Chapter in an edited volume

The cosmopolitics of 'niching'

Rendering the city habitable along infrastructures of mental health care

Milena D. Bister Martina Klausner Jörg Niewöhner*

2016

This is the accepted manuscript (postprint) of a chapter in an edited volume published as follows:

Title	The cosmopolitics of 'niching'
Subtitle	Rendering the city habitable along infrastructures of mental health care
Authors	Bister, Milena D.; Klausner, Martina; Niewöhner, Jörg
Date of publication	2016
Title of the edited volume	Urban Cosmopolitics: Agencements, Assemblies, Atmospheres
Editors	Blok, Anders; Farías, Ignacio
Pages	187–206
Publisher	Routledge
URL	`https://www.routledge.com/9781138813410`

*joerg.niewoehner@hu-berlin.de; ORCiD: 0000-0002-9034-9761

The cosmopolitics of 'niching'

Rendering the city habitable along infrastructures of mental health care

Milena D. Bister Martina Klausner Jörg Niewöhner

2016

Introduction

In this chapter, we use empirical material from an ethnographic project on community psychiatry[1] to think through the manifold pathways along which everyday practices shape urban existence. We develop the notion of 'niching' to account for the ongoing material-semiotic processes through which people render cities habitable for themselves. Niching – understood in a cosmopolitical rather than systemic-ecological sense – problematizes how this rendering is partially connected to positive medical knowledge, infrastructures of care, administrative routines, and urban governance, but also unfolds in the interstices of urban assemblages. In this way, niching articulates both protection and closure, thereby asking questions about the impositions raised by cosmopolitics. We begin this chapter by briefly sketching our understanding of cosmopolitics and 'niching' in the context of urban assemblages, before setting out the field of social psychiatric care in a German metropolis. We unfold three cases of post-clinical everyday life before discussing this material in ecological terms, critically assessing the theoretical alternatives that arise from cosmopolitics vis-à-vis established Foucaultian critique.

Cosmopolitics

We take our reading of cosmopolitics from Isabelle Stengers (2005). Stengers essentially asks how inquirers are to analyse and understand how people attempt to live together. What are productive epistemic and ethical modes of approaching the constant assembling and re-assembling of multiple ways of living? Her proposal – as we read it – unfolds in three steps: First, the cosmopolitical proposal is rooted within an ecology of practices, i. e. it is a relational perspective following the processes of 'showing face' (Haraway 2008) within material-discursive practices (Barad 2007). This has two implications. It means that the basic unit of analysis is practices not entities (or relations of relations, cf. Bateson

[1]The project entitled 'The Production of Chronicity in Mental Health Care and Research in Berlin' (Principal investigator: Prof. Stefan Beck) was carried out at the Institute of European Ethnology from 2010 to 2016 and funded by the German Research Foundation (GZ: BE 3191/3–1).

in Beck 2008). And it means that the question of legitimate action is not brought to the analysis from an outside or meta-level of analysis, but rather is constructed from following the obligations and reciprocities produced within the emerging ecologies of practice (see also Verran 2001). Second, the notion of politics refers to 'our signature' (Stengers 2005) in such ecologies. It is about accountability always understood relationally, in a partial, distributed, and incomplete sense. Thirdly, cosmos refers to an understanding of ecology that rests on the fundamental uncertainty of the quality of relations. Cosmos does not denote a Kantian common sense of the good world; neither does it point to the assembly of societies according to a singular architecture, where each relationship in the network is determined in causal terms under some overarching logic. Cosmos refers to an ecology, where the terms of relation-building are at stake and are being constantly negotiated and where legitimacy needs to be established from a state of uncertainty. This carries important similarities with John Dewey's notion of 'publics' as that form of sociality which is enacted around states of incomplete knowledge and uncertainty, around the indefinite moment that becomes problematic and requires attention by a collective rather than a single logic (Dewey 1927). Cosmopolitics, then, is centrally concerned with the role and authority of positive knowledge as the ordering logic always working on directing an ecology of practices towards a common vanishing point, ignorant of the always already excessive nature of practice.

We are first and foremost concerned here with Stengers' understanding of cosmopolitical assembling as starting from a quality of relation-building she refers to as 'in the presence of'. We develop Stengers' thinking insofar as we are not primarily concerned with people in the presence of each other, but rather practices. 'In the presence of' asks how practices are aware of other practices and how they legitimize themselves against an always already present social and historical contingency (cf. the notion of care in Mol et al. 2010). If relations are not built strictly according to a singular logic, e. g. positive knowledge, a certain morality, or the laws of nature, how are they established and what are the consequences for such ecologies of practices? In our ethnographic material, we describe how people living with a psychiatric diagnosis attempt to live their everyday lives in the city such that it is bearable for them. We demonstrate that these attempts are only partially structured by an overarching logic and explicit negotiation within health care infrastructures. In much of their everyday-ness, however, they unfold 'in the presence of' broader urban assemblages. We discuss how urban governance and health care fail to address this cosmopolitical configuration and how it is in the interstices of official policy and formal care that urban cosmopolitics sometimes succeeds and at other times collapses.

Community psychiatry and the city

We explore here how people living with a psychiatric diagnosis render cities habitable. We first need to clarify terminology: Firstly, throughout the chapter we use the phrase 'people living with a diagnosis' (cf. Martin 2007) to indicate that we consider psychiatric diagnoses performative constructions rather than objective representations of stable mental states.

We do so, because we are aware of the looping effects between classification and 'ways to be a person' (Hacking 1999 [1986]) and we do not want to restrict our analysis of everyday life to the analytical dichotomy of normal vs. pathological. We therefore confine the use of the term 'patient' to people during a clinical stay. How life unfolds beyond clinical treatment is our research object. Using the label 'patient' or 'former patient' in non-clinical contexts would prematurely foreclose the possibility of people living their lives largely independent of psychiatric institutions. Secondly, we will explore 'rendering a city habitable' in more detail later. The psychiatric discourse speaks of 'coping'. Yet we have difficulties with this term's individualistic and cognitive connotations. We instead consider 'rendering habitable' a set of practices with an individual cognitive and affective component, but still embodied and heavily embedded in social contexts and material environments.

Cities seem to get on people's nerves. Georg Simmel famously said so (Simmel 2006 (1903)) and current epidemiological and neuroscientific research appears to confirm his analysis (Lederbogen et al. 2011): Large cities display a high incidence of psychiatric conspicuousness. The debate within the human sciences is as yet undecided whether cities cause nervous troubles or whether people of certain mind-sets move to cities. Yet natural and social sciences largely agree in their diachronic as well as synchronic analyses that cities present highly intense places that challenge human co-existence in particular ways – the perspectives reach from much lauded creativity to much deplored segregation and marginalization (e.g. Fitzgerald et al. 2014).

