly the space around the hospital was called "sus la nebuni", up at the mad people. It was also remembered as the *cazarmă*, the military barracks since its main building was an old Hapsburg military barracks, but this related interestingly to the fact that confining and disciplining practices were at home in the building and the military barracks, just like long term psychiatric hospitals and orphanages are all total institutions in Erving Goffman's understanding. But it was also referred to as "like our fatherly home" or even "our fatherly home" by some of those who grew up there, like Manu and Ștefan.

As the staff of the center also pointed out: "On TV, they said that it was an orphanage, but this was not correct. An orphanage is a place for orphans - here these children had parents, they were here because of their disabilities." Abandonment for socio-economic reasons, as well as for disability reasons was entangled with a regime that promoted the state organized care of children in large total institutions. But it was rarely a total process: Elena's mother would still visit her at the hospital coming to see her sometimes only from the other side of the fence and her visits were still happening at the time of my fieldwork in 2015. In another

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[246] Also documented in a medical movie that I will analyze in the next past of the dissertation

story, the father of a disabled child had insisted on giving the child up and when he died, the mother started to visit her then already adult child.

Interestingly, the very severely disabled had families that would visit relatively often, whereas those who were very mainstream in their appearance and abilities would generally have families that would not want to have anything to do with them - probably because although they eventually came to be labelled as disabled the initial reason for abandonment was an economic or a "moral" one, prompting parents to feel more strongly that they had failed at being parents, either because they couldn't make ends meet or because they had had children outside of wedlock.

Take the story of Alexandru, who in one excursion with people from the center was brought "home" to meet his family, who lived a couple of tens of kilometers away from Siret. Upon seeing him one of his biological parents, in the house where many of Alexandru's numerous siblings were also living, allegedly told the accompanying staff: "see this axe, if you leave him here, I will crack his head open." This story was narrated to me, many times when talking about the families of the people from the center by staff. For some, social abandonment was therefore a recurring process that would be reproduced whenever the potentiality of re-kindling ties with the biological family would resurface.

In another staff told story, a resident's family once came to inquire about him, since they would come to sell metal roofing tables on Tuesday at the weekly market in Siret when the town would fill with people from all over the region. Their mother had become ill recently and they wanted to see, if he was fit to work, so that he could either join them or take care of the mother. When they saw that his productive capacities were not as promising as they had hoped, they continued to come into town, but wouldn't visit the house where he lived, which was just a few minute walk away from the place where they would set up their stall during market Tuesdays. In this story, the potential of being productive or useful made the biological family try to re-kindle the relationship, yet, by seeing that they were wrong to hope for a more productive regained family member, they returned to their initial stance of social abandonment.

Adelina, a woman in her thirties, also had a family that came to find her many years after her initial abandonment. Apparently, her mother had died and her grandparents had joined an evangelical cult. Looking to redeem their daughter's sins, they took Adelina into their home. When things did not go well, especially between Adelina and her sister, but maybe also because Adelina was a smoker of cigarettes and accustomed to moving freely through town, she was brought back to the hospital. In the manager's words: "she was dropped back at the hospital, like a bag of potatoes". Her family would continue to take her home on holidays and Adelina would complain that she doesn't have good living conditions at home - a point that the manager said was likely untrue given the documents, they had submitted to take her out of the hospital in the first place.

Yet and still, meeting one's biological family was a space of mythification and as I will return to briefly many still strived for it. Even those, who did not talk about it too much would be haunted by this imaginary of meeting. The stories of discovering that one was an orphan were a different way in which this dilemma was resolved, as I was told by two women, who had discovered they were orphans, Alina and Andreea.

There was a boy at the children's hospital, he insisted the carers find his mother and in the end, they managed and she came and took him and he became someone ("s-a realizat"). Alina thought to do the same and when in school in another town, she finally found someone who helped her and then she found out that both her parents had died. Andreea said she had lived through the same. She had talked so badly about her mother that she had abandoned her and did not keep her next to her, let her grow up in orphanages and then there came the letter: she is deceased. And she had to ask her friend to ask the teacher what "deceased" meant, since she didn't know the word. Then, she regretted having talked against her mother, since she had died.

Being haunted by the desire to see one's parents materialized in the most unexpected ways. For example, when playing dix it – the visual card game - with four women in my apartment. I started the game with a card with a mommy fish and very many baby fish and a seashell looking like a baby carriage. I said happy parent. The word parent then came up almost every second time during one pack of dix it cards. Once it was used to designate a genie looking over a child, another time a dragon spitting fire. Another time, one of the residents, a man in his late twenties who couldn't read or write, asked me to write a letter to his family. He had come into the possession of a phone number and was eager to communicate with his older sister and his parents. After he asked me to talk to his sister and request an address, we settled on writing a letter. The letter he asked me to write down and post, started as follows: "Dear mother, I want to see my parents. I desperately want to see my parents. I also want to see my children. I want to go to my parents, since I have not seen father [yet]….". The imaginary of the family was one based on separation from an ongoing social reality - he desperately wanted to reconnect not only with the parents, but with an imaginary line of descendants that includes children that to my best awareness he did not have[247].

Family imaginaries did not only haunt card playing and letter writing, more significantly they haunted the interactions between residents and staff. Ștefan remembered once that when he was a small child of around three years old at the *cazarmă* there was a caretaker woman, he used to call mother. At some point, she turned infuriated with this and said: "don't you call me mother, I am not your mother, your mother just shit you and gave you to the state". Ștefan's desire to transfer his longing for a mother figure to one of the carers, therefore failed and he was reminded of his abandoned state. Despite more than twenty years having passed since then (Ștefan and I were almost exactly the same age- twenty-eight at that moment), he still remembered the episode. Ștefan was also the protagonist of quite the opposite episode, one evening I was leaving the house where Ștefan lived quite late at night. The carer on duty, Mrs. Andreea was a woman in her thirties, who asked Ștefan to accompany me part of my way, to not walk alone in the dark for too long. As we were leaving, she started telling us of her recent troubles, how after having a vascular stroke, she couldn't afford to go to the doctor in the nearby town of Rădăuți, since it was September and from her salary, she had to buy her daughter's things for school. She started crying and as we comforted her, Ștefan also started crying. When she noticed this, she comforted him by saying: "don't worry, mother will take care of you". We left shortly afterwards and as we were nearing the gate, Ștefan told me he had cried since he remembered his

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[247] The sister that I spoke to on the phone was very keen on knowing what exactly we needed the address for, since it was quite obvious that she was nervous that we would try to integrate him into the biological family. According to staff, also each time they would try to organize a visit to his family, they would unexpectedly disappear to somewhere else on some urgent business, reappearing once they were gone.

uncle had also had a vascular stroke and he had been thinking about him. Ștefan was in touch with his family, but they rarely called back and wouldn't come to visit, although he would get in touch in every way he could. Biological family ties were stronger in his imaginary than the complex care social relations that emerged between carers and residents on an everyday basis, themselves also haunted by imaginaries of biological family ties.

But there were more successful cases still ongoing in adulthood where a carer at the psychiatric hospital on the ward for the most disabled, would refer to one of the woman residents as "my girl", saying that "she is my girl, that's why on my shift, she doesn't make any noise or trouble (gălăgie)". The carer would also take "her girl" to spend time in her home, in a form of a holiday of sorts. In the same ward, another woman once gave me a tour introducing me to all her mothers, by the end of the tour, she had introduced me to the three women carers present as "our mothers" and the one man, as "our father". This incident points to the fact that the imaginaries of nuclear families still haunt those abandoned and orphaned a long time ago, but the misfits between a plurality of carers and subjects that required care and affection leads to the awkward alignment at hand: the words "mother" and "father" lose their relational exclusivity and become floating signifiers for those, who perform care in the places that are more strongly confining.

The initial moment of social abandonment was not the end of the relationship with the biological family, even in the many cases in which the family was not interested in maintaining contact to the person[248], as the nuclear family continued to haunt the imaginary of the abandoned despite or maybe exactly because of the lack of materiality of the family the idea of one's parents and one's extended family haunted the everyday reality contributing to a constant re-kindling of one's abandonment, that went hand in hand with challenging it and trying to reclaim the relationship with the biological family. Moreover, through the existence both in the minds of administrators and carers and well as in those of the once abandoned of the idea of an existing family and its importance contacts would be remade often leading to a repetition and even reinforcement of

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[248] For example, of the 140 letters sent to the addresses of the families from the psychiatric hospital's patient field in 2005-2006, only three families replied, see https://www.monitorulsv.ro/Reportaj/2014-06-16/Aruncati-in-fostul-orfelinat-de-la-Siret-de-propriile-familii-peste-100-de-adulti-copii-au-invatat-sa-traiasca accessed on 26.11.2016

the initial moment of abandonment and the birth of a new related memory that of being dropped back at the hospital “like a bag of potatoes”.

The “children” beyond Never Neverland

As the stories of being given to the state show, the main reasons for being given to the state appeared as a complex entanglement of disability and poverty, as well as the breakdown of nuclear families through divorce or death. Once given to the state the disconnection with the biological family was solidified by the geographic distance of Siret to virtually anywhere in Romania.

Siret was also a starting point to going somewhere else. As a neuropsychiatric children’s hospital during state socialism, it was thought of as only housing children. Those who would go to school and obtain good results would be sent onwards to professional schools and could then hope to live on their own, while those considered unable to do such things would be sent to “hospital homes”. This is how those “children”, who came to the Asylum would end up there.

At the same time, growing up in an institution for children with disabilities would also mean that in most cases people would be haunted by a desire to get to know their families that would often lead to disappointment once the person would actually meet the family. Growing up in an institution meant growing up with the feeling of having been abandoned by one’s mother. This happened even in cases when the person was orphaned - a product of the asymmetry of knowledge and the limited or lack of access to one’s past as coded in one’s file. This feeling of abandonment was translated into the search for one’s mother among the care staff, which at times would come to be denied by those, thus reinforcing the feeling of being abandoned. Imaginaries of biological families therefore continued to haunt the social imaginary of asylums and their after-life, without materializing as actual places of care[249] and rarely materializing as actualizable social relations.

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[249] There was a man who was given into the care of the family, as the mother had come to request this. The staff of the institution was distrustful of this return to the family and claimed that he was not well taken care of.

Abandoning the "adults"

As mentioned before the population of "adults" was different from that of "children", since they had had a regular life outside of institutions with a nuclear family and sometimes children, which was interrupted at a certain point, causing the person to become institutionalized, mostly against their will. In the following, I will explore stories of abandonment that I have heard from people described as "adults" at the Asylum, as well as in other residential institutions were I carried out interviews, showing how the gendered failure to perform a certain role in the nuclear family was seen as having made institutionalization possible.

"My husband died. […] at first not much changed, I had children to raise, one was sixteen, the other thirteen. I went on with my life. Two years later, I couldn't make ends meet anymore, I asked my family for help. They saw that I was going around sloppily, taking less care of myself, wouldn't put make-up on anymore. Instead of helping me, they sent me to the psychiatric hospital. They [the office where she was working at the time] understood me, gave me medical leave. But then they [her family] took me there again. The office terminated my employment. I went to live with my mother until the forms for my retirement would be concluded, but she dastardly took me to a psychiatric hospital for the chronically ill. From there, I came here. There I realized that they were taking me somewhere else, since they kept me locked up for three months. The family arranged it with the doctor and took me here." Mrs. Laura was in her early fifties in the time of our repeated conversations, she inhabited the last floor of the "adult" building where the Asylum's elite women's ward was located. Often, I would find her half-sleeping on the bed, her overweight body leaning on one side. She had been a professional athlete in her youth and her overweight was probably a consequence of the doping practices of the 1980s. Without me asking why she would lay in bed during the day, she told me that she cannot sleep at night for fear of her roommate, who sometimes had violent fits and hit her with whatever she finds around her.

Her story is very telling of the gendered nature of the forces that led to what she described as her abandonment at the Asylum. Financial difficulties, associated with the unnatural death of her husband at a young age, pushed her into a situation of helplessness where she requested the help of her mother. When talking of others at the Asylum, she said: "don't think people here are that off, they just got here because they had a difficult moment in their lives and their close ones instead of helping them, closeted them further".

"My sister stopped answering her phone. My children are not even thirty yet, and are wondering what should we do with mother. Anyhow, they remained on the streets from thirteen and sixteen years of age. The younger one, I talked to him, told him where I was and he said: 'mother, stay there, I don't have where to take you in.' I am abandoned here. I will not go from here to be a burden to anyone. Police, post office, army and managers, they all work with computers now. You can be healthy and they won't take you. […] The state took everything from me, everything. [..] we are a washed-out family [o familie ratată]".

The financial burden of subsisting as a widow, made her fail as a mother, she was aware that her children had had the more difficult life, since they came to live with her kin in the northeast and were forced to leave their lives in Bucharest. "They suffer the most. At least the state gives me some hogwash [lături] to eat here. They don't get anything from anyone."

The gendered nature of abandonment in Mrs. Laura parallels interestingly also with research on the politics of gender during and after socialism (see Gal & Kligman, 2000). After the loss of her husband, she turns to the mother, who turns her over to another masculinized provider, the state. As Gal & Kligman (2000, pg. 5) note: "[During state socialism] There was an attempt to erase gender difference (along with ethnic and class differences), to create socially atomized persons directly dependent on a paternalist state. Yet, women in socialism were also sometimes constituted as a corporate category, becoming a special object of state policy […]. Women's full participation in the labor force was dictated by the state, on which women were more directly dependent than they were on individual men." It is not incidental that asylums generally, and the Asylum particularly are often publicly portrayed as the last bastions of "communism" that needs to be eliminated for Romania to become a "full" "European" democracy, since as we see in Mrs. Laura's case, her mother's actions of getting her committed made her explicitly dependent on the "state" as a surrogate partner taking the place of her dead husband[250]. The relationship with the state is far from an equal one, despite giving her hogwash to maintain her subsistence, the state takes away her teenage children, which she cannot mother from afar and who when coming of age come to reproduce the processes of continuously abandoning Mrs. Laura. Disposing of an economically unsustainable family member by having them be cared for in these places appears as a feminized activity. Both people, who were abandoned as infants, as well as those abandoned in adult age associated abandonment with being given to the state by the mother.

I have taken up so much space discussing Mrs. Laura's life story for two reasons, on the one hand she was my friend during my time at the Asylum, and during my days there when I would not be interviewing someone else on the lower women wards or in the "children" building, I would often come to her to have a relaxing conversation[251]. Thus, I am most familiar with her perspective on her life, helping me look at the structures behind her arrival at the Asylum, as well as her stay there. On the other hand, the gendered nature of these structures and the struggle between having subsistence ensured and the desire for freedom and responsibility, were tropes that came up in almost all my other conversations with both women and men.

At the same time, gendered patterns of abandonment were shared by many of those, who were abandoned at a later point in life and who had had lives outside of the Asylum's fences. Most were stories of gendered punishment, what Mrs. Laura and others termed "having done something to end up there". For women, many stories involved having been punished by their families for their perceived sexually too libertine ways. This paralleled interestingly an older and then already long outdated social policy category, which had been used in Romania in the interwar and early state socialist years, "moral deficiency"[252] . "Moral deficiency" seems to haunt the system through the biographies of some of the most articulate women residents, despite

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[250] Unlike in Gal & Kligman (2000) the dependence on a patriarchal state, in Mrs. Laura's case the dependence upon the patriarchal state does not go through employment but through institutionalization.

[251] Alongside Mrs. Laura, there was one more person, I can call a friend at the Asylum, Ioan who I will also introduce later on in the paper.

[252] Interestingly, even before "mora deficiency" to become a ground for re-education and confinement in Asylums, the madness of women was linked to sexual deviance. (see Vintilă-Ghițulescu, [2004] 2011, pg.355)

its lack of administrative salience immorality appears as a category strong enough to persuade the family to set a person on a path to institutionalization and the professionalized experts to consent to it.

With women, this manifested itself as generally sexual deviance, especially having sex with strangers, or extramarital sex that led to the birth of children or unwanted pregnancies (whether the pregnancy was initially unwanted by the family or by the women themselves remained quite unclear in conversations). The exile at the Asylum was perceived as a punishment for this conduct that was shunned but never spelled out as immoral or illegitimate, this remained self-understood both by the person speaking, as well as by the person judging someone else's arrival related to this. Irina, in her mid-fifties, described the relationship to her mother in the context of arriving at the Asylum: "As much as I have wronged, a mother forgives, even if I had that child born under a rose [din flori]. A mother forgives. I lived with that man, although I wasn't married. I don't want anything from her. I don't need her fortunes, her land." When discussing the rest of her family, she also said: "At home, you're good while you're young. When you are old, you are no good, you can be as aware as you are. They don't need you at home."

In Irina's story, the gendered and age related tensions entangled with one's "immorality", as well as one's potential lack of productivity become explicit. She comes to live at the Asylum, since no one needs her, her repeated plea "a mother forgives", most probably related to the fact that she felt un-forgiven and therefore punished through confinement. Irina is also one of the strongest critics of being deinstitutionalized: "Now I don't even want to go home. […] Here it is good. There's no one telling me don't smoke, don't drink coffee. […] They closeted me here because I speak my mind and I drink." Similar to other instances speaking one's mind is often entangled with other "disabilities", mainly the incapacity to be a productive member of the nuclear family, "at home" and in this and many other cases with deviant sexual behavior, as well as deviant biographies. The masculinized state steps in when mothers apparently felt their children to have strayed away too far.

So was the case of a young woman, Alexandra, who as her ward mates told me had been found by her parents pregnant in another large town broadly in the northeast. Her family got her a handicap certificate and put her at the Asylum, her ward mates nodded as one of them said: “they shouldn’t have done this to her, there are so many single mothers out there.” Alexandra herself talked about her time in that city by saying she had run away from home, because she did not get along with her step mother and that she had gotten involved with a group of gypsies that cause trouble. Here again gendered and ethnicizing dynamics combine to “normalize” the young woman by putting her in an Asylum.

This rather long excursion into the life stories of these women shows the normalizing function the Asylum holds within rural populations, which are far away from cosmopolitan centers, as Mrs. Laura much bemoaned Bucharest, where lives within certain circles of financially sustainable people do not need to go by the rules of a conservative society. The Asylum appears for the most vocal of its inhabitants, both as a place of material security, but entangled with this is the feeling of sitting off a sort of penitence for not having been able to perform as the daughter of a mother, or as a young woman - one’s failed womanhood. The punishment is not legal-judiciary as is the case for incarceration, but quite the administrative contrary of that, it is a “voluntary” service that almost no one can leave from. That is why also there is no end to this “punishment” disguised as a regime of care.

Although most of my interview partners at the Asylum were women[253], there were also men that I would talk to. For men, being brought to an asylum was generally associated with “being locked up” there, despite having performed economically. Adrian, a strongly built man in his early forties, said that he had worked abroad in two different Balkan countries. When he returned, he bought a flat and his mother put him in the Asylum and kept the flat for herself. Another man, Gheorghe, who I had met at a different asylum, similarly, explained that his confinement was connected to the taking away of his house, which he had worked for. Professionals then “censored” him and he was put in “concentration camps”. He also asked me for a piece of paper and wrote a letter, which I reproduce below (having erased all identifiable personal data). The story was confirmed by a social worker at the center, who said that there had been some problems with the house

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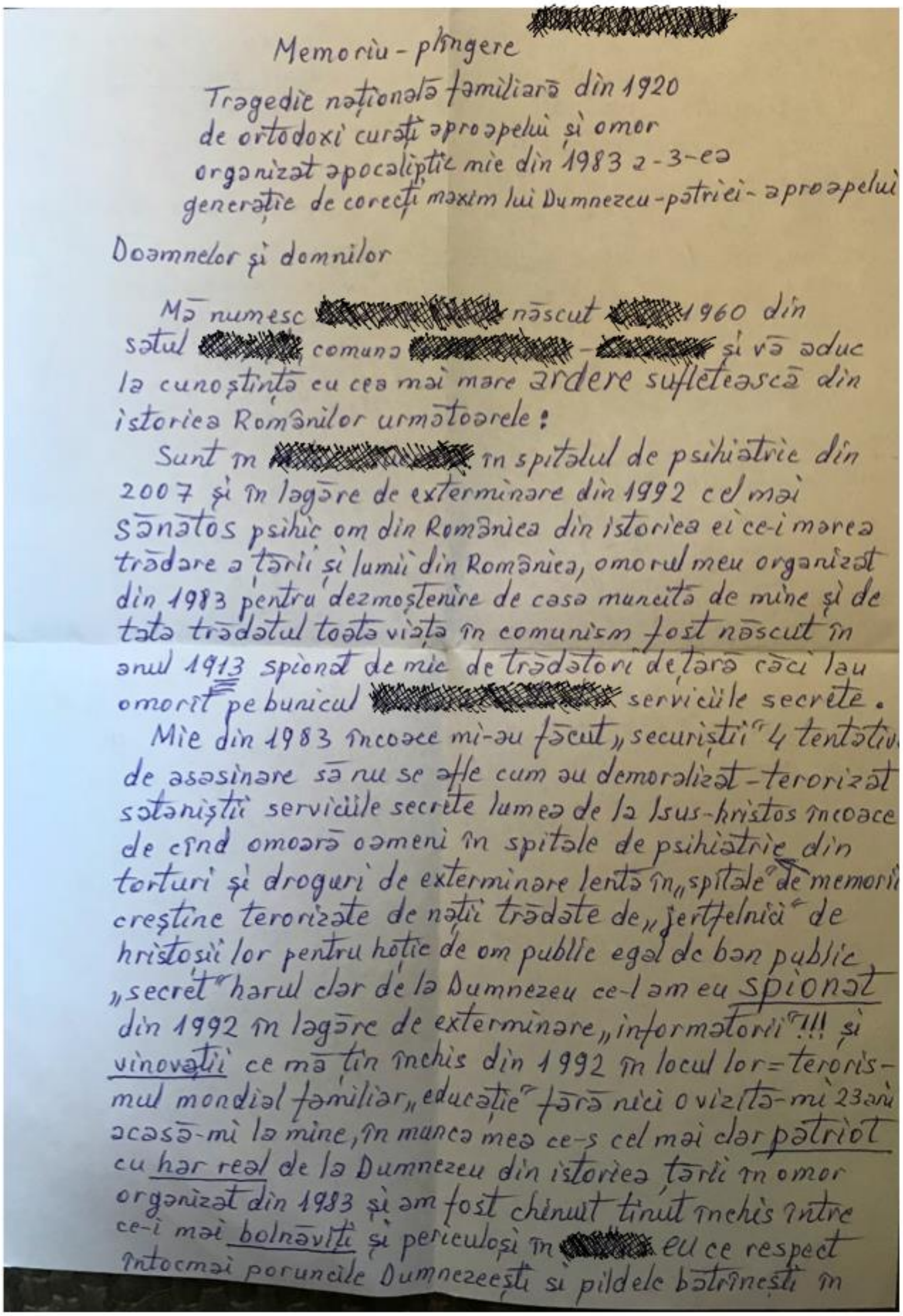
[253] A point which I discuss at length in the chapter on the social life of the project.

related documents, involving trials that had been judged in his absence, due to his confinement in the asylum.



[redacted]

Memoriu - plîngere

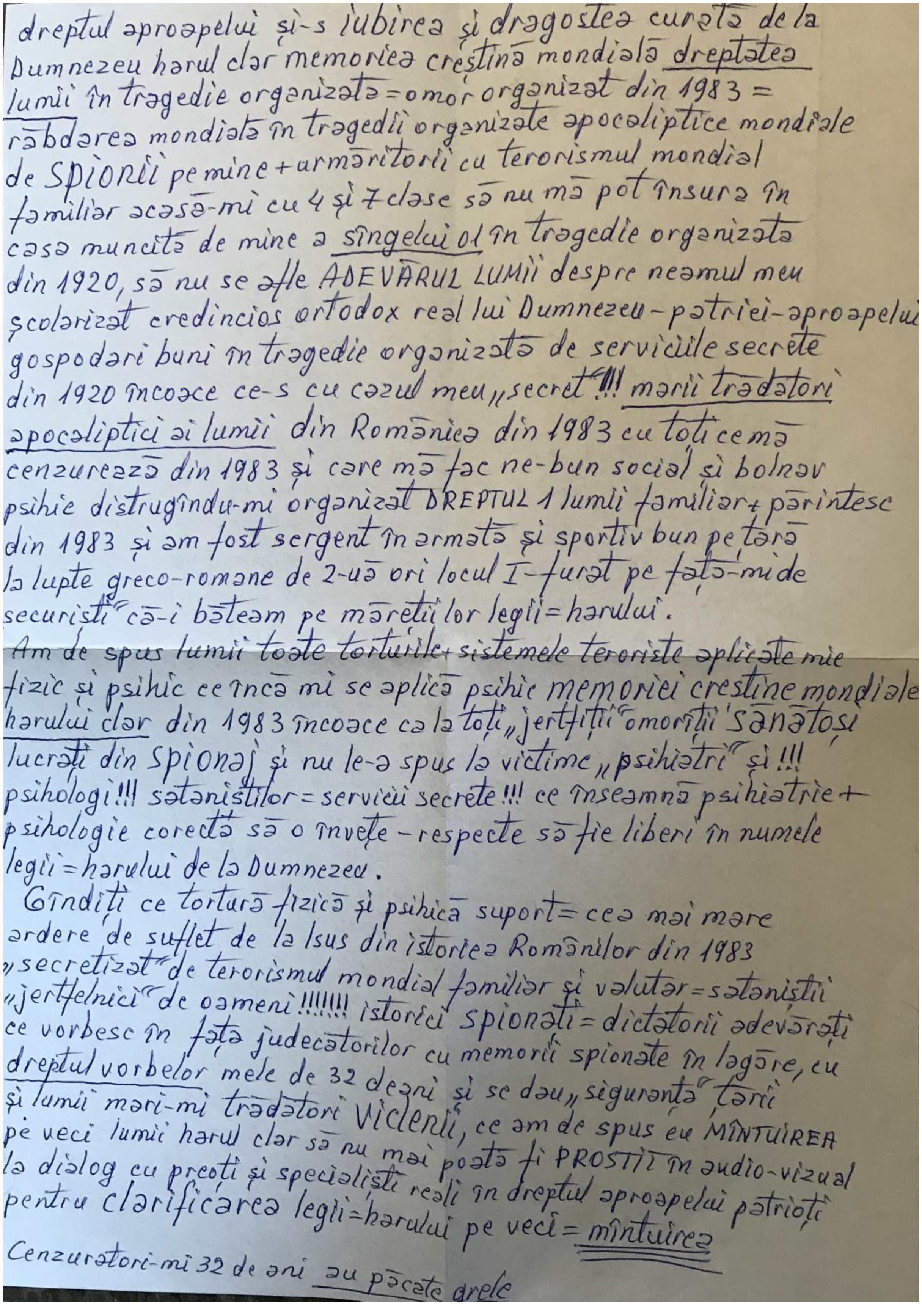
Tragedie națională familiară din 1920
de ortodoxi curați aproapelui și omor
organizat apocaliptic mie din 1983 a-3-ea
generație de corecți maxim lui Dumnezeu-patriei-aproapelui

Doamnelor și domnilor

Mă numesc [redacted] născut [redacted] 1960 din satul [redacted] comuna [redacted] - [redacted] și vă aduc la cunoștință cu cea mai mare ardere sufletească din istoriea Românilor următoarele:

Sunt în [redacted] în spitalul de psihiatrie din 2007 și în lagăre de exterminare din 1992 cel mai sănătos psihic om din Româniea din istoriea ei ce-i marea trădare a țării și lumii din Româniea, omorul meu organizat din 1983 pentru dezmoștenire de casa muncită de mine și de tata trădatul toată viața în comunism fost născut în anul 1913 spionat de mic de trădători de țară căci lau omorît pe bunicul [redacted] serviciile secrete.

Mie din 1983 încoace mi-au făcut „securiștii" 4 tentativ de asasinare să nu se afle cum au demoralizat-terorizat sataniștii serviciile secrete lumea de la Isus-hristos încoace de cînd omoară oameni în spitale de psihiatrie din torturi și droguri de exterminare lentă în „spitale" de memori creștine terorizate de nații trădate de „jertfelnicii" de hristosii lor pentru hoție de om public egal de ban public „secret" harul clar de la Dumnezeu ce-l am eu spionat din 1992 în lagăre de exterminare „informatorii"!!! și vinovații ce mă țin închis din 1992 în locul lor = terorismul mondial familiar „educație" fără nici o vizită-mi 23 ani acasă-mi la mine, în munca mea ce-s cel mai clar patriot cu har real de la Dumnezeu din istoriea țării în omor organizat din 1983 și am fost chinuit ținut închis între ce-i mai bolnăviți și periculoși în [redacted] eu ce respect întocmai poruncile Dumnezeești și pildele bătrînești în



dreptul aproapelui și-s iubirea și dragostea curată de la
Dumnezeu harul clar memoriea creștină mondială dreptatea
lumii în tragedie organizată = omor organizat din 1983 =
răbdarea mondială în tragedii organizate apocaliptice mondiale
de SPIONII pe mine + armăritorii cu terorismul mondial
familiar acasă-mi cu 4 și 7 clase să nu mă pot însura în
casa muncită de mine a sîngelui 01 în tragedie organizată
din 1920, să nu se afle ADEVĂRUL LUMII despre neamul meu
școlarizat credincios ortodox real lui Dumnezeu - patriei - aproapelui
gospodari buni în tragedie organizată de serviciile secrete
din 1920 încoace ce-s cu cazul meu „secret"!!! marii trădători
apocaliptici ai lumii din Româniea din 1983 cu toți ce mă
cenzurează din 1983 și care mă fac ne-bun social și bolnav
psihic distrugîndu-mi organizat DREPTUL 1 lumii familiar + părintesc
din 1983 și am fost sergent în armată și sportiv bun pe țară
la lupte greco-romane de 2-ua ori locul I - furat pe față-mi de
securiști" că-i băteam pe măreții lor legii = harului.
Am de spus lumii toate torturile + sistemele teroriste aplicate mie
fizic și psihic ce încă mi se aplică psihic memoriei crestine mondiale
harului clar din 1983 încoace ca la toți „jertfiții" omorîții sănătoși
lucrați din spionaj și nu le-a spus la victime „psihiatri" și !!!
psihologi!!! sataniștilor = servicii secrete!!! ce înseamnă psihiatrie +
psihologie corectă să o învețe - respecte să fie liberi în numele
legii = harului de la Dumnezeu.
Gîndiți ce tortură fizică și psihică suport = cea mai mare
ardere de suflet de la Isus din istoriea Românilor din 1983
„secretizat" de terorismul mondial familiar și valutar = sataniștii
„jertfelnici" de oameni!!!!!!! istorici spionați = dictatorii adevărați
ce vorbesc în fața judecătorilor cu memorii spionate în lagăre, cu
dreptul vorbelor mele de 32 de ani și se dau „siguranța" țării
și lumii mari-mi trădători vicleni, ce am de spus eu MÎNTUIREA
pe veci lumii harul clar să nu mai poată fi PROSTIȚI în audio-vizual
la dialog cu preoți și specialiști reali în dreptul aproapelui patrioți
pentru clarificarea legii = harului pe veci = mîntuirea
Cenzuratori-mi 32 de ani au păcate grele

In the case of men, the narrations seem to indicate that they have been confined as a result of having performed their economic function by providing a home, a house or apartment for the family. Yet, this role of provider was not reciprocated by an act of care, and the two men found themselves "locked up" in asylums reduced to previous bread winners by their nuclear families that no longer needed them[254].

The "adults" beyond the Asylum: trajectories of silencing

"The prepatient's career may be seen in terms of an extrusory model; he starts out with relationships and rights, and ends up, at the beginning of his hospital stay, with hardly any of either. The moral aspects of this career, then, typically begin with the experience of abandonment, disloyalty, and embitterment." (Goffman, 1961, pg. 133 in the Moral Career of the Mental Patient)

Personally perceived as being abandoned or locked up, the population of "adults" came to the Asylum, as well as other Asylums generally through acute or short term chronically ill psychiatric hospitals. As Mrs. Laura's story shows, while being committed to the hospital, an institutionalization file would be prepared without the knowledge of its object, the to-be institutionalized person. This process is described by a human rights activist as "transfer"[255].

