Have a Seat!: Approaching the Object of the Chair at the Site of Psychiatry

Lisa Landsteiner

Cultural studies in recent years has been dealing in greater depth with questions relating to the material production and composition of psychiatric space, taking up a thread of analysis that was laid out by psychiatrists like Jean Étienne Esquirol (1772–1840), Wilhelm Griesinger (1817–1868), and Johann Christian Reil (1759–1813) (Ankele 2018; Majerus 2017; Hess/Majerus 2011; Hicks/Beaudry 2010). As Monika Ankele (2018a) points out, psychiatric science always had to take into account the effects of the materiality and spatial quality of the psychiatric institution, since treatment never takes place under laboratory conditions. Reflections of these epistemological preconditions initiated the development of theory work concerned with institutional architecture, including scenography and material culture in the psychiatric space (Kaiser 2019; Topp 2017; Moran/Topp/Andrews 2007; Yanni 2007; Gittins 1998). In the sense of Michel Foucault's (1990) description of space as "heterotopia," psychiatry brings together several spaces in one place. These are, of course, socio-psychological spaces like safe spaces, trauma zones, emotional valves, and treatment limits, but also an extensive arrangement of physical spaces, for example entrances, treatment rooms, waiting rooms, meeting rooms, hallways, kitchens, studios, and offices. Differing in terms of use and accessibility, these rooms share one particular commonality that caught my research interest: they are all filled with chairs.

The beginning of my approach to the object of the chair in the psychiatric space marks a coincidental moment when I walked down the hallway on my way back to my desk during my internship at a Swiss acute day clinic. It was already after clos-

ing time and nobody seemed to be around, when I passed a group room next to my office. Without intention, unexpectedly, I stopped and came to a standstill. It was a brief moment of irritation, and its essence was that I knew the room was empty, but still suspected that a group therapy was taking place. I entered the room to make sure of the situation. Nobody was present. All I saw was a circular arrangement of chairs, which – similar to an empty stage – suggested the situation of something taking place. It was the constellation of the chairs which led me to suspect a particular kind of presence despite the absence of a group. This particular spatial experience was the beginning of my interest in the scenographic weight of the chair object, its meaning to the people that move in psychiatric spaces, and its influence on the perception of it.

In the context of this contribution, I will discuss which positions, relations, and performative practices are central to the phenomenon of sitting in psychiatry. First, I will briefly outline some aspects that have shaped the long-lasting cultural and historical dimensions significant to the use and relevance of the chair object. Based on the findings of a qualitative study I conducted in a Swiss psychiatric acute day clinic (Landsteiner 2017), I will show how patients and staff perceive the chair at the site of psychiatry and how their movements, communication, and perceptions are structured by the practice of sitting – also in (experimental) demarcation to other postures like lying or standing tested and discussed by patients and staff. Finally, I will deal with scenographic aspects when I address the importance of sitting as a positioning strategy in psychiatry.

Cultural Studies and Cultural History Aspects of the Practice of Sitting

Psychiatry today, in its spatial and social constellation, is strongly characterized by sitting objects and practices. During therapy, people usually sit at an angle of 45 degrees to one another, waiting on one of the linearly threaded chairs in the waiting room, documenting at the desk, eating, sitting together in group activities or in the circle of chairs. Cultural-scientific analysis of the object of the chair provides us with insight into the forms of human everyday life and the underlying constitutions of meaning and instrumentalizations (Dodel 1997; Eickhoff 1993, 1994, 2011; Eickhoff/Sting 1994; Schmidt 1971a, 1971b). The object of the chair holds a range of possibilities for the expression of power, individuality or creativity. Significant

examples of this are the arrangement of chairs in parliament, the fixed reserved place at the family table, the allocation of chairs to university professors, chair design as a form of applied arts, the arrangement of seats in public transport, or the often hesitant act of taking a seat at the presiding chair in a restaurant.

According to cultural historian Hajo Eickhoff (1993: 144), the posture of sitting is a basic posture of today's work and everyday activities. In Western societies there seems to be a tendency to "have a seat," to remain seated – especially when it comes to processes of mental creation which require a high degree of physical immobilization and calming of inner emotions. Elaborating this argumentation, Eickhoff quotes the ergonomist Heinz Gelbrich, who concluded in 1928: No work should be done standing if it can be done just as well sitting (ibid.: 144). The first people who sat on chairs were enthroned rulers (ibid.: 77). For them, the throne in the form of the practice of cultivated etiquette and the demonstration of courtly decency