People become patients when their everyday life becomes unbearable for reasons that most outsiders consider mental, irrational, or hard to follow. In such cases, often accompanied by severe anxieties, psychotic moments, or acute delusions, people enter inpatient psychiatric treatment. Without attending here to the details of psychiatric treatment in the German social psychiatric context (see Klausner 2015, Zaumseil et al. 2007), we emphasize that the 'troubled mind multiple' (cf. Mol 2002) is enacted in treatments through a mix of medication and therapeutic formats reaching from individual psychotherapy to various group formats (Bister and Niewöhner 2014). Of interest in this context is what Klausner describes as 'carescapes' and 'choreographies' on the basis of her ethnographic work in two clinical contexts (Klausner 2015).[2] Choreography denotes the assembling of clinical treatment. This is less focused on therapeutic interactions between psychiatrists and patients trying to understand what is 'wrong' with a patient's mind. Rather 'treatment' resembles the enactment of 'normal' everyday life within a choreography of e. g. doctors and carers, medication, ward architecture, forms, and chairs. Carescapes, as sets of practices, then emerge from careful choreographies in action, i. e. carescapes arise from a particular mode of assembling, namely one that responds to contingency with increasing degrees of freedom rather than insisting on the supremacy of a clinical or biomedical-psychiatric logic. The clinic thereby provides a heavily routinized

[2]The notion carescape derives from the original concept of taskscape (Ingold 2000: 189ff.). With taskscape Ingold refers to the ongoing interweaving of activities in an environment emphasizing that what holds this interweaving together is a task or a problem. His aim was to avoid conceptions of the engagement of people with their surroundings as a form of interaction *between* the material and the social but rather to highlight the fundamentally relational quality of being in the world.

rhythm of everyday life. Patients, who have lost exactly this sense of the quotidian-ness of everyday life, mimetically learn and habitualize this rhythm. Being able to go with the flow of the clinical carescape leads to a psychiatric diagnosis as 'stable' and usually to the release from the clinical setting. Thus carescapes render the everyday in the clinic habitable.

Much of the critical attention to psychiatry from the social sciences (Foucault 1967, Goffman 1961) has focused on the problematic subjectification of individuals through clinical psychiatric care. We have analysed in detail elsewhere why and how this critique has become problematic in itself (Klausner et al. 2015). Suffice here to summarize that (a) psychiatry has moved from largely clinically based care to a social and community psychiatry that extends in multiple formats into city life; (b) the target of psychiatric interventions has shifted in many ways from 'the mind' to trying to choreograph everyday life; (c) psychiatric infrastructures of care are significantly shaped not only by medical expertise, but also by administrative logics and, increasingly, by the integration into urban assemblages. It is particularly this latter point, which provides the link between psychiatric care and urban assemblages that forms the basis of this chapter. The analytical repertoire in analyses of psychiatry has been focused largely on the interpellating effects of clinical power/knowledge (cf. Rose 2001 and, more broadly, Rabinow 1996). Psychiatric care becoming enmeshed in urban assemblages leads us to develop here an ecological perspective that focuses on attempts at rendering urban assemblages habitable, i. e. establishing 'stable' everyday lives 'in the presence of' positive knowledge and infrastructures as well as the multiple impositions of urban assemblages.

Niche and niching

We are interested in practices of rendering urban assemblages habitable. This is where for us the psychiatric literature meets urban studies. It is clear from our own and others' ethnographic research in this context that the Foucaultian repertoire of normality and control does not account for the diverse practices that people living with a diagnosis engage in to render assemblages habitable (Biehl 2005, Klausner and Niewöhner 2012, Lovell 1997). While the psychiatric dispositive certainly continues to play a role, our ethnographic material demonstrates that much more goes on than can be captured solely by the vocabulary of control and resistance. In these processes of rendering habitable, agency is distributed more widely and across a wider set of actors and infrastructures than previously the case.[3] These are processes that are not adequately treated with an analytical vocabulary that has (only) the subject as its vanishing point. We need a more 'ecological', more relational vocabulary that allows us to bring in the urban assemblages that people living with a diagnosis are trying to render. The Deleuzian notion of 'becoming' offers a good deal of fluidity, where discourses of identity formation and subjectivation have proved too static (cf. Biehl and Locke 2010). Yet it is ultimately still aimed at broadening the received notion of the subject. By moving the psychiatric

[3]For a discussion on distributed agency and agencement see Callon 2008; Chapter 1 in this volume.

debates beyond Foucault and bringing them into dialogue with urban theorizing, we hope to do justice to the practices with which our informants engage and at the same time add to the literature on the cosmopolitics of urban assemblages.

Working through the psychiatric material demonstrates that urban assemblages are not simply inhabited or occupied by people. People do not simply live out in the open. Rather they require an atmosphere in Peter Sloterdijk's sense (Sloterdijk 2004). People need to contain open spaces and immunize themselves against the often careless impertinence of urban existence. Especially in urban settings characterized by 'atmo-active agglomerations of space-establishments in their own right' (ibd. 2004: 655, our translation), this requires substantial engagement in 'air-conditioning technics' in the sense of creating socially, biologically and ecologically viable surroundings (cf. Tironi & Farías in press). We introduce the neologism 'niching' here, because we are less interested in the technological and capitalized nature of managing atmospheres that Sloterdijk essentially addresses. Rather we are interested in 'niching' as one mode of the 'processual everyday practicalities of dwelling' (McFarlane 2011: 951). Niching is the attempt to render urban assemblages habitable, to develop a mode of dwelling that is bearable.