I first encountered this practice on my first visit to the Asylum in May 2015. I had requested to interview people confined to the Asylum and a number of people had been selected and gathered for me to interview in the social worker office. Realizing that this would mean exposing people's life stories to the scrutinizing eyes of the staff, I resolved to invite everyone to sit outside on the grass. The conversation thus unfolded more naturally, and one of my conversation partners said "I didn't know, they were bringing me here when

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[254] Until now, I was never offered an account by a man complaining that his abandonment was due to his lack of productivity. My hunch is that this topic is taboo for men, since it would involve negating one's own masculinity, the issue being perceptibly less sensitive with women.

[255] As I was also able to see people do not voice their consent to being taken to such places. The argument of the human rights activist was that if people did not consent to be there, then the process should be considered involuntary placement and thus the law on mental health should also apply to this situation. The person would then need to appear in front of a judge and state whether they want to be there or not. (interview with human rights activist, 2016) The fact that this is not the case reveals the silo-nature of the two policy systems, meaning that changes of legislation and ways of asking questions that occur in one field do not automatically travel to the other.

I first came”, “they told me they will take me somewhere with many trees where I can rest.”, “they told me their taking me home”, “to me they said, they will take me to the mountains”. Of my five or six conversation partners, none seemed to have known where they would be going. This state of affairs awoke my curiosity and I wanted to know, how this was possible and to document this process. I thus explored this process in individual interviews. Furthermore, I identified the hospital through which most of the people had come and went to interview people, who were at risk of being institutionalized there.

The short term ward of a psychiatric hospital for the chronically ill, had a capacity of around 50-60 people at a time. The manager had been reluctant to allow me to do participant observation there, since he said he could not guarantee my safety there. I stressed that this was not my primary concern, but that I was most interested in conducting interviews with the people at risk of being institutionalized. The manager conceded to this, pointing that at most there are one or two people in this situation. An impression confirmed by the hospital’s social worker. In a next step, I met with the head psychiatrist Mrs. Paraschiv, a doctor famous for her support of institutionalization. I explained to her that I wanted to talk especially to those people that were at risk of being institutionalized. She provided me with a list of nine people, from which she said one would be unlikely to succeed although he would really want it[256]. She also alluded to the fact that they might not know that they are going to be institutionalized.

The first person, I talked to was the man, who wanted to become admitted to a “hospital-home”, he was anxious and told me about the “difficult conditions” in which he lived, in “an old fatherly home” where it was cold. He was unmarried and did not have children. He wanted to go somewhere where he could escape unemployment and the difficult conditions he was living in. He was in his mid-fifties and had never visited an asylum.[257]Of the other people, the doctor had indicated only one was aware of the fact that she would become institutionalized. She refused to talk to me, since she thought I want to talk to her about the fact that she was going to be locked up. I thought she was correct but maybe in a different way than she had expected.

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[256] Visit to the hospital, end of June 2015

[257] Interview June 2015

The other seven people were unaware that their families together with professionals were preparing to have them "locked up" in institutions. The psychiatric hospital was therefore a traceable space of abandonment and silencing where no one stopped to explain, let alone allow them to challenge, the trajectory of their "forced transfer".

Feeling abandoned outside of asylums

The feeling of abandonment is not limited to those confined in asylums. Sometimes, the process of abandonment by the nuclear family makes use of the open psychiatric infrastructure and the person is not taken into a closed infrastructure or a space opens in which if there are or were alternative support structures to those of the nuclear family, abandonment would not end in confinement or suicide. Such stories were told to me by Andreea, the psychologist that I have also quoted in the previous chapter.

Ana was a patient at the hospital, who kept being readmitted. Between commitments to the hospital, she would sleep in the train station. She had stolen from the hospital, had tried to set the house of the head nurse on fire. To her as a psychologist, she confided that she had a problem with her brother, who had seized the house all siblings had inherited and had put her out of the house, since he did not want to have "mentally ill people in his house, since they stink". She stayed on at the hospital beyond the usual time, having come at the end of winter, she left after the Easter holidays[258]. It was then clear that she could not stay on in the hospital, since she would ruin commitment numbers, managerial indicators relevant to the funding the hospital would receive in the future. Together with the hospital priest and the social worker, Andreea decided to take Ana home. The funding for the trip to a nearby village was provided by the candle money from the hospital's chapel[259], since the accountant did not approve funding for taking Ana home. They arrived at the house where you could not "house even a dog". Then the priest said "we have to clean up

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[258] It was quite common that homeless people would be brought to the psychiatric hospital around holidays, especially Christmas and Easter, by the police, probably so that they wouldn't need to spend the holydays alone in the cold.

[259] In Orthodox churches and chapels, there are always candles for sale that people light in memory of the dead or in thinking of the living. These are an important income for churches- the one in the hospital selling them at 50 bani a piece, half the regular price of 1 RON.

everything here". They cleaned the house without gloves, despite there being feces on the ground and on plates. She stayed on in the house and they visited her there, while she also came to see her at the hospital where she would also shower since this was not possible in her house - probably also the reason why her brother considered she stank. The staff of the hospital would also administer her budget (capped at 50 euro a month), and help her out with smaller things, while trying to get ahold of her sister in a nearby town, who her brothers said might be able to take care of her. There was a trial regarding the house and Ana ended up selling her share of the house. That day she came to the hospital to see Andreea, who was very busy with the newly committed patients. The priest was also busy, since it was a Friday and there was always a sermon on Fridays. Andreea asked Ana to wait for thirty minutes, but she walked out of the hospital and killed herself by drowning in a nearby river.

In this case, all precautions to avoid institutionalization had been met, yet and still, the person found herself abandoned by her family with nowhere to go. Abandonment did not happen through putting Ana away in an asylum, that would have at least offered her a chance at being made live in an oppressive way. Her abandonment was even more desolate since she had literally nowhere to go but to the hospital. Andreea added that Ana had committed suicide when she had gotten better when she realized how much she had lost in life and not while she was struggling and that if there had been protected housing available, this would not have happened[260].

Another woman, who Andreea came to know through her work in this field had been put into an institution, since she was involved in sex work. The mother tried to convince her to quit, but this did not happen. Andreea tried to explain to the mother that it is her daughter's choice, yet the mother had no understanding for this. When the woman left the hospital, she had nowhere to go but to her mother, who put her in an asylum. Even here the situation could have been avoided if there were protected housing[261].

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[260] Interview January 2015

[261] Ibid.

Moreover, some of the conversations in the acute psychiatric hospital that I could observe during group discussions organized by a social worker, especially among women involved explicit confessions of sexual desire, even towards married men, as well as open acknowledgments of domestic and intergenerational violence, pointing to the fact that the acute hospital[262] had much lower normalizing intensity than closed asylary spaces. In turn this can mean that the open clinical infrastructure might be a good starting point for re-working abandonment and the oppressive normalizing logics that lead to it.

Abandonment: a relationship between failed nuclear families and asylums as embodiments of the state

The gendered failures connected to family break downs that are understood as the reasons bringing people to asylums, testify to what Erving Goffman (1961, pg. 133) called an “extrusory model”, in which at the beginning of each career as a mentally ill patient the person feels “betrayed”, “abandoned” and stripped of rights. What Goffman described of the late 1950s USA mental asylums, is true of similar institutions in Romania today: people who have reached them feel abandoned.

The feeling of abandonment corresponds to the subjective experience of taking part in the coming apart of a family, be it biologically (as in the case of the death of Mrs. Laura’s husband) or socially (as in the many cases of divorce, for example of Ștefan’s parents). Alternatively, the feeling of abandonment appears when a normative expectation of a nuclear family was never realized, as it in the cases of women having sex with married men, or having children without being married. Then abandonment appears to the confined person as justified and the confinement in an asylum is perceived as punishment. Moreover, those who had been abandoned early on, try to look into the moment of abandonment to find out, why they live and lived the life they have. Then, they often encounter similar structural reasons of broken-up families, poverty and the

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[262] Of course this is not necessarily a generalizable point, since the hospital was one of the few acute psychiatric hospitals with an explicit mental health approach, as well as had very well trained professionals of which the vast majority had studied in Cluj, one of the two best academic centers.

care burden of disability in a productivist society. This search feeds into a collective idealized imaginary where the "children" conjure their biological families and all social relations are haunted by the imaginary of family relations. Both the "adults" and the "children" ask why their mothers have abandoned them. The mothers appear as the implicit legitimate and exclusive actors of care that have failed to perform.

It is here that state interventions parallel these patriarchal desires to have a mother that cares for one. Deinstitutionalization as conceived by the minister of labor in 2015 pointed to the "reintegration into the family" as a process that did not require any resources on behalf of the state, pointing to the unconditional un-commodified nature of the act of care that should "naturally" take place in the family[263]. This conservative cost saving move appears legitimate as it seeks to undo the act of abandonment that has been made possible by a state infrastructure that for decades had encouraged the state care of disabled children and adults, thus unburdening families for production, as well as has inscribed into the state the role of provider for abandoned individuals[264].

Undoing the infrastructure, nevertheless, does not undo abandonment - rather it places the person outside both of the structural of support of the state and that of the family, risking to land on the street or commit suicide or both. Fighting abandonment in this way appears as a version of what Walter Benjamin (1969, pg. 249) called the angel of history - a figure that is turned towards the past, trying to "make whole what has been smashed", while being blown into the future by an uncontrollable storm.

That this imagery of anachronism would haunt asylary spaces and cost saving state projects is not surprising. Yet, it also haunts sociological and anthropological imaginaries. Most notably, such a move is visible in João Biehl's evocative portrait of Vita as a zone of abandonment through the eyes of Catarina, the ethnography's protagonist and a resident of Vita, see Biehl (2005). The ethnography starts with the sentence: "in my thinking, I see that people forgot me." (Biehl, 2005, pg. 1) and continues by describing

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[263] Of course there are disability payments, even for personal assistants, but these are much smaller than what is spent on institutionalization and hospitalization of mentally ill or disabled people.

[264] Which nevertheless came to be let die in these providing infrastuctures at least until the mid 2000s.

the place “Vita is the end-station on the road to poverty; it is the place where living beings go when they are no longer considered people. Excluded from family life and medical care, most of the two hundred people in Vita’s infirmary at that time […] lived in a state of abject abandonment.” (pg. 2)

Similarly, Tova Höjdestrand’s (2009) beautifully thick ethnography also chronicles this process of extrusion when homeless people stop feeling needed by their close ones. Her ethnography also testifies to the fact that mothers are the only ones of which her informants would have expected unconditional support and sacrifice, pointing to the wide geographic reach of similar processes of abandonment that spans from Brazil’s Porto Alegre to Saint Petersburg’s train stations and Romania’s northeasters asylums. To a certain extent, reproducing the patriarchal assumptions behind abandonment are implicit in siding with our informants, it is intrinsic to what Donna Haraway (1988) has called positioned knowledge.

However, describing this process of abandonment and how it is experienced by abandoned people is not enough. If structures of abandonment bring people into situations where they prefer to take their lives or when they need to halfheartedly consent to their own confinement or find themselves dropped back at hospitals like “a bag of potatoes”, then nuclear families are not necessarily the only alternative. The moment of abandonment needs be reframed as the beginning of something and not as a “end station on the road to poverty” (Biel, 2005, pg.2). Yet, for that to be thinkable the infrastructures of abandonment need to be transformed into infrastructures of hope - this is where progressive deinstitutionalization could be a fruitful avenue to explore.

Hope beyond abandonment

Elizabeth Povinelli in her recent book “Economies of Abandonment” (2011) how those who are let die by being constantly exposed to death come to live in endurance, thus those who are let die make an “otherwise” to late liberalism possible. I agree with Tania Li’s review of Povinelli’s book (2013) in which she points to the fact that the “otherwise” remains unspecified and that it is dangerous to assume that transformatory potentiality should come (somehow exclusively) from these spaces of let die. (compare Li, 2013).

Nevertheless, asylums as spaces of abandonment can be fruitful starting points for re-thinking and re-working processes of abandonment - as a more modest goal than establishing an otherwise to late liberalism as a somehow assumed totality of the present. As I hope to have shown, abandonment is oriented towards the past, it is nostalgic and anachronistic – and thus it leaves no room for hope. It is in this way that the zones of abandonment that I have come to be familiar with ethnographically (especially the Asylum) appeared to me the contrary of transformatory - they seemed blocked in time, in the reliving of the trajectory and the moment of abandonment, living with the hustle of the world outside as it has been when one had been brought there[265]. The feeling of being abandoned was central to this backward ontology of the present, which could be unpacked to create what Povinelli called a "sociology of potentiality", this potentiality which Povinelli (2011, pg. 14, see also Li, 2013, pg. 704) takes for granted as "always embodied in specific social worlds".

That potentiality is not realized, it is always latent is what makes it difficult to empirically, sociologically grasp it. We cannot know whether it has been there or not until it has been realized. Nevertheless, assuming a transformative horizon, even where hopelessness is matter-of-factly is what a politics of hope in the context of abandonment could look like. In this philosopher Brian Massumi's (2002, pg. 211f.) understanding of hope as an affect that reframes the potentialities of the present without having the paralyzing effect of utopian thinking could form a starting point.

Yet, of this to be possible the afterlife of asylums needs to emerge infrastructurally as an openness towards a different kind of life for the people, who are currently their inmates. This could mean reconnection with the past and past responsibilities, yet, it could also mean a series of new things that emerge as relevant in the process of developing new aspirations. The present hopelessness and the potentialities of the present as hope needs to be bridged in two ways: on the one hand, infrastructurally through a new understanding of how asylums can be reworked and pedagogically in a Freirean sense by creating the space for producing

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[265] Of course my ethnographic context is only similar to Povinelli's as both the everyday life of Australian aborigines and institutional inmates are determined by structural forces that make them emerge as abandoned.

knowledge about one’s condition collectively and using it to transform the present situation. A point that involves un-silencing those who have been silenced in order to become inmates of asylums. I will return to in chapter 10.

PART 3: Never Neverland

Introductory section: the making of the population of “children” and its spatialization in Never Neverland

Whereas, in the previous parts, I have focused on both populations produced by the current trajectories of abandonment, “the adults” and the “children”. In this part, I focus exclusively on the population of “children”, its production and its spatialization in the place, I chose to call Never Neverland, a place where disabled people are treated like children that never grow-up. In this introductory section, I will first introduce the population of “children” and the policy and social context of its emergence, as well as the fieldsite I chose to study the making of this population.

The making of a population: children that were “given to the state”

As explored in chapter six, the population of “children” started emerging in the wake of the pronatalist policies of Ceaușescu’s early time in office (most notably the decree 770/1966[266]), and the pro-institutionalization legislation that followed them (law 3/1970[267]). Basically, these two subsequent pieces of legislation set the ground for the creation of a population that made specific kinds of biopolitical interventions possible. The famous decree 770/1966 that prohibited abortion in all but few exceptional cases came in a context were birth control was inaccessible, since it wasn’t being imported (see Betea, 2012). The decree was issued by the state council of the socialist republic of Romania, on the grounds that ending pregnancy bears grave consequences upon “the health of the woman” and the “natality and the natural increase of population”.[268] The brief motivation of the decree, shows that demographics were part of this repressive and life enhancing calculus from the very beginning, as much as the reproduction of a particular family model.

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[266] http://www.legex.ro/Decretul-770-1966-363.aspx accessed on 02.04.2018

[267] https://lege5.ro/Gratuit/gu4tmobu/legea-nr-3-1970-privind-regimul-ocrotirii-unor-categorii-de-minori accessed on 02.04.2018

[268] The text of the decree is available here http://www.legex.ro/Decretul-770-1966-363.aspx accessed on 22.03.2017

Challenged on the question of consequences of the decree for families, considering that barely any extra support was made available[269]. Ceaușescu justified the rejection of the idea of "buying these children" from the mothers with his own family history: "we were also ten children and lived in one room" (Betea, 2012). The family model of poor rural families during and before the second world war was therefore becoming the normalizing ideal for populations in urban centers and other rural centers in the late 1960s. This shift in demanding reproduction with repressive means was doubled by two moves: the first was increasing bureaucratic hurdles for divorce and stigmatizing those who were choosing to divorce anyway under the banner of establishing "communist morality", which went hand in hand with accusing the previous elite of the Dej time of immorality (see Betea, 2012).

The other was a reaction to the consequences of the decree – among these consequences was the fact that the natality doubled the year following the decree, causing it to be the year with the highest birthrates since 1944, see Betea, 2012) and concerned the protection of minors, law 3/1970[270]. The law regulated the protection of minors including their institutionalization in either orphanages or institutions for "deficient" children under specified circumstances. As explored in chapter six, the law aimed at the protection of diverse categories of minors in specialized state institutions away from their families. The justification of the law laid out that the law targeted the sheltering/ protection (*ocrotire*) of minors that "do not have the necessary conditions for a normal physical, moral and intellectual development ensured in their families"[271]. A further analysis of the law[272] makes visible that the state actively encouraged poor people to abandon their children after having repressively helped them into life by making contraception unavailable and abortion illegal. Moreover, disabled children were also considered to be better cared for in specialized state institutions[273].

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[269] The only extra form of support made available at the same time as the decree was establishing extra day care facilities for infants (creșe), see Betea, 2012.

[270] Interestingly this law does not specifically mention neuropsychiatric children hospitals, although my fieldwork material suggests the fact that they were in practice terms part of this infrastructure. I will continue to look for the exact piece of legislation that allowed for these places to operate.

[271] See law 3/1970 avaialble here https://lege5.ro/Gratuit/gu4tmobu/legea-nr-3-1970-privind-regimul-ocrotirii-unor-categorii-de-minori accessed on 02.04.2018, the law was valid until 1997.

[272] For the analysis see chapter 6, where I also listed the criteria for institutionalization by extensively quoting the text of the legislation.

[273] This point will be explored in depth in Chapter 7.

What Ceaușescu is quoted to having called “communist morality” (see Betea, 2012) enforced a moral structure that opposed divorce and childlessness. “Communist morality” re-instated the importance of a nuclear family with up to four children (after which the decree allowed abortion if all the children were in the care of the mother) in which both parents should be integrated into production without much help from the state. This nuclear family ideal came to be upheld by the mushrooming of institutions for child protection that in the 1990s came to be known as “orphanages” and that came to counter for an estimate of 100.000 children (Morrison 2004, pg. 168) away from their families. The “orphanages” were not what the name would suggest, since as is apparent from law 3/1970, these children were not orphans in the biological sense of the word, but abandoned by their families[274] or entrusted to the state on the then legitimate understanding that state structures were more fit for dealing with (disabled or otherwise different) children’s special needs. This resulted in a form of social orphaning in relation to the ideal of the nuclear family, which paradoxically this complex of policies had been put in place to uphold and protect. The nuclear family was both reinforced as an ideal, as well as challenged as an actual practice through the contradictory policy moves of the beginning of Ceaușescu`s time in office.

Moreover, these policies came in a context of ensuring the right (and obligation) to work and gender equality by integrating as many family members as possible into the workforce and unburdening families of caring for children, especially for disabled children (compare Milea, 2004, pg. 38 and Popescu, 2012 pg. 52). Paired with insufficient funding this led to a mushrooming of the category of “unrecoverable” as it came to be applied to many children, since it “appeared reasonable that, in order to take the burden off the parents’ shoulders, such cases should be given priority to hospitalization” (Milea, 2004, pg. 28). At the same time the institutions themselves, especially those for infant children came to produce intellectual “disability” in children through lack of family like stimulation (a phenomenon termed *institutionalism* and studied by René Spitz in the 1940s and 1950s[275]), paired with professional committees designed to evaluate children

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[274] This point was later picked up in the deinstitutionalization of the child protection system, where children were sometimes forcefully reintegrated into their biological families.

[275] See Maclean (2003), pg. 855f.

regularly on their biological age specific competences (see Jinga, 2011, pg.208f.). More so, the consequences of illegal attempts at abortion, in some cases may have resulted in the harming of the children during pregnancy and thus also an easier entry into giving them up to the state.

Not all children that were "given to the state" came to be labelled as disabled or unrecoverable, since many of the children entrusted to the state would end up growing up in children's houses[276]. Humanitarian documentaries of the early 1990s (see Spiegel, 1990, pg. 197) show that from the children that came to grow up in children's houses, selections would be made. From the "strongest" of children some would be selected for serving in the *Securitate* (the secret service of the time), and some would receive a very good education (ibid.). On the other extreme of the selection process were those who would end up in disability related residential institutions and in the most extreme case those labeled as "unrecoverable". Hospital homes *cămine-spital* and *neuropsychiatric children hospitals* were very precarious institutions that catered for at least one third, if not more than half of the children entrusted to the state, totaling a number of around 40.000 children at a time[277]. Yet, as Luciana Jinga observes for *cămine spital* in general and as Popescu (2012) notes for the neuropsychiatric children hospital in Siret, the death rates for people in these places were very high. Jinga (2011, pg. 210) notes that cold and hunger could reduce the population of a hospital home in one winter to half, but this then could be again increased through evaluation committee being sent to other children's institutions. Popescu notes a more modest proportion of deaths to the number of interned children in the neuropsychiatric children's hospital in Siret: 490 of 2300 interned children in ten years (probably those preceding 1980, see Popescu, 2012, pg. 58)[278]. Moreover, as explored in the chapter dealing with the different biopolitical modalities of sense making in transition, the deaths of at least 771 minors of

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[276] "Case de copii"- a term that is generally translated as orphanages for the Romanian context, but more appropriately be translated into English as poor houses for children

[277] compare Jinga, 2011, pg. 210 to which it is necessary to add the four neuropsychiatric children hospitals which are unfortunately not considered in her rich outline of residential institutions for children

[278] The actual numbers are likely to be somewhere in between, yet, in either instance they show that residential institutions for the "disabled" were places where a significant number of people were let die. The difference in numbers comes most probably also from the fact that the numbers for Siret come from the head of the hospital, and therefore may reflect a euphemistic version of the biopolitical past of the institution.

preventable causes (such as pneumonia) in three institutions for “unrecoverable” children from the late 1960s onwards have now become part of a penal trial[279].

It is this population of children institutionalized at an early age that have grown up in institutions on the grounds of their disabilities, once grown up that this part of the dissertation is concerned with. To study this, I have chosen a central location – Siret, Romania’s border-town with Ukraine, once home to one of Romania’s largest children asylums.

Siret: a capital of abandonment, state infrastructure and humanitarianism

Siret is Romania’s border-town with Ukraine, which between 1956 and 2001 housed one of Romania’s largest children’s institutions - the neuropsychiatric children’s hospital. At its peak the hospital must have housed somewhere between 1200 and 2000 children - in the time following the rise in the population of disabled children that came into being after the pronatalist policies.

This peak probably was at its onset around 1970 when the generation designed for abandonment started to be taken into the state infrastructure and then became more and more important once this practice became codified through the law 3/1970, which interestingly does not mention neuropsychiatric children hospitals. Yet, I can comfortably assume based on the accounts of people who worked and grew up at the hospital that although not part of the law, the hospital was part of the institutional infrastructure of institutionalized upbringing of children.

It was in vivid biographical exchange with *leagăne* (institutional places for infant children up to three years of age) and boarding schools for special education. The vast majority of children who grew up at the hospital had reached the place through a *leagăn* and those selected for schooling and through that for life would leave the hospital to go on with their education at such boarding schools, while returning to the hospital for holidays when their peers would go visit their families. Those who remember the former hospital, from the

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[279] https://www.iiccr.ro/sesizare-penala-privind-tratamentele-neomenoase-perioada-comunista-in-caminele-spital/ accessed on 10.03.2018, which I have explored in Chapter 3

head of the hospital to one of its former drivers, to the now adult children that live in Siret, remember that a vast series of state and empty buildings, more precisely sixteen buildings had once housed the hospital. The hospital and the town could almost be confused with one another, since Siret is and has for a long time been a small town a town of around 8000 inhabitants. The hospital was downsized during the 1980s, an event which both the head of the hospital and another local remember as having been the first significant step towards deinstitutionalization. The local even linking this event with Nicu Ceaușescu's (Nicolae' and Elena's son) visit to Siret, upon which he had publicly declared that each county should take "their handicapped" back.

Around Christmas 1990, the hospital again came to be a capital for the influx of a population, but of a different kind, English and other foreign volunteers, as the BBC show centered on Anneka Rice helped the hospital to world publicity as "the Romanian orphanage". Incidentally, the episode was also the most successful of the televised thunder humanitarian actions for which the show was popular. This inaugurated a time of humanitarian aid that stretched from the 1990s to Romania's accession to the European Union, putting in place a vast infrastructure, that in the very beginning wanted to better the life of all in the hospital and then came to select several tens of people for preparation for "independent" nuclear family, protected employment life. These efforts became infrastructurally coded in new houses that were either bought or built in Siret, everywhere in town. At the same time, the hospital infrastructure itself was disappearing due to larger policy shifts that are associated with Romania's pre-accession negotiations. It was in this time that the hospital came to be downsized through-out the nineties leading to a separation of people on the grounds of pathologies and then closed in 2001, leading to a separation on the grounds of age and birth county - those legally under 18 years old, were transferred to their birth counties, of which they most likely had no recollection and those over 18 years of age came to live in Siret in the old building of the orphanage, itself having been dissolved as a consequence of deinstitutionalizing the child care infrastructure.

Although the pre-accession negotiations with the European Union brought deinstitutionalization to Siret, the actual accession brought re-institutionalization, since it became increasingly hard to justify transnational humanitarian aid to a formally European country. The common practices of bringing medicine that was close to expiration date and collected by donations in England or other EU countries, also came to be outlawed through European regulations. It therefore became difficult to sustain humanitarian aid in a context that was resembling less and less a humanitarian crisis, and most transnational NGOs came to withdraw from Siret. The reasons given in town for this withdrawal ranging from alleged corruption and inefficiency in relation to a capitalist ideal of value for money: with this money, more houses could have been built[280], as well as the outbreak of the humanitarian crisis following the tsunami in Indonesia - which made visible the transnational market of suffering subjects into which the now adult suffering children of Siret occupied a less deserving place than the tsunami victims in Indonesia. It is now that new agreements with the state were made. Different levels and categories of state funding came to be embedded from the mayor's office, to the psychiatric hospital and the directorate for social protection. Most of the philanthropic housing infrastructure came to be integrated into the state infrastructure, which at this time also extended itself by turning what remained of the hospital's infrastructure: the school and workshop building into social housing for people who had grown up at the hospital. This solved a problem that the elites of Siret perceived as "unnatural" homelessness - meaning that the homelessness of the former inmates of the hospital was understood as exogenous to the economic processes of the small town. Part of this process involved for some re-institutionalization, the re-incorporation into the social protection state order and its eugenic undertones: family life and having children were no longer options, neither was employment. Living standards according to some improved with the incorporation into the state, but life projects came to be side-lined by the general argument that this arrangement allowed for everyone's subsistence – both the staff that was now employed by the state and the residents that now became administratively re-institutionalized. It was in this context that during the year of my fieldwork, the Minister of Labor, announced full and sudden deinstitutionalization by 2020, exposing the fragility of this entire arrangement[281].

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[280] I thank Tania Li for the suggestion to think through the implications of philanthropic capitalism in this case.

[281] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 24.03.2017

Summing up, Siret is both truly unique and representative, since it condenses in one site experiences central to the political history of Romania in the past decades. These experiences although connected can rarely be observed as they affect the same population in roughly the same place over time. The hospital was a socialist capital of abandonment for children labeled as “unrecoverable” and “disabled”/ “handicapped”. The children were brought to live at the hospital on the Ukrainian border from everywhere in the country. The hospital thus embodied socialist social policies for the most vulnerable. Later the hospital emerged as a site scandalized for its decrepit infrastructure and came to be a Mecca for English and other foreign volunteers during the 1990s. Finally, Siret became a site where the state again came to play an important role in the reinstitutionalization of the then already adult population in the 2000s in relation to EU accession.

Never Neverland[282]

In my thinking I came to refer to Siret as Never Neverland. I chose this name in order to underline the main discursive dynamic actively producing populations in everyday interactions in Siret. The people who grew up at the hospital and still live in Never Neverland are mostly aged twenty-three to forty something. Yet, they are constantly referred to by people in town and themselves as “the children” (*copiii*) in case of those hospitalized in the psychiatric hospital or “the young people” (*tinerii*) for those institutionalized at the recovery and rehabilitation center for people with handicap. People who managed to escape the system and live on their own are generally not referred to in this way, unless to stress their lack of independence or maturity.

For example, I could observe such a situation play out during a conversation between Manu (an evangelical woman in her thirties) and another woman of a similar age who had both grown up at the hospital and lived independently in NGO funded housing. Manu was stressing that it is okay for her friend to accept a jewelry

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[282] I chose the name Never Neverland, reminiscent of the Neverland of J.M Barrie’s [1904 play] (1987 [1911 novel]) Peter Pan, or the Boy Who Wouldn’t Grow Up (initially called Peter and Wendy), since I see it as a space for imaginary eternal childhood. The fact that this space was created by an English language author is also a fascinating small detail that connects well into the jest of how the eternal childhood of the previous children of the hospital came to be created under English influence during Romanian transition, which is the time they should’ve grown up by regular standards, but most were denied this right.

gift that I wanted to make to Manu, since she was a *copii mici* (small children) and did not need to abide by the evangelical rule of not using jewelry. Manu did not mention whether her friend was evangelical or not, but rather than this insisted on her belonging to the social category of *copii mici* that would automatically discredit her other social affiliations as unserious. Interestingly, although Manu generally spoke very correct Romanian, she used the term *copii mici*, despite the expression being grammatically incorrect repeatedly in plural, so I inferred it pointed to a larger category than her friend. It was this category that inspired me to call Siret Never Neverland. It also moved me to try to trace the processes that lead these people such as Manu's friend to become stuck in an eternal childhood with which some came to wrestle with and others came to uncritically reproduce.

The difference in naming practices did not reflect a difference in age, but in degrees of independence: the most telling example thereof is that most of the "children" are those people who were made to stay in Never Neverland after the closure of the hospital in 2001 on the basis of the fact that they were over 18 years old and therefore not part of the closing of the officially children's hospital. After two attempts of finding an administrative solution to this significant population (over one hundred people), a chronically ill psychiatric hospital was opened, where most of them still live today[283]. Therefore, all the "children" were in 2015 at the time of my fieldwork over 34 years of age (since they had administratively been adults 2001, meaning that at that time they were 18 or older).

The "young people" on the other hand were selected and taken out of the hospital starting 1998/1999, at that time the state did not allow for small children to be taken out, but it did allow for young people to be taken into these newly established structures. So some of them were at that time in their teens, and are now in their late twenties to mid-thirties, but some are also in their forties. They received preparation for an independent life through a half-way house and were then moved into protected housing, but as the foundation ran out of money, many of the "young people" were administratively re-institutionalized and became again part of a (now transformed) state infrastructure in a form of public-private partnership.

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[283] Account based on several conversations with the current manager of the hospital.

Nevertheless, both those people, who are being catered for by the state and by the foundation are being referred to as "young people", despite being ironically visibly younger than the "children" of the psychiatric hospital, who had not undergone ability selections and preparations for independent life. More strikingly, although I was as old, overall a bit younger in age terms than most of the "young people", I was never referred to as a "young person".

In short, the eternal childhood of the "children" and "young people" of Never Neverland was produced through the process of closing the hospital and the end of the criminal biopolitical regime that I will be describing in short: in the 1990s and especially 2000s children stopped graduating from the hospital either into special professional training or hospital homes, where there would be high chances that they will be left to die (if at all they had survived to reach the age of differentiation). Instead many remained in Siret, where they had been known as the children from the children's hospital. While growing up, few of them graduated to being full-citizens of the Siret community, their otherness remained to be carried out by the reified infantilizing appellatives "children" and "young people".