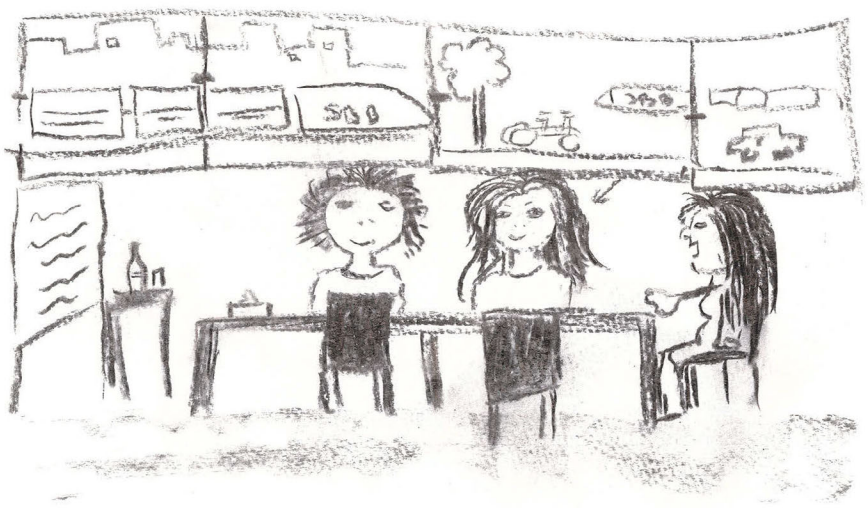

Fig. 1: "Morning Round" [*Einstiegsrunde*]
(drawing by patient BT, Landsteiner 2017: fig. 10)

played an important role in education and everyday life. Enthroning must be practiced. In former times, individual members of the communities deserved neither the privilege nor the torment of sitting. They were free to move, but exposed and subjected to those who were not.

Sitting in a chair in everyday life is a European invention (ibid.: 40). European bourgeoisie transformed the consecrated royal and heavenly throne into a profane object – the everyday chair. Initially merely an object of the upper middle class, all social classes fought for centuries to gain the right to sit (Schmidt 1971b). These fights found a striking political and economic turning point in the course of the French Revolution and the increasing purchasing power of the masses in the wake of Industrial Revolution. As a consequence, the seating privilege for secular rulers and clergy over the middle-class lost its validity.

In the rising discipline of ergonomics during the late 19th century, the mastery of a correct posture of sitting was elaborated as a mechanism for inner formation (Eickhoff 1993: 158). Here, Marcel Mauss's (1979: 70) notes on the human gait as the product of a culturally influenced education in movement also seem to have an essential relevance in the case of sitting: Similar to the upright gait that must be learned by the growing human being, it is indispensable to learn how to maintain an upright, "correct" sitting position and to guarantee this by means of appropriately designed seating that supports this posture. Sitting can thus be regarded as a cultural achievement to the extent that it enables people to suppress and postpone spontaneous inner expressions (e.g. hunger, thirst, sex drive) in order to devote oneself to longer-term, mentally demanding activities. Under the effects of breathing reduction and muscle tension, one of the first things children learn during their socialization is how to sit. Early in the morning, pupils sit longer than they stand, run, walk, and lie down, and those who leave school after years are used to the posture of sitting (Eickhoff 1993: 221).

Against this background, it is not surprising that the famous French psychiatrist Jean Étienne Esquirol notes that the inability or unwillingness to sit properly is a characteristic feature of "idiotism"[1]: "Never was she made to sit on a chair, she slept, her body rolled up, always on the ground" (Esquirol 1827: 507).

In the early 19th century, a special type of chair was used in psychiatric institutions: the so-called "tranquilizer" chair [*Zwangsstuhl*], originally invented by the American psychiatrist Benjamin Rush (1745–1813), in which agitated patients were fixed in a seated position for up to 48 hours. The enforced sitting was intended to have a calming effect on the patient (Siefert 1983).

Your Chair, My Place, Our Setting: The Object of the Chair and the Practice of Sitting in Psychiatry

In my qualitative study (Landsteiner 2017), for which I applied the research style of Grounded Theory (Glaser/Strauss 2008), I asked staff (doctors, nurses, psychologists, social workers, and movement therapists) what effects the paradoxical situation of a sudden disappearance of all chairs from the psychiatric interior could have and what conclusions they would deduce for the significance of sitting at the psychiatric site. I repeated this reflexive gesture within the framework of a performative group discussion, but in doing so I put the hypothetical situation used for the experts in reality: a group of four patients entered a room in which there were too few chairs for all of us. I waited for the reaction of the patients. Afterwards, I asked them about their reflections on sitting practices during psychiatric treatment and everyday routines in psychiatry.

In both constellations, the indispensability of the object stood out in its absence. The first verbal reaction to the entrance situation of the group discussion took place when the patients were entering the room. CC, one of the patients, made the ascertaining statement:

CC: The chairs are missing here.[2]

After a short time of looking around, two participants went to fetch stackable chairs from an adjoining room for the whole group and for me as well. Subsequently, the group formed a circle of chairs.