Niching: a brief ecological genealogy

When readers see the term 'niche', most will probably think of the adequate place for a species within an ecosystem. Or they will think of the Chicago School of urban sociology that divided the city into 'natural areas' and heavily drew on ecological metaphors.[4] In fact, the notion of the 'niche' has proved a powerful concept in ecology that has been defined in very different ways depending on the dominant disputes within the discipline.[5] In evolutionary biology, the concept of the niche had been initially advanced to rethink the qualities of species-environment relations as pertaining to speciation and species community structure (Griesemer 1994). Accordingly, an ecological niche was first discussed as a specific place of a species within definable environmental parameters ('environmental niche'). Later the concept was extended to take into account that species impact on their environments as well ('population niche') (Colwell 1994). Ecologists engaged with what became known as 'niche theory' put considerable effort into understanding (and quantifying) competition between species and within populations as fundamental in manipulating the dimensions of a niche (Griesemer 1994). Recently, niche *construction* theories, both in the ecological and evolutionary tradition, start to account for the interactions between organisms and their environments as mutual, reciprocal, adaptive,

[4]The Chicago School of Sociology expanded insights from animal and plant ecology to societal questions of human existence. Notably though, Chicago School sociologists did not explicitly take on the notion of the niche, but instead developed their own vocabulary to elaborate on the interdependency, as it was seen, of cultural and natural characteristics of (urban) communities (Park and Burgess 1921, Park 1936, Wirth 1998 (1928)).

[5]Many concepts in the biological and life sciences have had a similar status: over a long history only ever vaguely and often ambiguously defined, but immensely productive largely because of that vagueness. The concept of the 'gene' is probably the most prominent example (Müller-Wille and Rheinberger 2009, Rheinberger 2000, Fox Keller 2008).

and/or selective processes (Kylafis and Loreau 2011, Barker and Odling-Smee 2014). Contrary to prevalent popular understandings of the term then, the 'niche' does not figure as a delimited physical place, but rather as a complex process composed of calculable, testable, and unknown environmental factors in interaction with population dynamics and selection.

We take our cue from this relational reading and import it into social science thinking.[6] Our use of the term remains metaphorical. We do not suggest that the practices of rendering urban environments habitable can actually be modelled as processes of niche construction. The focus is not on populations. And while the possibility of failure of niching is omnipresent, it is hardly captured adequately with the concept of 'selection'. Yet we employ the term to highlight an important ambivalence in our material: people living with a psychiatric diagnosis constantly negotiate the multiple tensions between both being part of urban assemblages, exploring them, building social networks, conquering unknown urban spaces and engaging in modes of dwelling that close them off from urban assembling, that fold in on themselves and that individualize experiences. Psychiatry frames this tension in terms of individual strategies, coping, and the importance of social support. We introduce the term niching to explore these tensions in relational or ecological terms. How do people manage to be alive to urban assemblages (Ingold 2011, McFarlane 2011)? These ongoing processes of creating viable surroundings are by no means restricted to people with a psychiatric diagnosis. They are necessarily part of everyone's quotidian life.

Modes of niching: moving through the city along infrastructures of care

In our analysis of the everyday lives of three informants[7] we elaborate on different modes of niching that emerge in the specific articulations of urban assemblages. We will depict how people living with a psychiatric diagnosis navigate urban environments with and through psychiatric infrastructures and how the respective infrastructures become present in their daily lives. Moving along such infrastructures – be they mental health care or otherwise – does not result in homogeneous trajectories. It does not result in institutionally defined niches. Rather it produces pathways. Focusing on these pathways – continuous movement and togethering (Ingold 2011) – we discuss how this affects agency. We try to show that niching distributes agency. For community psychiatry the aim

[6] Joseph Rouse has recently argued for applying niche construction theory to scientific (image) practices. See Rouse (2014), and Trizio (2014) for a commentary.

[7] The empirical material through which we work here is taken from a project on community psychiatry in Berlin (cf. endnote 1). Part of the project involved two of the authors (MB, MK) following individual 'patients' through their everyday lives over the course of two up to four years. It is this in-depth, individual-based ethnographic material that we analyse here. For this paper we have chosen to focus on the lives of three among the eight people we followed to allow for a more detailed analysis. Hence our objective is rather the thick description and generalisation *within* a case than a generalisation between cases. The chapter contributes to a theoretical exploration rather than advancing theoretical closure.

is to reinstall agency. Most psychiatric models operate as follows: as an effect of a psychiatric disorder a person loses his or her capability to act in a meaningful way. Through a heavily regulated and routinized rhythm of everyday life, agency can be regained. This conception of agency is not limited to psychiatric reasoning but prevails in much theorizing about social action. In niching, agency does not belong to an agent – be it a human or non-human actor (cf. Callon 2008). Rather, agency evolves in relation and movement and becomes distributed. Discussing our material in terms of niching then helps us to break the dominant logic that understands patients, their (mental) needs, the psychiatric care system, and related housing arrangements as interacting entities, where one helps, objectifies, or resists the other. Instead we discuss niching as producing or reducing degrees of freedom within movement (cf. Haraway 2008).

Taming the street: anxiety, drugs, friends

First, we turn to the living situation of Angelika Siebert, a woman in her early forties, who had lived with a diagnosis of schizophrenia for twenty years. She lived in a nursing home for chronic mental patients where she had moved a couple of years ago. In Angelika Siebert's case the decision was fostered by her request to live on the first floor because of her fear of heights as well as her inability to move around in the urban surroundings by herself, which would be a precondition for living in a group home. Besides the mentioned limitations she was – in comparison with the other inhabitants of the nursing home – very capable of taking care of herself and – as a social worker commented once – the nursing home did not seem to be an adequate living situation for her. She loved to prepare her own food but had very limited access to the common kitchen, which was open only for specific hours a day. She set up her own little household, as she called it, in her room, which she shared with another woman. Her efforts to make the room 'her own place' were met with constant restrictions based on the organizational conditions of a nursing home (no food storage in the room etc.). A major problem for her was that she could not lock her room and at any time staff (and basically anyone else, since the facility was itself not locked during daytime either) could enter her place. Her plan was to move into an own apartment in the near future. While the nursing home limited Angelika Siebert in the way she could arrange her own place, it also provided her with an undemanding network of social contacts. As she once explained, there was always someone around with whom she could talk. When she felt alone or anxious she could talk to one of the nurses or therapists or other inhabitants in the nursing home. She was also active in organizing companionship for her walks, for going shopping, or to a café. With some of her housemates she regularly visited a little Turkish bakery around the corner where they could sit and get affordable drinks. They also discovered a little second hand store close by, with whose owner they became friends and where Angelika sometimes helped in sorting the shelves. Those little spots of social contact outside the nursing home were especially precious to Angelika and nothing she took for granted, particularly when she recalled the last three years in her life.