Siret as Never Neverland was therefore produced by humanitarian aid and the related scandals caused through introducing a humanitarian modality of sense making in the early 1990s, causing the children of the hospital to no longer be confined to the premises of the former buildings of the hospital, this infrastructural intervention did not modify the discursive boundary that separated the disabled from the able, which thus came to be expressed through the language of childhood, discrediting the actions and sense making of the "children" and "young people". Nevertheless, while some struggled to escape this category, most unquestioningly and willingly reproduced it[284].

Doing research in Never Neverland

I have explored my different positionalities in Never Neverland, as well as beyond in chapter one. Here I want to return to some relevant aspects related to my fieldwork that I feel would make this part (3) of the

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[284] I will return to this point in chapter 9.

dissertation more understandable. I spent six months (May to November 2015) doing ethnographic fieldwork around the former hospital neuropsychiatric children's hospital in Siret and the institutions that were established around it, as well as after its closure to cater for the people who grew up at the hospital.

When looking at my notes and thinking about the age of my conversation partners that had grown up at the hospital, I realized that neither of them were older than fifty. This is easily explainable since the neuropsychiatric hospital during state socialism was a children's hospital from which child patients could then be sent to different institutions, either for disability oriented (in the language of the time "special") professional schools or to hospital homes for people with disabilities[285], this in case they survived their hospitalization. As described above, in the 1990s and 2000s this came to change on the hand through localized deinstitutionalization projects run by humanitarian NGOs and the fact that the state sought a follow-up solution to the children's hospital, for those who had reached adult age. So a significant number of people, came to live for the entire lives in Siret as a consequence of these changes. Apart from them, there were also people, who had returned to Siret after completing their professional training somewhere else, since this was the only home they knew. These groups were the people, I spent most of my time with.

But, there was also the former staff of the hospital, the carers, teachers and doctors that I came to know and talk to in town. Understanding their perspective on their work and the relationships with the children they had cared for or supervised, alongside the memories of the former children helped me complexify my understanding of the hospital and the work and experiences surrounding it actually were.

Apart from generally sharing in the daily and weekly rhythms of Siret by going to the market on Tuesday, or to local fairs when they were in town, receiving people in my home and going for visits to other people's homes, I regularly visited several foundation and state-run day-care facilities and also volunteered at the two state residential institutions in Siret for several weeks in each case. Volunteering meant that I spent time with institutionalized people in their free time, as many mostly foreign volunteers had done in the past 25

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[285] There are of course, also stories of people staying in Siret in the children's hospital after turning eighteen, but the profile of the hospital still remained that of a children's hospital.

years. Being a volunteer was therefore a specific positionality, which helped me gain access to the life worlds of people, who had grown up at the hospital, since they generally harbored pleasant memories of foreign volunteers.

Despite having grown up in Romania, albeit in a different place, I was sometimes taken to be foreign because of the way in which I was associated with the foreign volunteers, as well as the fact that I had not grown up in Siret. In one particular instance this experience was connected to the fact that I was perceived to not be embarrassed to be seen walking on the street with someone, who had grown up at the hospital. In other instances, this lead people to expect of me that I cause a scandal in order to improve the lives of people, who were still living in a form of institutionalization, most notably the new psychiatric hospital. But the positionality of the somewhat foreign volunteer also allowed me to distance myself from the staff of the new state institutions: as a volunteer I could disrupt common practices operating to delimit staff from people, who grew up at the old hospital such as segregated eating (staff eating the same food, separately from residents), as well as surveillance as a main activity.

But, I was also automatically delimited from the "children" and "young people", despite our similar age, I had not grown up at the hospital, so I did not know everyone from time immemorial. This did not mean that we couldn't form very close human relationships, we could, and interestingly, these relationships sometimes came to be framed in the language of practical kinship: I was likened to the mother of at least two people (I have told of one such instance in chapter one).

Being a volunteer also allowed me to spend time with people that were not easily interview-able. Some contexts, such as a psychiatric chronic ward located on a hill, where many tens of people were housed in very decent and well-kept conditions, they were nevertheless institutionalized in that classical meaning of the word, which gave rise to *institutionalism* as a name for a specific kind of pathologized behavior[286].

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[286] René Spitz institutionalism, see https://www.youtube.com/watch?v=VvdOe10vrs4 accessed on 14.06.2016, although institutionalism is not mentioned explicitly, the emotional deprivation in infancy is strongly associated in

I spent afternoons among many tens of people that had been brought on a terrace by the staff, interacting with some of them as they sat on mattresses alongside the sides of the large closed terrace, and as some rocked themselves throughout the afternoon and as others would come together as a crowd in anticipation of contact with someone new – be it myself or one of my visiting friends.

This was on several occasions an emotionally demanding experience that allowed for little personalized interaction. Institutionalization had led these people to be massified, a dynamic which I tried to counter through taking walks through town or the nearby cemetery alone with one of the people that had asked me to do this. The difference in communication patterns between myself and each of the people facing more advanced intellectual barriers would have required a more adequate way of communicating that I was unable to find at times. Yet, it was not difficult to perceive the desire for freedom of moving around, taking walks and exploring more, as well as of authentic interaction in all of these settings that were common to all my partners of walks. So, where interviews were not possible to conduct in the classic and extremely ableist sense of the word, I draw upon my impressions that I gathered as a volunteer.

At this stage I did not go after people, who had not returned to Siret after being taken to other institutions. Yet, I met and interviewed a number of people that had grown up at the hospital and now lived in other institutions within a few travel hours reach of Siret, which I visited as part of my broader fieldwork and interviewed regarding their experiences at the hospital.

During my time in Siret, I conducted innumerable interviews and informal conversations with people who grew up and some with people, who had worked at the hospital, as well as people who knew the hospital from its outside. I visited people, who were now living on their own or with their new families, in their homes after being invited or brought over by a friend of theirs, I listened to many life stories and problems. Technically speaking, I did not only use a notebook, but also recorded some of the interviews, but only few

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later research building on Rene Spitz with institutionalism, see for example https://www.youtube.com/watch?v=bF3j5UVCSCA accessed on 14.06.2016.

of them, since I perceived that recording generally created an uncomfortable atmosphere. Also one of the state institutions explicitly prohibited recording.

I chose to always make my position as a researcher visible to everyone, and when carrying out especially first conversations in people’s homes, I would mostly bring a notebook and take notes after asking if I may do so for a book and promising the person I will not use their name. Yet, I don’t think this was always necessarily understood by all, nor was it always seen as relevant. When my position of a researcher was understood, generally by those more privileged of the formerly institutionalized people, I came to be asked how the PhD is going and when I will finish, sometimes people’s willingness to help me and authentic interest in my work travelled into the lives of people in interesting ways: Manu, who I quoted above, some time after our initial meeting told me that she had in one of the past nights dreamt of me, she had dreamt that she would come to Bucharest (where we are both originally from), we would meet and she would help me with my PhD thesis, since I needed her help. Interestingly, we did meet in Bucharest, where he told me of her complex relationship with her mother, who had abandoned her as a child and who she came to know much later in life.

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In the following chapters, I will first look at the neuropsychiatric hospital in Siret (from a genealogical and an ethnographic perspective) to look into the situated histories of a contested place and the way in which it was experienced by people at different moments (in chapter 7). In chapter 8, I will look at the way in which people participated in the biopolitical orders and interventions that operated onto the population of “children”/ “young people”. Finally, in chapter 9, I will look at the way in which everyday life in Never Neverland offers a possible understanding of the potentialities and difficulties of thinking a different way of social policy making.

Chapter 7: A genealogical and ethnographic approach to the closure of a children's psychiatric hospital

Image 1 (my photo) The *cazarmă* in Siret towards the end of its demolition, which coincided with the time of my fieldwork (2015). A Habsburg military barracks, it later housed North Korean child refugees during and immediately after the Korean War[287]. In 1956, it was turned into a hospital home for children with disabilities, considered mostly irrecoverable. Later the hospital extended into many other buildings in Siret, housing between 1400-2000 children, but the *cazarmă* remained its emblem. In 2001 the hospital was closed in the wake of EU accession negotiations. In 2015, despite previous plans to transform it into a museum of Romanian institutionalization, it was demolished, and the spot should now be used for building social housing. Although evocative the demolition of the hospital's main building did not put an end to its legacy.

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[287] http://www.blogprinvizor.ro/2009/10/27/o-fosta-cazarma-austriaca-siret-judetul-suceava/ accessed on 01.09.2016, as well as information provided by the former head of hospital.

Introduction

I could notice that Mr. Marin had alerted the three young women to my coming to their afternoon weekly meeting and that I will want to ask about their past at the hospital. Alina said she would talk, and if I ask she will tell me and this she did, of all three of them she talked most. Another young woman, Andreea, said she had decided not to talk about anything. If she talks she cannot sleep at night, she doesn't want to talk about it because it will keep her up at night. Manu did not say whether she wanted to talk or not, but during the conversation I noticed that it was difficult for her to open up. I said I know it is a delicate issue and I don't want to trample people's memories, so if someone does not want to talk, I respect that, and Manu said then you need patience (răbdare) and you must have o strong heart (inimă tare), if not I think that with this phd topic, you must cry every night. Throughout the conversation which took long to start Andreea would keep saying that what is important is: you tell mothers not to abandon their children, so that they don't grow up in orphanages. Yet, at a certain point Mr. Marin. asked a question that opens up a different way of talking about the hospital:

Mr. Marin: are you sorry that the *cazarmă* is being demolished?

Alina and Manu: Yes… we go there every day and take a picture.

Alina: I will go there to the very last day, until it will all have been taken down. I am really sorry they are taking it down. I grew up there.

Manu: Yes, it was like our home, I mean, it was our home. When we were kids that's where we were.

Alina: I will go there every day until it's gone.

Mr. Marin: But didn't you live through bad things there?

Alina: Yes, at the hospital it was really bad, I didn't like it at the hospital, but I feel sorry for the *cazarmă*. (Siret, June 2015)

The conversation quoted above took place at a weekly meeting organized by one of the foundations that are active in Siret. The weekly meeting had grown into a friendly meeting place for formerly institutionalized in Siret to come and have an afternoon tea that I was told they called "going to meet the family". The three young women were around thirty years old, close friends and would come regularly to these meetings. They all had grown up at the neuropsychiatric children's hospital in Siret, which later came to be known as the orphanage of horrors- a place famous for beatings and degrading living conditions, where as much as 2000 people are assumed to have lived at a time[288]. Yet, as is apparent from the above their memories, as well as those of others of growing up at the hospital were much more complex than the televised representations could account for.

The three women were part of a wider group of people, who had grown up at the hospital and were now working mostly in the wood industry and living on their own or in foundation housing. One of the three women, had been abandoned as a child, whereas the other two women had later found out that their parents were deceased. Their small community cut across working areas, forms of housing and religious ties. These three articulate young women could be considered as part of the most privileged of the previously institutionalized people, as they lived (almost) completely autonomously and could, except for working hours in case of those who were working, spend their time as they wished, without having to explain what they are doing to anyone. Their acquired social distance from their experience at the old hospital might also be the reason why, they were the most successful in articulating the ambiguities the memory of the former hospital aroused in Siret.

In this chapter, I want to look at what the neuropsychiatric children's hospital, its history from its establishment during state socialism to its closure, as well as its memory and its infrastructural and discursive legacies. As I have shown in chapter 3, the dominant biopolitical modalities of sense making (humanitarian and human rights) inscribed places like the neuropsychiatric hospital in Siret as places of let-

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[288] No one can tell for sure how many children actually lived at the hospital at one time, see https://www.antena3.ro/actualitate/orfelinatul-groazei-spitalul-de-neuro-psihiatrie-din-siret-va-fi-daramat-sute-de-copii-au-avut-o-287081.html accessed on 20.10.2016

die that need to be undone by having them closed. In this chapter, I want to open up a space of rendering more complex and more understandable the modalities of sense making that lead to the establishment and closing of this hospital and their effects on everyday life. In this I will explore, how the hospital was represented through filmic artifacts characteristic of each modality of sense making and how these were entangled with the way in which the hospital and its afterlife was understood and experienced.

Methodologically, this chapter combines insights from genealogy that as Foucault (1976, pg. 81ff) that seeks to establish the historical knowledge of the struggles surrounding subjugated knowledges and ethnography that allows to see how knowledge is lived in everyday life and the practices that different knowledges or differently put, modalities of sense making (as structures of active sense making) make possible.

What was the hospital? An inquiry into two discursive makings of the hospital

Any person who remembers the 1990s also remembers the images of Romanian orphanages that sparked horrors through Western European media reports. Many residential institutions or in Goffman's 1961 terms total institutions especially those for disabled children labeled as unrecoverable were exposed as places where children were being let die by a transnational humanitarian modality of sense making[289]. In this chapter, I want to go beyond this very dominant understanding of the hospital and contrast it with other understandings of the hospital in Siret, that circulated before, after and around the scandalizing dynamics of the 1990s.

From this perspective, what occurred in the 1990s was rather a shift in modality of sense making regarding the understanding and emphasis of things that were worth knowing about the hospital and everyday life within it outside of its walls. Before 1990 a medical- disableist modality of sense making, in which doctors were the main authorized speakers and therefore producers of publicly relevant modes of understanding the everyday life of these institutions, was dominant. After 1990 the humanitarian modality of sense making

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[289] I have explored how the humanitarian modality of sense making worked to expose these places as places of let-die in chapter 3.

replaced the medical one in the public sphere, and doctors were replaced by foreign volunteers with contact to different newspapers and TV programs. The needs and voices of institutionalized children thus did not begin to speak un-mediated in the 1990s, rather their desires and "condition" were mediated by a new discursive instance the foreign volunteer. Thus, the silencing of medicalized disabled subjects continued throughout state socialism and transition as a characteristic of both the medical and the humanitarian modality of sense making.

Understanding the hospital during state socialism

To understand the shift and interplay in modalities of sense making between a medical-disableist and a humanitarian modality of sense making and their vernacular and distanced interpretations of the hospital, consider a film shot in 1981. The film presents the hospital's recovery activity for children with disabilities directed by the head of the hospital- a medical doctor, yet a radiologist, who was advised by a renowned psychiatrist, Eduard Pamfil, on his endeavor. I received this film from the doctor, who had directed it, who gave it to me proudly and asked me to digitalize it. It was filmed for the conference that took place in Siret in 1981 to celebrate the twenty-five years of its existence.

Labor productivity and performativity, total institutions and state-socialism

The 17 minute and 16 second-long film was shot in 1981 for the 25th anniversary of the hospital[290], where also a large psychiatric conference took place. So, the audience is most likely to have been one of professionals engaged in the psychiatric field at that time: mostly doctors, but probably also psychologists and defectologists. It is interesting to think about what it is that made the hospital's activity related to the recovery of children with neuropsychiatric disabilities (so also the title of the film) become the subject of the film. Most probably, the film was addressed to an audience that was going to consider those children that would end up in Siret as being unrecoverable. Thus it is very likely that the progressive ambition of the

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[290] The film was given to me by the former director of the hospital in 17mm film, which I managed to have digitalized in order to be able to watch it,

film was to convince them that among those unrecoverables there are also recoverable children, as well as that all children are well cared for.

It is very likely that the year 1981 constituted the peak of the development of the hospital, since in the 1980s afterwards both the economic conditions everywhere in the country worsened to an incredible degree, making the eighties the time of scarcity in the collective memory everywhere in Romania. Also in terms of size, the hospital had grown to 1310 beds in the immediate aftermath of pronatalist policies in 1968, and had thereafter housed more children informally. Whereas by 1981 the (official) number had slightly dropped reaching 1217 (Popescu, 2012, pg.49 and 58). Yet, by 1990, when the British volunteers came, the estimated number of children was around half the size, namely six to seven hundred[291], although this number may not be correct, and probably by 1995/1996 the number of children in the hospital had dropped to around 250[292]. So, the 1981 film allows for an investigation into the publicly oriented representational dynamics of the hospital at its peak of glory. Unfortunately, the sound of the movie has not survived the more than 30 years that have passed since its recording, so that my interpretation is solely based on the very telling images present in the film.

There are a few things that can be seen in the movie, on the one hand the emphasis on the medical character of the recovery of the children in the hospital and the diversity of the means by which this is done. The second is the seemingly never ceasing amount of activity happening in the hospital, in which medical activity is seconded by work-related training and activity, as well as leisure-related activities (singing in a choir, playing on a playground and an obviously staged snowball fight). The movie creates the impression of a highly dynamic and strongly medicalized, as well as work oriented environment, which is not congruent with the many accounts of boredom and being locked up and violent abuses of which I will give an example

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[291] BBC 1 Challenge Anneka Romanian Orphanage, available at https://www.youtube.com/watch?v=XinM8vNkteY accessed on 15.06.2016, 1:29; [291] Nevertheless, it is also important to note that the actual numbers of children growing up in these hospital structures both before and after 1993 and 1994 might have been much larger than he is likely to declare, since accounts by former children speak of as many as five children sharing one bed (see http://news.bbc.co.uk/2/shared/spl/hi/picture_gallery/05/europe_life_as_a_romanian_orphan/html/1.stm accessed on 05.07.2016).

[292] Conversation with the former head of the hospital.

briefly. What the people represented are concerned, the different hierarchized categories of people are easily discernable by their clothing: children are either wearing school uniforms (certainly only those that were allowed to go to school), white shirts (identical through-out the entire movie and among themselves) or had naked upper-bodies (probably those with more severe disabilities). When going outside for the snowball fight (all) the children wear hospital robes. This hierarchizing is made visible and is based most probably on a scale of ability-disability, as well as the medicalized representation of their stay in the hospital paired with the medicalization of care staff through the presence of robes, especially when directly interacting with children. So, apart from being represented as disabled seeking recovery, the children are also implicitly represented as ill through their presence in the hospital.

Interestingly, there are also elements that will resurface in later times as problematic, the rooms are packed with small metallic beds, the children study and sleep in the same rooms packed with tens of beds and some tables.

Below I have selected few images that capture, how I understand the movie.

Image 2 Screenshot from the film: Recuperarea copiilor cu dizabilitati, Siret 1981 (given to me by the former head of the hospital, dr. Georgie Popescu), minute 5:15, total duration 17 minutes and 16 seconds.

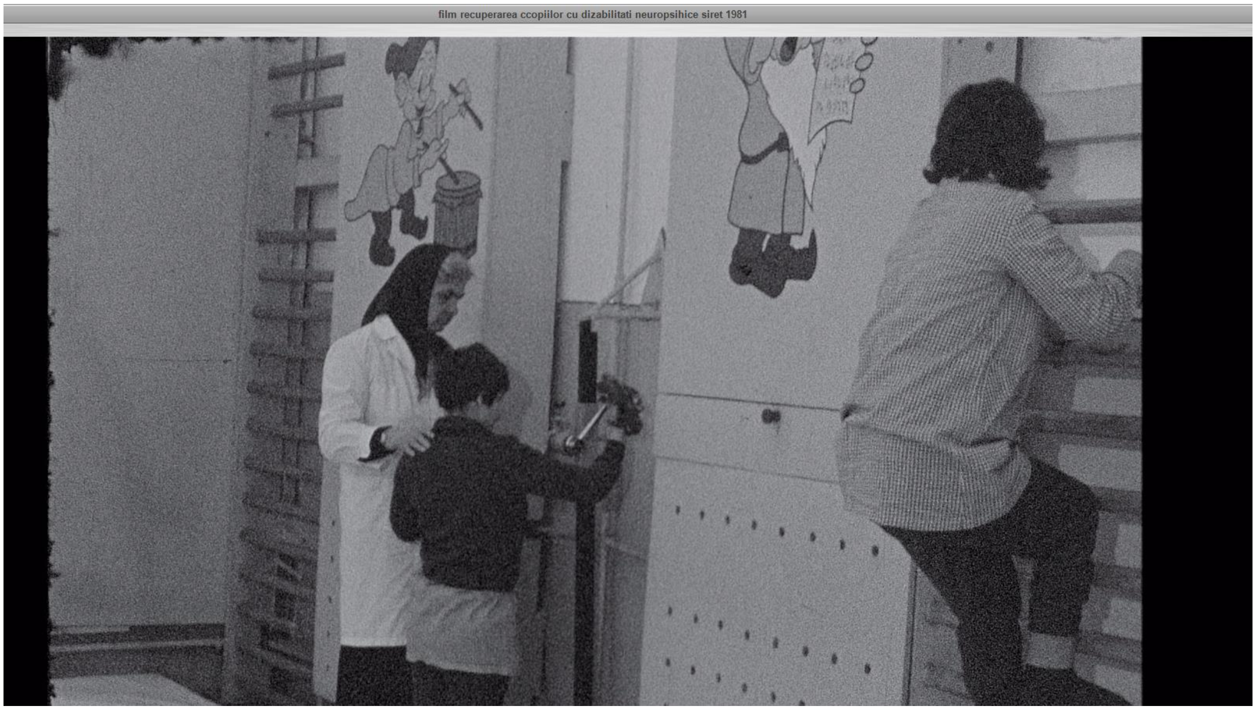

Image 3 Ibid. minute: 6:11

Image 4 Ibid: 11:52

Image 5 Ibid. 13:50

Image 6, ibid.5:52

Performative productivity of the disabled

What is apparent from this epochal representation of the socialist state’s social policies towards people with disabilities is that there is such a category as a disabled child that needs medical forms of support and surveillance in a well-equipped recovery oriented setting. Moreover, in those cases, where it is possible by the standards of the day, gendered professional oriented training – for boys shoe-making, for girls tailoring/sewing. This representation of the hospital is perfectly coherent with the disableist/productivist, modalities of sense making that lead to its establishment.

The opening of the hospital in 1956, reflected an ideological critique of the policies of the previous regimes towards people with disabilities (that I have explored in chapter 2 and will continue exploring in chapter 8). This critique established that disabled people should be rendered productive, in order to be independent of the "alms of the propertied classes"[293] and foresaw this recovery activity as a professionalized one that should be carried out by psychologist (among other professions, later also defectologists).

Nevertheless, this critique of the social policies towards people with disabilities of previous times, did not prevent the extending to unpreceded dimensions of the asylum-based system of the interwar years during early socialism by re-emphasis re-education work. It is this simultaneous medical recovery and rendering productive that the presence of complex recovery instruments, medical uniforms and shoe-maker and sewing workshops in the hospital, the film seeks to perform, showing thus that the hospital in its grandeur was realizing its goals towards the children interned in it.

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[293] See Ministry of Labor and Social Protection report MMSOS 9/1950, ANIC Bucuresti pg.140-142, Referat approved by L. Rădăceanu, 16.01.1950

Unburdening families for production

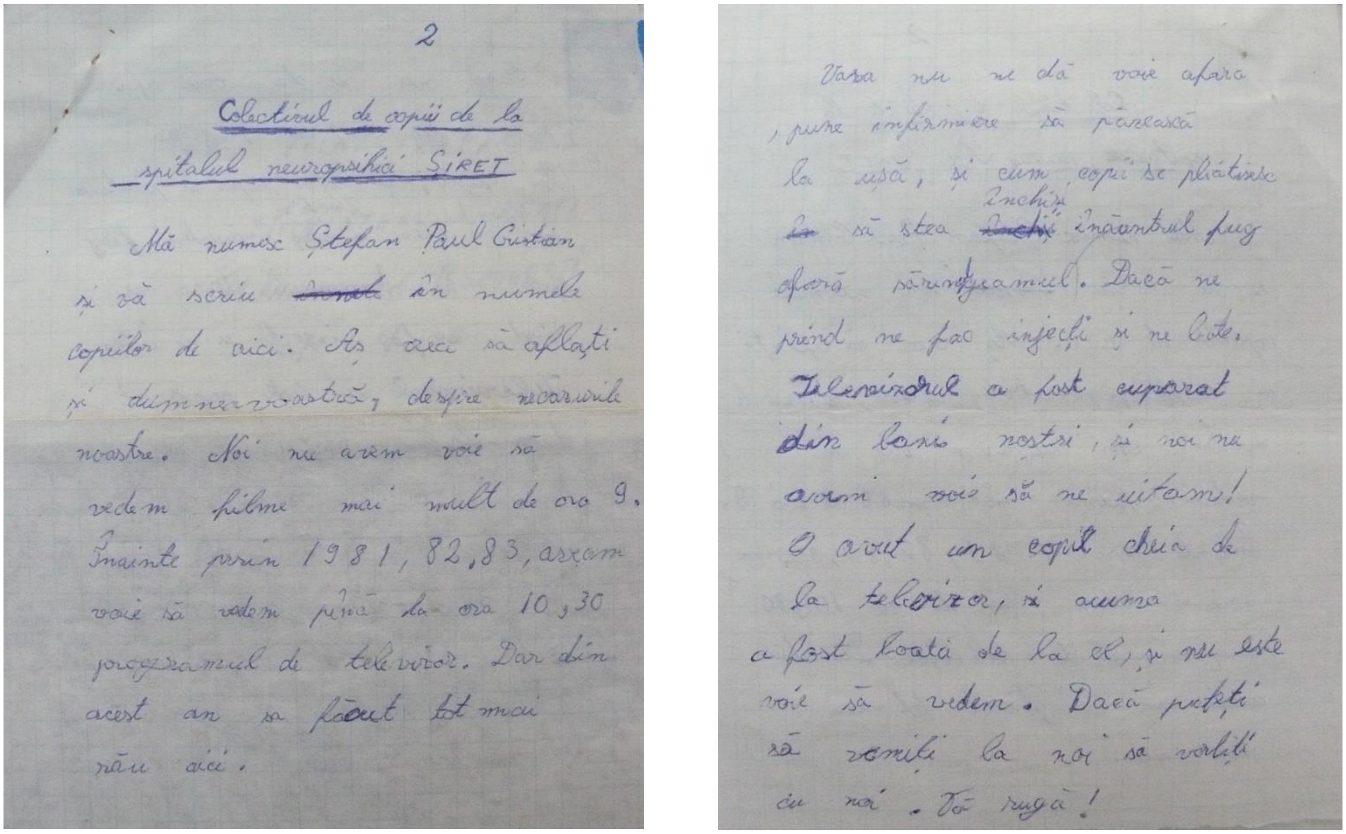
Disabled children were not the only ones that were to be rendered productive through the existence of total institutions. What is invisible in the images, yet implicit in the construction of such policies, was a second maybe even more important emphasis on work availability, namely of the family members. In his memoirs the head of the hospital praises the efficiency of the hospital in responding to what he sees as a real social need. “Namely through the permanent surveillance of the children, families could be relieved of certain difficulties, thus making it possible for one more family member, who had previously been taken out of the production circuit to re-enter production” (Popescu 2012, pg. 52).

So, in both the social policy and medical understanding, the primary role of the hospital was aiding production in different medical forms targeted at both the child and his or her separated family. A letter from a grieving father quoted by the same doctor in his memoirs, gives the following account of the relationships involved:

> “Dear Mariana, please be good and listen to your doctors, who care for you and to your teachers who teach you, because they are your parents now, because it wasn’t meant for us that you be by our side, that you be cared for and dressed nicely at home, and go to school in the village, that we feed you, and you go to bed, and then play with children your age, but God wanted it this way, we cannot do anything, but you kiss the hands of those who care for you, because they are closer to you than your daddy.” (Popescu, 2012, pg. 59-60, my translation).

The fatalism of this account reflects a religious modality of sense making that permeates the disablist/ productivist one. An ultimate consequentiality between the fact that his daughter had a disability, and that this immediately meant that she would need to grow up in a medicalized setting away from her family is established. The state socialist-modernist ambitions of increasing production through extending the national work force becomes equated with god’s will as the agent of this tragic situation in which the father sees handing over his parental authority to the care workers as the only legitimate option. More telling of the entire power-relations behind is the fact that such letters can be found in the memoirs of the doctor, meaning that he had also come to read them, despite being clearly addressed to the child and not the care workers.

Medicalized disciplining and the closed nature of the hospital



2

Colectivul de copii de la
spitalul neuropsihiac SIRET

Mă numesc Ștefan Paul Cristian
și vă scriu ~~[illegible]~~ în numele
copiilor de aici. Aș vrea să aflați
și dumneavoastră, despre necazurile
noastre. Noi nu avem voie să
vedem filme mai mult de ora 9.
Înainte prin 1981, 82, 83, aveam
voie să vedem până la ora 10,30
programul de televizor. Dar din
acest an s-a făcut tot mai
rău aici.

Vara nu ne dă voie afară
, pune infirmiere să păzească
la ușă, și cum copii se plictisesc
~~în~~ să stea ~~închiș~~ închiși înăuntrul fug
afară sărind geamul. Dacă ne
prind ne fac injecții și ne bate.
Televizorul a fost cumpărat
din banii noștri, și noi nu
avem voie să ne uităm!
O avut un copil cheia de
la televizor, și acuma
a fost luată de la el, și nu este
voie să vedem. Dacă puteți
să veniți la noi să vorbiți
cu noi. Vă rugă!

Images 6 and 7 Arhiva Ministerului Sanatatii Fond Cabinetul 1 Dosar 88/1973 (not numbered, file unbounded)[294]

Yet, what still remains invisible in these multiple representations is what did children in the hospital think worth sharing about their condition and lives. A letter sent on the 29th of February 1984 reveals what the writer wanted to tell in the name of the child collective to the then Minister of Health ([Eugeniu] Proca). Translated the text of the letter says:

"The collective of children from the neuro-psychics hospital Siret/ My name is Ștefan Paul Cristian and I am writing to you in the name of the children here. I would like you to find out about our troubles. We are

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[294] I came across this letter through the work of Luciana Jinga (Jinga, 2011), and Corina Dobos has kindly sent me the photos of it from the Ministry of Health archives. The year of the ministry of health file is most surely wrong (1973), since the letter speaks of things happening in the hospital from 1981 onwards and the postal date on the envelope also part of the file date (the postal stamp) dates it to 29.02.'84.

not allowed to watch movie later than 9 o'clock. Before in 1981, 82, 83 we were allowed to watch the TV program until 10.30. But since this year it is getting ever worse. In the summer we are not allowed outside, they put the infirmary to guard the door and since the children are getting bored sitting closed-up inside they run outside jumping the window. If they catch us, they make injections and beat us. The television was bought from our money and we may not watch! A child used to have the key to the television, but it was now taken from him and we may not watch it. If you can come to us and talk to us we plead!"

Apart from being an unmediated (neither directly by time that has passed since then as a memory is, nor by the voices of different types of professionals from doctors to journalists) account of the voice of someone who lived through the hospital as a child patient, the letter also brings into light the boredom of everyday life (as opposed to the everlasting activity geared towards productivity present in the movie), and the closed nature of the hospital, as well as the medicalization and violence of disciplining practices within the hospital. It also shows that much which has surfaced about hospitals in the 1990s was true for long periods of time, yet also points to a worsening of the situation towards the mid-eighties, which coincided with a worsening of economic conditions in the entire country at that time. Moreover, something that although obvious is often disregarded. That disabled child subjects although apparently vulnerable and innocent act in purposeful political ways that are in stark contrast with the dominant understanding of innocence as unknowingness (on innocence see Ticktin, 2017).

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Summing up, so long as the neuropsychiatric children's hospital represented the medicalized containment and confinement of children with disabilities, where a reliable hierarchy of the useful and not useful children could be established, the hospital's importance was acknowledged, for example through the fact that the 1981 conference attended by very many professionals from through-out the country. This meant that the hospital operated to separate those "re-educable" for production from those who would need life-long care in hospital-homes or did not survive the hospitalization, ensuring the unburdening of families and the selection and recovery for the production process of those children that were considered educable. The overcrowding, as well as the high number of deaths (490 of the 2300 children interned in the ten years most probably preceding 1980 had died, as opposed to under 300 children that were considered recovered and had left the hospital[295]) were part and for some still are part of the condition or faith of ill or disabled children.