In the course of the interviews, the perception of sitting as a matter of implicitness can also be demonstrated on the part of the staff members. When they are confronted with the question of the effects of a sudden absence of all chairs, it is noticeable that the focus is primarily on the restoration of the social order, which is obtained in a way by the sitting arrangement. In the interviews, the main point is that if all the chairs are missing, therapeutic routine is interrupted. It was common to all the staff members interviewed that they wanted to restore the material foundation for psychiatric treatment. In some interviews, ideas were expressed to save the situation by supplementing the chairs with quasi-objects such as rolled up gymnastics mats as stools, tables as chairs, or walls to lean on. In the hypothetical situation, it was the members of the staff who would assume the role of those re-

sponsible for restoring the order: they had to become active in order to reorganize the chairs as the basis for therapeutic work and at the same time create an alternative framework for the patients. In addition, staff members mentioned that the lack of chairs could also have far-reaching effects on the relationship with the patients, the daily routine and therapeutic goals as a whole. As an illustration, here are some responses given by staff in the examined Swiss psychiatric clinic: SA, a social worker, responds to the question of the effects of a sudden absence of chairs:

> SA: Oh. (.) First of all there would be quite a bit of unrest (.) I have the feeling (.) everyone would be looking and saying that is not possible, you can't do that? (7) Because to work there without chairs is a little difficult (5) yes, I think there would be a little revolution (.) @(.)@ you can't ask them [note: the patients] here and not offer them a place to sit.

LA, a psychiatrist, estimates the hypothetical absence of chairs in the clinic as an exceptional situation outside of everyday practice. To deal with it, she suggests following reactions to the hypothetical situation:

> LA: We would investigate why they were stolen (.) the patients will surely be afraid that someone has entered the clinic (1) and removed the chairs (.) without others knowing about it.
> LL [note: Lisa Landsteiner, interviewer]: How do you think such a hospital routine would run without chairs?
> LA: This will not be a normal everyday life, so I strongly assume that there should be a discussion with the patients (2) if I, so I refer this to our everyday routine //mhm// if I now (1) out of therapeutic considerations, you know? or experimental, but in clinic routine (1) I would have an emergency meeting with the patients (.) where (.) so emergency not //@(.)@// but simply (.) depending on what the need is from the patients, I would also approach patients and and and offer answers to the (.) certain questions will probably exist and to be able to simply perform. I also assume that this also could be no no (1) not a big topic for the patients (.) if that is so, then this conversation, then I would like to discuss it with them. How that is for them. Yes.

In his assessment, the psychoanalyst RO describes the effects that would result for his therapeutic work if all chairs had disappeared. In his opinion, therapy would not work in the absence of chairs:

RO: This is a nightmare, isn't it? (.) for an analyst. his space is (.) is suddenly no longer what it needs to be (.) what will he do, right? (.) it would be a huge nervousness or would break out in the question what do I do now? (.) well, you can say ok, look, this is something (1) like (2) it's not (1) uh:m like it's not planned, we have to move (.) sorry, so we have to move (.) I have to sort the things out with the chairs, right? (2) when can you come again?, right? (.) and you would make a new appointment (.) That would be the best case, wouldn't it? where you could "contain"? that you can just focus on the patient (.) who has his needs (.) yes
LL: That means no therapy without chairs?
RO: Mhm. Mhm (.) no, impossible.

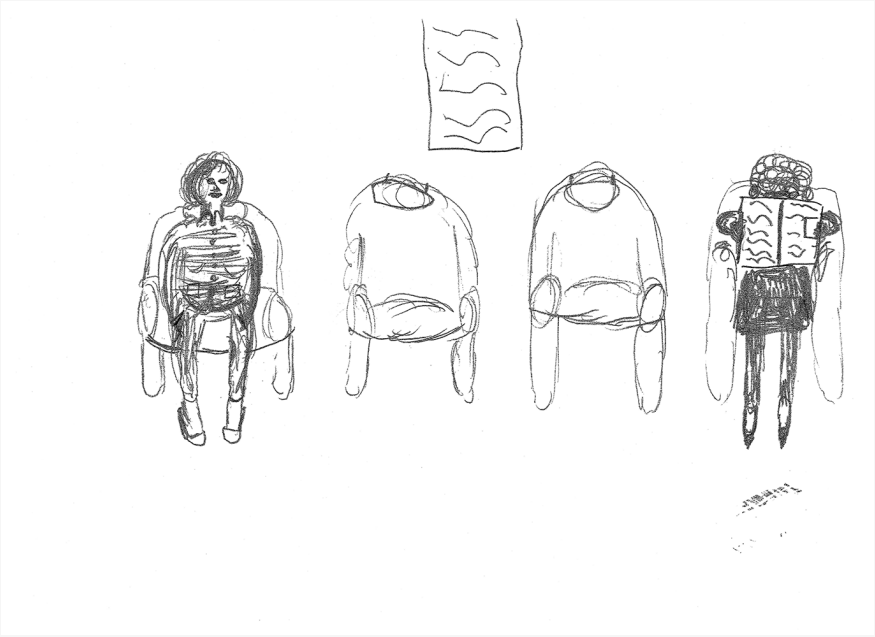

Fig. 2: "Waiting" [*Warten*]
(drawing by patient LO, Landsteiner 2017: fig. 16)