When we first met in the hospital, one main therapeutic goal for her was to slowly

increase her radius of movement. Before she was admitted to the hospital she had not left her room in the nursing home for almost two years. 'It was unbearable', she recalled. Being too anxious to move outside the nursing home or walking up to the facility's upper levels she was limited to her room and the small hallway on the first floor. To keep moving she walked around the 30 m^2 room for an hour a day but most of the time she stayed in bed. At that time she took her night medication at five in the afternoon to end her day and go to sleep. A friend of hers whom she had known for many years at one point decided it was time for her to move to the hospital again, where she stayed for almost a year before returning to the nursing home. In the hospital she learned to formulate some demands towards herself again, as she saw it. When she was released from the hospital she was able to walk up the stairs in the nursing home to use the common kitchen on the second floor, for example, and to go for walks outside the nursing home in the company of others like therapists, housemates, or friends. During one of our walks in the surroundings of the nursing home we both recalled our walks in the hospital park. 'Isn't it amazing how far I got! Now I walk along a busy street and it is no problem for me at all! That was unthinkable a year ago.' We recalled the first time she managed to cross the busy street just outside the hospital, the first time we went to a nearby drugstore. We remembered the complicated detours to avoid busy streets and stairs and all the planning it took to find the right way to the department store. For Angelika Siebert moving around in the streets was still hard work and always a bit risky and potentially overwhelming: too much noise, too many people, too intense for her to keep control. The challenge was to find a balance between the sensory overflow of the life around her and withdrawal at the right time. To keep this balance she engaged with two forms of assistance: the companionship of housemates, therapists and friends and the assistance of medication. During her stay in the hospital the dose of her medication was slowly reduced to increase her ability to be active. As she put it: in the hospital she had learned that she did not need to constantly sedate herself to make her life bearable but to occupy herself, to be active. This has not always been an easy learning process for her: 'You get a thick skin through meds. Less medication means you get thin-skinned.' Nevertheless she would never discontinue her medication. For her, medication was an indispensable assistance in managing her daily life and extending her radius of movement into the urban surroundings. In this sense, taking medication is distributing agency away from a contained self and into a carefully managed daily routine. Sticking to this routine opens up degrees of freedom. It renders a wider urban environment habitable by reducing the intensity of percipience, increasing the capacity to face social situations and calming, e. g. overwhelming feelings of anxiety. Yet at the same time dependence on medication may reduce degrees of freedom. It makes one docile and sluggish, reduces motivation to go out and about and makes social interaction more difficult. Managing a personal drug regime thus highlights two aspects of niching: Niching is an embodied practice as infrastructures reach under the skin. New pathways and movements are possible, others are foreclosed.

Still, as Angelika Siebert's case also highlights, meds alone were no solution, rather she needed both: pills to reduce her symptoms and relax and the companionship of

housemates and friends. Over time she had created her own network of places and people in the area around the nursing home. Crucial to her life were her close friends whom she had known for a long time and who stuck with her through all the ups and downs in the course of her illness. It was one friend in particular whom she trusted enough to let him challenge her current radius of movement: every time he pushed her a bit further, crossing a bridge, taking a taxi, going to a busy market. While at the beginning she was anxious to carefully plan every route in advance and was exhausted after being outside for a rather short time, at some point she was able to go for long spontaneous walks. All in all, her friendships were an extremely important part of her life and she claimed herself to be very lucky, especially compared to other inhabitants of the nursing home. For most of them their social world was restricted to their housemates and the healthcare professionals.

For Angelika, the urban surrounding around her nursing home in a sense has become her 'therapeutic landscape' (Laws 2009). With the help of friends and meds, she had learned to extend her reach initially restricted to her own bed and to a single room into something much more flexible. But this also clearly blurs the boundaries between therapy and living a daily life: while she never completely lost a sense of therapeutic work when she was on the move she increasingly regained some sense of normalcy of living in the city. In a sense she has learned to tame the streets and make them available for her needs. While psychiatry would interpret this development in terms of regaining agency, we show here that this is not really a meaningful reading of the situation. She is still dependent on many friends and meds, her surrounding infrastructures and urban features. Agency is still distributed along a movement. Yet the degrees of freedom for all participants in this movement have increased. There is room to manoeuvre and it is in this flexibility that new possibilities arise to enter and engage urban spaces and render them habitable for her own everyday life.

(Re-)arranging the street: bikes, bins, money

Olaf Mattes' niching was quite different to Angelika's. Olaf Mattes had moved into his own apartment nine years ago, after he had lived in a group home for some years. His social worker stopped by once a week, brought him money, and worked with him on structuring his everyday life, especially cleaning up his apartment. Every once in a while Olaf Mattes got in trouble with his neighbours and the owner of the apartment building, because he piled up things in the hallway and the staircase when all rooms in his own apartment were fully packed. He collected things in the neighbourhood, which he thought he could use or sell. For the therapists and the social worker this hoarding was a symptom of his illness and his incapability of differentiating between useful and useless things. But as Olaf Mattes insisted, he did not collect garbage but 'meaningless things from the streets' (meaningless to others). From part of the mental health care service there had been regularly efforts to motivate him to move back into a group home – something that Olaf Mattes strongly rejected. Olaf Mattes' interaction with the mental health care system was ambiguous. He accepted some of the offers and used them in

a rather pragmatic way but at the same time tried hard to keep the assistance in an 'acceptable dose' and at a certain distance. When he was released from the hospital for example after his last relapse (he lived with a diagnosis of schizophrenia for half of his life) the psychiatrist at the hospital encouraged him to enlist the social service's assistance in the administration of his psychopharmaceuticals. This would mean a nurse would stop by every day and monitor him taking his medication. Olaf Mattes rejected this recommendation; he would do this on his own. There was a constant worry on the side of the health care professionals that Olaf Mattes could become non-compliant and risk another relapse. Every once in a while he rigidly excluded medication from his life, against the advice of his psychiatrist and even though this led to a relapse every single time he did so. Medication, in his case antipsychotics, did not only have good sides, he explained once. Besides possible long term effects on organs and metabolism, Olaf Mattes (and also several other informants) problematized the 'visibility of psychopharmaceuticals' through side effects: weight gain, sedation, dizziness, blurred speech and vision, drooling, increased need for movement or extrapyramidal side effects (the body appears to be 'frozen' or stiff). This visibility sometimes led to withdrawal from social life, be it friends, family, neighbours or 'the public'. Olaf Mattes also told the story of a friend who had refrained from leaving his apartment lately because he feared people could see that he is mentally ill. As we already discussed in the story of Angelika Siebert, medication strongly shapes niching. In this sense, pills are important participants (Hirschauer 2004) in niching as they enable as well as limit the daily activities and movements. While taking drugs or not is a matter of free choice in principle, most people operate with different types of drug regimes rather than not taking any drugs at all. How they render their urban environment habitable then is not merely a matter of an unmediated subjective experience and individual choice. Rather aspects of health insurance, of side effects, of schedules, and of biomedical knowledge all become agents in shaping niching. It would be too simple an interpretation to frame drugs merely as extensions of psychiatric control into patients' bodies. Rather people like Olaf Mattes and Angelika Siebert live through medication – or as Ingold might say: they live *along* medication (Ingold 2011).