The label recoverable/ unrecoverable doubled by the label productive/ unproductive was definitive in deciding upon not only a person's possibilities, but also his or her life. This was the case, since as was openly talked about in the 1990s, places like Siret were also places, where the unproductive were left to die (see Kligman 1998, especially pg. 227), basically through neglect and exposure to heightened scarcities. I will return to the way in which biopolitics operated around the hospital in chapter 8.

The celebration of the end of state socialism296: The display of humanitarian aid in the hospital

The medical productivist modality of sense making strongly came into question during transition. The humanitarian modality of sense making and the reporting it gave rise to focused on different children's institutions of which Siret was one of the most mediatized and scandalized at the time, started with and led to an even greater influx of foreign volunteers that came with their own interpretation of what it means to care for children with disabilities. Their voices in time came to replace those of the doctors and other medically oriented professionals. The new public dominance of the transnational humanitarian modality of sense making also reflected the new post-Cold War dynamics in Romania. If in the late 1940s and early 1950s the Ministry Labor and Social Affairs archives abound of requests for purchasing Soviet books on the recovery of deficients, the 1990s see an increase in international media reports attesting to the shock foreigners from Western Europe and the USA experienced when seeing the conditions prevalent in the Romanian social protection system.

One modality of sense making replaces the other in terms of public relevance in the early 1990s: whereas before in order to credibly publicly speak in the context of the recovery of "deficients" one would need to

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[295] Popescu, 2012, pg. 58

[296] I thank Erdem Evren for suggesting this line of thought about the televised inauguration of humanitarian post-Cold War politics that I will present below.

be a medical doctor or at least a psychologist or defectologist (!), afterwards one would need to be a humanitarianly oriented Western foreign volunteer. It is important to note that this shift was concluded publicly (meaning outside the hospitals in terms of what made it into the transnational media representations), and that on a local level the medical productivist modality of sense making is in many places still dominant today in different forms that are adapted to the workings of capitalism. Whereas the medical-productivist modality of sense making and its associated forms of credibility were connected to professionalized voice-making characteristic of modernization regimes, the scandalizing humanitarian forms of credibility speculated the asymmetry of transnational power relations of the post- Cold War period.

Yet, interestingly there were also significant points of overlap between the two modalities of sense making that were struggling for local dominance- the medical-productivist and the humanitarian ones. As it will become apparent from the following, the initial plans the British volunteers brought with them for the improvement of the lives of the hospitalized children were not that different from what the 1981 movie I have analyzed above wanted to convince people the hospital had already been doing. Yet, what started as an excursion into an unknown no-man's land for spontaneous English volunteers came to transform both the public understanding, as well as the local modalities of sense making and practices that they made possible.

The dynamics of scandalized anonymization

The 1980s in Romania were renowned for the scarcity of goods and this most surely was felt in Siret and especially in the hospital. The children were not allowed to leave the hospital in search for food or for any other reason (of course such rules although apparently set in stone were generally more flexible in certain cases, an activist now working in Bucharest remembering that those that had come of age were working informally in town in the 1990s, a practice that probably dates back much longer). This meant that the shortages felt within the state infrastructure were experienced much more strongly by those solely dependent on this form of subsistence. It is of no surprise that the hospital looked in 1990 much worse than in the 1981 movie filmed for a celebratory and not a defamatory event.

It is in this context that it is filmed by the BBC crew that flew in with scores of volunteers for a four-day trip to renovate the hospital. This second epochal representation of the hospital is funded no longer as a small ad hoc production, but by the BBC as a British national television channel and can be assumed to have been viewed by millions of people in the English speaking world, especially in Britain. In the making of the film, as well as from its context, we can infer a subtle message about who are the true saviors of Romanian disabled children: whereas the doctors and carers clearly occupied this stance in the 1980s, the BBC film inaugurates an era where the volunteers aided by companies (generally relatively small ones) take in this space. This is why the film also both begins and ends with the naming of several company donors of goods to be brought to the hospital.

British volunteers descend upon the Romanian no-man's land

At the very beginning of my stay in Siret, on the day I took the picture presented at the very beginning of the paper, I met a man whom one of the demolishing workers suggested I take a picture of, as well since he had grown up there. After asking if I may, I took a picture and we then went for coffee and some food. The camera and my explanation that I am doing research prompted him to suggest to me I need to cause a scandal about the new psychiatric hospital and how the "children" are being locked up. Saying also that he would do it himself, but you need have been to school [îti trebuie școală pentru asta] for this.

Scandal making was not only the domain of formerly institutionalized people, since the manager of the hospital himself felt causing scandals always helped the hospital financially by giving him leverage to make pressure for improvements. So, how did media scandals reach such importance and such popularity and what were the discursive dynamics that gave rise to this way of dealing with the shortages experienced by the children's hospital and its legacy institutions, be they of a social or material nature?

Immediately after the execution of the Ceaușescu couple on Christmas day 1989, humanitarian missions started pouring into the country. I had met a group of around seventy-year-old volunteers that at the time of my fieldwork were still coming to Siret, which they had first visited in March 1990. Apparently, they were not the only British humanitarian visitors to Siret, since two women teachers from Birmingham, one of which will continue to come to Romania many years after, visited the hospital in the summer of 1990. Right before Xmas 1990, they challenged Anneka to renovate the "home of Ștefan[297] and his friends", an "orphanage" in Northern Romania completely for the Christmas celebration party.

The format of the *Challenge Anneka* show entailed that the presenter, Anneka, is not allowed to know what the challenge will be about and that the people and companies she mobilizes to fulfill the generally humanitarian challenge need to do it voluntarily (aka do not get paid for it). It is in this format that the *Romanian orphanage* episode about the hospital in Siret is shot. The episode[298] is roughly one hour long (59:56 minutes) and was aired on BBC1 on the 22nd of December 1990[299] and was often seen as the most "daunting", hard etc. challenge Anneka Rice was faced with.

The "plot" of the episode proceeds as follows: two teachers from Birmingham introduce Anneka to the challenge. After a roomful of phoning staff, motivated by the fact that "we need everything", among the everythings needed are also "doctors, plumbers, nurses" and after 1000 phone calls were made in less than two hours, we hear from one of the women phoning that "we have gallons and gallons of paint, nurses and plumbers" (6:40). At least a warehouse full of donations is gathered which are sent with a convoy of trucks, whereas most of the volunteers are flown in on a sponsored flight. On the flight, they are told that (16:00) the "smell of the place is pretty awful and that it's advisable to tie the hair back, especially the ladies with the long hair, since many of the children who have hair, have lice, the other children have their heads shaved". They are also told that "AIDS is something everyone will be worried about, although it is not a disease they are spreading among themselves or to their carers", followed by Anneka informing everyone that it is now too late to change their minds about coming. When arrived at the orphanage, they are given a tour of the hospital and Anneka displays her horror at the appalling conditions, as well as the suffering of one seemingly speechless small child. After which everyone waits for the trucks to arrive, which apparently

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[297] It is interesting, but quite hard to verify whether this Ștefan is the same as the author of the letter, who might have been an informal leader at the time.

[298] Since relatively recently available here: https://www.youtube.com/watch?v=XinM8vNkteY accessed on 15.06.2016.

[299] http://genome.ch.bbc.co.uk/bf007c23b49842c1a5c858080e940cca accessed on 15.06.2016

are a day late, which prompts them to have the police start looking for them (31:00). Once the convoy of trucks is bestowed upon the hospital, a renovation starts in which we see everyone (including staff of the hospital, volunteers, children) being involved. Everything is freshly painted and the toilets and showers replaced. Finally, the climax of the renovation is the replacement of the old metallic beds with new wooden ones to the tunes of the anthem of the Romanian Revolution "Olé, olé, olé, Ceaușescu nu mai e" ["Olé, olé, olé, Ceaușescu is no more"] with changed lyrics that say: "Olé, olé, olé, dă-ne ajutoarele" ["Olé, olé, olé, give us the aid."], while children are dancing behind the bars in a room staring out the window at the volunteers moving freely in the courtyard of the hospital [51:20]. But in order to make the renovation sustainable, the staff is taught that they need to make the children brush their teeth, as well as shown how to clean the floor properly [41:00]. Finally, the volunteers are impressed by how meaningful their intervention was, among thank you's from both staff and children, and a volunteer saying that what had brought tears to his eyes was the fact that a child had turned around and told him god had sent them [58:30].

It is hard not to notice, the subtle classism and colonial undertones of this post-imperial English endeavor. Except for the fact that the two volunteers that had launched the challenge had been to the hospital before, the massive swarm of volunteers appeared to be going into completely unknown territory without the need to be informed about anything except the un-renovated state of the hospital, number of children and the fact that they have lice and AIDS.

There is of course a romantic beauty in this kind of middle-class momentary activism and it did result in more long-term projects. Nevertheless, the basis upon which it was originally built, constructing Romania as a "pretty lawless society"[300], as well as assuming that there were no doctors, nurses or plumbers in the country at that time is a colonial assumption. So is the fact that the care worker women from Siret did not know that children needed to brush their teeth or that the care workers needed to be taught how to clean floors. There is no answer given by the British volunteers to the care worker women's explanations that

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[300] Where trucks could ambushed by bandits in the hills, see http://www.express.co.uk/news/uk/429453/Anneka-Rice-returns-to-Romanian-orphanage-22-years-after-first-visiting-living-hell accessed on 14.06.2016

there is no running water in the hospital, apart that from now on there will be such[301], as well as to the complaint of care worker women that they need to attend to between 22 and 30 children at once and this is too much for them.

It is on the grounds of the asymmetry of the distribution of the capacity to make sense of the situation that a volunteer praises their own work by saying that once they have started emptying a room in the cellar, the staff emptied another two, despite having been able to do this before as well. Adding that he now hopes that they have determined the people there in Siret to also do something, shows how he felt the volunteers were the only ones entitled to understanding the immediate needs of the hospital and the children.

Strikingly, at the successful end of the less than one week stay at the hospital of the volunteers, the hospital looks much like the way in which it was perfomatively presented in the film of 1981. Even more so, with great pride the volunteers paint cartoon figures, such as Donald Duck, which apparently had been absent (despite the 1981 film showing dwarves from the Snow-white story on the walls of a room with recovery equipment).

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[301] The sustainability of this ad-hoc fix to the economic problems of the hospital is of course noticeable in the fact that problems with hygiene in the hospital persisted until its closure in the 2000s, according to local volunteers and former staff that had worked in the hospital.

Image 8 British Volunteer in the town hall showing the care workers how to clean the floor.

Image 9 Breaking apart the old metallic beds to make room for the new wooden ones.

Image 10 Children cheering to olé, olé, dă-ne ajutoarele [ole, ole give us the aid], while the volunteers are outside down below in the courtyard.

Summing up, what is most fascinating about this account, when looking back at it today, is that although critical and even offensive to the care workers and their practice, it remained silent on maybe the most crucial issue that would have been worth criticizing at that time, namely the issue of abuse. Of the many forms of abuse that occurred in the hospital, three different forms are worth mentioning and reconstructing. The first is violence (both through medical tranquilizers and physical beatings) from the side of staff (and in this case it is important to mention that only stories of lower care staff have become known). Second, violence between the older and the younger children, both in the segregated girls and boys dormitories. Third, sexual abuse which occurred when people from the outside would break in (which appears to have happened on rare occasions). These accounts of abuse are based on many accounts by the then children, now adults, as well as volunteers and other locals. Generally, people with ties to the staff would stress the cases of abuse among the children and (former) volunteers would stress the abuse by lower level care staff, whereas the former children spoke of both. Yet, in all accounts, the other version also resurfaces.

It is worth asking why this does not form the object of disclosure: on the one hand, a trip with little a priori information to a hospital with the sole purpose of renovating it might not have been enough in order to uncover such dynamics to the point of confidently publicly exposing them. On the other hand, the volunteers that launched the challenge had been to the hospital before and knew enough about it, in order to launch such a challenge. This makes it hardly possible that they had no knowledge whatsoever of the violence that must have gone on between older and younger children, as well as how it was encouraged and carried out by over-burdened care workers that would try to co-opt older children as surveillance agents, giving them more leeway, as well as taking matters into their own hands. Why they probably chose not to make this an issue can be explained through the apolitical nature of everyday humanitarianism, as another volunteer, who had come to Siret then, explained in an interview. When dealing with young gap-year volunteers that had started coming from Britain in the 1990s to Siret to work at the hospital, she faced the challenge of finding effective ways of stopping them from going to the head doctor and complaining about what was going on in the hospital. This troubled her and she sought to find a local coordinator, who would be able to do this all year round, since they were guests in the hospital and they wanted to be able to come and work there again in the years that followed. Later, when children care homes were exposed as places of abuse in Britain as well, she was troubled by their initial stance[302].

Finally, what this film did was not to question the medicalization of the childhood of these children (although some mention is made that they would have been housed in group homes in Britain), and little critique of this form of institutional upbringing, but focused on the living conditions and how they had greatly been improved by the visit of the foreign volunteers.

The humanitarian modality of sense making in practice

The making of massified anonymous victims

The year after my fieldwork (in 2016), when attending an international social fair in Germany to present a social project from another place in Northern Romania, I was several times asked by the Germans attending

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[302] Interview May 2015

the event whether this place is close to that horrible orphanage and what had happened there since. Such questions came even from people who were my age or younger, proving how the scandalized accounts of this particular and other similar hospitals (framed as an orphanages[303]) had become part of a socially engaged collective memory- a consequence of the workings of the transnational humanitarian modality of sense making.

The emblematic nature this established is by far not the most interesting effect of this 1990 film. Maybe, its most insidious dynamic was the way in which it represented the children from the hospital. Anyone with any access to television, who has lived through the nineties, when asked what do Romanian orphans look like would see a black and white picture of a uniformed in rags bald child with many others looking just like him or her. It is this representation that the reproduction in TV broadcasts of the massification already produced by the system that I myself found very difficult to overcome. When being presented with childhood photos of the now very individualized former inmate children, I would be struck by a certain awkwardness not knowing how to react to this image with something else than pity, although the person sharing it had obviously no intention of causing me to feel pity or sorrow. This denied individuality, in which the middle-class viewer comes to recognize a suffering other, a sole anonymous bald victim of a system is maybe the most objectifying of the effects of this modality of sense making[304].

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[303] It is probably the center for “unrecoverable” children in Cighid presented in Chapter 3, that is most likely to have captured the imaginary of the German social fair attendees. Nevertheless, in both cases the distinction between orphanage and hospital in this case is a very difficult one to make, since as is apparent from the parent letter quoted above, parents were encouraged to abandon their children in such places, where they are better cared for. In the memoirs of Dr. Popescu, he also mentions that yearly the hospital received more than 1000 letters and 800 visits from parents (Popescu, 2012, pg. 59). Compared to the number of children, namely 1300, it means that at best each child was visited once a year by his or her family. Probably, this was not the case. Rather most families decided on abandonment and few faithful parents visited and wrote more often. This is probably also the case, since of these disabilities that lead the children to end up in such places some might have been due to a perverse effect of the pronatalist policies, which prevented contraception and prohibited abortion, since different forms of trying to get rid of unwanted pregnancies though unsuccessful in that, might have been successful in leaving the child long term disabled. Also, since the institutional system was also overloaded as a consequence of pronatalist policies and abandonment, this turned any total institution open to receiving children into an orphanage. (on the chaos of post-pronatalist trans-institutionalization compare Jinga 2011)

[304] I have explored how the humanitarian modality of sense making worked to homogenize the population of Romanian orphans through creating the visual effect of seeing “only kids in cots”, in chapter 3.

When first watching the *Romanian challenge* episode that I have described above with people in the new psychiatric hospital at their suggestion, they did not speak of how great the visit of the British volunteers was, but recognized the beautiful voice of one of the girls, who had died since then, as well as remembered the names of each and every child that comes up during the film. After the time spent in Siret, I too came to watch this film, as well as others, in search for known faces until eventually recognizing someone I knew.

Invizibilizing the medical-productivist modality of sense making and the making of the humanitarian modality of sense making's public dominance

Another important effect of the humanitarian modality of sense making is the kind of invizibilization of the previously dominant modality sense making around the hospital and its meaning and social role. As explained above the medical productivist modality of sense making centered on increasing productivity through unburdening families from their disabled children and educating those considered to be recoverable was the official goal of the hospital that also secured its prestige. At the same time, it was important to present the hospital as clean and sterile environment, which offered a large variety of activities to its child patients. That this presentation was lived in different ways by the child inmates was also apparent from the above.

The first seminal intervention of the English volunteers coordinated by Anneka Rice, soon after the events of December 1989 that came to be known as the Romanian revolution inaugurated a new way of representing the hospital that became publicly influential. In time wrote itself into the infrastructural components that came to determine the everyday life of the (former) inmate children.

Yet, the humanitarian modality of sense making also reinterpreted the infrastructure overstressing the contribution that the group of volunteers on their few day visit had to the long term transformations in Siret. It is in this context that upon Anneka's visit with a group of volunteers, one year after the initial visit [1991], a man interviewed was positively impressed that the children now look like children should look (meaning mainly with longer hair), and that they are using the playground despite not having been able to move before[305]. Interestingly, it is probably the same playground that is also used by children and presented in the 1981 movie and that as the letter from Stefan shows, probably came to be off limits to the children some time in the mid-1980s.

The playground is thus re-inscribed with meaning associated with the intervention of the volunteers, regardless of the qualitatively similar way in which it was previously invested with meaning by a now publicly marginalized modality of sense making. The humanitarian modality of sense making thus stakes its claim on public dominance through staking its claim on representing children playing in the playground.

Infrastructural effects of the humanitarian discourse

As was apparent from the above, there were other important mostly political and economic shifts that favored the change in modality of sense making during the 1990s: namely the state-centric mode of organizing economy was progressively being abandoned, which also lead to the reworking of the care versus employment relationship. As employment was no longer guaranteed and also no longer obligatory, as well as the pronatalist policies ending briefly after the events of 1989, the role of the hospital in the more general workings of society also had to change. This does not mean that institutionalization of children disappeared in the 1990s, rather than this it probably increased due to the economic insecurity of transition[306], yet, the justificatory narrative of the hospital and the way in which it addressed disability and society needed changing since it had come to be redundant.

It is in this context that the groups of foreign volunteers start organizing charities and Romanian branches of charities, to establish new services for the children of the hospital, as they realized that just working in the hospital would not greatly improve the condition of the children. It is in this time that institutionalization as such comes into question, and several foundations take up establishing protected housing and the size of the hospital is for the first time radically decreased.

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[305] See https://www.youtube.com/watch?v=4iAoD0EtZbk accessed on 15.06.2016

[306] Kligman (1998) building on different reports from the early 1990s states that immediately after the fall of the regime, institutionalization decreased as a consequence of international adoptions and the legalization of abortions, but then shortly after started rising again as a consequence of postsocialist economic instability. (see pg. 228)

Leaving the hospital

The activity of the volunteers from many places in the Western world from the USA, through Sweden and the Netherlands to Britain, continued in the 1990s and it soon became apparent that a structural change was needed, so at least three foundations started thinking about building alternative structures to the hospital-centric ones. It is important to mention that the presence of the volunteers also re-worked the local's ties to the hospital, since it became possible to interact with the children in the hospital as something else than a member of the (generally lower level) care staff, for example as volunteers (that would sometimes receive some subsidies from the foreign foundations that started being active in Siret). The children of the hospital started to be taken out from behind the walls of the individually closed pavilions of the hospital that were once spread across the entire town. People grew accustomed to seeing people with disabilities in town more often, generally in the presence of foreign volunteers. Alina, who I introduced in the beginning, remembers that in the hospital she would just get bored and wait for the *engleji* to come, because then she could and would go into the town and do other things.

Yet, at the same time, what appears to have happened is that it is now that a medical selection on grounds of diagnosis takes place and children are sent according to their diagnosis (HIV, tuberculosis) or age (under three years of age) to other institutions within Suceava county, reducing the hospital to around 250 beds.[307]

But increasing the self-confidence of the children and spending time with them in or outside the institutions soon came to be regarded as insufficient, and a solution to take some of the children still left at the hospital out of the hospital started to be sought after. It is at this point that the humanitarian modality of sense making opens up the possibility of challenging the medical-productivist modality of sense making on a local level as well, after having replaced it in the mediated public sphere. The establishing of a new local hegemony regarding discourses of care and the opening up of new possibilities of subjectification for the children of the hospital entailed the establishing of a new infrastructure that could be infused with the understandings

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[307] This account is based on compiling information from the head of the previous hospital, as well as an account by the current manager of the psychiatric hospital, also a local from Siret.

carried from England (and other places in the Western world) through the transnational humanitarian modality of sense making.

Foreign charities opened Romanian branches in order to be able to buy land and build or buy houses and a selection process of those children most fit to become integrated into society began again, this time on the basis of the criteria established through the foreign volunteers and their local helpers, who in the meantime had studied psychology and social work and had themselves become agents of change. It is again interesting that such hierarchizing of opportunities based on selection processes were not foreign to the way in which the hospital operated before the volunteers, since those that were considered recoverable were sent to professional training outside of Siret with the intent that they would afterwards become independent on the grounds of the profession learned.

It is now that ableism is transcended and re-worked in an interesting way: the [then truly] young people are told that they will have houses and families and a job. And the engineering of a responsible productive and conservative subject emerges not just a possibility, but as a goal to which many seem to have strived and some still strive towards. The most encompassing of foundations built and bought a series of houses, as well as established an economic agricultural society that would employ the young people, once they would have accommodated to independent living. Other organizations just built houses and day-care centers.

The most elaborate strategy saw that a half-way house with less than thirty places be developed with the clear purpose of ensuring preparation for an independent life. At the time, in the end of the 1990s (around 1997) the young people were selected (under some protest from the care workers in the hospital that now they will have no one to help them clean anymore), and moved into the house. While they were being prepared, another number of houses was being set up as shared protected housing, where they would move in to live there once everything was in place. They became employed at the agricultural company that also belonged to the foundation and things seemed to be going in a steady direction. A further block of houses was being built with one-room flats for those most independent and/or seeking to get married, pointing to a further sharpening of the hierarchizing process, as well as a new perspective for those willing to have it.

Similar stories could be heard from the other smaller social initiatives, albeit not as clearly structured. This is the way things worked until more or less 2008.

Of course, the process was not as linear and in the few cases where the staff and a formerly institutionalized person did not get along, the later came to be sent away back into the state system, generally in institutions that at that time were maybe slightly more comfortable, but as confining as the follow-up institution to the hospital. Furthermore, these institutions were asylary places from which it was (and is) almost impossible to leave or escape- similar to the Asylum described in several places in Part II of the dissertation. Thus the power of NGO staff over deinstitutionalized young people rested exactly in the fact that they could always "be given back to the state" and thus pushed into the trajectories of abandonment that I described through Part II of the dissertation.

The foundations did not work with the entire 6-700 [1400/2000] children, and young adults that they had found living in the hospital, the largest foundation managed to take out around fifty people, others generally stopped at numbers ranging from four to twelve. The medical- productivist modality of sense making had maintained its power in the hospital and most probably also in the other medical institutions, where people were transferred, while the humanitarian modality of sense making opened up a space for multiple smaller ways of asking questions and doing things to operate confidently. One was related to the import of a toolkit regarding the new governing of the lives of people with disabilities, involving establishing (group) homes, and getting them employed –pointing to the productivist side of the humanitarian modality of sense making. Another, was about obtaining a space for the formerly institutionalized people in society, which involved getting them baptized (in different Christian confessions ranging from Catholics through Orthodox to evangelical), and accepted into church communities and in some significant cases arranging marriages- pointing to the religious side of the humanitarian modality of sense making.

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Despite starting out by largely and indiscriminately ignoring local political economic and social realities, as well as by reproducing the power relations of the hospital by refusing to protest them, humanitarian initiatives grew roots in the local context in Siret throughout the nineties. They subsequently set out to create a new type of subject as a successful subject different from the productive subject of state socialist disability policies. The productivist subject with conservative touches, that lives independently, works in (steady) employment relations and engages in heterosexual marriage, as well as goes to church on Sunday came to be an aspirational ideal for some of the volunteers and some of the previously institutionalized people alike. This project was not successful in all cases, giving rise to many practices of subversion and resistance, as well as aspirations that once the high time of humanitarianism had passed would continue to haunt the imaginaries of some of the people, who had grown up at the hospital.

Closing the hospital, yet empowering the state

The EU-lead neoliberal modernization, construction of Romania's backwardness and closing the hospital

The hospital had already been in such media attention that something still needed to be done politically. The reform of the child protection system was a large issue in the time before Romania's accession to the European Union (roughly 1998-2007) and its inclusion in the pre-accession negotiation process was legitimized largely by the fact that Copenhagen Criteria for accession included the assuring of institutions respecting human rights[308]. So that, the media reports such as the one analyzed above formed the fundamentals for the EU to engage in a policy field of which it was little aware of before (Iusmen, 2012). Marian Negoita (2010), an analyst of the child protection reform that involved both decentralization and deinstitutionalization, notes that the EU accession process was one of the rare occasions on which a modernization project involving the export of in this case advanced liberal or neoliberal European institutions to other contexts was so explicitly stated[309]. The problems deinstitutionalization had caused in

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[308] See Copenhagen criteria for EU-accession here http://eur-lex.europa.eu/summary/glossary/accession_criteria_copenhague.html accessed on 19.09.2016

[309] EU-accession was definitely not the first institutional context in which high-modernist improvement narratives were translated into practice, state socialism had been all about a production oriented modernization project. Yet, with the accession to the European Union high-modernism regained force. In understanding of high-modernism James Scott's description of it as an ideology with "a strong, one might say even muscle-bound, version of the self-confidence about scientific and technical progress, the expansion of production, the growing satisfaction of human needs, the mastery of nature (including human nature), and, above all, the rational design of social order commensurate with the scientific

other settings became invizibilized due to the Romanian reformer elite's belief of the superiority of the reform paradigm, just because it came from Western Europe as opposed to Romania's backwardness. Inadequacies were seen as part of the incapacity of adapting local circumstances to flawless Western models (compare Negoita, 2010, especially pg. 96).

Informed observers of this in Siret, such as the current manager of the new psychiatric hospital, link the closure of the old hospital to the pre-accession negotiations and the need to report to the European Commission that children's hospital in Siret had been closed. The General Directorate of Social Assistance and Child Protection in Suceava, established also as a consequence of the programs towards child protection reform, retrospectively presents as its greatest success of the year 2001 the closure of the hospital in Siret[310] together with another two children institutions. The children had been: reintegrated into the natural family, transferred to placement centers, transferred to the directorates of counties of origin (most cases) or placed with professional maternal assistants [311]. It is quite remarkable that the way in which deinstitutionalization was solved was again predominantly through trans-institutionalization, similarly to the way the initial making smaller of the hospital had occurred in the early 1990s. But now, the criteria of selection of children to be taken to different places was not based on medical diagnosis, but on the initial county of birth, a place of which most likely very few children had any memories of.

This was in line with what Negoita describes to be an import of Western neoliberal ideas about re-establishing the balance between the state and society. This works by responsibilizing the local community (as a unit closer to the family), and not the state, with the task of raising children (a task which is framed as produced by totalitarian regimes) (Negoita, 2010, pg. 101).

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understanding of natural laws" (see pg. 4, Scott, 1998). It is interesting that although Negoita (2010) quotes Scott he chooses to only do so towards the very end of his paper, diverting the attention from previous high-modernist projects of improvement that became localized in Siret. It is also interesting that Siret offers an opportunity to study both forms of deinstitutionalization that were high-modernist in their approach (such the establishment of the hospital as a place, where disabled children from everywhere in the country would find a home and be if possible educated for production, as well secondly the closing of the hospital due to pre-accession EU negotiations, as it was considered not to fulfill the needs of the children), co-exist with more localized forms of thinking improvement that similarly do not guarantee their success if improving life in Siret.

[310] http://protectiacopilului suceava.blogspot.hu/ accessed on 16.06.2016

[311] See http://protectiacopilului suceava.blogspot.hu/ accessed on 16.06.2016

Yet, what was most tragic about this was that it separated people that had known each other for years, without asking their opinion, on pure administrative reasons in a context that was supposed to be fulfilling their human rights. It is even more telling that brothers and sisters already abandoned by their family had then been separated, with no one making an effort for them to stay in touch. A man told me in an informal conversation the story of how he was separated from his sister and how another former colleague from the hospital had managed to put them in contact after a significant period of time[312]. In the collective memory of Siret, this event remained as minibuses coming taking the children to the counties of origin and everyone crying.

It is important to note that in the case of this modernist top-down reform "communities" were understood as pertaining to the county of birth to which the children probably had little connection and not to the place, where people resided and had friends and were part of very hierarchically structured power-laden lived community- that of Siret. So the EU and central state-lead model of closing large institutions though also neoliberal and built also on an idea of community was sharply different from the one promoted by humanitarian organizations. Whereas the EU-lead reform understood the community as the place of birth (and implicitly as the location, where the biological family must be residing), the way in which humanitarian organizations saw community was something to be built-up in Siret by tightening the social fabric of the town to include formerly institutionalized people.

Nevertheless, for some of the people who were made to leave at that time this departure was at least a momentary progress. Ioan, the thirty-year-old man I met at the Asylum recalled the institution he came to live in after leaving Siret was one where he felt best in life. Nevertheless, upon completing 18 years of age, he was moved to the Asylum and from where he does not have any clear perspective of leaving[313].

Similarly, those that at the time of the closure of the hospital were over 18 years old were kept in Siret. They came to inhabit the building of the former orphanage, a run-down facility desperately needing renovation

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[312] The conversation took place in May 2015

[313] Interview December 2015

until around 2013. After a further scandal caused by a media documentary titled *România irecuperabilă* [Unrecoverable Romania][314], the funds for the construction of new buildings were secured. Those that stayed in Siret are now patients of the psychiatric hospital, which was founded officially in 2003, although it existed on another administrative basis after the closing of the former hospital. So, the reform (like most deinstitutionalization efforts in Romania), was only targeted at those that could administratively be labelled children, doing little to prevent them from starting on a life-long path of institutionalization.

"And then, they gave us back to the state": the comeback of the state after EU accession

The foundations that had come to the fore in the 1990s and early 2000s also did not hold out indefinitely. Many different narratives existed in Siret, as to why this was the case. There were arguments between British donors and local administrators that were narrated and understood by others in town as cases of corruption, but there was also the much cited fact that Romania was now in the European Union and needed to manage such situations differently. Moreover, it was mentioned that the rules regarding intra-European donations had hardened over the years, as well as new challenges arose such as helping the victims of the tsunami in Indonesia.

The Romanian branch of the foundations re-oriented themselves towards the state, either handing over the housing infrastructure to the psychiatric hospital, which transformed the halfway house into a psychiatric ward for the most independent of the now patients, and the protected housing to the mayor's office for it to provide social housing to formerly institutionalized people from the former hospital.

Different yet simultaneous processes of statization of the humanitarian infrastructure took place. Maybe the most compelling example thereof is that most of protected housing established by the largest foundation mentioned above were ceded to the general directorate for social assistance and child protection, and it was at the time of my fieldwork a center for recovery and rehabilitation for people with handicap run in the tense partnership with the foundation. The people were re-institutionalized administratively, which limited their access to both substantial incomes from waged labor (since 80% up to around 600 RON needs to be

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[314] http://inpremiera.antena3.ro/reportaje/romania-irecuperabila-209.html accessed on 16.06.2016

transferred for the boarding costs to the state[315]), as well as other perspectives such as marriage and having children. The promises of independent living were referred to by a (new, state employed) member of the staff, as follows: "They were lied to by the foundation, they were promised that they would get married and have jobs and that is impossible. They were given false hopes. They are not capable of this." When institutionalized people talk about this, they say "they gave us back to the state", a phrase also used to describe the moment of abandonment by the biological family. The foundation also sold the economic society and those that live in the few houses that the foundation still runs, support the costs mostly on their own.