Psychiatries As Sitting Societies

The scenography in psychiatric space is strongly influenced by the presence of an immanent and frequent practice of sitting (Landsteiner 2017). In the Swiss acute day clinic which I examined, there were 151 chairs, i.e. three chairs available for each person at the same time. When I asked patients to draw themselves in a typical situation in the acute day clinic, in most cases the picture showed themselves in a seated posture (see fig. 1). For therapeutic reasons, but also influenced by deeply rooted, implicitly inscribed cultural aspects, people moving in psychiatric space form "sitting societies." They vary in their temporal existence and size and take on different forms. These are: sitting in a circle of chairs, sitting at a table, sitting at a desk, sitting opposite each other (frontally or at a slightly open angle), sitting next to each other, and sitting alone. The forms of movement in the psychiatric space are essentially differentiated into medical-therapeutic, nursing and administration staff, patients, and visitors. Some differences occur between patients and staff. For example, only staff members spend part of their time in the psychiatric space at the desks of their offices writing documentation and reports, doing internal and external communication, and preparing group and individual therapy.

Sitting societies, which almost exclusively include patients, are those that are predominantly formed in the context of waiting. Reading the newspaper, using their phones, having conversations with fellow patients, and drinking coffee, patients spend a lot of time in waiting areas and waiting rooms that have been specifically created for this activity. Figure 2 shows a waiting scene chosen as a motif for the depiction of a typical situation in the acute day clinic.

The forms of sitting societies can be dissolved – albeit predominantly by the staff members – or merge smoothly into one another, e.g. getting up from the desk in order to sit together in the kitchen and drink coffee before the start of the introductory round, or patients rising from the circular arrangement of chairs in group therapy in order to talk one on one with the therapists in their offices.

A special form of sitting societies at the place of psychiatric institutions are so-called non-sitting societies. These rarely occur and are formed within the sitting culture inherent in psychiatry. In the interviews, patients as well as staff members referred to non-sitting when actively distancing themselves from the sitting posture. They are formed, mostly consciously, with the aim of "not sitting all day and bringing movement into everyday life" (Landsteiner 2017: 109).

Fig. 3: "Untitled" [*Ohne Titel*]
(drawing by patient TM, Landsteiner 2017: fig. 14)

Sitting As a Hybrid Formation with the Object of the Chair

At the psychiatric site, the chair appears as a transparent object. In contrast to monumental objects, such as the automatic coffee machine in the patient's kitchen or the table tennis table in the acute day clinic, the chair's meaning and relevance for the everyday life of patients, doctors, therapists, and other clinical personnel in the day clinic remains invisible.

In its use, the chair becomes an integral part of human body work and posture when sitting and being seated. Due to the robustness of the material, the person can be supported completely; the sitting person's legs are almost completely relieved and have room to maneuver, making the chair a tool and "device," so to speak. The specific thing about the human–chair connection is a transformation of the human action radius. If we take a closer look at the connection between a sitting person and a chair, the constitution of meaning of the human back in particular becomes especially relevant. The chair carries the weight of the seated person, protects her or him from behind through the backrest, enables him or her to fall back, to sink into it, to lean on it, to be supported and to help bear the apparently unbearable on it.

The patient TM draws a typical situation in the acute day clinic in less than 60 seconds (fig. 3). TM does not want to give his work a title; it speaks for itself, he says. There is nothing in particular that he experiences as "typical" in the acute day clinic. However, in the conception of what he depicted, he thought of the first days in the clinic when he was not feeling well, "sitting around" all day.

The interpretation of the drawing shows that the center of the picture lies exactly between the depicted seat and the contoured thighs of the self-depicted person. The person seems to float, but at the same time he supports himself with his arms on his thighs.

In the picture, another aspect of the chair–human connection is depicted: When TM was predominantly "sitting around" when he was not feeling well, the chair was a supporting instrument for him. However, it could not support him fully in order to feel better – here, TM's chair reached its hybrid material limits. The depicted void between stool and TM presents more a test of tearing apart than a hybrid fusion. Facing physical as well as psychological demands, TM schematically needs to use his hands to maintain the supporting sitting posture.

On the one hand, chairs can be – or appear – homogeneous in their design and form, while on the other hand they can be considered outstanding in their perception as personal objects (e.g. "my chair", "our seats"):

> BR: Can you remember, that just comes to mind, VV's seat? I think, you weren't there yet (.) VV would always come into the room, in which the morning round takes place, and she always sat on the very first chair, so right at the front, always. And if "her chair" was occupied, she reclaimed her seat, so she really always sat there (.) of course, because of that, her seat was kept for her, even when she had left the clinic (.) it was simply her seat @(.)@)

The first chair in the room is a hybrid object, shaped by the patient VV even after being discharged from the clinic. The connection between VV and her seat is expressed in the action rituals of her fellow patients who are still in the clinic in such a way that having a seat in her chair evokes memories and concrete behavior patterns in the other patients and staff, which they associate with VV. The perception of the chair object and its arrangement coincide and materialize for a certain time in VV's chair. The demanding of the seat and the establishment of the pattern of action that the place was always kept free for VV can be called personalization. In this case, the chair is linked to a material quality, a surplus, a re-/presentational, emotional, normative, ritual added value (Breuer 2013).