Similar to his use of medication according to his personal agenda Olaf Mattes was also eager to keep control over the type and amount of assistance the system offered him. He looked back at a long history of psychiatric treatment and as he claimed himself: 'I know it all: TWG [therapeutic group home), BEW [assisted living], different hospitals, and day clinics, PIA [outpatient treatment at the hospital], PTZ [therapeutic day care], ÜHW [contemporary housing programme], all kinds of sheltered working programmes.' In the district where our informants lived most of the community psychiatry facilities were situated within striking distance. Several therapeutic day care centres, sheltered workshops, outreach clinics etc. were located within one 'Kiez' (neighbourhood) and therefore provided a rather dense topography of community care. Olaf Mattes used part of the respective therapeutic offers on a regular basis and over the years had learned to arrange support in a way suitable for him. Similar to Angelika Siebert, Olaf Mattes had his own map of where to go and engage in different kinds of activities. At a therapeutic day care centre for psychiatric patients, for example, he was enlisted for lunch, where he

had to pay only one Euro for a meal. 'Very helpful at the end of the month when I run out of money', he explained to me. While from the perspective of community psychiatry, the therapeutic aim of all the programmes where he was enlisted was to constantly work on a 'therapeutic progress' to ensure 'stability' and avoid 'potential relapse', Olaf Mattes' idea of stability was different. For him it meant to reduce professional assistance as far as possible. He used therapeutic offers but arranged them for his own needs. For him the urban environment was populated by all kinds of potentials. This included institutions of community psychiatry but was not limited to them. Rendering the city habitable for him meant to creatively use what he found around him: a cheap lunch, bins in a large park, a bike he could repair and sell. At one of our meetings to eat a Currywurst at his favourite snack bar, he showed up carrying a bike with a flat tyre. When I asked him what happened to his bike he replied 'It's not mine. I found it on the street. I was watching it for a couple of days but no one picked it up, so I will fix it and try to sell it'. As part of his rehabilitation plan he worked at a sheltered workshop for people with mental illness. The workshop offered different areas of specializations like catering, woodwork, and so on. Olaf Mattes worked in the bike shop of the sheltered workshop where he was allowed to work on his own things as well. While we ate our Currywurst he checked his watch several times, stating he needed to rush to be in time at the workshop before it closed. He did not want to carry the bike back to his apartment all the way. And, with a smile, he added if his social worker got to see the bike he would be worried that he had started collecting again.

Rather than 'using' a predetermined niche of professionalized care, Olaf Mattes' case underlines possible ways of embedding institutionalized care into quotidian life. In this sense, navigating the topography of community psychiatry becomes continuous work; work that is not primarily a subjective act of acceptance or resistance of infrastructure. Navigating the infrastructures of care is a process that heavily depends on the ability to enrol others, to shape spaces and institutions, to work with and through technologies to arrive at what informants refer to as an autonomous mode of urban existence. Clients like Olaf Mattes neither simply 'fit' into an existing space, nor do they live out in the open in a total rejection of the control implied in the infrastructures of care. They render multiple topographies habitable. While for Angelika Siebert rendering the city habitable foremost meant expanding her movement with the assistance of infrastructures (medication, therapist and housemates) and friends, Olaf Mattes' mode of niching was less about expanding his mobility but constantly working on establishing some kind of stasis, in the sense of a status quo, that allowed him to distance himself from therapeutic care and control. Stasis for him, however, did not mean repetition and sameness as it might do for psychiatrists. Rather stasis was an ongoing achievement that arose from different forms of engagement with urban assemblages.

Drifting along the street: pocket money, 1,50 jobs, personal affections

For Karin Laringer, a women in her thirties with a diagnosis of depression, niching first and foremost meant rendering habitable a house with paper-thin walls with the assistance of her social worker. In contrast to Angelika Siebert and Olaf Mattes, she still lived in the district where she had grown up. As a teenager she moved about 300 km into a home for mentally challenged children, but she came back to Berlin after five years. In contrast to her boyfriend who wanted to leave town and start a better life somewhere else, Karin Laringer insisted that her district was her home: that she knew the streets and the corners, she knew where to buy groceries and where to get a manicure. She knew her neighbours, whom to trust, and whom to avoid. As opposed to Olaf Mattes she had no relapses that brought her back to the clinic. Suggestions for improving her living situation came predominantly from her social worker, whom she met weekly. While Karin Laringer truly disliked the house she lived in and most of her neighbours, she could not find the courage to move. She refused both the offer to move into an assisted living facility and the social worker's assistance to find a new apartment. She preferred living in a less pre-modelled environment. Over the course of the two years of our ethnographic encounters, she stayed put and plans were abandoned to make her move. We consider her living situation frozen and it demonstrates that niching does not necessarily result in a good 'fit'.

Rendering habitable does not preclude an experience of constant frustration. In Karin Laringer's case frustration was a close companion. Whereas she saw the city as a place with a huge range of activities and a crowd of people, which should both make friendships and entertainment easy, for her the opposite was the case: She missed company, felt lonely, and suffered from an abundance of time. The only people she met privately on a regular basis were her boyfriend and her mother. Dependent on unemployment benefits for more than ten years, Karin Laringer believed that if she had more money, life would just start to become liveable. Instead she said that she merely struggled to survive. In care of a financial assignee she had 60 Euros a week for groceries and for those expenses her assignee either deemed surplus, like the manicure she loved, or taboo, like consuming cannabis. Such activities were not acknowledged by extra money. Hence she decided to eat cheaper, to frequent local food banks, to avoid any place with entrance fees and to get small jobs, called 1,50 jobs, if possible. The latter brought 1,50 Euros an hour and were not jobs to be found directly on the street, but work opportunities arranged by the Job Centre for about 16 % of all inhabitants of Berlin (April 2015). To get any of these, Karin Laringer had to convince her personal job adviser at the Job Centre face-to-face that she was motivated to work on her daily routines and that she still aimed for working on the regular job market in the future. She succeeded in that, but was frustrated by the working conditions of the 1,50 job after a couple of weeks. Basically there was nothing to do, or how she phrased it: 'We keep ourselves busy. If we did not have any fantasy and came up with our own ideas, we would just hang around.' These jobs frustrated Karin Laringer and she skived frequently until she finally

stopped going altogether. Consequently she again spent most of her time alone at home or in her boyfriend's flat, who lived in the same house, with some regular tours into the neighbourhood: She saw her financial assignee once a week to pick up her money; she went out to the social worker's office; every couple of weeks she went to see her local psychiatrist; she left her home for manicure, for groceries, and for getting aliment from the food bank. From time to time she visited her mother or met her boyfriend outside their homes.