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During the 2000s the humanitarian organizations gradually lost their power on a local level, and at the same time the closure of the hospital foreclosed the possibility for taking other people out of it and on a path to deinstitutionalization. At the same time, the path was itself foreclosed through the retreat of the humanitarian organizations giving way to instances in which people were re-institutionalized curbing the conservative productivist life trajectory (family and employment) that had been envisioned and set out for formerly institutionalized people in the high time of humanitarian intervention in the 1990s. I will take up the experience of having been given back to the state again in the next chapter.

Humanitarian organizations nevertheless shaped both the infrastructural and discursive everyday realities of Siret in a way in which the shear current lack of resources and activity could not undue. The houses that had been built to deinstitutionalize "the young people", while still belonging to the foundation, also based on an understanding with the state are still the buildings, where "the young people" live. Social institutions

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[315] Although I have not managed to find this information publicly available for the county, this is based on the vernacular knowledge of a high number of actors, who all held different positions regarding this proportion. The actual costs the state transfers for this activity per year per person (are fixed to at least 24, 423 RON - about 5400 euro- for centers for recovery and rehabilitation for people with handicap, see HG 23/2010, available at http://www.mmuncii.ro/pub/imagemanager/images/file/Legislatie/HOTARARI-DE-GUVERN/HG23-2010.pdf accessed on 05.07.2016)

where they are consulted also were carried into the state infrastructure. Yet, the state infrastructure also came with its ableist understandings of the subject and its securitizing understandings of care.

Living in Never Neverland today [2015]

Siret has one of the richest history in terms of deinstitutionalization in Romania, yet, as I hope was apparent from the above it was not a straight-forward process, nor was it one single process. Rather deinstitutionalizations were focused differently on either the person or the institution, and always lead to a hierarchizing of people based on different criteria (medical, geographically-administrative, related to intellectual abilities or disabilities), that were developed in their vast majority independently from the people who had grown up at the hospital's desires and that were explicitly meant to govern their lives. Neither deinstitutionalization process was irreversible, although some people like Alina and Manu managed to stay off the continuous institutionalization path to which others came to be subjected.

This was so, although of course in those structures that were infused with the humanitarian modality of sense making and what it imported from the (mostly English) Western contexts, a clear emphasis on life plans and desires was stated. This came to be imported into the new state-infrastructure after the take over as a technicalized form of progressive care practice. It involved involved asking the residents what they would like to eat the next week or what they would like to do – upon which generally such answers as French fries, go to church or take a walk would be suggested by the staff in meetings still labeled "the Council of the Young People" [Consiliul Tinerilor].

Conclusion

In this chapter, I have given an overview over the way in which the hospital was constructed by different dominant modalities of sense making (the medical-productivist one and the humanitarian one). Furthermore, I have shown how the humanitarian modality of sense making came to replace, as well as rework the medical-productivist one, while finally both were rendered redundant by a new state centric yet philanthropic modality of sense making, where care and not production is central to the expansion and reproduction of the system. Moreover, in the chapter I have shown that none of the modalities of sense making operated without being fractured and that disabled children and later adults acted politically, despite being inscribed as objects and not agents of each modality of sense making.

The hospital emerges as a space of complex socialities that despite having been abusive and repressive (to the brutest biopolitical extremes of letting die, which will be explored in the next chapter) still was perceived by some as a space of care or of childhood.

Chapter 8: “I don’t like people who make a difference”

Shirting hierarchies of the disabled subject: biopolitics, everyday life and the growth and demise of a large confinement and care institution

“I don’t like people who make a difference. At the cazarmă it used to be like this, if you were prettier or something else, it would be better for you. That’s why I still don’t like people who make a difference.” (Alina, 2015)

During the time of my fieldwork, Alina was a woman of around thirty years old. She had grown up at the neuropsychiatric hospital in Siret and had come to live on her own in town, and support herself financially by working the tough twelve hour shifts in the wood industry. Her dislike of “people who made a difference”, a quite counterintuitive way of complaining about someone’s way of doing things in a world that comes to celebrate “making a difference” as a heroic task, puzzled me at first. After several conversations with Alina, I came to understand that “making a difference” to her meant, favoring some people over others and thus discriminating those who did not appear to be as deserving of care and privileges as others. She saw her own past as that of those who had been on the losing side of “making a difference”, at least during the time that she had spent growing up at the neuropsychiatric children’s hospital in Siret.

In this chapter, I explore what making a difference meant in the context in which Alina spent her life: the neuropsychiatric hospital in Siret, its deinstitutionalization and the demolition of its symbolically laden main building. I show that making a difference was connected to the way in which biopolitical practices of social hierarchizing would play out in everyday life. In a next step, I look at the broad shifts in biopolitics that occurred surrounding the hospital in Siret and its afterlife- and the way in which the population of “children” was subdivided and reframed according to different criteria of differentiation that inscribed subjects as worthy (or not) to have their lives fostered and the way in which their lives should be fostered. In looking at each of these phases, I look at different modes in which biopolitics are enacted, re-worked or resisted in everyday life- returning to what Fassin has termed the “substance of life” (2011, pg. 189f.).

Bio-power and social hierarchizing

As I was searching for a conceptual way to make sense of what “making a difference” means in the context of a large care institution established during state socialism where children came to grow up in a completely medicalized setting where those “recoverable” for production whose lives and minds would be fostered were separated from those “unrecoverable” who came to be let die - I realized that these practices of selection and hierarchizing were akin to those described by Michel Foucault when theorizing biopolitics as a form of power that enables to make live or let die specific populations (see Foucault, 2003 [1997] and 1978) through the “entry of phenomena peculiar to the life of the human species into the order of knowledge and power” (Foucault, 1978 pg. 141-142).

The entry of life into the realm of calculations (Foucault, 1978, pg. 143) and the hierarchizing of subjects it implies, did not stop once the institutional order of state socialism was gradually replaced by different ones. Rather than this although processes of selection and hierarchizing changed both during and after socialism, as will be apparent from the following the importance of biopolitical calculations for those who grew up at the hospital in Siret remained in place. This assumption allows me to trace biopolitical orders as they interact and shift in the setting of Siret.

First, I will underline what I mean by bio-power by building on Foucault, as well as Didier Fassin – pointing to the tension between biopolitics as abstraction of life from the living of it by political calculation and Didier Fassin’s politics of life- the connections between moral orders of legitimacy and inequality that enable the fostering of certain lives and the non-fostering of others.

Biopolitics and the politics of life

For Foucault bio-power and its calculations are tied up with two points: the first is normalizing power that serves “to distribute the living in the domain of value and utility. Such a power has to qualify, measure, appraise, and hierarchize […]; it effects distributions around the norm” (Foucault 1978, pg. 144). Yet, the standards for this normalization in the present context are derived from Foucault’s second point, which he makes in his famous “Society must be defended” lectures at the College de France about the relationship between biopolitics and racism. For Foucault, racism was that which allowed bio-power to work, since it enabled the disavowing of life (compare Foucault 2003 [1997], pg. 258f.). Racism is what makes the letting die and even killing of populations in the name of future vitality of a living community possible. For Foucault, it is social racism that enables a biopolitics of letting populations die. Whereas for Fassin it is inequality, which enables a biopolitics of letting die certain subjects, while enhancing the lives of others (Fassin, 2011, pg. 193).

Yet, Fassin is not primarily concerned with biopolitics in a Foucauldian tradition which in his understanding overpowers biology over biography (compare Fassin 2011, pg. 193) – but with a politics of life which is concerned with the everyday life of fostering and disavowing life (compare with Fassin, 2006 and 2011, especially pg.181f.). If for Foucault understanding how life came to be separated from the living through power technologies was key to establishing the concept of biopolitics, Fassin calls for an interesting dialectic return to looking at the living of the life through the lens of moral anthropology. Put differently, Fassin calls for investigating the structures surrounding what is regarded as just action in everyday life. In turn, I try to repeat this dialectic move, so as to look at the tensions between life as abstraction and life as lived in the context of ongoing politics of life. Through this, I explore the question of what kinds of inequality and in relation to which political and moral orders these come into being shaping the subject and providing the discursive means by which subjects come to shape themselves as subjects (see Foucault 2000).

Yet, neither racism (Foucault) nor inequality (Fassin) are sufficient explanations for the way in which biopolitical hierarchizing processes work to separate those whose lives are or aren’t fostered in practice.

What Foucault refers to as "social racism" appears as a way of biologizing different deviant orders to a dominant one (from dissidence to mental illness or disability, compare Foucault 2003 [1997], pg. 261f.). Although compelling, this explanation remains superficial as it is too complete- whenever someone is arguably let die in a coherent observable way, it can be claimed the person was a victim of "social racism". "Social racism" thus circumscribes the practice of letting die and the populations it produces rather than explaining it. Similarly, Fassin's explanation of inequality as the driver of biopolitics can be seen as similarly tautological. If practices of social hierarchization are fundamental to any form of biopolitics than establishing an unequal order is paramount to reasoning biopolitically. To put it differently, what is interesting about biopolitics is how social hierarchization operates in everyday life and how its modes of operation shift over time. Also interesting from a different angle is how the abstract biopolitical orders are resisted, reworked or enacted in everyday life.

An overview of the four main biopolitical orders

In the following, I will explore how and which people were selected for life, and which were let die within the confines of the hospital in Siret, and how these biopolitical distinctions and their corresponding interventions for the fostering and disavowing of life shifted through the decades following the institution of state socialism until the time of my fieldwork. I have grouped my findings into four main biopolitical orders that correspond to periods following broader biopolitical shifts. The findings from this section are grouped into Table 1(at the end of this section). Although, I first outline each of these biopolitical orders narratively before introducing the table, the space available for explaining them does not allow for going into each of the points listed in the table. Therefore, the table is a more comprehensive, yet rather schematic overview of the different biopolitical orders and their associated processes of subjectivation.

The four biopolitical orders I explore are early state socialism (1950s- mis 1960s), state socialism after pronatalism including (partly) early transition (1966- 1990s), humanitarianism (1990- 2007/9) and the comeback of the state after EU accession (2002- present). Although there is significant overlap between these phases in what was politically and infrastructurally, as well practically understood to be the disabled subject and appropriate care, there are significant difference in biopolitics between these periods and their subjectifying effects, which I aim to explore here.

State socialism: productivity in a planned economy and the (un-)recoverable disabled subject

So, what how did practices of social hierarchizing (the fundamentals of biopolitics) in the context of the establishment of a hospital-home for 360 mostly "unrecoverable" neuro-psychiatrically "handicapped" children in the mid-1950s[316] as part of the extending state infrastructure during the consolidation phase of state socialism in one of Romania's most remote places, its border-town with Ukraine mean?

It is tempting to see in this establishment, an infrastructural translation of state socialist social racism towards children labelled mentally ill. Yet, the story of the establishment itself is much more complicated. Done in a time when psy-experts rebranded as socialist developed their position in relation to social policies towards the vulnerable, the hospital came to be integrated into an approach that thought of itself as something novel and empowering towards people with disabilities through rendering them productive and incorporable into the work force.

This approach is visible in such ideological shifts as that that took place within the psychological profession operating within a social policy setting: briefly before the establishment of the hospital in 1956, an ideological critique of the policies of the interwar time towards vulnerable people was being developed. The Psycho-technic Institutes and the Bureaus for Professional Orientation (something similar to vocational training today) were criticized, and in their place psychologists demanded and managed to establish the Institute for the Scientific Research for the Recovery of Deficients [317]. The reason given to the then Minister of Labor, Lotar Rădăceanu, for this change in focus of the activity of psychologists was that "in a popular democratic State on its way to socialism, *work* becomes the main preoccupation through its economic, social and political effects. That is why, everyone's possibility to work and to be included in social life[318] must be

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[316] Conversation with the previous head of the hospital

[317] Institutul de Cercetări Științifice pentru Recuperarea Deficienților

[318] "încadrare în viața social"

ensured. Our ministry having as its task social provisioning needs to also attend to those categories of people that have been considered *by past regimes to be socially dependent, forever awaiting the alms of the propertied classes.*"[319] (my emphasis)

It is tempting to discredit this new positioning of psychologists as mere ideological accommodation of the profession to the policies of the new socialist regime. This does not do justice to the type of shift that must have occurred at the time, since in the end psychologists did shift their area of expertize from vocational training (which meanwhile has regained its popularity) to the recovery of people considered to be vulnerable to exploitation on the grounds of their so-called deficiencies. Nevertheless, this critique of the social policies towards people with disabilities of the interwar times as perpetuating inequality and dependence of the "deficient" towards the propertied, as well as of those initiatives preceding them, did not prevent the extending to unpreceded dimensions of the asylum-based system of the interwar years during early socialism, albeit under a different reasoning mainly regarding the emphasis on re-education and a twofold emphasis on work.

Taking over the care of people with disabilities from the family meant both potentially rendering people with disabilities more productive through re-educating them according to their disabilities (therefore long term less dependent; this went hand in hand with a policy of creating cooperatives for people with disabilities), as well as rendering their families more productive through relieving them of what was conceived as a care burden a point made by the former head doctor in his memoirs (see Popescu, 2012, pg. 52).

But work was also important in itself as a reason to establish the hospital in Siret in the first place. As I was told by the former head doctor, it was important to place the hospital in Siret, so that the people of Siret would have work. The hospital during state socialism fulfilled a manifold official role towards the rendering productive and thus to ensuring the subsistence of many different marginalized categories of people from

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[319] MMSOS 9/1950, ANIC Bucuresti pg.140-142, Referat approved by L. Rădăceanu, 16.01.1950

unqualified care workers that would be employed to those of children whose abandonment on the grounds of disability was encouraged to render their parents more productive and more easily incorporable into the order to state socialist full employment.

Productivity was the buzz word that organized the relationship between the power-knowledge nexus made up of psy-professions such as psychiatry, psychology and later the deficiency-centered discipline emblematically called defectology and the disabled subject and her care workers on the other side. Productivity went hand in hand as is apparent from the above with a transformation of the disabled subject: she is no longer to be left depending on the alms of the rich, she needs to be rendered productive and thus independent of the goodwill of those less needy. As Foucault in his work on bio-power has pointed out (1978, pg. 140f.), there is an intrinsic link between the development of capitalism and the emergence and deployment of bio-power, since the instruments of state that were used to institutionalize production relations and the corresponding effects of segregation and social hierarchization were the proto-forms of bio-power. In this case, the hospital appears as outside socialist production relations[320] - very similar to capitalist ones, since as pointed out by political philosopher G.M. Tamás, the means of production were not owned by workers themselves as producers, since the surplus generated through production was reinvested by a small number of agencies, meaning a small elite of technocrats. (compare Tamás, 2010, pg. 126) – yet, it is in constant dialectic relationship with them. It aims to produce the productive subject- be it directly by educating the disabled subject or as a by-product by giving work to care workers or relieving parents of their duty of *surveillance* (sic! see Popescu, 2012, pg. 52).

It is in this quest to produce the productive subject that the need for a new category emerges: those that for whatever reasons cannot be shaped into productive subjects. It is here that a biologist essentialization of disability resurfaces at the heart of state socialism: if productivity offered an alternative to charity and the implicit relationship of dependence and inequality, then the exclusion from productivity rendered the subject

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[320] Here it is worth mentioning the very old debate about the difference between the socialist and capitalist forms of government to which Foucault alerted that socialism had never developed its own art of government, an interesting contribution to this debate is that of G.M. Tamás (2010)

useless and the relationship of inequality, is re-inscribed with full blows - since “salvation” had been already attempted through rendering the subject productive.

It is through this that productivism - the reduction of people to resources (Mladenov, 2015) [321]- aimed at empowering disabled subjects that the truly undesirable disabled subject emerges: she who cannot be integrated into the production process, despite efforts to do so - “the un-educable”, “the un-recoverable”. Once the term “un-recoverable” becomes available as a diagnostic category, full blown social racism can also be put to work to let those considered un-recoverable die, thus making the community of productive individuals more vital and paradoxically, more equal as well among those who remain alive or free. It therefore became imperative to determine who was potentially productive or not, in order to decide which lives should be fostered and who should be let die within the disability related protection system, which was built on a series of asylums the model for which was inherited from the interwar times, but extended during early state socialism.

The scientific fundament for these practices was the soviet originated science of defectology[322]. As later critics of this discipline have observed, the main idea behind defectology was to separate those potentially productive from those potentially unproductive (see Nelson, Fox and Zeanah, 2014, pg. 64). This potentiality was understood in biological terms, since disability was considered a morbid state (= a disease) that rendered the person “defective or abnormal”, while the environment was considered to have no influence on the development of this disease (compare Nelson, Fox and Zeanah, 2014, pg. 64). Thus, it is understandable why the “unrecoverable” children would come to be brought to a neuropsychiatric *hospital* on the grounds of their disability.

It is in the context, in which the term un-recoverable existed that the hospital-home for children with neuropsychiatric handicap is founded at Siret with 360 beds. The head of the hospital, himself a radiologist

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[321] See Mladenov (2015) on a very insightful introduction into how productivism can be read as the missing link, tying the state socialist to neoliberal disability policies,

[322] A very productivist equivalent of today’s disability studies

was given the position only provisionally - yet, came to hold it from the mid-1950s to the 1990s, basically his entire working life with a few years of notable exception between 1959 and 1963, when the hospital was headed by Eduard Pamfil. The famous psychiatry professor had been moved to Siret, due to alleged participation in nationalist manifestations related to the celebration of the centenary of the small unification (see Buda, 2013, pg. 293). The politically undesirable professional apparently tried to integrate the children from the hospital with the local community (Buda, 2013, pg. 294), a project that much later came to fruition during the high-time of humanitarian aid.

During early state socialism, the hospital grew from 360 beds to over 1200 beds after the onset of pro-natalist policies in the late 1960s and the encouragement of the institutionalization that followed it in the early 1970s. Yet, in conversation the head doctor stressed that the numbers of beds had reached 1310 by the 1960s. It is very likely that after the pro-natalist policies, the number of child inmates would keep growing but not the number of beds (and associated funding).

State socialism after pronatalist policies

The policies of establishing hospitals and other asylary care structures came in a context of ensuring people's right to work and gender equality by integrating as many family members as possible into the workforce and unburdening families of caring for disabled children (compare Milea, 2004, pg 38 and Popescu, 2012 pg. 52). What changed once the pronatalist decree (770/1966) and the law supporting institutionalization (3/1970) were passed, was the incentive of families or single parents to abandon their children into state care.

Paired with insufficient funding of the state care infrastructure, this led to a mushrooming of the category of "unrecoverable" as it came to be applied to many children, since it "appeared reasonable that, in order to take the burden off the parents' shoulders, such cases should be given priority to hospitalization" (Milea, 2004, pg. 28). The context in which these policies were passed was also one in which, the state socialist regime was becoming increasingly conservative on moral issues, leading even to the marginalization of party members who were divorced and to a public romanticization of nuclear families with several children (compare Betea, 2012). It was then, that the hospital was probably informally extended and that its official population reached over 1200 beds, but most likely the number of children was much higher since accounts speak of up to five children sharing a bed[323].

These were places where certain children were let die. The distinction between who was made live whose life would be fostered through three course meals and professional education and who was let die through being exposed to the heightened scarcities – cold and hunger - of which Luciana Jinga (2011) wrote that could kill half of the population of such a residential institution. Of similar institutions, anthropologist Gail Kligman (1998, pg. 227.) wrote "Some of these institutions housed children who had been diagnosed as "unrecoverable". These children [..] were disabled in various ways. Some were blind, others were mentally deficient, yet others had physical handicaps. Thought to be incapacitated by such ailments, these children were condemned by Darwinian notions separating fit from the unfit. Labelled "non-productive" in a society ideologically dependent on production, the handicapped were effectively sentenced to death. 'It is a place they go to die," said one medical director of a facility from which the productive and nonproductive were selected to be sent to other institutions where they awaited their faith."

Siret came to be known as one such institution, with the mentioning that after initial selection, the efforts to separate the recoverable from the unrecoverable children were still going on within the hospital- a point that makes it a central site for the study of state socialist biopolitics in practice. According to the head doctor in at the end of 1983, the total population was 1350 children[324], of which 121 were recoverable for the school and 104 were recoverable for the workshops. Whereas some of the institutionalized children were made

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[323] http://news.bbc.co.uk/2/shared/spl/hi/picture_gallery/05/europe_life_as_a_romanian_orphan/html/1.stm accessed on 25.03.2017

[324] According to the head doctor, the numbers of children had already gone down by that date, since they started decreasing in 1981, because those initially abandoned as a consequence of pro-institutionalization policies were becoming adults or transferred to other asylums or hospitals. Nevertheless, this means that the number of children must have been higher than 1350 before 1981.

live, others were let die based on hierarchizing mainly on the distinction recoverable/ unrecoverable. This meant that about 20% of the children at best were considered recoverable at a time.

The account of one of my friends from Siret who had grown up at the hospital Manu, a woman of about thirty years of age, helps shed some light on the way in which this hierarchizing was lived daily. She told me how much she enjoyed having been able to go to school and that this was the only good thing about having been at the hospital. She also remembered that when she came of school age and it was decided that she could go to school, she started receiving food that was divided into three courses, which she was given cutlery to eat. The others who had not gone to school would still receive food with the bucket "la găleată"[325]. The same story about the bucket food that was replaced with a three-course meal once being sent to school was told to me by a man who was a few years older than Manu. He remembered having been told that "from now on they are bound to go into the world and they needed to know". Needing to know what food looked like for other people in the world outside of the hospital, as well as how it is to be properly eaten appear as practices that foretell a normalized existence once the stay in the hospital would be concluded (generally after the 8th grade).

The lives of the chosen "recoverable" ones would be fostered biologically, through better food, socially through learning how to properly eat it and intellectually and professionally through receiving education and professionalizing training - in shoe-making and tailoring (see recovery film analyzed in chapter 7). Since both Manu and Georgel were in their thirties in 2015 these practices can be assumed to have been going on throughout the 1980s and 1990s at the hospital - meaning in the time before it was closed.

This biopolitical order based on a form of biologizing and productivist understanding of disability was not unfractured, as people in Siret remember how some carers would bring food from home to feed the children,

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[325] I struggled for a long time to understand what this meant, and later while volunteering at the new psychiatric hospital on a ward for severely disabled people, I witnessed food being brought to the eating room with a bucket, the meal consisted of two courses both made up of watery dishes into which the bread had already been inserted and which would then be divided into the bowls of each of the people eating. the watery food despite being fluent nowadays is quite consistent, but I assume that this looked very different during late socialism and early 1990s.

while others stole from the food and served it to their own families at home. The social hierarchizing practice going on within the social hospital helps to explain conflicting interpretations of the hospital prevalent in Siret today- some remember it as a place, where the disabled were very well treated and helped to recover, while others remember it as a place of bad hygienic conditions, terrible meals, violence and idleness.

An accountant and daughter of a former employee of the hospital remembered with quite some envy how the children had schweizer-cheese and how butter from the hospital would be thrown away down the river. This phantasy of prosperity in a time of general scarcity might be true. Yet, it cannot be true for all groups of children, since some clearly depended on the food brought from home by the carers. Probably those who received food with the bucket were more vulnerable and considered to be unrecoverable and those that received three course meals, occasionally received butter and exceptionally, schweizer cheese. The fact that food would be thrown away meant that rather than redistribute the food excess to those less deserving, the biopolitical hierarchy was built on doing away with it. Much like the poisoning of expired goods in supermarkets once expired so that the needy cannot help themselves to unpaid goods works today.

Carers participated in the biopolitical order of the hospital by disrupting rations and thus the categories of distribution for the fostering of life. Moreover, two other types of subjects emerged from the ethnography: beautiful and useful children, whose life would be enhanced irrespective of their formal recovery related diagnosis.

Beautiful children’s lives would be enhanced by the sympathetic care of certain carers, irrespective of the “severity” of their disability. A now adult man in his twenties with rather severe autism and a speaking disability was known since he was a child by his carers as everyone’s favorite, due to his looks. Interestingly, these anecdotes were not only part of everyday life. As ethnographer Lynn Morrison (2004, pg. 171) has shown of the institutionalization of children in Romania, children with “visible differences, such as having large ears or being cross-eyed, were also considered to be disabled”. This shows that a concern with the aesthetics of the body and its entanglement with disabilities cut through different levels of the state system having biopolitical consequences that went through practices of administrative selection, as well as practices of care.

Another important such disruption was that carers also allegedly preferred to enhance the lives of and support those who helped them: the generally older children that disciplined the younger ones, as well as performed carer duties, such as cleaning the floors of the hospital. A woman who had participated in this as a child patient, remembers having wanted to help the carers, so that she could learn how to perform these tasks later when she would have her own family. At the time of the interview, she was in her late thirties, worked as a carer at the new hospital, was married, had two sons and was living in one of the social housing apartments in the former school building of the old hospital. The second disruptive element nevertheless is likely to have mostly coincided with the general normalizing frame of productivity, since in this case it was not projected productivity but present usefulness in terms of working that had to be performed to have your life fostered through disruptive practices- so again usefulness cut across practices of administrative selection and care.

Humanitarianism

One of the New Beginning Center's employees remembered that when he was a volunteer at the foundation, it was the best time since "they were still all there". With these words, he described the times volunteering at the hospital together with the English volunteers that had come after Anneka Rice's BBC show episode, before the first houses were opened for those to be deinstitutionalized and before the hospital was closed. "All" meant that volunteering with the inhabitants at the hospital at the beginning did not involve an a priori selection of deserving subjects.

Those considered deserving were to be included in the community of Siret by being deinstitutionalized. This processes involved multiple challenges for the young people, carers and foundation volunteers and workers alike. One was setting up housing, another employment, but there was also the much trickier question of marrying off the most successful of the deinstitutionalized people.

A state employee that had also started out as a volunteer for the foundation established by the English remembered that once the houses had been put in place by one of the foundations and people were selected for "independent living", the carers started to complain that no one would help them do the work in the hospital anymore. This observation pointed to the fact that both the foundation and the carers were looking for a specific kind of productive subject whose life should be fostered. Yet, the carers expected productivity to manifest itself by relieving their burden, whereas the foundation projected this productivity as a future process in protected employment that would enable sustainability for the nuclear families that were to emerge from its activities.

Protected employment was set up to ensure that the family members of the newly made families, as well as those not yet married would come to sustain themselves. When a few months before my fieldwork (around 2014), the foundation run farm had proved not to be lucrative enough and was closed, it marked the end of an era of encouraging productivism and solidified the reinstating of the state into a new set of duties and space of power. At the time of my fieldwork in 2015, previous employees of the farm would roam the streets of Siret asking people in management positions for jobs. Yet, their prospects appeared to be very dim. Some of the previous employees of the farm could not read and write, a point which made them unemployable in state institutions.

On the other hand, humanitarian aid included an injunction to create nuclear families that in some cases reached as far as arranged marriages. This was not at all a trivial intervention into people's lives, since marriages started being arranged by the hospital staff and humanitarian foundations.

In 2015, I visited a couple living with their two sons in their one room social housing apartment, which had been offered to them by the mayor's office, the mayor a liberal party member and previous head of the hospital enjoying a very good reputation precisely for having provided some of the former institutionalized people with housing[326].

When they recalled how they had gotten married, they said she was still hospitalized at the time and he had just returned from England, where he had lived for several years after arriving there through a connection established in the high time of humanitarianism. She was asked by a man, who had been a head nurse at the hospital and whose daughter, she was looking after, despite still being committed to the hospital. The head nurse had proposed them to get married on a Saturday and a week later the next Saturday, they were married. She was given a job as a carer in the very same hospital, which she left as a bride with a man, she had barely met before. The marriage apparently earned the head nurse some money from English sponsors. At that point, the carer had graduated to adulthood and was being referred to by the other "children" as auntie ("tanti"). When I asked how come she had gone along with this, she said she had wanted freedom, a word she stressed with more passion than anything else we discussed that day. Yet, the arrangement itself was probably based on her previous usefulness to carers, which she described as having helped them not because she was exploited, but in order to learn how to do chores around the house for her own future.

Another less successful case of arranged marriage was told to me by a man in his late thirties, who had married a woman that had not grown up at the hospital, as well as the now seventy-year-old English volunteers that had come to visit him at his home, as we were finishing our interview. When talking of his marriage he said: "It was those from the foundation that also got as married, we stayed as friends six months and we were married for another six months." The English volunteers, who I met the very same day of the interview, confirmed that it was almost an arranged marriage. After the wedding, despite the English volunteers insisting, as well as him wanting him and his wife to remain in Siret, where he had a job at a factory he was urged by his father-in-law to live with them in another town. He had been treated badly by

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[326] Interestingly all of this housing was either part of the former hospital infrastructure as was the case with this and other apartments, that were located in the building of the hospital's school, workshops and recovery oriented rooms, just meters away from the hospital's main building that was then in 2015 being demolished. In other instances, the social housing had been given to the mayor's office by humanitarian foundations that no longer wanted or could administer it themselves. I will return to this shortly.

his in-laws and when he finally left back to Siret to arrange things for him and his wife to come and live there, his in-laws got them divorced in his absence. Both the marriage and the divorce appeared to be mostly outside of his powers in the way he talked about these important moments from his past. And although there had been efforts to conceal the fact that he had grown up at the hospital, his father-in-law kept calling him "handicapped" in order to offend him, probably since he actually knew where he had grown up. This vulnerable position within society probably made him disposable socially to his father-in-law, when he proved he was not docile and exploitable.

But not all marriages of people, who had grown up at the hospital were narrated as products of patriarchal style arrangements on behalf of staff and humanitarian volunteers. In some cases, people talked about their decision of marrying someone, who had grown up at the hospital as well, since he would know what she had suffered. The prelude to getting married was also sometimes narrated in terms of the flirting that preceded it[327], somehow normalizing the account of getting to be with someone.

And yet, when I came to Never Neverland in 2015, the marriage era had ended, as one man living in foundation housing without being married put it when talking about the fact that his previous girlfriend had left him to marry another man, who had not grown up at the hospital. The thirty-year-old man told me that his ex-girlfriend is now a lady, he couldn't force her if she didn't want to stay with him, but "now the time is gone" to be with someone else. I thought about it and when talking to his previous girlfriend and her husband, I was told that the foundation had discouraged them from getting married, saying that the foundation will not pay for another wedding. But they went ahead with their plans on their own funding, since both were working. This even though the one-room apartments on the grounds, where both she and her former boyfriend had been living were still being referred to as a space "for making families".

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[327] See a local media reportage from 7th of December 2013 on one of the foundations here https://www.youtube.com/watch?v=i3iggZ-_efw accessed on 22.10.2016 [the part about flirting and getting married starts at 3:53].

Another practice that came to fruition during the time of humanitarian aid was that of mourning, as can be read in another ethnographic example. It had been one of my first days at one of the houses of the center and the carer on duty, to make it nicer for me asked three of the residents to take me to the grave of their friend Caraxone. I went along and five minutes later, we were in the Catholic cemetery at the grave of László Karácsony, their collegue[328], who had died several years before. There were two people from the community of around forty people who had been deinstitutionalized during the high time of humanitarianism and then given back to the state who had died in the years following the 1990s. The woman's name was Sava after her last name and the man was called Caraxone[329]. I rarely ever looked at a photo album with someone (previously) institutionalized in Siret without seeing pictures of either one of them and being told the story of how they had died. Sava had been ill for a long time and she died of cancer after struggling with the illness for an extended period of time, whereas Caraxone died suddenly and his death was attributed to the fact that he was very short and dwarfish people if they do not have large heads are exposed to dying young - at around forty years of age. Their deaths were memorialized through such visits to their graves and affectionate mentioning when looking at their photos (especially Sava's), much in the way that one would mourn a family member.

The mourning practices of these two premature deaths point to something broader than just a post-kinship affective community that of the former children of the hospital, namely to the fact that death among the previous inmates of the hospital had become personal and the suffering the death of a close one provoked, an instance which requires mourning to be transcended. In an interested reversing of what Judith Butler (2003) describes as the potentiality of practices of mourning to bring about non-violence by re-drawing the

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[328] Colleague was the word British humanitarian volunteers had probably introduce to describe the relationships between deinstitutionalized people that shared this condition and the deinstitutionalization program. Similarly to English, it has an affectively neutral, professional connotation, which sits awkwardly with the emotional intensity of some of the relationships it seeks to describe.