Have a Seat, Lie Down, Move Forward! A Comparative Note on Postures

As it has emerged in the analysis of the interviews and group discussions with patients and staff, there are indications that, in contrast to lying or standing, the sitting posture is related to the present in terms of time. Thus, the position of lying is associated with the re-experience of the past or standing or walking with a focus on the future. Sitting seems to occupy an intermediate position in the demarcation between standing and lying: due to the poles of positive engagement with the present, it mediates between the past and the future, while lying carries the danger of falling too far into and sticking to the past, and standing carries the risk of moving forward too quickly. Although in the course of the interviews with staff and the group discussion a tendency is emerging that the concept of sitting at the site of psychiatry might take shape in its definition by means of a delimiting distinction from lying and standing, it has to be conceded that the following findings are preliminary and should be subject to detailed review in the future. Chairs offer fixed frames, define minimum distances, and are per se a medium of communication:

on the one hand, they bring people's bodies into the posture of the seated person; on the other hand, they bring them into a certain spatial relation to each other. Thus, the chair appears stable in its composition, but it also can become a support.

At first it seems as if it is mainly patients who attribute great importance to the protective dimension of the chair. Among other things, the chair provides support and is like a shield for them when they are no longer able to hold themselves physically or mentally. On the other hand, it is also practitioners who attach great importance to the protective component of the chair–human connection within the framework of the interviews. This is how the movement therapist CI describes this protective function of the chair, who has set up only a few seats in her movement space:

> CI: Yes, oh yes, we are also talking about protection, I think the chair has a lot to do with protection (3) if you feel like sitting down, you hear that when people come in to my room, but I don't have any chairs @(.)@ and then they come in, and mostly they sit somewhere in the niche (.) or on the bench, I just have a small bench.

If there are no or hardly any chairs, CI describes that patients tend to create a supplement to the hybrid chair–human prosthesis. The niche replaces the essential features of the chair: the slight elevation of the wall serves as a seat; the wall itself serves as a backrest offering support and protection.

If chairs were missing as the basis for therapeutic work, standing – according to the psychiatrist AA – would be connected to the task of taking over the supporting and protective function of the chair for the patients:

> AA: (clears throat) (4) it all depends on (2) of course I could bring it in more movement (.) I've never thought about how this would all be done standing up, I think there are moments of (.) exhaustion, where also feelings lead to the fact that then you just (.) so to speak (.) would like to sit down or fall into a chair or would like to be supported somehow and (1) I would be worried that I would have to take over something, what the chair does, that would be my fear, that if I would always do psychotherapy while standing, I would have to hold somebody, so to speak, and (.) that the chair also somehow relieves me of something. I would be a little worried about that.

The psychologist TA confirms these impressions when she also states that with sitting a moment of being present arises:

TA: It is like one takes his or her time and because of that takes a seat (.) like this: now we sit. there is space for each other in the here and now.

Movement therapist CI also describes associations with thoughts of fleeing when she dedicates her assessment to the posture of standing in the psychiatric context.

CI: Actually, standing is also a little (1) when you stand it is more possible to escape. that you get away faster (.) yes, you can turn your back (.) so when you walk, you continue and follow your own thoughts and when sitting on the chair I find that, well, you also sit opposite each other and also rather open up. It's less possible to escape your thoughts. it does not mean that you always listen while sitting, but turning away is simply more difficult.

CI also emphasizes the aspect of the danger of re-experiencing traumatic experiences. When working with patients suffering from trauma it would therefore be advantageous to work with them in the physical posture of sitting, which as such refers more to the present.

CI: Yes (.) lying down is also natural, because if you don't know people so well and for example when people have a trauma (.) lying down (.) is quite difficult, so I think because the traumatic experience might reappear easier when lying down (.) or you might be more vulnerable. now in my relaxation groups patients lie down a lot (.) on the floor (.) but e:h, patients with trauma, I usually let them sit on the bench (.) and just make them lean against something or so. Yes.

On the basis of his observations, the nurse MO compares the experience of sitting as a comfortable "resting position" with the postures of standing, walking, and lying:

MO: When sitting it is possible to rest, it is a resting position, in contrast to standing or walking (1) and it has the advantage of comfort (.) you get up again faster than if you lie on the floor or in bed @(.)@ (.) and you can (.) rather stay in the here and now: (.) and it's the same eye level when you sit

Patients explore the use of different postures in the group discussion. In the concrete situation, ST, CC, BR and RS were asked to jointly explore what it is like to stand in a circle instead of sitting in a circle of chairs.

ST: Yes (3) so I think it feels funny.
BR: Yes, it feels weird. It's like (.) you're walking, a little, a little (.) you have the feeling that the therapy session is finished now and you're moving on with the next one, so, already out, so it's like this ((goes two steps towards the door)) @(.)@

This is also shown by a remark made by the patient RS during the group discussion. Standing has something escape-like about it, whereupon her interlocutor BR underlines the importance of taking a seat together on chairs: by sitting the person is more "present."