In summary, having only 60 Euros at her disposal impacted significantly on Karin Laringer's life. Her social radius of action, her leisure activities, food shopping as much as her scheduling of daily and weekly activities revolved around the challenge to get by with this amount of money. As such her financial situation did not determine her life, but rather deeply affected her doings and finally her being alive. Further, the way she spent her spare money partly went against health care system rationality. For example, both her social worker and her psychiatrist urged her more than once to stop smoking weed. Especially the latter argued that the antidepressant she took on a daily basis would not work properly in conjunction with cannabis. Despite Karin Laringer's awareness of the health effects, she felt absolutely incapable of abandoning the habit. With the assistance of the social worker she once started a treatment for drug addiction with a therapist she liked and trusted. Nevertheless, after a couple of meetings, she told me that she did not see the therapist anymore, because he insisted that she would have to change her social environment if she seriously wanted to refrain from smoking. She argued that would mean to break up with her boyfriend, with whom she smoked. That was not an option for Karin Laringer, because he was, beside her mother, the only person who met her with personal affection.

Karin Laringer's case indicates how niching processes might bring the supporting infrastructures to a limit: Through skiving off the 1,50 job she had lost extra money and the option of being supported by the Job Centre in finding her way back to the main job market. Through remaining true to her boyfriend she lost support of her therapist in fighting drug abuse. Her mode of niching led to temporal social paralyses and largely ran against her own goals. Instead of improving her life according to her own visions – e. g. living in a different flat, with a regular income, and uninfluenced by drugs – basically nothing had changed. Nevertheless Karin Laringer's life did not 'end' in an unchanging niche. To the contrary, niching proceeded: She continued taking antidepressants, she started thinking of working in a sheltered workshop and continued seeing her social worker, her financial assignee, and her psychiatrist. Niching in this sense never stops, but remains indicative of a mode of experimental being-in-the-world that includes the arrangements with (care) infrastructures within the possibilities and limits of the urban (cf. Schillmeier 2009).

Reflecting urban niching

We have elaborated on a range of elements that constitute niching processes: Laringer's and Siebert's stories have shown how social contacts are an elementary component in

the ways people navigate their everyday life and render urban assemblages habitable. Niching in all cases involves family and friends as well as professionals such as social workers and therapists. Laringer's and Mattes' cases demonstrate how financial resources substantially interfere with niching, whereas Siebert's and Mattes' examples show the impact of medication. While all of our informants were engaged with the infrastructures of mental health care, we have also shown that niching as a mode of urban existence goes significantly beyond psychiatric carescapes.

Three facets of 'niching' are of particular importance to us: First, niching is a process heavily shaped by people's experiences in and of the city. Our informants – and we believe that this is typical for many people living in cities – do not develop and execute great designs of their lives. Rather they navigate an urban existence very much on the basis of everyday experiences: what works and what does not work. They muddle through. Secondly, this muddling through is not simply a process that people undertake out there in the city or in the environment. Rather it is a process heavily mediated by institutions. In our case, these are infrastructures of psychiatric care, but others – social services, labour, migration – are obvious. People's experiences in and of the city are heavily shaped by these infrastructures. Thirdly, niching does not lead to a conclusion in a successful niche. It is merely a mode of rendering habitable urban assemblages. It is an ongoing process and it may produce moments of stasis. Niching never results in some sort of 'fit' of individual lives in an urban space. Rather niching is a mode of engaging with urban assemblages.

Niching in cities under pressure

With the ethnographic sequences we have shown how individual experiences are enmeshed with urban assemblages. We have focused on niching as experienced and lived by individuals. Yet niching occurs in a broader urban context. Our examples are all situated in a district in Berlin that is currently undergoing fundamental transformation. It is being gentrified from an area perceived as socially problematic with high unemployment and a significant number of immigrants to an area for young urban professionals and middle class families. As a consequence, rent increases are amongst the highest in Europe. For our informants and their ability to engage in niching, this is highly problematic: Finding affordable apartments is virtually impossible. Hence leaving sheltered housing without leaving the district is extremely difficult. Shelter programmes, which currently provide a dense topography of therapeutic offers in the area, are increasingly unable to afford to pay rents. They have to relocate. The service infrastructure is changing rapidly from rather quirky, low-budget cafés and workshops to high-end coffee shops, restaurants, and galleries. While this change is not in in itself reducing the degrees of freedom, it is reshaping the distribution of agency. This is a matter of money and resources. Yet it is also a question of care. It is an empirical question whether the new district environment will prove as careful towards our cases of niching as the old one has done. Will people in bike shops have time for Olaf Mattes and his orphaned bikes? Will the low-priced bakeries and cafés remain where Angelika and her housemates spent their afternoons?

Will Angelika Siebert find a landlord renting out an affordable flat in the area? Will food banks and other supportive infrastructures hold up and continue attending to Karin Laringer's routines? It is likely that overall, people living with a psychiatric diagnosis will find rendering these new upmarket urban environments habitable next to impossible. Most probably, they will be pushed to the margins of the city where degrees of freedom are low and their dependence on psychiatric infrastructures will increase. While individual actors – a café or an organic pastry shop – might well appreciate the consequences of this development and accommodate different modes of niching, across the board and individual cases this change is likely to alienate the current clientele from their residential neighbourhood.

Niching in practice: politics failing cosmopolitics?

We close by bringing back niching to the notion of urban cosmopolitics. Stengers thinks of the cosmos as relationality 'in the presence of'. We suggest that our ethnographic cases demonstrate how in many contexts 'in the presence of' does not necessarily lead to careful reciprocity in ecologies of practice. Perhaps we have to distinguish between two sets of practices that stand in tension with each other although both contribute to urban assemblages. On the one hand, we witness ecologies of practices that constitute urban public spaces and that include people with a diagnosis. Parks and cafés, libraries, kiosks, and other places that provide the degrees of freedom necessary to show face and accommodate difference.