[329] Since both have died, I allowed myself to use their original names which have powerful connotations for their friends in Siret.

boundaries of “what makes for a grievable life” (Butler, 2003, pg. 10), the new biopolitical order by being less violent allowed subjects to also publicly mourn their losses.

This is probably in stark contrast with previous practices, as Ștefan pointed out when speaking of the time at the hospital: „The Russian cemetery is full of children from the NPI [children’s neuropsychiatric hospital]”. In the same conversation Ștefan remembered how a child was killed at the hospital, and how upon the discovery of a nurse who wanted to hang another child, they took away from the nurse’s salary that month. The fact Ștefan still remembered these deaths that must have occurred during his early childhood (he was in his late twenties at the time of my fieldwork) points to the fact that he felt the need to mourn and remember them. Yet, this was not a public but a private act at that time that could become public through our conversations.

The shift in biopolitical regime, did not mean that making live and letting die were not still ongoing processes within Siret when I was there in 2015, and both forms of biopolitics were operating alongside each other, yet, they appeared to me to no longer describe the dominant power dynamics. During one of the afternoons that I spent at the psychiatric hospital’s ward for the most severely ill, I noticed a woman who had been running around naked. One of the carers had chased her and made her put some clothes on and I soon saw her emerge again albeit imperfectly dressed with her genitals and her rear occasionally showing despite holding on to her pants. The previously naked woman made some rather husky movements, and sat down on a wooden bench. One of the infirmaries chased her away again to the mattress and then explained to me ‘she cannot sit on hard surfaces. She has a part of intestine coming out through her rectus, sometimes it is purple colored and it is very large. She sometimes yells for hours on end, two days in a row and they won’t give her any medicine, they say she should yell. I am telling you these are not working conditions, they just won’t give her a painkiller/ tranquillizer - *calmant.* And we have to deal with this.’ ‘Do you think it’s because of the pain?’ I asked ‘Yes, it might be. She was taken to the doctors in Rădăuți (larger town close to Siret), in Suceava (the county capital), but they won´t perform surgery on her. Because she is from here. No one to give the doctors money'. 'What does she have?' I asked 'Do you think they tell us, they only tell the nurses'.

The absence of a make live intervention in the context of acute enduring pain and the namelessness of this woman's illness are very telling about the let-die regime that still haunts not necessarily the hospital in Siret were the effort was made to bring the woman to a doctor, but in the absence of the resources for informal payments to doctors and the fact that her commitment to the psychiatric hospital was a stigma broad enough to ensure that outside of the institution no make live intervention would be performed.

Yet, I have also seen the opposite situation: among the more well situated inhabitants of the center for recovery and rehabilitation, there was a young man who was around twenty-three years old at the time. He was a well-spirited and kind hearted person who often liked to help. While playing football one day, he was hit by a ball in the nose. A few days later, his nose was still bleeding and he was taken to a doctor, and then to other hospitals, going up until the hospital in Iași, ˙the historic capital of the region. It was apparent that although asymptomatic to date, there was a malign tumor behind his nose that would not have been discovered had the healing process after being hit by the football not taken so long. When asked, whether he would like to have a chirurgic intervention to remove it and what this would mean, according to the staff, he allegedly declined saying that he doesn't want to be "deformed" (*diform*). In this case, the make-live interventions on the side of the staff and even the broader medical system had been in place, but it was the man directly affected by this who decided to be let-die to avoid what he perceived as becoming a deformed person. He most likely associated "deformity" with the aesthetic ideals and their consequences in terms of "making a difference" that I have explored when discussing state socialist biopolitics.

These changes show that let die has become something more diffuse and less palpable: a homeless man who had grown up at the hospital from where he had gone to Bucharest later returned to Siret to seek housing and a way to make ends meet. There he slept on a bench in the park waiting to be given a home, which he never received. He returned to Bucharest and no one knows anything about him anymore, but some of the residents from the center remember the bus he left with one evening. The consequences of the absence of a make live intervention in his biography are intuitive for a man without means who was desperate enough to return five hundred kilometers to the place of his childhood to sleep on a bench.

The new biopolitical regime within Siret was reverted sometimes during the 2000s to a life enhancing regime from a biopolitical regime of letting die, yet this life-enhancing biopolitics was limited in scope, it did not incorporate people as the man from Bucharest or the woman suffering from the nameless illness - the real names of both I quite tellingly also never came to learn and that is why I have refrained from assigning them a name. Yet, it became more generalized: most people were no longer nameless victims in Siret, the dead became objects of collective mourning and uttering of their names and pictures contributed to their memorialization and the valorization of their lives.

The comeback of the state as biopolitical intervention

When humanitarian NGOs started pulling out of Siret gradually and the protected employment strategy proved to be nonfunctional, the solution of administratively reinstitutionalizing some of the previsouly deinstitutionalized people emerged. In some instances, this was done individually, people who had once been deinstitutionalized returned to the psychiatric hospital, while in other cases an entire service would be taken over by the state. In the most prominent case, protected housing established by a foundation was transformed into a center for recovery and rehabilitation under the guise of the Ministry of Labor and Social Protection- the “New Beginnings” Center . Initially, the initiative of offering protected housing was supposed to be funded as such by the state, but protected housing as defined by the standards for the funding of such services by the Ministry of Labor is much more limited than what the foundation with transnational funding was able to secure.

After an initial trial of running the center as state funded protected housing, the decision was made to run the center as a center for recovery and rehabilitation (initially neuropsychiatric, later on for people with handicap). This meant that the rules were stricter and a higher degree of dependency of the people living in the center needed to be proven and performed. It was this logic that secured decent funding but invalidated the life plans of those residents who during the high time of humanitarianism had come to aspire to establish their nuclear families and lead a sustainable life through working in protected employment.

These two features came to affect those who did not end up in the state infrastructure in similar ways as well: that the time for marriage had passed had been told to me by various people, in different positionalities albeit with different interpretations. As the man quoted above mentioned “the time (of marriage) was gone” by the time of my fieldwork. This meant that those, who had such aspirations would be reprimanded interestingly in both some foundation run services, as well as in most state run ones. Similarly, those who has aspirations of getting a job and leaving the system would also told off by staff[330]. The promises of independent living were referred to by a new, state employed member of the staff, as “lies”, since the disabled were incapable of keeping a job or getting married. While other even more progressive professionals considered that it had been irresponsible to entrust some of the previously institutionalized people with raising their children. This was connected to a mistake one mother had made of cutting off the base of the nail together with the necessary excess, while trimming the nails of one of her children. No alternative programs were referenced when discussing what could be done to support the mother in raising her children.

This telling off of previous aspirations was connected to threats of deinstitutionalization. Since the threat of sudden deinstitutionalization made it more and more apparent for the staff that they needed to justify why the institutional services they offered were extremely necessary. Thus, staff re-fashioned an ableist modality of sense making, stressing that residents are “persons with handicap” and sometimes even unrecoverable that were in need of their care. Thus, they expressed their insecurity related to being unable to sustain their livelihoods without emigrating if the services would be completely closed by solidifying the able-disabled

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[330] I will return to exploring these struggles in Chapter 9.

binary. Disableism appeared as a solid defense against the plans for sudden deinstitutionalization announced by the now former Minister of Labor during my fieldwork[331].

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Below I have tried to group the different biopolitical interventions into a table that maps the shifts in biopolitical interventions, in relation to important events in the history of the hospital. I have tried to analytically separate here, what appeared as entangled and interrelated biopolitical interventions and processes of subjectivation.

I have chosen to focus on the time since the establishment of the hospital until present day or more precisely the time of my fieldwork (2015). I have divided this time period into the four previously explored phases, roughly corresponding to the broad phases of biopolitical intervention: the establishment of the hospital, the aftermath of pronatalist policies, humanitarianism and the comeback of the state after EU accession. The vertical column lists details about the nature of the biopolitical intervention that are shifting.

As the axis of normality in relation to which biopolitical interventions were carried out, the normalizing power produces at the same deviant subjects whose lives should be disciplined or disavowed and deserving subjects whose lives should be fostered from the population of "disabled" subjects that populated the hospital and its afterlife. In parallel to this, I track the changes in carer positionalities and forms of subjectivation, as well as identify the main agents of biopolitical intervention at each of these times. After this, I go into two forms of biopolitical intervention: one is sexuality and reproduction, the other is the fostering of life, as well as look into the forms of disciplining that work together with these biopolitical interventions.

The table is a skeleton structure that I found helpful as an analytic tool, as a site of grouping and organizing my ethnographic and other forms of material. Three points about the misgivings of using this table: on the

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[331] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 26.02.2017

one hand, it suggests that biopolitical interventions in Siret and their forms of subjectivation can be neatly grouped in form of a temporal progression. Clear tendencies can be identified in the way in which previous forms of subjectivation and their corresponding biopolitical regimes came to shift over time. Nevertheless, the complexities and contradictions involved in these processes are difficult to represent in form of a table. Concretely it means that such terms as "unrecoverable" although no longer justified by scientific discourses continue to haunt the imaginaries and processes of subjectivation, as well as the political infrastructure, especially once the state has become more powerful. Previous abstract biopolitical intervention categories have moved into the realm of a politics of life. In the same vein, the family centric ideals of the high-time of humanitarianism continue to haunt the desires of some of the people who once were made its subjects and are now trying to claim these processes of subjectivation and their ideals. Yet, in order to trace the anachronisms at play in the biopolitical interventions and processes of subjectivation here, it is useful to first map the progression according to the high times of specific forms of biopolitical intervention as abstract political process.

A second misgiving is that the table form homogenizes the consistency of practices within each of these high times and leaves little room to map out the contradictions of each time, as well as gives the impression of ruptures between one high time and the other - a point which is connected to the first point. As will become in the second part of this paper, biopolitical orders were resisted or enacted differently in practice.

A third misgiving is that it homogenizes the sources I used to track these shifts in biopolitical interventions: which are different for each of the times: for the comeback of the state, I used ethnographic data. For the high time of humanitarianism, I used interviews with both humanitarian volunteers and those who had grown up or worked at the hospital: yet interviews have one major misgiving, they only allow for the voices of those who can speak in a relatively coherent manner to my inquiries to be heard. Those severely disabled whose communication patterns did not match my own remain voiceless or spoken for and about by others. The same for the period preceding 1990s, though here the memories are dimmer and filtered through the scandalizing dynamics of the 1990s transnational media campaigns. I have tried to integrate visual material, as well as other information available about the hospital - like the memoirs of the previous head of the hospital published in 2012 (Popescu, 2012).

And yet, the table allows for a mapping of the main dynamics and their constitutive relationship.

Table 1: biopolitical orders from early state socialism to 2015

	Early state socialism	Aftermath of pronatalism	Humanitarianism	Comeback of the state
Events	1956- founding of the NPI with a few beds	1966- Decree 770/ 1966 prohibits abortion 1968- hospital reaches 1200 beds 1970- law encouraging institutionalization of poor and deficient children 1981- big psychiatric conference in Siret, hospital's 25th anniversary, film representing the hospital's recovery activity is filmed 1980s- decreasing of the hospital size	12. 1990- BBC films hospital, showing its terrible living conditions and English volunteers improving them; many foundations take the film as their starting point for humanitarian aid actions 1990s- hospital decreases in size, children with HIV and other illnesses are sent to other hospitals throughout the country Foundations build protected housing for those selected for integration into society 2001- closing of the NPI (children hospital), children are taken to residential institutions in the country of residence, pre-accession negotiations	2003- opening of an adult psychiatric hospital that caters for those of adult age 2007- EU accession; humanitarian aid becomes more difficult to justify and carry out 2008- last houses built by a humanitarian foundation
Siret	Hospital part of a plan to support disabled children and separate them from the families to relieve care burden and the burden on production	Hospital as a final place for abandoning growing numbers of "unrecoverable" children Place for politically undesirable professionals	"Romanian orphanage"	Previous "orphanage of horrors"; heroic figures of change

	Early state socialism	Aftermath of pronatalism	Humanitarianism	Comeback of the state
Normalizing Power	Productivism in a planned economy as escape from dependence on the alms of the propertied	Productivism in a planned economy as a privilege of those considered recoverable	Productivism in a free market economy, yet, with employment tailored for the "disabled"; no more specialized production oriented training, but the proper husband/ wife that can care for self and others Nuclear Families Religious Beliefs	Non-productivism in order to maintain the lucrative ability - disability binary; exclusion of sexual and reproductive rights and of family life Eugenics Incapacity Security
Agent of BP intervention	State		Transnational NGOs and state	State and transnational NGOs
Deserving subjects	Recoverable for production		Suffering, anonymous children	Eternal children and young people
Disabled Subjects	Potentially unproductive= Deficient /Disabled = Ill		Potentially independent young people willing to found a family Abandoned = "given to the state"	People with a "handicap certificate"
Deviant subject	Un-recoverable	Un-recoverable category grows	Homosexual subject Demanding subject	Heteronormative employed subject Homosexual subject Demanding subject
Carer subjects	Hospital is established to offer work to the people in Siret. Medical staff is de-professionalized (head = radiologist).		Volunteers versus hospital staff Some of the "children" graduate to becoming carers by getting married.	Volunteers versus hospital staff divide is carried into newly established state infrastructure.

	Early state socialism	Aftermath of pronatalism	Humanitarianism	Comeback of the state
Sexuality and Reproduction	Reproduction deferred to the world outside after leaving the hospital Cases of rape Alleged homosexual relations among inmate children and later adults		Reproduction within heterosexual nuclear families encouraged for deserving subjects Arranged marriages Homosexual relations discouraged	Sexual relations discouraged Family formation and thus reproduction discouraged on the basis of alleged generalized homosexuality of previous inmate children
Fostering	Hospitalization: medical solution to the enhancing of productivity through fostering the lives of those deemed recoverable. Disavowing of the lives of those deemed unrecoverable. Three course meals versus food from the bucket		Individualized education for protected employment and family life for those chosen for "independent" nuclear family life.	Maintaining a high standard of living without employment and family life.
Disciplining	Biochemical disciplining Disciplining through confinement Disciplining through co-opting older children as para-carers and agents of surveillance		Through life projects Through potential exclusion and re-institutionalization in other asylums	Through confinement Psychiatrization of critique
Locus	Hospital, school within the hospital premises, workshops as part of the school, but also catering for the needs of the hospital		Home-like environments for the chosen few (schools disappear) Hospitals for the others Occupational therapy	
			Protected employment in a farm	Etatization and clinicization of homes

Conclusion

The relationship between biopolitics as abstract calculation and a politics of life, as different understandings of deservingness of the subject play out in everyday life relate to each other through a form of anachronism: abstract calculations based on the divide recoverable/ unrecoverable productive/ unproductive were carried into the humanitarian biopolitical actions, albeit the nature of the intervention was different. In a similar way, the fostered subject of humanitarianism with its nuclear family and employment possibilities became a dominant frame for claiming one’s rights in the state infrastructure that gradually came to take the place of the humanitarian one. The abstract calculations once outside of infrastructural translations would not cease to exist but would be remolded into the infrastructures, reshaping the biopolitical ambitions within them.

Although “making a difference” remained a common practice throughout the decades following the establishment of the hospital in 1956, it served different biopolitical purposes and produced different forms of subjectivation - yet, interestingly it also produced an unexpected way of being a subject: a subject critical to the practices of social hierarchizing implicit in biopolitical intervention in this context. This is best illustrated by Alina’s rejection of the practice of hierarchizing per se.

Chapter 9: Reproducing and challenging eternal childhood

Introduction

In this chapter, I look at the way in which being a "child" operated to discredit alternative life plans of people, who had grown up at the hospital during the time of my fieldwork in 2015. I look at the way in which, people disciplined and governed into not wanting more than a comfortable institutionalized life worked to challenge these assumptions and make claims on social and economic incorporation into society. The substance of these claims was often tied to the subjectifying dynamics of the humanitarian aid time, while other projects although lived out in everyday life would not mature as political plans. This chapter allows to set the grounds for chapter 10, where I look at how policy can work with and not against the complexities of everyday life in institutionalized settings.

Being a child and being with the children

As decribed in the introductory section to part 3, "disabled" or "handicapped" as stigmatizing attributed were replaced during the time of transnational humanitarian aid with the less ableist formulations children and young people. Yet, the replacement occurred one-to-one, as the "handicapped" became "children", ableism became infantilization. It is in this way that children remain "children", since growing up is reserved for those considered able. This infantilization translates into many other practices still around in 2015, such as forty-year-old people asking for permission from the staff to leave the premises of the hospital or the group, whenever one would want to leave for a few hours or even minutes.

Being *cuminte* was a category they needed to abide by in their everyday life. This was mainly true for those who were in some way or another part of the state infrastructure, those who would also be referred to as "children" or "young people". Being *cuminte* was what the staff asked of the infantilized adults, they were caring for. As explored in chapter 4, the consequences for not being *cuminte* could reach as far as being transferred to a more confining and asylary state institution that could be as far as two driving hours away from Siret.

How did being *cuminte* become so relevant to the everyday disciplining of people who had become adults in the meantime? It was clear that they were not children or young people, like the ones that were part of the staff's families. Often when the manager of the psychiatric hospital spoke about doing something with the children, I often needed to ask whether he means his own small children or those from the hospital. A point that interestingly depending on the context always appeared self-obvious to him.

But, it was not only the staff and people in town that referred to grown-up residents of state institutions as children. When me or someone close to me was being shown around by Nicu, a forty-year-old considerably chubby man who lived at one of the state facilities, he would often tell us that "copiii sunt chinuiți", the children are tormented or mistreated, while introducing a room of relaxed people peacefully watching TV in one of the nice British built houses. The language of suffering children developed in the high-time of humanitarianism (see chapter 3), came to infuse everyday practices of recognition 25 years after the first documentaries were shot. It was clear that Nicu's intention was to induce pity and compassion and thus later build on this sympathy to make claims.

Other times he would also refer to past employment conditions, as well as to aspirations in these terms: "I want a profession for these children". For Nicu making claims about both abstract and material things – including asking me or others to bring gifts that went far beyond our material capacities (winter jackets- of which once Nicu and I figured out that he owns a far larger number than I do; or tape recorders etc.) - or making demands related to working conditions and future possibilities, to be successful needed to take up the language of suffering tormented children. It was the language that had brought change to Siret and to his life, since it was the language that brought the English volunteers and all their material and financial infrastructure that came to shape his life and the life of his friends. Or thinking with Foucault: both the conduct of the infantilization of the former children inmates and the counter-conduct took up the language of suffering children (compare Foucault, 2000).

But being an eternal child was not only limited to infantilizing and policing people, nor to making claims, it is also a basis for some of the services offered in day care facilities. One foundation was built around offering education for life and in fact repeated primary schooling with those that could keep up with it, one of the main rooms even being organized as a class room with a black board where the teacher would stand. Another foundation was criticized by staff from other institutions for only offering to play "don't get mad"[332], a children's board game, as a pastime for the adult people coming to spend their days at their day care center.

I as a volunteer also came to reproduce these infantilizing dynamics: many of the residents were not allowed to leave the premises of the institution on their own for some people were unlikely to find their way back home. But their incapacity to orient themselves, served as a way of keeping many others from wandering the streets of town as they pleased and occasionally doing something that could in town pass as deviant (such as masturbating in public). Nevertheless, as a volunteer I was expected by the residents and sometimes also by the staff to take the residents out to town and occasionally offer soft drinks or candy - a practice that was associated with foreign volunteers. I often took people on a visit to my place, and offered them soft drinks and chocolate there. I noticed that the first time, I took a group of people over to my place, I would keep on counting how many we were and whether we had lost someone, constantly looking around, reproducing a securitizing discourse and practice of care that I thought I strongly rejected.

Things did not stop here: on another occasion, while descending my bike, which I rode to a ward of the psychiatric hospital that used to be an English built half-way house pertaining to a foundation, and was located farther away from the town's center, one of the women residents asked me whether I would teach her how to ride the bike. I said, of course, and before I knew it our group became very large, leading to me

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[332] "Nu te supăra frate", a children's board game that can be played from a very early age onwards.

coordinating teams of people to support each person that wanted to learn how to ride the bike. On the first day, surprised by the fun we were all having, one of the residents said: “we have a *pisălog*, he should teach us how to ride the bike” [333]. This clinicization of a fun activity[334], which is generally associated with a children’s pass time, was very instructive in showing how the state socialist medicalization of childhood that opened the previous chapter was carried through into the eternal childhood of the time post-humanitarian intervention.

Maybe the most interesting point about the category of the “copii” or “copii mici” was that it was that the word children was always and without exception used in plural by both staff and the “copii” themselves, pointing to the fact that being a “copii” or more accurately being part of the “copii” is an emic social category. This category served both to empower previously institutionalized people as a discursive device to substantiate their claims for better employment or gifts, but it also served to keep them in place demanding that they ask permission for most steps that they undertook, both on a small scale but also on a larger scale when it came to important events such as taking on employment or intending to get married.

In a different way, eternal childhood also connects the people of Siret who grew up at the hospital with their biological families in an interesting way: those who are still called *copii* continue to strive to find their biological families, a quest into which I was pulled as well by being handed pieces of paper with names, told to take pictures of the “children” and told of parents who were allegedly from Bucharest. As a person that knew how to read and write - a skill that was not accessible to those who had not been to school or whose minds did not fit the patterns this practice requires – I was drawn into writing letters: such as a letter to the biological parents of a relatively young man of over thirty, obtaining their address and sending the letter. Although he knew of his parents and had spoken to his sister on the phone, he had never met any of them. He wasn’t exceptional in this regard. A continuous quest for the biological family haunted all of those

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[333] *Pisălog* means pestle, but it is phonetically very close to *psiholog* which is psychologist and was used by the residents of the hospital synonymously.

[334] Similarly in other places, such as the Asylum, every activity that involved the asylum’s inmates would be clinicized, playing games for example for termed ludotherapy. As in games therapy.

who had never met their parents and the three young women (Manu, Alina and Andreea, who opened chapter 7) remembered how they had pleaded carers to find their parents, back when they were children at the *cazarmă*. Some of the previous inmates of the hospital, had met their parents and it was indeed a distinction marker to know your family, although many of those who succeeded were disappointed by the encounter. Reaching adulthood and escaping the category of *copii mici*, mostly involved reckoning with one's own family: be it by finding out that they had died and accepting an identity as orphan or by meeting them and then being able to blame their abandonment on someone real.

The category of "copii mici"/small children and more generally the category of people who grew up at the hospital were being constantly separated from the rest of Siret locals by a variety of segregating practices that were not limited to the confinement of some of them to some of the state institutions. Through these practices social abandonment continued to operate despite the absence of an intense let-die regime. Of course, these two categories are quite different from each other: if someone grew up at the hospital, they escaped the category of *copii mici* by finding stable employment, as well as by getting married and living on one's own. Yet, this does not mean that people who were successful in that would escape being subjected and subjecting themselves to practices of segregation. These practices (re-)drew the lines between those considered able and disabled constantly in Siret, therefore, I will address them in the next section of this chapter. But it is not the ability per se that was separating people - hence people in stable employment still became part of this, but the fact that one grew up at the hospital and was one of "those people/ children" that drew this separation.

Dynamic practices of segregation

The hospital in Siret had been so large that most probably the children at the hospital made up around one fifth of Siret's population and many inhabitants of Siret had been employed at the hospital. This led to an interesting composition of Siret in 2015: The parents of the working age people who did not grow up in the hospital, that I had met in Siret had allegedly all worked for the hospital and on many walks through town with the former inmate children, now grownups, I would be told in a whisper: this was our teacher or this was one of the carers and then told whether she had been a good one or whether she had been abusive in one way or the other such as forcing children to take naked baths in cold water in the courtyard as a punishment for misbehaving.

At the time of my fieldwork, this meant that almost everyone of working age in Siret is either the child of someone who worked at the hospital or his or herself grew up at the hospital - leading to dynamic practices of segregation of which the discursive infantilization that opened this chapter is just one form.

During state socialism, the hospital was a closed total institution and children were confined to the overcrowded rooms of thirty people according to age and ability. Rarely, would children be allowed outside to go and play, and then only in the courtyard of the institution. When English and other foreign humanitarian volunteers started coming in the 1990s, these practices were reworked, as volunteers would come and take the children out for a walk, as well as pizza and soft drinks, a practice I came to reproduce with the now adult institutionalized *copii* during my fieldwork. As Alina who was about thirty at the time of my fieldwork remembered, as a child in the 1990s, she used to get bored all day, sitting close to the fence, waiting for the *engleji*[335] to come and take her out to town, this on the event that there were English volunteers in town.

After the subsequent downsizings and later closing of the hospital, as illustrated in chapter 7 most people still lived in state residential institutions, some of which were housed in large buildings with many tens of people sharing a building like those of the psychiatric hospital, whereas others would live in small houses or small apartments (mostly built or bought by NGOs and ceded later to the state) in very good living

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[335] *Engleji*- is a locally differently pronounced word for the literary Romanian *englezi* which I use since it reflects the way the English [volunteers] are referred to in Siret; in some contexts in Siret especially when used by people who have a less disciplined command of language, engleji is used synonymous with foreigners, Nicu once telling me that a “un englez neamț” had bought the farm where he used to work.

conditions and having their own room. In these places, only people who had grown up at the hospital and a very small number of people who entered the system later after having been to boarding schools for special education - another form of total institutions - were living among themselves, aided and surveilled by a number of people coming there daily as staff.

Living in a state residential institution did not mean being confined to its premises in Siret. In this respect, Siret was truly exceptional when compared to all other residential institutions that I have visited in Romania where mostly people are confined to the premises they inhabit. More so, since Siret offered the small urban pleasures of pizza places, cafés and market bars that occasionally were also used by some of the institutionalized people, as well as regularly used by those who grew up at the hospital and were working in steady employment.

Confinement far from being a uniform practice in the state institutions in Siret was a matter of degree: some institutionalized people could move freely through town and I would regularly meet Nicu in front of the mayoralty on a bench talking to people. This mobility was nevertheless restricted to those considered more able and was denied to those that had bad eyesight or were confused as to where they were or needed to use mobility devices such as wheelchairs. Yet, even they could leave if someone - an able minded or bodied resident, a volunteer or a staff member would take them out to town. I too participated in taking people for walks many times.

Mobility in town was tied to obtaining permission from one of the carers on duty, further underlining infantilizing dynamics while overcoming the confining ones. For example, one day, I had an appointment with Georgel and Adelina to go into town, as I arrived to the ward, I only met Georgel, who was visibly excited since he very rarely had the chance to go to town. I inquired about Adelina to find out that she was out working in Siret, since it was sweeping day. We left and ran into Adelina as we reached town. She had just finished sweeping the staircases due that day and wanted to join us and explicitly asked whether I had told the nurse that she would be joining us as well. I had not. “You should have told her”, she said. I insisted she join and help us find our way, since Georgel wanted to buy a radio and I didn't know where I could get it from. She joined us, but mumbled something about me having dealt with this the wrong way. Adelina was recognized as the inmate boss by everyone at the ward, where she lived. Despite her special positionality, the infantilizing dynamics also operated through her pushing confinement upon her own self, even when she was not on the actual premises of the hospital. I am unaware whether she was punished for breaking the rules on that occasion, but on subsequent meetings she never mentioned it, despite being an outspoken person. So I assume she was not punished or not severely so, since she could claim she had not been alone.

Confinement was a dominant feature of the relationship between residents and the staff in state institutions. Although it was sometimes legitimately done from the concern that something bad would happen to the person because of their lack of ability of finding their way back and was understood as such by the person confined, in other cases this securitizing discourse that operated towards confinement was enabled by very different instances - most notably the stigmatization of the residents.

While having one of the long conversations in the staff office at one of the state institutions, a dispute was sparked by what one of the staff members perceived of as my desire to advocate the residents coming and going whenever they pleased. This was impossible from the perspective of the staff, although efforts were made to accommodate the desire to move freely with a desire for security. I was given a very telling example, why this was necessary by the head of the center: "If one of these people is run over by a car on the pedestrian crossing and it's his word against the driver's, the driver can say 'he jumped in front of the car' and everyone will believe him. That's why there needs to be *un personal* [literarily: a staff] there, the staff - he will be believed."

Interestingly, here too "un personal" is grammatically wrong Romanian, despite the head's very cultivated usual use of language pointing to another emic social category that of the staff. The staff needs to be there on the spot, if something bad happens to testify to the innocence of the victim - because an institutionalized person, who grew up at a children's psychiatry could not be expected to be believed by anyone. The fear of something bad happening was often tied to its consequences for staff: it was imperative to establish that in the fictive example the institutionalized person was not at fault, had they been at fault - I was told many times - the heads of the staff would be rolling in no time: "First they fire you, then they ask questions" I was told over and over again by state employed staff when engaging in conversations about confining practices.

The head of the "New Beginnings" center was often told off for her perceived too libertine ways in which she allowed confinement to operate in the center in Siret by her superiors in the state bureaucracy, who said she was very brave to let them – the residents of the center - go into town. She was also told by the older lady psychiatrist of the psychiatry hospital, incidentally also the daughter of the former head of children's hospital that "yours are a bit [too] free" - referring to the fact that the psychiatrist kept seeing them walking freely in town. Summing up, where staff decided on more progressive politics regarding confinement, staff too would come to be sanctioned by other authoritative figures within the system, who would normalize and enforce a confinement oriented discourse.

But segregation was not limited to confinement: segregation practices operated both within the confines of relatively closed buildings[336]; as well as operated in the everyday life and through the actions of all people, who had grown up at the hospital, as well as others living in town.

The mildest of this segregation practices operated through shame: one day when I was returning from one of the farther away wards of the psychiatric hospital, I ran into Alina and a group of people, who I knew had similarly to her grown up at the hospital, now lived on their own and worked in the wood industry as regular employees. I crossed the street to say hello to Alina. The group soon after broke off in different directions and I remained with Alina and one of her neighbors, both lived quite close to where I did and it

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[336] Both state institutions – the center and the psychiatric hospital- had multiple buildings of which some were especially destined for those that needed to be kept in place and where mostly at a larger distance from downtown

was still a fifteen- twenty minutes' walk from where we were. I was surprised to see Alina deciding that she wants to cross the street, despite living in the opposite direction invoking that she wanted to pick nuts from the tree in front of an American volunteer's house. I joined them in this sudden change of direction and we found that there are no nuts ripe for picking and shared the nuts I had in my pockets as we walked home. Once the initial awkwardness was gone, Alina said: "I am surprised you are not ashamed to walk with us". And her friend, added: "you must be a foreigner". Alina, who had previously opened-up to me about her past so freely during the conversation about the hospital, I quoted in the previous chapter, wanted to spare me the embarrassment of being seen with her in town. It is this internalization of shaming that people, who had grown up at the hospital despite their independence, as well as present participation in the working world that makes previous child inmates become socially adults, who police their own segregation and through this become active in bringing about their own social abandonment through avoiding new relations.

I also experienced a similar situation (described in chapter 1), when residents of the psychiatric hospital were surprised that I did not mind eating with them and having the same bread as them. In this example, they had again tried to spare me the embarrassment of having to ask for different bread on the account that I wouldn't want to eat the same one as them and try to enforce segregation to make me feel comfortable. This might sound shocking, if one is not familiar with other stories from the house next door, where a man who came to volunteer there would feel sick when eating with the residents at the table and would therefore refrain from eating with them and then go to the diner in town to eat, once he had left the house that pertained to the psychiatric hospital.