RS: Yes, but you're much more protected (.) on the chairs, so I wouldn't tell a psychiatrist my life story while standing (1) just because (2) I don't have any other protection, besides (.) honestly, then I could go right away, if I'm standing around with him.
ST: Well, you don't have a position in the room either.
BR: That's right, and you're more present as well, so you can get more involved with the chairs.

According to Claudia Guderian (2004), sitting on the chair prevents these concerns, in which concentrated, controlled thinking and talking affect the adult sense of reality and reasonable discussion. Following Sigmund Freud (1856–1939), Nixon (2005: 50) states that a function of the setting of couch and chair typical for psychoanalysis is that analysts and their patients are kept separate in order to prevent them from getting tangled up visually or reflexively. In psychoanalysis, the lying position on the couch, which loosens the muscles, reduces energy consumption, and promotes immersion in early memories and regression, is predominantly chosen to give room to free association.

In the context of systemic therapy, special attention is paid to the use of the chair in the therapeutic setting, especially when it comes to therapy with outpatients. For inpatients it has to be mentioned that the object of the bed plays a long and important role in the history of psychiatry (Ankele 2018; Majerus 2017). In psychiatry, the chair is used and arranged in various forms of systemic constellation work. Chair techniques such as the "empty chair," which originated in psychodrama, coined by Jacob Levy Moreno (1889–1974), are particularly worth mentioning (1965: 213; quoted after Staemmler 1995: 31–32). Therefore, chairs are used to experience and understand inner conflicts or contradictions or conflictual social dynamics and to find a better way to deal with them. For this purpose each part of the patient or the

social system is represented on a chair of its own. With the "hot chair," Fritz Perls (1893–1970) developed a technique for group therapy that allows the therapist and patients to perform individual therapy in a group setting (Perls 1974: 80). Therefore, one group member is assigned a special place on the hot chair and the focus of the group is on his or her exposed immediate and often unconscious thoughts, fantasies, emotions, and physical gestures and attitudes.

Sitting As a Positioning Strategy

As the sitting posture represents the characteristic setting of patients and therapeutic staff, the chair is a defined terrain in the psychiatric space. The setting – a term of special importance in the context of psychiatry – can be understood as the constellation of spatial (room size), material (furnishings, objects), temporal (duration), and inclusion factors (role, relationship) that is adapted to the context of action (therapeutic, private, professional, etc.). When sitting, each person occupies a seat which isolates her or him from the others and prefigures boundaries between people: The chair ensilages the seated person, whereby the space of the chair becomes a microcosm for the individual (Eickhoff 1993: 173). At the same time, the chair makes the boundaries explicit through its spatial arrangement.

By sitting down, not only the body sits down, but also other forms of experience may be addressed and expressed. Furthermore, the posture of sitting does not allow one to fully stay in position. It rather requires – initially on a purely physical level – adapting muscle movements, modifications in the positioning of body parts, the shifting of weight, etc., in order to retain oneself in the position, meaning to stay seated. The assumption of an unmoving body posture however seems to be paradoxical: although culturally trained seating postures appear anything but moving, the body is constantly in motion, e.g. with blood supply, transmission of stimuli, breathing, etc. Concerning the multiple non-static characteristics of the sitting posture, the psychoanalyst RO explains:

> RO: Exactly where you just brought it up, right? or? Posture is really interesting (.) to distinguish, I think, it is more ambiguous, or? and, of course I meant the (psycho)analytical setting. Regarding the psychological relationship between analyst and patient, but (.) also regarding that they sit, physical, opposite each other.

At the site of psychiatry, people adopt more than just physical postures, but position themselves in many different dimensions. Taking a seat and the offering of a chair also happens in the midst of power relations inscribed in the psychiatric space itself. In their positioning, patients and staff members therefore not only affect, but also always are affected when they experience various therapeutic settings. In the following example, the patient BR shares the following experiences in the group discussion:

BR: So what I would like very much would be, if a therapist or psychiatrist would ask a patient (.) in which setting would you like us to talk? And that they work on different possibilities, that the patient (.) that I feel comfortable in that position. and not just: there, chair, do this, sit down, so that there really are several (.)) that there is the possibility for patients to choose (.) If a patient feels comfortable, then he or she also are more open about their issues (.), and then he or she won't shut him- or herself in, is it really difficult (.) so you have to feel comfortable.
ST: Yes, me too, you know, he just sat in the opposite and I felt totally stupid (.) so I (.)
BR: Like a job interview actually
ST: Yes. And he also asked me so many things and (.) yes.

In the vast majority of cases it is the therapists who determine certain aspects of the setting by adjusting something beforehand, starting with the therapy plan and also including the material quality of the psychiatric space: here, the spatial pre-arrangement dominates on the side of the therapeutic staff, the potential of power, of seating the patient here, there or somewhere else resonates quietly with it. This is a point of reference that directs a critical gaze to the mechanisms of power expressed in sitting or in the choice of seating position and arrangement of chairs.