Niching here is a truly cosmopolitical process in that it enjoins people in mutual attempts to render urban assemblages viable and habitable for very different sorts of experiences and lives. On the other hand, niching also marks an ecology of practices where agency is not shared and distributed throughout urban assemblages, but heavily restricted, in our case, to 'patients' and infrastructures of care. The Foucaultian critique of psychiatric practices has so far problematized this development as an expansion of psychiatric control from the 'total institution' through infrastructures of care ever further into communities. Our ecological analysis shows that it is exactly the diminishing degree of control that might cause difficulties for people with a diagnosis. Clinical choreographies contained sufficient degrees of freedom for carescapes to emerge. Infrastructures of care transport some of these degrees of freedom into urban assemblages. Yet increasingly people with a diagnosis need to and are expected to engage with urban assemblages without the support of psychiatric infrastructures. These urban assemblages, however, are shaped by competing agencies and as such they are seldom careful. They often lack the sensorium to recognize alternative forms of practice or they are under pressure to defend their own logic against contingencies. It is this competition of agencies within the assembling of the city that necessitates the rearranging of atmospheres and the provision of shelter. This is why we introduced the notion of niching – to show how people try to work towards atmospheres where contingency is reduced and everyday life is bearable. People with a diagnosis more often than not struggle to enter this process. Neither they as subjects nor the subject positions they inhabit within urban assemblages are conducive

to reducing contingency and making their social, material, and emotional surroundings viable. Rather their niching creates remote atmospheres, regions of disconnection, and operational closure. Consequently, people withdraw into the psychiatric realm. While this in effect moves them back under psychiatric control, agency within this process does not lie with psychiatry. The ecological perspective reveals the particularities of niching processes and hence demonstrates how urban assemblages play a role in impacting on the degrees of freedom on which people with a diagnosis have come to rely through mimetic learning within clinical carescapes.

Finally, the ecological perspective onto community psychiatry and post-clinical trajectories shows – almost ironically – a failed medicalization of urban assemblages. Social psychiatry insists on releasing people into urban assemblages rather than keeping them closely tied to professional infrastructures of care. A particular 'private' way of using public spaces is seen as a necessary part of integrating people with a diagnosis into urban life. Yet these public spaces are being governed without recognition for the degrees of freedom necessary to make urban assemblages viable for people with a diagnosis. This has many reasons and we can only hint at these in closing: (1) Urban development has little to do with health policy. Links are emerging around issues of urban planning, obesity, and cardiovascular disease, but the entanglement of urban built environments (let along assemblages) and mental states is virtually non-existent in practice. While we are not suggesting that urban planning ought to be medicalized to arrive at the 'total city', degrees of freedom within urban assemblages are not only part of treatment but also address fundamental concerns about quality of life in and through urban assemblages. (2) These degrees of freedom are increasingly undermined by changes in the nature of public spaces. Often reduced to the heavily politicized notion of neoliberal reforms, even a more differentiated view of these changes shows how privatization, increase in rents and property prices, commercialization, and changes in public discourse all narrow public spaces geographically, socially and morally. Heterogeneity and degrees of freedom are reduced within such assemblages. Hence informal and careful urban infrastructures that enable niching for people with a diagnosis beyond the psychiatric institutions increasingly fold under pressure. (3) Urban studies knows all-too-well the intense conflicts around the role of public spaces within urban assemblages. Yet while these thought collectives try to open space for a diversity of agencies and everyday forms of life, they are often propelled by a milieu with a very different sort of niching in mind. Often these are middle class movements arguing for space for creativity, innovation, artistic expression, openness in general etc. This does not preclude niching as described in this article, but neither does it have it high on the agenda. It pursues a different set of practices and logics.

In conclusion then, urban cosmopolitics rests on the notion that relationality 'in the presence of' is something that requires careful work. We have used the case of people with a psychiatric diagnosis here, because it brings into view a group of people and their niching practices that react with extraordinary sensitivity to changes in urban assemblages. We have shown how urban assemblages can provide or hinder the degrees of freedom that enable very heterogeneous ways of experiencing public spaces in cities and how these experiences in turn contribute to particular urban assemblages. We have

also discussed how these degrees of freedom increasingly come under pressure making particular forms of niching difficult or impossible. A cosmopolitics of niching is not a given – it needs to be constantly negotiated within urban assemblages and their degrees of freedom for multiple ways of experiencing the city.

References

Barad, K. 2007. Meeting the Universe Halfway. Quantum physics and the entanglement of matter and meaning. Durham, NC: Duke University Press.

Barker, G. and Odling-Smee, J. 2014. Integrating ecology and evolution: niche construction and ecological engineering. In: Barker, G., Desjardins, E. and Pearce, T., eds. Entangled Life: Organism and Environment in the Biological and Social Sciences. Dordrecht: Springer Science+Business Media, 187–211.

Beck, S. 2008. Natur | Kultur. Überlegungen zu einer relationalen Anthropologie. Zeitschrift für Volkskunde, 104(2), 161–199.

Biehl, J. 2005. Vita. Life in a Zone of Social Abandonment. Berkeley: University of California Press.

Biehl, J. and Locke, P. 2010. Deleuze and the anthropology of becoming. Current Anthropology, 51(3), 317–351.

Bister, M. D. and Niewöhner, J. eds. 2014. Alltag in der Psychiatrie im Wandel. Ethnographische Perspektiven auf Wissen, Technologie und Autonomie. Berlin: Panama Verlag.

Callon, M. 2008. Economic markets and the rise of interactive agencements: from prosthetic agencies to habilitated agencies. In: Pinch, T. J. and Swedberg, R., eds. Living in a Material World. Economic Sociology Meets Science and Technology Studies. Cambridge, MA: MIT Press, 29–56.

Colwell, R. K. 1994. Niche: a bifurcation in the conceptual lineage of the term. In: Fox Keller, E. and Lloyd, E. A., eds. Keywords in Evolutionary Biology. Cambridge, MA: Harvard University Press, 241–248.

Dewey, J. 1927. The Public and its Problems. New York: Holt Publishers.

Fassin, D. 2009. Another politics of life is possible. Theory Culture & Society, 26 (5), 44–60.

Fitzgerald, D., Rose, R. and Singh, I. 2014. Urban life and mental health. Re-visiting politics, society and biology. Discover Society, 5. http://discoversociety.org/2014/02/15/urban-life-and-mental-health-re-visiting-politics-society-and-biology/. (accessed March 30, 2015).

Foucault, M. 1967. Madness and Civilization. New York: Mentor.

Fox Keller, E. 2008. Nature and the natural. Biosocieties, 3 (2), 117–124.