Eating was not the only spatial segregated practice within state institutions, but it was the most emblematic of all. Generally, interactions between lower level staff and the less able residents were kept to a virtual minimum of food intake and personal hygiene, but there were also cases of true closeness as I mentioned earlier. The segregation was most expressive where people were least able, for example in the way in which summer afternoons went by in the farther away ward of the psychiatric hospital, where mostly people with severe disabilities were living. After lunch during summer, all the about sixty residents of the building would be brought on an exterior terrace sealed off from the garden. On the margins of the terrace there were old mattresses and the residents would be put to sit down on these mattresses and would spend the remaining six hours until dinner rocking themselves. The carers, generally, about four women and a man would seat at the extremity of the terrace closest to the door, on much higher chairs – separated from those who sat on the mattresses by an invisible line. This line was only crossed by those residents that had ties to the staff, for example by a man, who was good at knitting and would also help with other activities, and who whenever the carers would look away would pride himself of his proximity to the care taker women by saying “we are like this” and putting his fingers together in a gesture that I took to mean tight closeness.

As I hope is apparent from the above confinement was not limited to the physical confinement of people to buildings (as is the case in many other closed institutions), Never Neverland was diverse in terms of practices of segregation and the main actors participating in them. Generally, these practices were operating to separate the former inmates of the children’s hospital from the rest of the people living in Siret, but there were also other more complex relationships of governing between the staff of both state and foundation run facilities and those, who grew up at the hospital operating paradoxically through practices of inclusion.

Eternal Childhood Challenged

I previously described how the EU accession had brought the state back in as a provider of social services for many of those, who had previously been deinstitutionalized, partly leading to their administrative re-institutionalization. The influence of humanitarian foundations and their emphasis on marriage plans faded away with the scaling down of funding, prompting one of my interview partners to conclude “now the time [of/ for marriage] is gone”. The emphasis on employment, a family and an individual family home was replaced by a modality of sense making that re-instated a different disabled subject, which was no longer concerned with marriage and reproduction, but if being a docile object of care.

If marriage had been to-date promoted among the former institutionalized people, it then came to be combatted actively by even the most progressive of professionals, yet it kept haunting the desires and imaginaries of some of the institutionalized and foundation based people. Wanting to get married and have children, as well as getting into paid employment became a ground for contestation in the post-humanitarian state dominated service landscape that emerged in Siret starting with the late 2000s. The term unrecoverable must have regained popularity in Siret with the comeback of the state, since the state infrastructure had remained its spatial home even as in the 1990s and early 2000s the state infrastructure was shrinking and the humanitarian based one was extending. Unrecoverability was in practical terms re-connected to the old tropes of state socialism, but with a neoliberal flavor: now, it was no longer that those unrecoverable could not be integrated into the standardized guaranteed and mandatory waged labor of state socialism, but rather that their deficiencies would make them unemployable in market terms[337]. If humanitarian aid created the basis for the emergence of a space of eternal childhood, which I then called Never Neverland, it also laid the grounds for a form of challenging the position of the eternal child.

Maybe the most illustrative of such stories is the story of Marian, a man in his late twenties/ early thirties. He was deinstitutionalized during the high time of English humanitarianism by the largest foundation in Siret but once most of the services of the foundation were handed over to the state to secure funding, he was also given back to the state. His aspirations remained in line with the conservative productivist subject of humanitarianism: he wanted to find stable employment, receive social housing from the mayor's office and get married. Yet, these were smaller points, his struggle was escaping the condition of an institutionalized person. When I asked him why he wants to leave this comfortable life, he said: "I know that by staying here, I will never accomplish anything. Why be a burden and torment[338] you and the carers for the rest of my life?"

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[337] Compare Mladenov 2015 on productivism as a link in disability policies between state socialism and transition neoliberalism

[338] "de ce să vă chinui"

His struggles would award a chapter in themselves, since he had left the state infrastructure at least twice, once by being taken out by the foundation, the second time to work in protected employment at another foundation in a faraway city, from which he returned after a month for reasons that were framed by the staff as his inability to cook for himself and to handle money. Occasionally, he would inquire about social housing and was promised a flat that did not materialize to my best knowledge until the time of my writing [November 2016]. Similarly, he would try to get hired, the head of the center would always send a carer to accompany him to job interviews, which probably reduced his chances of getting a job as he probably appeared as someone in constant need of surveillance. In September 2016, Marian got a job, which he was only able to keep for a few days - to me he explained his health was the reason why he couldn't put up with the longer than 12 hours shifts in the wood industry - which everyone who worked there agreed were very though. He let me know about this episode through facebook, as he complained about being reprimanded by the staff because of his incapacity to keep a job and feeling like a complete failure, knowing this meant that he would not receive social housing and would remain in the center. Yet, he had also recently resumed high-school, so it was this path and some computer courses that he planned as another exit route.

What was interesting about Marian's story is that he got reprimanded for trying to get a job from within the state system many times, even more so, his incapacity to keep a job was often connected in the narrations of the staff to the fact that he claimed his workers' rights. In the words of a staff member: "He knows how to use the internet very well, he tries to get hired, but he never makes it through the trial period. He starts with his rights, how long is the working day, how are extra hours dealt with and then goes into some onomatopoeia." Voicing his claims to decent working hours and pay thus was discredited as unintelligible speech (onomatopoeia), underlining the futility of the entire endeavor.

His demanding attitude, so the same staff member, is also the reason why the foundation did not take him when the more able to support themselves were given flats and the others were given to the state. They rather chose someone else, who was more quiet, so the same state staff member. Interestingly, in accounts of why Marian could not escape the system from the side of the staff, his willingness to claim rights was also intertwined with his other disabilities, like “being schizophrenic” pointing to a normalized understanding among staff that to claim your rights is a form of deviance in a neoliberal labor regime with so much surplus labor as that of Siret[339].

There were others, who also struggled with the centripetal forces that came to bound people to residential institutions and their securitizing regime during the time of the comeback of the state: Adina was one of the women, who lived at the psychiatric hospital and was in her mid/late thirties. Once, as I was spending time in a workshop kitchen in the occupational therapy part of the hospital, she came in, while I was in the room with a carer lady. Adina said: “It’s not good here, I want to get married, I raised all four children of a lady from town. I don’t want to live in the hospital anymore. I want kids and my home.” Immediately after saying this, which was clearly intended at me, she exited the room. The carer commented: “See what happens when life’s too good? She has everything and look at what she wants.” My comment about her biological clock ticking was countered economically: “Where and from what would she raise children? You need a home, meals. It’s hard even for us… let alone them. Life is too good on her, that’s why she is saying this”.

Life within residential institutions, irrespective of the gender of the person or the nature of the institution (psychiatric hospital or center for recovery and rehabilitation) ensured a decent livelihood that could only be aspired to by most of the people, who staffed these institutions as lower level staff. Yet, the tradeoff meant that the person would also give up life plans that diverged from spending time in the institution, waiting to be cared for and eventually die. Official marriage relations and having children were anathema

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[339] Interestingly, staff would also ty to claim their rights in terms of holiday days and replacements, as well as salary increases and would be disappointed that their employer, the state did not grant them even their legally secured rights. For example the project for establishing an industrial park in Siret advertises its geographic advantage by saying that the county of Suceava (of which Siret is part of) has twice less jobs per capita than Cluj or Timișoara (the wealthier counties) and a brut medium income which is two thirds of the same in Cluj or Timișoara. see http://industrialparksiret.ro/15-argumente/ accessed on 03.04.2018

in the residential system, as where homosexual relationship throughout the county and I can comfortably assume that this is the case throughout the country as well.

The lack of guaranteed livelihood outside of residential institutions led to a hostile attitude to different life projects, which rejected the paradigm of sitting around in decent conditions awaiting life's end. Challenging eternal childhood was done within frameworks that were established during the high time of humanitarian intervention and who lost their popularity with the comeback of the state. The counter-conduct to the state discourse on actively preventing disabled people's reproductive rights[340], was organized around the humanitarian discourses designated conservative subject position.

Nicu's love story is very illustrative of the shift that occurred in Never Neverland from a patriarchal promotion of marriage by the staff and volunteers to a contrary patriarchal move on behalf of state employed staff to actively prevent marriage.

A couple of years before I came to Siret, but already after the state was back in, Nicu had apparently fallen in love with a woman living in social housing. He was still working at the farm (in protected employment), which also guaranteed him a form of income. The staff was concerned that the woman was after his money, which was probably in the best-case scenario less than 100 euro (around 400 RON) a month and some savings in the bank. Nicu was actively prevented to marry her and because of that he would often sit on the porch and write for hours, saying he will complain. He always wrote when he was upset - a practice that I myself witnessed more than once during my time in Never Neverland. But Nicu was not literate, meaning that his writing did not take the form of intelligible letters and words. After spending several weeks writing and becoming more and more aggressive, so the staff, they solved the conflict by sending him to the

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[340] A human rights report based on interviews with institutionalized women found that the setting of residential institutions is extremely prone to the violation of the rights to private life (going up to administering of contraceptives without the consent of the woman), as well as to family life (by children being sent into foster care, if they were born in an institution), see Gîrlescu, Oana; Obreja, Monica and Tănăsan, Gabriela (2014) *Drepturile Noastre: Drepturile sexuale și reproductve ale femeilor cu dizabilități intelelectuale și psihosociale, available* at http://www.drepturisexuale.ro/wp-content/uploads/2014/05/OUR-RIGHTS_raport-1.pdf accessed on 1.12.2016

psychiatric short term hospital “to the old people” (la bătrâni), as it was termed among the “children”, since people of all ages coming for short commitments due mostly to severe psychiatric illness would stay there for up to six weeks. His lover upon hearing that he had been committed there despite probably knowing where he had grown up, broke up with him, saying that she doesn’t want to have anything to do with crazy people.

This story was never told to me by Nicu, but by a staff member of the center, where he lived, to stress that them getting married is impossible and therefore the foundation had lied to the “children” when promising they will get married and have children. Now Nicu was both unemployed and alone and his aspirations were focused on becoming a police man – that’s why he would wear a policeman shirt every time important visitors would come and direct the cars passing in front of the house when someone would try to turn or park on the narrow street.

Narrations of deinstitutionalized people’s lack of socially acclaimed success in marriage were also brought as arguments to support the general incapacity of those growing up at the hospital to lead successful family lives. The childlessness of a couple living in foundation housing was brought as evidence that they (people, who grew up at the hospital generally) do not know what to do as married people, stressing again that they are “like children” because they sleep with teddy bears in their common bed. When I asked the couple, how come they did not have children, they answered that he has some liver related health problems that they would like to first put on track before having kids. Whereas, some of the former children of the hospital were struggling to have the right to aspire to have children, others needed to publicly justify their childlessness. A process that my inquiry apparently was also becoming part of.

Lack of heterosexual reproductive drives was also often brought in as a reason why people who grew up at the hospital should not get married. The fact that those who had grown up at the hospital were either made homosexual there or were homosexual now at the time of my fieldwork was brought as a reason why generally people who grew up at the hospital should not be encouraged into marriage. There was no opening of a space of potential difference between the sexual and gender identities of people, who had grown up at the hospital, in the minds of the staff both foundation and state. Nor did there appear to be a possibility to escape both heteronormativity and institutionalization. Homosexuality or queerness never became a ground for making claims, since it fell outside of the powerful discourses promoted by either the state or mostly conservative humanitarian NGOs. Among staff, practices of homosexual sex between men, generally ran under the label of "abuse" of the more vulnerable by the stronger and more able bodied and strategies to prevent this from happening by keeping an upper hand over those, who were likely to be abusers, but there were also professionals that would discuss the occurrences in the men's bathroom on one of the wards in terms of, if it is consensual, it is not a problem. Yet, it was also not a life plan. Similarly, women's sexual desire for other women would sometimes be dealt with circumstantially and if it were to amount to something, it was the invalidation of the humanitarian driven story of marrying off the former inmates.

These anecdotes could give the impression that people in Siret, who had grown up at the hospital, were either working in full employment or were unable to sustain this. Yet, the political economy of Siret was far more complex allowing for a large sector of informal employment to emerge especially for those, who were still living in residential institutions.

Working in Never Neverland: the intricacies of Never Neverland's political economy or the prosperous proletariat of the children and their precarious work

"When we were small, we used to look for chewing gum underneath tables and chairs, where people would stick it after chewing it or in the garbage and then chew it, because we couldn't afford it. And then I wanted this so badly, I said God please give me work that I will have with what to buy things and no longer need to go through the trash looking for chewing gum." Alina remembered this about her childhood at the hospital, a point that she talked about in relation to the fact that now she was very happy to have a job in the wood industry, where she would work the long twelve hour shifts without complaining. The fact that she had a stable job, allowed her to rent an apartment with the aid of an evangelical network, since former inmates of the hospital were not easily trustable with property, even when they had the means to afford renting it.

Those that had jobs and held them were generally not institutionalized – also because the state would retain 80% of a person's income for the board in a residential institution making paid contractual employment nonsensical - since the person would only be left with pocket money at the end of the month and would receive the same house and board, he or she would anyway receive without paying. But there were ways in which, institutionalized people engaged in labor activities.

The most common of them was for institutionalized women to sweep the staircases of the apartment buildings or clean the flats of working class people in town including those of caretakers from the state institutions. For this they received (regular) informal pay, which would allow those, who lived at the hospital and worked like this to buy hair color, soft drinks and other such things. Daily laboring was common for men especially in the agricultural sector, whereas regular domestic labor was common for women.

There was also an elite of these licit, yet unregularized activities, like Manea who could earn up to 80 RON (almost 20 euro) for a day's work on the condition that he bring his own tools. Manea's elite status was recognized also by the fact that on the grounds of the psychiatric ward, where he lived, he also had an entire workshop, which was entrusted to him, where he kept tools of the most sophisticated kind: from tools, necessary to fix the electric system to those necessary to chop wood. His workshop was looted once, after which moment he returned to making much less money every day. He generally reinvested all the money in new tools, which increased his income, since he didn't need to pay for neither board nor housing at the hospital.

At the opposite end were people like Dan, who was a strong, twenty-year-old man, who had just moved to the psychiatric hospital from a boarding school for special education. Once during one of the days at the foundation that offered the school like activities, I sat next to him and he asked me to practice money play-cards with him. It was obvious to me that he could easily be fooled, since he could tell how to use a fixed amount of money to buy something, but he never understood how much change he was entitled to. As the activity went on, I asked about whether he earns money and he said, yes people pay well for hoeing and weeding [prășit], even 10 lei - a bit over two euros. To demonstrate his success, he took his wallet and demonstratively showed its content - a huge stack of green one leu bills - the equivalent of 20 eurocents each. He then went on to say, he is keeping this for when he will go away, making a gesture with his hand that meant that he will keep going far-faraway. Dan's dreams of running away related to saving money, but since he apparently didn't know the value of the money, he was saving, he was often made work for far less than he believed he was working for and his strongly built body must have satisfied many a person looking to exploit proficiently cheap labor.

"From the green ones"[341] was an expression often used to denote the precarity of the payment one had received by describing the color of the smallest Romanian Leu bill (1Ron more or less 20 eurocents). Institutionalized people would often use the color of the bills to discuss the amount of money, since not all were numerically literate, but many could find their way around financially by looking at the colors of the bills.

Once, while having pizza with my partner downtown, we were spontaneously joined by Adelina, who complained about having spent the morning beating carpets and received only three lei for her work - "from the green ones" she stressed in disappointment. I inquired whether, they hadn't talked about the price before doing the work and she said "I thought she was a good girl, but now I will not go to her anymore". Adelina's

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[341] "din'ăia verzi"

financial literacy allowed her to not keep doing low paying chores, and this wasn't the only activity, that I heard her say she had quit because of a misfit between payment and chores.

It is most likely that the woman entrusting the task to her, assumed she would lack financial literacy and would be more easily exploitable than she was. Yet, others were fooled by people looking to pay as little as they could for their work. There were even rumors that one of the foundations that was offering protected employment paid the people working there proportional to their knowledge of money. Despite the validity of this information being very difficult to verify, it speaks to the perceived precarity of those, who were not financially literate on the labor market in Siret. Administratively, this was difficult to be done, since not all work performed by institutionalized people in Siret was considered labor.

Many a time when I would come to the house, where Ștefan lived, I would see him cooking, cleaning or looking after the plants around the house. When I asked, what he was up to he would say, stressing each syllable in an ironic didactic exercise: "I am doing occu-pa-tio-nal the-ra-py". I would laugh with him, saying next time I will sweep my floors, I will call it that as well.

Not all were as friendlily ironic about this activity as Ștefan, and chores around the house were referred to by others as helping staff, since they "the women" (since caretakers were most but not exclusively women) also had chores to do at home: here, chores, there, chores, we need to help them since they also help us - was mostly the way in which this was narrated by residents explaining their activity. Yet, the practices of helping the caretakers take care of the home were not homogenous: some women were not helped at all, since they were considered hot tempered or mean, others did not like to be helped and would close themselves up in the kitchen while cooking and sending everyone away. Men were helped more, especially when they performed duties that were considered feminine like cooking.

Going to work was perceived by staff as good for the residents, in the sense that they had something to do especially when the activity was outside of the hospital or institution. As an occupational therapist put it:

"One of the boys, he helps someone in the morning and sometimes he gets five lei (1 euro) for a soft drink or some cigarettes. He never spends more than fifteen minutes, it's just so he has something to do".

Being productive as a disabled person and its framing as occupational therapy served both to legitimize legally illicit practices such as precarious domestic and agricultural labor in the houses and on the land of working class people from Siret, a practice which could have been prohibited by the heads of institutions because of its legally illicit nature. Yet, occupational therapy gave the higher-level university trained staff a justification to allow these practices to operate as part of the person's institutionalization. The fact that these were precarious, yet, non-taxable incomes also meant that the residents could keep whatever they earned, while keeping their tax-funded board and housing without having to contribute to it.

This led to prosperous existences, way beyond the hopes of Siret working class people: Marian for example owned a PC, a laptop, a tablet, an electric, as well as a classic guitar. Although, he was the most prosperous of the center's residents, others too had phones or even tablets. Similarly, many but not most of the institutionalized people would go on holiday to the seaside or the mountains each year, an event for which many would save money as much as one year in advance. Some of these trips were state funded and organized by the head of the center as summer camps for children, leading many to complain about the small food portions. In other cases, NGOs sponsored these trips, but the residents needed to have a significant amount of money saved up to cover their meals and pocket money while away, while other trips were fully sponsored by humanitarian or evangelical NGOs. Some trips were (almost) fully funded by the residents, but this would happen exceptionally and generally it would be former residents, who had been in stable employment for a long time that could afford them.

Holidays, but also the general prosperity of living conditions made residents the object of the envy of some of the working-class people of Siret, especially those staffing these institutions. As one of the accountants of a state institution put it: "I only went to the seaside once with my children, many years ago and my husband stayed at home since we couldn't afford all of us to go. They go for free". This difference between the comfortable lives of institutionalized people, their privileges in material terms and the hardships of making a living in a highly peripheral part of Romania, made the stress upon keeping residential institutions powerful even more. What could one do outside of these institutions? Especially someone with a disability?

Not all residents of state institutions had access to the informal economy of Siret and some complained about not being taken to work on the grounds of either their gender or their disability (especially less able bodied people). Making pocket money and the privileges it entailed remained an aspiration for people, excluded from regularly participating in Siret's informal economy.

Yet, being excluded from labor, did not mean being excluded from its fruits.

The gift economy: separating the haves from the haves not

On another day at the school like foundation I came to participate in the gift economy that links those who have to those who do not have. One of the women who lived in the protected housing that was also on the premises of the foundation, came into the garden of the foundation. It was a Tuesday, market day, and she had bought a second-hand sweater with a hood - I complimented her on her choice and upon which she gifted it to me, saying I should keep it, not give it to anyone else and remember her. My efforts to refuse the gift were declined promptly and I came in the possession of a sweater which I still have and wear. It wasn't the first such gift, I received and it wasn't the last either - but it was most surely the most voluminous. Upon ending the conversation, just a few minutes later I was asked by one of the people attending the "school" to gift her a spray, I did not understand at first - but then realized she is asking for a deodorant - the ultimate aspiration of all people, who had grown up in institutions and were bold enough to ask for it. Before I could reply, she was reprimanded by the group of people also attending the "school", who told her she will get into trouble and she should stop it immediately. I had often seen staff reprimand residents for this practice of asking for gifts, but here again people, who had grown up at the hospital were policing each other for this practice. I also witnessed unilateral exchanges between the wealthier residents and those that were excluded from informal labor, some even bringing soft drinks home that they would share with everyone else, from which they wouldn't even have a sip. Generally, there two categories of people those, who would make gifts and those who would ask for and sometimes receive them. Making unilateral gifts to others, just like meeting your biological family was a marker of not being part of the "small children".

In other contexts, like the psychiatric ward from far away that I mentioned previously, where I was not perceived that much as a foreigner, I was once asked to write a letter to an English volunteer. Radu asked me to put in the letter his request for a CD player, some shampoo, the ever-present deodorant spray, clothes, the toilet paper - the pink one - and a package. The package seemed the space of unnamed and unknown small treasures to be brought from abroad. After writing the letter to the volunteer, whose address I was never able to find out, I run into Radu sometime later in a group of people, who had also witnessed him dictating the letter to me, a fellow resident accused him of having lied to me, saying: "we have shampoo and soap and toilet paper and everything we need. He is lying, you shouldn't believe him." A comment that Radu countered by saying that "here they [staff] are niggardly with things, when it's over, they don't give you any more". Even those that were not proficient with language would hold their hands to their ears, shaking their heads miming headphones and a CD- or cassette-player, upon which another of the more vocal residents would translate their request to me.

Whereas those that had access to financial resources through their labor, would generally insist of me and of others to accept their gifts, those who did not have access to these activities would regularly ask for things, while taking the risk of being reprimanded for their demands by residents and staff alike.

Commenting on, the practices of complaining about the present well-kept conditions of the state residential institutions from Siret, Alina once told me: "they [the residents] still say, they don't have [living] conditions, but it's not what they want. They want freedom, that's what I wanted as well. And to have a job and work, I always wanted, even at the *cazarmă.* [the old hospital's main building]*"*. As Alina pointed out about living conditions, I think that the demands for gifts too are more than just an aspiration to the commodity of desire, but one of incorporation into a different social order, which would bestow upon them the contemporary neoliberal and productivist values of freedom and employment.

People of Never Neverland made live, disciplined and governed

Unlike in Biehl's Vita (2005) and unlike in the past in Siret the potential to become productive no longer mainly decided whether a person would be made live or let die (compare chapter 8), the state infrastructure put in place by a conjuncture of scandal-making centered on human rights abuses around the former hospital in Siret, as well as humanitarian aid and a state sponsored increase in funding of residential institutions (both medical and medical-social) changed the biopolitical regime operating in Siret and introduced both a new culture of mourning, as well as new forms of power relations that reworked the social and economic relationships between people, who grew up at the hospital and the other inhabitants of town, generally who had worked at the hospital or were the children of people, who had worked there.

In this chapter, I showed how socially, people would be disciplined and sometimes governed into confinement and segregation, practices through which they would be actively incorporated into the processes that perpetuated their social abandonment, or would struggle to develop a counter-conduct on the basis of the ideals propagated during the humanitarian era such as nuclear families and employment, while excluding alternative life-projects that nevertheless would be practiced, but never mature into political claims, like homosexual sex.

Economically, whereas most institutionalized people would survive on what the state provided for as board, which was generally and unanimously understood to be a very decent living standard above that of working class people in Siret, others also participated in the domestic economy of Siret to gain pocket money, a resource sadly unavailable to institutionalized people anywhere in Romania.

This enabled the creation of in Marx' words a non-precarious relative surplus population (Marx, 1976, pg. 794f.) that ranged from those unable to work without being paupers to those involved in domestic and agricultural activities, yet without possessing neither their own home, nor their own land. At the same time, this population is very unlikely to get employed in the private sector and work directly in regularized waged labor, since the current state regulations would involve them remaining with very little money after paying for their accommodation and board. Through, this a relative surplus population emerges, who is partly easily exploitable mostly because of the lack of financial literacy, but whose livelihoods do not depend on work. This lack of dependence on selling their labor to survive does not translate into power of any sorts: although, they are mostly no longer subjected to a biopolitics of let die, people, who grew up at the hospital are still governed and disciplined by both the staff of state institutions, where they live (if they live in such an institution), other people from town, as well as themselves - further complicating power relations.

Rumors of Deinstitutionalization: bringing about abandonment by the state?

Yet, this biopolitical and economic equilibrium problematic as it is, is fragile as I came to learn more or less half-way through my fieldwork in Siret when the then Minister of Labor Rovana Plumb declared that by 2020 the centers for people with disabilities will no longer be funded by the state and that institutionalized people would be given into the care of the family[342]. In Siret, this would have meant the closure of the "New Beginnings" center that was funded by this ministry. Again, this ran under the label of deinstitutionalization and the project-based (therefore timewise were limited) European Union funding was to be used to move to new principles such as "community, care and normality".

Given what I knew about the biological families of the people abandoned in Siret and the entire generation of people abandoned by their families everywhere in Romania, this policy as it was presented was troublingly ignorant of the meaning of the word family and the way in which it operated in the lives of abandoned people. Families were to be remade somehow naturally, the only obstacle to this process appeared the confinement of people to institutions and not the initial and continuous acts of social

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[342] http://www.mediafax.ro/social/plumb-centrele-pentru-persoanele-cu-dizabilitati-nu-vor-mai-fi-finantate-14400787 accessed on 1.12.2016

abandonment that pushed people into residential institutions, nor the ableist understandings that kept people like Marian trapped in a system that comfortably provided for their livelihoods, while governing, disciplining and confining them.

An employee of the center, I met with after the declaration and that knew of it appeared desperate, as she was seeing herself turned into a member of the reserve labor army, worrying about her age and how she and her husband also an employee of the “New Beginnings” center would support their family. This turned onto the residents in such questions, as “who will want you now?” further reproducing the ableist and infantilizing tropes that were pulling people into the institution. Of the residents of the center, only Marian appeared to know of this political move and his attempts to explain it to other people, would be viewed by uninformed staff as an attempt to “scare” the others.

An employee of the new psychiatric hospital funded from different state funds, jokingly said: “we just need to hold on until 2020, then we will surely have many residents with these plans” and as we discussed it, the possibility that a new larger hospital would emerge to cater for this population so often moved from one institution to another without being asked, appeared more and more plausible.

This plan to my best knowledge never started to materialize, as the minister who has made the declaration is no longer in office. Nevertheless, this declaration exposed the full precarity of this arrangement.

Concluding section

Chapter 10: Freirean Social Policymaking

I have started the dissertation by asking how do people come to defend psychiatric asylums against closure, even when they have been systematically turned into places of let die. In this final chapter, I return to the question of how the system reproduces itself despite concerns and critiques against all of the oppressive practices that are reproduced with it, as well as explore a different way of policymaking that could allow for a partial escape from the hopelessness of abandonment that is one of the defining features of how the system functions today.

Although at the time of my fieldwork, total institutions were no longer as murderous as when the scandal related to Poiana Mare broke out at the beginning of the 2000s, by building on human rights monitoring materials, I have shown that still many people are abandoned and let die within the system (see Chapter 3). Yet, I have also shown that people who come to asylums have been abandoned by their social networks previous to the actual "forced" or willing transfer to an asylum (see Chapter 6) - showing that it is not asylums that produce abandonment. Therefore, I see asylums as challenging abandonment by providing the possibility of subsistence and the promise of care, while at the same time reproducing it by solidifying social distance from initial social networks through geographic distance, as well as through everyday practices of confinement of the mentally ill and disabled to asylums. But, as Never Neverland as a site allows to show, processes of abandonment can provide a creative space of potentiality and hope - abandonment can be reworked into something generative of something else than suffering (see Part 3, especially Chapter 9).

In this chapter, I pick up the idea, I have ended Chapter 6 with that spaces of abandonment can be reworked into affective spaces of hope and that this transformation is potentially intrinsically linked to a process of making policy otherwise (Clarke et. al, 2013, especially chapter 7).

In this, I understand hope in Brian Massumi's (2002) terms as an affect that enables starting a transformation from the potentialities of the present without being paralyzed by utopic horizons. Similar to Massumi, yet much earlier educator Paulo Freire has also explored hope as a transformative force that allows to rework oppressive relationships (compare Freire, [1992] 2013). The work of Paulo Freire will serve as a guide through a different way of thinking through the ideas presented in this dissertation in view of developing a different mode of policymaking.

The subject between Foucault and Freire

After having used a mostly Foucauldian way of understanding the subject as formed and shaped by discursive objectifying power relations (compare Foucault, 2000, especially pg. 326f.), I will now shift to a Freirean understanding of the subject as a human being that is becoming aware of the transformative potentialities of their "action-reflection" (compare Freire, [1968/1970] 2005). The reason for this theoretical move that might seem rather abrupt is that I do not take the two understanding of subjects to be incompatible or mutually exclusive, rather than this I take the two notions to point to different aspects of intrinsically similar concepts.

For Foucault, the notion of power is intrinsically tied to his notion of the subject (compare Foucault, 2000, especially pg. 327). The subject is shaped by power relations, yet, power relations are only present when there is also freedom from them, when more than one way of reacting and behavior are available (ibid., pg. 342). Or as Foucault put it "in this game, freedom may well appear as the condition for the exercise of power" (ibid.). The absence of freedom, brings with it the impossibility of power, since power would come to be "physical determination" otherwise (ibid.). Power in Foucault's understanding therefore opens the space for subjects acting otherwise as prescribed and renders this otherwise based on the "mutual incitement and struggle" between power and freedom a political task (compare ibid., pg. 342- 343). Foucault does not make clear how these struggles can be taken up by subjects, rather than this he presents it as a generic theoretical elaboration on the nature of power and its relationship to freedom and the subject.

It is here that Freire comes in. If Foucault's thinking allows for the space of thinking the subject as acting between different potentialities within the power relations she is subjected to, Freire's work allows for an investigation into the way in which these potentialities can be taken up collectively to craft a politics of hope.

Hope and Freirean thought

For Freire, hope is also intrinsically connected to his concept of utopia (see Streck, 2013, pg. 161, and Souza de Freitas, 2013, pg. 412). Yet, for Freire as opposed to Massumi (2002), utopia is not a paralyzing, but a mobilizing force. Utopia is understood by Freire not as something unrealizable, but as "rendering dialectic the acts of announcing and denouncing, the act of denouncing a dehumanizing structure and announcing a humanizing structure" (Freire, 1979, pg. 27 quoted in Souza de Freitas, 2013, pg. 413). For Freire, utopia and hope are connected to a political dream of the possible (compare Streck, 2013, pg. 161) that is being rendered concrete through practice (compare Souza de Freitas, 2013, pg. 413). This rendering concrete is based on the understanding of history as unfolding and as possibility, meaning that history "is not" but "is being [made]" and as it is being made, it can also be transformed (see Souza de Freitas, 2013, pg. 413).

The transformation of history is done by people that come to understand themselves as subjects of history through a process that Freire (1979, see especially part 2) terms *conscientização* – the rendering aware of a subject's role in the making of history and their capacity to transform it by becoming aware of their condition as unfinished human beings. In this, hope is essential as a motor for the willingness to transform oppressive (and thus dehumanizing) social reality. Yet, hope is not sufficient for transformation. Transformation requires action as an active way of hoping and not just hoping as a form of waiting[343] (compare Freire, [1992] 2013, Primeiras Palavras). Nor is being hopeful and acting upon a sufficient

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[343] *Esperar* in Portuguese means both to wait for something, as well as to hope for something. Therefore, there is a certain passivity to the notion of *esperança* that Freire (2013 [1992]) feels the need to argue against.

condition for transforming reality, since too much hope might turn into its reverse (hopelessness) through disappointment at unreachable aims (compare ibid.).

For Freire hope is a necessary condition for transformative forms of dialogue (compare Streck, 2013, pg. 161), which in turn are a means of exploring the possibility of human beings to oppose their dehumanization through oppression and find a way to liberate themselves, as well as their oppressors through processes of action-reflection (compare Freire [1968/1970] 2005). It is this process that for Freire renders human beings subjects of history and not objects of the oppressors.