In the interview, psychiatrist AA advocates a de-hierarchized encounter with patients. She rejects an asymmetry of the seating constellation – as it would be expressed for example in different heights of the chairs – and adapts its spatial position to the people who enter her treatment room as patients.

AA: And I do this for example in my room, when the room was cleaned (.) for a while, the room care staff always set my seat height higher, this one here ((points to the desk chair)). and that means I always came in and then (.) when a patient

visited, then I sat like this ((shows a height of about 80 cm above the floor)) and I always put the height down immediately (.) so that I am at the same level. Patients sometimes notice it, then they also tell me that they were with therapists who sat there on his or her chair and looked at them closely from above sitting in his or her 'fat armchair' and (.) that comes very quickly actually, that patients complain so much about these seating constellations or (.) sometimes they also say that we sit too far away (.) sometimes.

The psychoanalyst RO describes this tightrope walk of power structures in the encounter of therapist and patient. In his perspective, seating orders can never completely produce an anti-hierarchical or experiential quality:

RO: Yes yes (.) yes yes what is of course quite obvious, that is of course the thought (.) that the chairs don't have to be the same model (.) I think it has to be the same two chairs (.) but now of course the next question comes, because where I sit it's a little different than where you sit, you can see the window, I can see the door and so it comes again and again that it is different @(.)@ it's never quite the same (.) it's never quite the same. and you, as the therapist, you have to prepare the space (.) Are you really preparing the seat, the place, metaphorically speaking, where you have the feeling as a patient that you can think reasonably, fearlessly about exactly that stuff with someone? (.) and fearless means that he or she is not too scared where he or she sits and (.) and whether someone should have the door in his or her back now is really (.) I think yes (.) that could be unpleasant (.) for others, and of course for others who are more constricted in the corner and so on, but (.) I am not (1) so each setting (.) constructs something, too, isn't it? it's not just the relationship that creates something (.) it's not just the fact that someone goes to see the other (2) but the person that is seen has set something up before, chairs and the setting in a broader sense.

Summary

Sitting proves to be an essential positioning strategy at the site of psychiatry. The chair is a space-structuring instrument that creates order. This important aspect already becomes manifest when patients enter the clinic. Psychiatric treatment does not begin with the discussion of the treatment contract, medical history, or diagnosis, but rather with a gesture of presence: entering the building, shaking hands and having a seat opposite of each other. In this way, sitting at the site of psychiatry is an important strategy right from the beginning of the treatment.

Psychiatry encompasses a large number of sitting societies whose foundation is the chair. Much of therapeutic progress is directly related to the practice of sitting. In hybrid interaction, the chair functions as a vessel, a protective boundary for the sitting person. The chair functions as a media for communication and the creation of meaningful relationships in which therapeutic progress and regression take place. The success of a treatment seems to consist in positioning oneself relatively from each other in order to establish a trusting relationship that gives security to both patients and staff members. The chair crystallizes as a medium of positioning. Its supporting function not only offers protection and can be an expression of individual style, but sitting on it also creates a basis of communication which is inherent in and a prerequisite for the many forms of therapeutic work.

Notes

1
Esquirol refers here to the description of idiocy (in the German translation: *Blödsinnige*), which he describes using the example of observations of the behavior of a female patient.

2
Since I conducted my interviews in German, I translated the original parts for this article into English. The interviews were transcribed with the TiQ (Talk in Qualitative Social Research) system. Here is a brief overview of the most important symbols: (.) Pause up to one second, (2) Number of seconds of a pause in speech, *Mississippi-* Termination of a word, *oh=noo* combined pronunciation, *combi::ned* elongation, *@no@* laughing, e.g. "no" spoken, *@(.)@* short laugh, *@(3)@* three seconds laughter, *//mhm//* audible, overlapping signal.

Bibliography

Ankele, Monika (2018): "Sich aufführen: Rauminterventionen und Wissenspraktiken in der Psychiatrie um 1900." In: Ankele, Monika/Ledebur, Sophie/Kaiser, Céline (eds.): ***Aufführen – Aufzeichnen – Anordnen. Wissenspraktiken in Psychiatrie und Psychotherapie***, Wiesbaden: Springer, pp. 71–89.

Ankele, Monika (2018a): "Horizontale Szenographien: Das Krankenbett als Schauplatz psychiatrischer Subjektivation." In: Friedrich, Lars/Harrasser, Karin/Kaiser, Céline (eds.): ***Szenographien des Subjekts***, Wiesbaden: Springer, pp. 49–64.

Attali, Jaques (2008): ***Die Welt von morgen: Eine kleine Geschichte der Zukunft***, Berlin: Parthas.

Breuer, Franz (2013): "Hybride Objekte verbinden Personen und Generationen: Weitergabe – Gedenken – Transzendenz." In: ***Journal für Psychologie*** 2/21, 34 pages, http://www.journal-fuer-psychologie.de/index.php/jfp/article/view/267, accessed April 30, 2018.

Brückner, Burkhart (2010): ***Die Geschichte der Psychiatrie***, Cologne: Psychiatrie Verlag.