Goffman, E. 1961. Asylums. Essays on the Social Situation of Mental Patients and Other Inmates. New York: Doubleday.

Griesemer, J. R. 1994. Niche: Historical perspectives. In: Fox Keller, E. and Lloyd, E. A., eds. Keywords in Evolutionary Biology. Cambridge, MA: Harvard University Press, 231–240.

Hacking, I. 1999 [1986]. Making up people. In: Biagioli, M., ed. The Science Studies Reader. London, New York: Routledge, 161–171.

Hacking, I. 2006. Kinds of People: Moving Targets. British Academy Lecture, 10, 1–18.

Haraway, D. J. 2008. When Species Meet. Minneapolis: University of Minnesota Press.

Hirschauer, S. 2004. Praktiken und ihre Körper. Über materielle Partizipanden des Tuns. In: Hörnig, K. H. and Reuther, J. eds. Doing Culture. Neue Positionen zum Verhältnis von Kultur und sozialer Praxis. Bielefeld: transcript, 73–91.

Ingold, T. 2000. The Perception of the Environment. Essays on Livelihood, Dwelling and Skill. Abingdon, Oxon: Routledge.

Ingold, T. 2011. Being Alive. Essays on Movement, Knowledge and Description. Abingdon, Oxon: Routledge.

Klausner, M. 2015. Choreografien psychiatrischer Praxis. Eine ethnografische Studie zum Alltag in der Psychiatrie. Bielefeld: transcript.

Klausner, M., Bister, M. D., Niewöhner, J. and Beck, S. 2015 (in press). Choreografien klinischer und städtischer Alltage. Ergebnisse einer ko-laborativen Ethnografie mit der Sozialpsychiatrie. Zeitschrift für Volkskunde, 111 (2).

Klausner, M., and Niewöhner, J., eds. 2012. Psychiatrie im Kiez. Alltagspraxis in den Institutionen der gemeindepsychiatrischen Versorgung. Berlin: Panama Verlag.

Kylafis, G. and Loreau, M. 2011. Niche construction in the light of niche theory. Ecology Letters, 14, 82–90.

Laws, J. 2009. Reworking therapeutic landscapes. the spatiality of an 'alternative' self-help group. Social Science & Medicine, 69 (12), 1827–1833.

Lederbogen, F., Kirsch, P., Haddad, L., Streit, F., Tost, H., Schuch, P., Wüst, S., Pruessner, J. C., Rietschel, M., Deuschle, M. and Meyer-Lindenberg, A. 2011. City living and urban upbringing affect neural social stress processing in humans. Nature, 474 (7352), 498–501.

Levinson, J. 2010. Making Life Work. Freedom and Disability in a Community Group Home. Minneapolis: Minnesota University Press.

Lovell, A.M. 1997. 'The City Is My Mother': Narratives of Schizophrenia and Homelessness. American Anthropologist 99 (2): 355–368. doi: 10.1525/aa.1997.99.2.355.

Martin, E. 2007. Bipolar Expeditions. Mania and Depression in American Culture.

Princeton, NJ: Princeton University Press.

McFarlane, Colin. 2011. Learning the City. Knowledge and Translocal Assemblage. Malden, MA: Wiley-Blackwell.

Mol, A. 2002. The Body Multiple. Ontology in Medical Practice. Durham, NC: Duke University Press.

Mol, A., Moser, I. and Pols, J., eds. 2010. Care in Practice. On Tinkering in Clinics, Homes and Farms. Bielefeld: transcript.

Müller-Wille, S., and Rheinberger, H.-J. 2009. Das Gen im Zeitalter der Postgenomik. Eine wissenschaftshistorische Bestandsaufnahme. Frankfurt/M: Suhrkamp.

Park, R. E. 1936. Human ecology. The American Journal of Sociology, 42 (1), 1–15.

Park, R. E., and Burgess, E. W. 1921. Introduction to the Science of Sociology. University of Chicago. http://www.gutenberg.org/files/28496/28496-h/28496-h.htm (accessed March 30, 2015).

Rabinow, P. 1996. Artificiality and enlightenment: from sociobiology to biosociality. In: Rabinow, P. ed. Essays on the Anthropology of Reason. Princeton, NJ: Princeton University Press, 129–152.

Rheinberger, H.-J. 2000. Gene concepts. Fragments from the perspective of molecular biology. In: Beurton, P. J., Falk, F. and Rheinberger H.-J. The Concept of the Gene in Development and Evolution. Historical and Epistemological Perspectives. Cambridge: Cambridge University Press, 219–239.

Rose, N. 2001. The politics of life itself. Theory, Culture & Society, 18 (6), 1–30.

Rouse, J. 2014. Scientific practice and the scientific image. In: Stoler, L., Zwart, S., Lynch, M. and Israel-Jost, V., eds. Science After the Practice Turn in the Philosophy, History, and Social Studies of Science. New York, London: Routledge, 277–294.

Schillmeier, M. 2009. Assembling money and senses. Revisiting Georg Simmel and the city. In: Farías, I. and Bender, T., eds. Urban Assemblages. How actor-network theory changes urban studies. London: Routledge, 221–256.

Simmel, G. 2006 (1903). Die Großstädte und das Geistesleben. Frankfurt/M: Suhrkamp.

Sloterdijk, P. 2004. Sphären. Plurale Sphärologie – Band III: Schäume. Frankfurt/M: Suhrkamp.

Stengers, I. (2005). The cosmopolitical proposal. In: Latour, B. and Weibel, P. eds. Making Things Public. Cambridge, MA: MIT Press, 994–1003.

Tironi, M. and Farías, I. (in press): Building a Park, Immunizing Life. Environmental management and radical asymmetry. Geoforum.

Trizio, E. 2014. Is Rouse's scientific image really scientific? Commentary on 'scientific practice and the scientific image', by Jospeh Rouse. In: Stoler, L., Zwart, S., Lynch, M.

and Israel-Jost, V., eds. Science After the Practice Turn in the Philosophy, History, and Social Studies of Science. New York, London: Routledge, 295–300.

Verran, H. 2001 Science and an African Logic. Chicago, IL: University of Chicago Press.

Wirth, L. 1998 (1928). The Ghetto. New Brunswick, New Jersey: Transaction Publishers.

Zaumseil, M., Vock, R., Zimmermann, R.-B. and Manderla, S. 2007. Mit der Diagnose 'chronisch psychisch krank' ins Pflegeheim? Eine Untersuchung der Situation in Berlin. Frankfurt/Main: Mabuse-Verlag.