This objectivation by the oppressors and its reifying undertones are often interiorized by the oppressed so that the process of *conscientização* can only be made possible by an expulsion of the oppressor from within the oppressed (Freire [1968/1970] 2005, chapter 1, especially pg. 51). Through this liberating process the oppressed regain their awareness of their vocation to become more fully human (ibid. pg. 52) and of their unfinished-ness and incompleteness as human beings in an incomplete and unfinished world (ibid. pg. 84). In short, they become aware of their historicity and learn to act upon the world in a collective and not individualistic way.

The dichotomous vocabulary of oppressor - oppressed and oppression - liberation might appear rather simplistic, totalizing and antagonizing. Yet, the stakes of using this vocabulary for Freire are connected to politicizing processes of education and making critical thinking an integral part of becoming a subject. Freire proposes a pedagogical morphology of oppression and how hope can be a driver to overcome it. Nevertheless, Foucault and his understanding of power and the subject, remain necessary in complexifying the dichotomies inherent in Freire’s thinking, as well as overcoming an understanding of oppression (and implicitly power) as something that is overwhelmingly and almost exclusively class related.

As my analysis shows, the questions of madness and disability have historically been entangled with questions of the subsistence of the unproductive and thus with class and the management of surplus populations - yet, just as much they have been entangled with gendered and ableist normalizing processes that cannot be reduced to a class related analysis but need to be understood in terms of how power is exercised and how people come to share in this exercise through reproducing the system.

Individual aspirations and reproducing the system

People come to share in the system as patients, inmates, residents or carers and professionals. For some, as for Ioan (see Chapter 6), the everyday life of asylums circumscribes the aspirational horizon - the better life is seen as a similarly foreign determined life but without violence and with affection and daily activities such as wood carving workshops. But for others, who like Mrs. Laura (see Chapter 6) have known a different life previous to institutionalization, their hopes are circumscribed by their previous lives, which they dream of resuming once escaped from institutions. While for Marian (see Chapter 9), the escape from institutions is not tied to a past but to a potential future as a non-institutionalized person, where he can make a living on his own and have his workers' rights respected. All of these different life projects need to be considered when thinking of doing deinstitutionalization and when thinking of how the biopolitics of let die can be reworked into one of make live. Yet, these aspirational horizons although narrated individually, I argue should also be considered *collectively* when doing deinstitutionalization.

Aspirational and collective deinstitutionalization

When going on a tour of sites of social psychiatric reform in Vienna and its surroundings with one of its main promoters, a social psychiatry professor, we also went to a previous large hospital, that now held an Art Brute Museum. The social psychiatrist had been involved in its closing from the very beginning of the process and remembered that the inmates of the psychiatric hospital had once been reluctant to move out of the place that had been their home for many years. A nearby local community was also reluctant to receive them, since they had stigmatizing prejudice regarding the mentally ill.

How the professional team managed to find a solution to this was to find out about the fact that the community would actually need to reach a certain number of inhabitants in its administrative locality to enter into a superior funding category from the state budget. When realizing that there were financial gains in this process, the local community became much more supportive of the project of protected housing for the mentally ill. Yet, the inmates of the hospital still were not set on moving out, based on individual professionally designed plans that followed clinical categories. Then the professionals realized that the people living in the hospital had been friends for years and they wouldn't want to move out based on categories that described their clinical conditions, but on their social networks acquired during their time at the hospital. Then they started making offers for people to move out and in together and the process started.

The social psychiatry professor's anecdote points to the situatedness of doing deinstitutionalization – the need to understand the conjunctures in which the project plays out and the aspirations and the desires of participants. Of course as a professional account, it over-privileges professional practices and understandings but situates them in the social relations between people. Yet, another interesting point this account points to is that doing deinstitutionalization cannot be built upon a clinical categorization of subjects, but needs to start from their collective realities and social networks.

Such a mode of doing deinstitutionalization should allow to craft this reform with the people it "targets" and whose lives it seeks to foster and improve and not against them or in their name. It is here that this mode of carrying out reform is markedly different from previous ones, like those supported by human rights organizations (through the campaign the *Lagers from Next Door* in 2015 or through the Amnesty International report in 2004), as well as the sudden deinstitutionalization proposed by the labor minister, Rovana Plumb. In a different way, this mode of thinking reform should have more in common with individual acts of running away from institutions, like that carried out by Eli (Ungureanu, 2017) when she left the center to get a job in town. This is the case since the act of running away embodies an aspiration of living on the outside and a practice that is coherent with this aspiration by going beyond what Freire ([1968/1970] 2005, pg. 99f) has described as "limit-situations" – as the boundary between the familiar world and "untested feasibility" as the space in which practices of the otherwise apparently impossible can emerge. The boundary is normalized through practices of oppression and the beyond appears as a space of "non being"[344]. Yet, through developing a critical understanding, the boundary can be de-normalized, giving way to "limit – acts", which open the space of "untested feasibility" - as a previously unknown lived potentiality (compare [1968/1970] 2005, pg. 99ff.)

Thinking beyond the dichotomy oppressor- oppressed

The dichotomy oppressor / oppressed so central to Paulo Freire's thinking is based on a Marxist understanding of class struggle as the historic struggle between oppressed and oppressors (see da Rosa Oliveira, 2017, pg. 294). Although Freire does not shy away from using the language of class, he insists that the defining feature of the relationship is that of oppression and that relationships of oppression can take place between oppressed people as well (compare ibid.). This happens through the fact that the oppressed internalize the oppressor, as their model of being human (compare Freire, [1968/1970] 2005, pg. 45). Relationships of oppression are dehumanizing on both sides, since they are based on negating the vocation of the oppressed to become more fully human and work to keep them less aware of their transformatory potential in the world. The oppressors are themselves dehumanized by dehumanizing the oppressed (compare Freire, [1968/1970] 2005, pg. 40fff).

Liberation, so Freire, can only be carried out by the oppressed, since they are better positioned to understand the "terrible significance of an oppressive society" (see Freire, [1968/1970] 2005, pg. 45). Yet, here a tension arises between the oppressed as the class with the historical task of liberation and the divided self of the oppressed as harboring the oppressor alongside their own selves (compare Freire, [1968/1970] 2005, pg. 44 - 45). The role of critical education therefore is to create a space in which the oppressor can be objectified and expulsed from within the oppressed (compare ibid.). The realization of the situation of

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[344] Here Freire builds on Alvaro Viera Pinto's reversed appropriation of Jaspers understanding of limit situations, compare Freire ([1968/1970] 2005, pg. 99)

oppression and the way in which it operates is not enough for liberation to take place for the oppressed, but is only the beginning of the struggle for becoming more fully human (compare ibid., pg. 48-49). Similarly, for oppressors realizing that they find themselves acting as oppressors is not enough to stop the process, but authentic solidarity with the oppressed is necessary for that (compare ibid.). This solidarity, so Freire, “requires that one enter into the situation of those with whom one is in solidarity; it is a radical posture” (ibid., pg. 49).

Returning to the context at hand, it is difficult to say, who are the oppressed in the situation of the hospital at Poiana Mare in the early 2000s. Obviously, the people who were locked up and let die in the asylum and that nevertheless came to defend it against closure found themselves in a situation of oppression. But, so were those people who peripherialized by the transition to capitalism or previously put in place by the rigid labor regime of state socialism could not imagine any beyond to reproducing the let die biopolitics by continuing to work as carers, despite witnessing so many untimely deaths.

The oppressor can be said to be located outside of the immediate reach of the cast of the situation – in those who have profited from capitalist transition or state socialist economic practices, as well as from the confinement of the mentally ill in the name of public order and security. Yet, it soon becomes obvious that these oppressors are difficultly identifiable and their relationship to the everyday life of the hospital difficult to trace.

What appears more intuitive in the everyday life of such asylary places is the personification of oppression in the carers, who are seen as “holding people hostage for their salaries”, as the German psychologist I previously quoted put it. Nevertheless, the dichotomy oppressor – oppressed remains difficult to sustain. This is due to the complexities of the relationships between carers and inmates (as explored in Part 3) that cannot easily be dichotomized, as well as to the evasive positionality of the oppressor that cannot easily be identified. Nevertheless, even in the absence of the oppressor – oppressed relationship, there are still power relations that can be read as relationships of oppression between differently oppressed groups of people in peripheral parts of Romania, where asylums tend to be located.

These relationships of oppression rest on the reproduction of a normalizing ableist understanding of the subject that cast the mentally ill and disabled subjects as "less" than able ones (compare Kumari Campbell, 2009), re-inscribing asylum inmates as people, who cannot be accepted into society and thus are best cared for in a confining setting, which ensures their subsistence. This description of the disabled subject and their adequate loci of care, works to keep both the institutionalized subjects, as well as their carers away from becoming relative surplus populations in a Marxist sense. Yet, as shown in Part 2 and Part 3, it also curtails the aspirations of institutionalized people and casts them in a diminished state of personhood. How then to think and act beyond the limits imposed by the fear of producing surplus populations from those bodily and intellectually or geographically vulnerable?

In Freire's terms the entanglement between subsistence of carers and inmates and asylums for the mentally ill and disabled appears as a "limit-situation" (Freire [1968/1970] 2005, pg. 99f) that appears to circumscribe the possible from within the situation of oppression. The politics of hope that I propose, seeks to go beyond the limitations of this situation by thinking through how Freirean social policymaking could help to go beyond this apparent impasse.

Freirean social policymaking

The limit-situation of subsistence

The "limit-situation" described above is connected to the question of subsistence (explored in Chapter 5) and its entanglements with the asylary system as the alternative to failed nuclear families or as places of work for those that were left behind by deindustrialization. The question of what one can do outside of asylums to economically stay alive haunted both inmates and (mostly lower level) staff of asylums – leading the question of subsistence to be rendered clinical by both staff and inmates.

The vital part played by asylums in the economic everyday life of people experiencing them, made it vital to reproduce the ableist tropes that had led to the establishment of asylums, casting disabled people as unwanted by wider society and potentially unproductive, thus unfit to survive outside of asylums. This cast an air of hopelessness over people's life plans and aspirations, causing one of my informants and friends Ștefan (then in his late twenties) to say he does not want to have children, so that they do not end up "at the state", as he himself did.

Yet, that the centrality of the question of subsistence does not mean that it is unsurmountable. Since deinstitutionalization does not necessarily imply cost cutting, but rather redistributing resources in a less oppressive way, it might not necessarily mean that the reproduction of the present system is necessary for people to find a way to connect to the economic process of post-transition Romanian economy.

Moreover, thinking economic questions with Freire points to the fact that it is a marker of a situation of oppression that the burden of subsistence is unequally distributed among people in society. Understanding ableist, but also economic oppression (relevant especially to the situation of the carers and one of the main reasons why people end up in asylums) allows to open up a space, where new radical modes of thinking economy and thus the distribution of resources can emerge. Yet, Freire too leaves this question without clear prescriptions. Yet, as a Marxist sees social classes as antagonized parts in economic processes, from which the relationship of oppression derives. The realization of this relationship for Freire opens the possibility for different practices to emerge[345].

The transcending of the dominance of the imaginary of the impossibility of subsistence outside of asylums should be discussed in dialogic groups with the people, who are affected by this situation thinking of ways

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[345] How these could look, should be a question best investigated in the process of doing deinstitutionalization.

in which this could be surpassed. For this a decentralization of resources (coupled with flexible forms of control to prevent abuse by local leaders), as well as of the infrastructural development should be carried out in order to bring power within the reach of those who seek to transform their asylary everyday lives.

Generative themes and transcending a banking understanding of knowledge

For Freire generative themes were topics that made possible a critical understanding of the world starting with words that made sense to the oppressed in the process of their education for freedom (compare Freire, [1968/1970] 2005, pg. 96f.). The themes should both emerge from the dialogue with the oppressed, as well as be proposed as ways of making sense of their reality by the educator (ibid.). That is why, generative themes are central to “taking the (policy) conversation” to those who are directly envisioned by it (compare Clarke et. al 2013, pg. 222).

Generative themes are key to transcending what Freire called the banking understanding of education, in which the educator deposits knowledge into students as empty containers to be filled up (compare Freire, [1968/1970] 2005, pg. 72). This understanding of education assumed an oppressive anti-dialogical representation of knowledge that did not allow for students to become subjects of their own education and be transformed by the process of knowledge making.

Similarly, in social policies pre-codified understandings of the “family”, “care” and the “disabled”, as well as other hierarchizing attributes work to oppress people by reifying the knowledge that determined the everyday life of people while this knowledge constantly remained out of their reach. For past and present state reform projects, this has been the case for all that I am aware of. Moreover, the unreachability and reification of knowledge is not only true for the inmates of asylums, but also for the staff (especially lower level staff) of state institutions.

Therefore, the future in reform terms should not be pre-codified as a technical predetermined infrastructural transformation in the name of the human rights of people described only as numeric targets. Rather than this, the reform process should include a way in which the complexities of individual and collective aspirations can be incorporated and developed within the process of reform and the unfinished-ness of both the situation and the human condition can be restored and rendered comprehensible to (almost) everyone involved.

Moreover, generative words such as “social cases”, “mad(wo)men”, “handicapped” as well as possible others that would emerge from dialogue should be used as part of dialogic practices among asylum inmates that should help to transcend the hierarchization that these terms have implied. In this way, the ableism and disableism of disabled people’s imaginary’s could be made explicit and the way to building solidarity among equals in a situation of oppression could be opened.

Similarly, the word “word” or “theme” should not be misleading. Since not all inmates of asylums have developed capacities of accessing standardized forms of language, different methodologies for dialogue, such as pictograms and prolonged interactions (including in spaces to later be inhabited or interacting with people that will come to be one’s neighbors) should also be included in the process of developing a less objectifying way of doing deinstitutionalization.

Recently, methodologies for including people with intellectual disabilities in surveys have been developed (see Malan, Emerson & Davies, 2014), as well as for interpreting with more confidence communication processes with people with severe and profound intellectual disabilities (see Grove et. al, 1999). The second methodology mentioned is explicitly built on a constructivist understanding of meaning-making as an always situated and partial process (compare Grove et. al, 1999) – where constantly the question of how can one’s interpretation be validated emerges.

This question is particularly appropriate to the situation at hand, since it replicates the problem posed in chapter 1 – how can a situated account of meaning making inform a universalizing process as that of policymaking. My answer to this question, remains that knowledge is always produced from a specific position and the political move I argue for is a refocusing of this position to include those most vulnerable envisioned by policy change.

Nevertheless, the question of "validating" or contrasting one's interpretations of what has been communicated in a way to which one as a researcher or social worker is not necessarily accustomed remains - especially since the stake of inclusion depends on a thorough understanding of the aspirations and desires of those with which one enters the communication process. From my ethnographic experience with people with intellectual disabilities in Never Neverland was that often when I could not understand what someone was trying to tell me, another person from the residents (and rarely, if ever a carer) that had known the person for a long time would come and translate the person's intentions to me. Incorporating people that are similarly positioned in respect to the able/disable binary distinction into the process of designing the communicative process would help to challenge the binary in practice, while drawing on important positioned and situated knowledge[346].

The role of the social worker as a facilitator in the transformation process

Some questions remain open in this process – who could be the initiators of this common dialogic action? On which grounds should the exchange take place? And how can the dialogic practices become infrastructurally translated?

A central role in this process of transformation could be attributed to social workers as potential progressive educators, provided that they come to recognize the equality of people beyond the able/disabled binary. Social workers do not necessarily need to be trained social workers, but rather than they would ideally be differently positioned across the able/disabled binary. This being said, what the position of the social worker should be in this process is where Freire's thinking on the role of the social worker can be put to work.

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[346] The involvement of a self-advocacy group of people with intellectual disabilities in the first survey for people with disabilities in the UK at all stages of the process is an example of such a practice. (see Malan, Emerson & Davies, 2014)

In a talk given at the Social Workers World Conference in Stockholm in 1988 (translated in 2009 by Marilynn Moch), Paulo Freire outlined his thinking on social work as a critical educative practice. The social worker in Freire's thinking is an educator, who renders explicit a "dream about social relations, which is a political dream" (Moch, 2009, pg. 94). The social worker thus can compromise herself if she believes that she possesses technical expertise, separate from the "political battles of society" (ibid.).

The rejection of technical expertise, thus awards to the social worker the role of developing her own curiosity, as well as a "pedagogy of the question" in lieu of a "pedagogy of the answer" (see ibid., pg. 95), while working to develop both an understanding of "the limits of social work practice" (ibid., pg. 97), as well as those of what is historically possible (ibid.).

Returning to deinstitutionalization, social workers could work as the facilitators of a process of on the ground policymaking, by which collectives of people from institutions could make informed decisions about how to allocate resources for a transformation of the system based on their personal and collective aspirations, developed in the process of action-reflection initiated by social workers by embracing generative themes that define the "limit-situations" of everyday life in those asylary spaces that are most prone to hopelessness and abandonment, as well as those where the complexities of carer - resident relationships are more striking.

Conclusions or the political stakes of this project

Freirean social policymaking could help to redefine the loci of making decisions regarding people's future trajectories. In my view, such a move is key to the underlying assumptions that deinstitutionalization is about setting those confined to asylary settings "free", yet, without leaving them completely without support and endangering their subsistence. Deinstitutionalization should work to rework abandonment into a more hopeful process and not to reproduce abandonment by the state.

Thus, Freirean deinstitutionalization helps to redefine the relationship between policies and vulnerable subjects, by including them in the process of knowledge production. For this, the concept of policy knowledge needs to be redefined away from a banking understanding over into one that emphasizes the situatedness of knowledge and experience. Moreover, this change in the understanding of knowledge and the importance of contextuality should be politically consequential in the process of deinstitutionalization. Technical solutions – enumerating the numbers and types of services to be closed or established - should not take the place of including and developing collective and individual aspirations of those involved in the process. In this way, I hope that the hopelessness of asylums can be reworked into a hopeful aspirational horizon of untested feasibility.

Conclusion

Promises and contributions

I started the dissertation with three theoretical and a situated promise. Whereas I cannot yet determine whether I have fulfilled the substance of my situated promise to offer a familiar account to those who have experienced the system (as inmates, residents, patients or carers and professionals), I will explore here the theoretical promises I have made in the introduction.

Firstly, my exploration of deinstitutionalization promised to offer a way of expanding the policy imaginary (see Lewis, 2000) contributing to efforts to rethink social policy (compare Lewis, Gewirtz and Clarke, 2000). Through my genealogical exploration of the government of madness and disability starting in the pre-modern time (in Chapter 2), I hope to have shown that policy is a deeply socially embedded process. This embeddedness even when appearing in the guise of modernizing narratives (as those of modern psychiatry in the mid 19th and early 20th century) was built upon meaning structures and practices of everyday life that have little to do with either modernity or science (like the monastic model of confinement and healing). Moreover, the biopolitical structures (economically autonomous nuclear families and asylums) upon which the policies related to mental illness were built were also already socially in place before the advent of the modern state in the 19th century. Through this, I hope I have contributed to exploring what Timothy Mitchell ([1999] 2006) has called the "state effect" and Joe Painter (2006) has described as processes of statization in the setting of the emergence of the modern Romanian state and mental illness related policymaking practices.

Moreover, I had promised to expand Dvora Yanow's (see for example [2000] 2011) fascinating and inspiring work on the way meaning making processes operate surrounding policies in practice. In order to do this, I have bent and extended Ian Hacking's concept of "styles of reasoning" into my concept of modalities of sense making, as a heuristic device that allows to explore policy related meaning making processes in practice without needing to attribute the reasoning to “communities”. I hope that this concept can be useful to scholars of policy related meaning making processes.

My final contribution to the theoretical-methodological field of policy studies is connected to the previous point. At the very beginning of the dissertation, in chapter 1, I have introduced the rhizomatic mode of policy analysis and have continued by showing what this approach has produced in terms of knowledge in the rest of the dissertation. I propose a situated approach to researching policies that is built on the work of anthropologist George Marcus (1995) on multi-sited ethnography, as well as Deleuze and Guatari’s ([1987] 2005) work on the rhizome. This approach helps to produce policy relevant knowledge by embracing the contextuality of all knowledge claims, while at the same time working to inform a different modality of social policymaking.

This brings me to my second promise that of contributing to the practical fields of policy analysis and policymaking. As a situated policy analysis of psychiatric deinstitutionalization, chapter 4 has shown that the relevant fields for policymaking in terms of this process span across two segregated fields of policy and resulting care and treatment settings - psychiatry/ mental health and disability. These two fields although catering to almost the same populations (sometimes the same person is moved from one system to the other) are framed in two different languages (that of health/illness and that of ability/disability) and are governed as if no overlap existed. This artificial policy separation leads reforms towards deinstitutionalization in one field to have counterintuitive effects on the other field. As explained in chapter 9, if one type of service closed, it might lead the other type of service to grow into a larger structure. Concretely, this observation should be taken into consideration when designing policies towards deinstitutionalization in either field. Ideally, the reform should be carried out at the same time and in collaboration between people in both fields.

My mode of conducting policy analysis, also allowed me to look at the governing of more subtle social processes, like that of abandonment. A leading topic in what Joel Robbins (2013) has called the anthropology of the suffering subject, abandonment is understood as a process that brings people to a “dead-end", where they are let die (compare Biehl, 2005). Yet, an understanding of suffering and how it can be overcome should be part of social policy thinking for the most vulnerable as well. I have shown that abandonment isn't necessarily a final process, meaning that it can be reworked through what I have called a politics of hope that can inform social policymaking. Moreover, in a policy relevant analytical move, I have traced the locus of abandonment beyond asylums – looking at how people come to be abandoned first and then be brought to asylums. This observation can inform policymaking, since it allows to see asylums not primarily as perpetrators of abandonment, but, as the outcome of a fracture in social relations that had already occurred.

My practical contribution to policy, also extends to social policymaking for vulnerable groups as a process. Through ethnographically exploring the different aspirational horizons of the people, I have done research with, I came to develop an understanding of the question of subsistence as a key driver of keeping people in institutions. This was true for both carers and inmates of state funded institutions and worked to inscribe ableist understandings of those governed as disabled or mentally ill. The fear of not being able to subsist outside institutions haunted both the staff and the inmates, and made institutions despite all of their oppressive dynamics desirable to many. In order to counter the dominance of subsistence in the imaginary surrounding asylums, I have developed a Freirean mode of policymaking. This would allow for the design and implementation of policies to happen closer to the people actually affected by them and allow for dialogic practices (in a broad inclusive sense) to open the way for finding solutions to subsistence and life beyond asylums. This would involve allowing people to decide the way in which resources allocated to them should be spent and develop their future related aspirations. I will return to what still needs exploring at this point in a bit.

My third promise was to contribute to the anthropological literature on biopolitics by looking at the way in which people participate in processes of fostering of life and letting die. I have shown that abandonment and a biopolitics of letting die although entangled are not one and the same thing and that both processes can be reworked through developing a politics of hope and exploring the aspirational horizon of the question of what kind of life do people desire to live. Moreover, I have shown that biopolitical orders are never merely calculative, but that they are moral and affective orders at the same time. Furthermore, the everyday politics of biopolitics involves reworking, resisting and ignoring biopolitical orders as they reach practice.

Finally, my inquiry into biopolitics has presented me with an interesting question that I find I cannot yet answer. Namely, the politics of letting ("unrecoverably") disabled or mentally ill people die has been systematically carried out by the state[347] throughout the history of the government of mental illness. Yet, in all the policy documents I have analyzed and consulted, I have not found a single trace of letting die as a planned and official policy process. Or put differently, the practice of letting people die to my best knowledge was not openly proposed by people acting on behalf of the state as such (as was the case of the German T4 operation during Nazism, where the death of people considerable "unworthy of life" had been officially decided[348]). Recently, this has created the problem of how to juridically punish those who participated in a systematic let die politics on behalf of the state socialist state (see chapter 3). Yet, for me this opens up a further question: namely, how does one delimit actions carried out on behalf of the state (as systematically letting die of "unrecoverables" during state socialism) from state policy? Or what is the relationship between state biopolitics and state policy?

Unanswered questions

Another question that is very relevant to thinking the transformation of asylums into more hopeful settings is related to exploring the positionalities and genealogies of carers. How have they come to participate in the system and what are their aspirations beyond the system? How do they understand their work and how could these understandings be reworked towards a politics of hope? Both in Never Neverland and at the Asylum, I have interviewed and spent time with carers, as well as have looked into personal genealogies

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[347] It is generally assumed by intellectuals writing in transition that this practice was common (only) during state socialism, but actually as chapters 2 and 3 show, letting the mentally ill and the disabled die in asylums, unfortunately, has been a common practice before state socialism, even before the modern state, as well as during and after transition.

[348] On Operation T4 see https://www.ushmm.org/wlc/en/article.php?ModuleId=10005200 accessed on 13.04.2018

that cut across different positionalities (such as those of local humanitarian volunteers turned carers). Moreover, as described in the introduction carers have huge stakes in maintaining institutions since they ensure their own labor based subsistence and thus also reproduce the ableist narratives that support through, but also confine people to institutions.

This is also connected to a second question, I wish to explore more thoroughly, namely the political economy of the relationship of care around asylums. The setting of my research, namely the Romanian northeast is a region that has been highly peripherialized in capitalist transition, making people fear being turned into surplus populations, since they have witnessed factories closing and even trains being put out of service that once connected them to the larger cities[349]. This fear of becoming surplus to the needs of capital and the state intrinsically connects asylums to productivity. The lack of economic activity beyond asylums necessarily strengthens asylums as economic actors. But showing how exactly this works, is an engaging avenue for analysis that I plan to explore in the future.

Furthermore, connected to this point would be an empirical exploration of sites of asylums, where the risk of being surplus to capital's needs is not as pressing as in northeast of Romania. My intuition is that in such places, the lack of geographical and thus economic vulnerability, inscribes asylums as normalizing institutions that are more connected to enforcing a moral and affective order than an economic one, but this would require empirical work to see whether it is indeed the case.

Finally, academic writing (in English) although perfectly appropriate for explaining complex relationships between processes, is unfortunately inaccessible to most of my informants and friends, who have participated in the project. In the future, I wish to find a complementary way of communicating my thinking that is less ableist and pretentious and that could help me enter the dialogic practices I propose.

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[349] The train connecting the Bukowinian town of Rădăuți to the county capital Suceava was taken out of circulation in 2011/2012, see https://www.monitorulsv.ro/Local/2012-08-21/Gara-Radauti-omorata-cu-buna-stiinta-de-conducerea-CFR accessed on 14.04.2018

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Appendix

Glossary

Sites

The Asylum – a Center for Neuropsychiatric Recovery and Rehabilitation, established in the 1960s, where four hundred people live and over three hundred people work located near a small village, where I spent around one month in December 2015 to January 2016. It is the place where Ioan and Mrs. Laura (see below) and others lived. Typically, people residing at the Asylum were not expected to leave. The site plays a central part in Part 2 of the dissertation.

The Asklepion – is an acute psychiatric hospital, where stays at the time of my fieldwork were limited to around 13 days. It integrated religious (orthodox Christian), social, psychological and psychiatric approaches to mental illness and was considered by reform advocates a progressive place. I spent a little over three months at the Asklepion from January to May 2015.

Never Neverland – is the name I gave the social world of the town of Siret, Romania's 8000 inhabitant border town with Ukraine that once housed one of Romania's largest children neuropsychiatric hospitals (that functioned between 1956 and 2001), where around 2000 children were considered to have been held at a time in the wake of pronatalist policies and before the advent of first deinstitutionalizing measures in the 1980s. In the 1990s it was the site of a humanitarian show that led to a large influx of foreign volunteers from everywhere in the Western world. It was further downsized during the 1990s and in 2001 it was closed due to pressure preceding the accession to the European Union. Many of the previous inmates were taken to their counties of birth, and institutionalized there or re-integrated into their or other families. The follow-up of the hospital consisted of a Psychiatric Hospital for adults who remained in Siret, as well as a series of humanitarian NGO based deinstitutionalization projects. After EU-accession many of these projects were taken over by the state, which lead to the re-institutionalization of some of the previously deinstitutionalized people. Most of my fieldwork (from May to early December 2015) was spent in Never Neverland.

The Psychiatric Hospital (Never Neverland) – is the administrative name for a number of different residential services offered in Never Neverland to people, who had grown up at the neuropsychiatric hospital in Siret and had at the time of its closure passed the age of 18. The hospital consists of two main buildings in different locations in town and on the outskirts, where the more severely disabled are housed in well kept, but massifying conditions, as well as two more homelike environments called houses for the more able minded and bodied. One of the two houses had been a halfway house that had prepared selected teenage inmates of the previous hospital for an independent life and had once these moved on into protected housing (that later was mostly taken over by the state as well) been given over to the psychiatric hospital. The other house started as an independent housing project as well.

The "New Beginnings" Center – is administratively speaking a center for recovery and rehabilitation of people with disabilities that is run in a private public partnership between the "New Beginnings" Foundation and the *Direcție* (the county level social protection directorate). Yet, the word center should not be misleading. The residential services the "New Beginnings" Center offers are dispersed throughout town, the houses - some of them built exclusively with British materials - have even British electric systems. The infrastructure was established to offer previously hospitalized young people a chance at independent living, and people, who are still residents of these houses have once been prepared for independent living at the halfway house (now part of the psychiatric hospital). Yet, through the partnership with the state and the formal re-institutionalization of the residents, these plans came into a form of limbo.

Other residential and day services in Never Neverland - apart from the two major ones described above, Never Neverland is full of small NGO run initiatives. One of them is a day care center mostly for the residents of the "New Beginnings" Center, while a school-like daily activity, as occupational therapy workshops focused on craft works are offered to the residents of the psychiatric hospital. Protected and social housing used mostly by former inmates of the children hospital also exists.

Key People/ Main Characters (ages at the time of my fieldwork in 2015)

Mrs. Laura was a woman in her fifties, who had lived in Bucharest and worked in an office prior to her abandonment at the Asylum. Her arrival at the Asylum was preceded by the untimely death of her husband that in a couple of years resulted in the financial unsustainability of her family (herself and her two teenage sons). Upon requesting the help of her mother, she eventually came to live at the Asylum. She aspired to return to living on her own and helping her sons out financially by founding a small business or going into farming. She was part of the "adults" population.

Ioan turned thirty during my time at the Asylum. He had grown up at the hospital in Siret and had afterwards come to live in a more friendly residential service, from which he was brought to the Asylum upon reaching the age of 18. He was perceptive in claiming his rights and opposing injustice, but would refrain from imagining a life for himself outside of the Asylum. He was part of the "children" population.

Ștefan had been abandoned when he was a little over one year of age, together with his two older brothers, on the grounds of a physical disability, which he could not remember ever having had. At the time of my fieldwork, he was in his late twenties and lived in Never Neverland, at the "New Beginnings" center. He had been deinstitutionalized during the high time of English humanitarianism, only to be re-institutionalized during the comeback of the state after EU accession. He came to meet his family, including his sister later in life and appreciated the contact with them very much, but did not want to have children so that they do not share his destiny of ending up at the state.

Marian was in his thirties at the time of my fieldwork and like Ștefan, lived in Never Neverland at the "New Beginnings" center. His ambition was to leave the social protection system and the destiny of being an institutionalized person by finding a job, where his worker's rights are respected and receiving social housing from the mayor's office. He also went to evening high-school.

Alina was in her thirties and lived in Never Neverland. She had grown up at the neuropsychiatric children's hospital and had come to be brought to another closed residential center during the closing of the hospital in 2001, since she had not been 18 years old at that time. From that center, she was helped to leave by a humanitarian transnational group that had worked in Siret and had come to visit her there. After coming back to Never Neverland, but also before, she helped institutionalized people leave the system. She was a vocal critic of the hierarchizing practices that had determined her life, before she came to live independently and make a living by working in the Wood Industry.

Adelina was considered informally the boss of one of the wards in the psychiatric hospital. She had been in touch with her grandparents who had intended to deinstitutionalize her. But once "returned home" after a series of conflicts, she was brought back to the hospital causing her to have an ambivalent relationship with her family, as well as with her hospitalization. She worked informally and was aware of the sums of money she was entitled to.