Dodel, Franz (1997): ***Das Sitzen der Wüstenväter: Eine Untersuchung anhand der Apophtegmata Patrum***, Freiburg im Breisgau: Universitätsverlag.

Eickhoff, Hajo (2011): "Thronen als Denken und Meditieren." In: Hackenschmidt, Sebastian/Engelhorn, Klaus (eds.): ***Möbel als Medien: Beiträge zu einer Kulturgeschichte der Dinge***, Bielefeld: Transcript, pp. 33–46.

Eickhoff, Hajo (1994): "Die Sedativierung im Sitzen: Eine Strategie der Perfektion." In: Kamper, Dietmar/Wulf, Christoph (eds.): ***Anthropologie nach dem Tode des Menschen***, Frankfurt am Main: Suhrkamp, pp. 216–231.

Eickhoff, Hajo/Sting, Stephan (1994): "Fortschritt als festsitzende Mobilität." In: Kamper, Dietmar/Wulf, Christoph (eds.): ***Anthropologie nach dem Tode des Menschen***, Frankfurt am Main: Suhrkamp, pp. 245–249.

Eickhoff, Hajo (1993): ***Himmelsthron und Schaukelstuhl: Die Geschichte des Sitzens***, Vienna: Carl Hanser.

Esquirol, Jean Étienne (1827): ***Esquirol's allgemeine und specielle Pathologie und Therapie der Seelenstörungen***, edited by Karl Christian Hille, Leipzig: C.H.F. Hartmann.

Foucault, Michel (1990): "Andere Räume." In: Barck, Karlheinz (ed.): ***Aisthesis: Wahrnehmung heute oder Perspektiven einer anderen Ästhetik***, Leipzig: Reclam, pp. 34–46.

Gittins, Diana (1998): ***Madness in Its Place: Narratives of Severalls Hospital, 1913–1997***, London: Psychology Press.

Glaser, Barney G./Strauss, Anselm (2008): ***Grounded Theory. Strategien qualitativer Forschung***, Bern: Huber.

Guderian, Claudia (2004): ***Die Couch in der Psychoanalyse: Geschichte und Gegenwart von Setting und Raum***, Stuttgart: Kohlhammer.

Hess, Volker/Majerus, Benoît (2011): "Writing the History of Psychiatry in the 20th Century." In: ***History of Psychiatry*** 22/2, pp. 139–45.

Hicks, Dan/Beaudry, Mary C. (2010): "Introduction: Material Culture Studies: A Reactionary View." In: Hicks, Dan/Beaudry, Mary C. (eds.): ***The Oxford Handbook of Material Culture Studies***, Oxford: Oxford University Press, pp. 1–21.

Kaiser, Céline (2019): ***Szenen des Subjekts: Eine Kulturmediengeschichte szenischer Therapieformen seit dem 18. Jahrhundert***, Bielefeld: Transcript.

Landsteiner, Lisa (2017): ***Platz nehmen: Zur Psychologie des Sitzens am Ort der Psychiatrie***, Bielefeld: Transcript.

Majerus, Benoît (2017): "Material Objects in Twentieth Century History of Psychiatry." In: ***BMGN – Low Countries Historical Review*** 132/1, pp. 149–169.

Mauss, Marcel (1979): ***Sociology and Psychology: Essays***, London/Boston: Routledge and K. Paul.

Moran, James E./Topp, Leslie/Andrews, Jonathan (2011): ***Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context***, London: Routledge.

Nixon, Mignon (2005): "On the Couch." In: ***October*** (MIT Press Journals) 113, pp. 39–76.

Perls, Fritz (1974): ***Gestalt-Therapie in Aktion***, Stuttgart: Klett-Cotta.

Schmidt, Leopold (1971a): "Bank und Stuhl und Thron." In: ***Antaios*** 1/12, pp. 85–103.

Schmidt, Leopold (1971b): "Stuhl und Sessel: Zur Geschichte des europäischen Sitzmöbels." In: ***Studia Ethnographica et Folkloristica in Honorem Béla Gunda*** 10, pp. 349–359.

Siefert, Helmut (1983): "Der Zwangsstuhl. Ein Beispiel für den Umgang mit Geisteskranken im 19. Jahrhundert in Haina." In: Heinemeyer, Walter/Pünder, Tilmann (eds.): ***450 Jahre Psychiatrie in Hessen, Veröffentlichungen der Historischen Kommission für Hessen*** 47, Marburg: Elwert, pp. 309–320.

Staemmler, Frank-M. (1995): ***Der leere Stuhl: ein Beitrag zur Technik der Gestalttherapie***, Munich: Pfeiffer.

Topp, Leslie (2017): ***Freedom and the Cage: Modern Architecture and Psychiatry in Central Europe, 1890–1914***, University Park, Pennsylvania: Pennsylvania State University Press.

Virilio, Paul (1978): ***Fahren, fahren, fahren***, Berlin: Merve.

Yanni, Carla (2007): ***The Architecture of Madness: Insane Asylums in the United States***, Minneapolis: University of Minnesota Press.

All quotations originally in German were translated by the author.