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WASHING THE CITIZEN: WASHING, CLEANLINESS AND CITIZENSHIP IN MENTAL HEALTH CARE

ABSTRACT. Participation in the community and citizenship for patients are common ideals that inspire improvements in mental health care. But what is meant by citizenship? Here an analysis is made of washing practices in psychiatric nursing in long-term mental health institutions. Four repertoires of washing are described, each oriented towards a specific notion of citizenship. In the first repertoire, washing is part of individual privacy; the patient is ''enacted'' as an individual whose authenticity should be respected in order to equip him or her for participation in the community. In the second repertoire, washing is a basic skill; the patient must learn to take care of her body in order to become an independent citizen. In the third repertoire washing is a precondition to citizenship; patients are to be helped to develop their potentials so that they can find their way in the community. In the fourth repertoire, washing is one opportunity among others to develop social relations; the extent and quality of these relations define a citizen. This analysis opens up not the question *if*, but *which type* of citizenship should be promoted.

KEY WORDS: psychiatry, citizenship, participation, care, washing

INTRODUCTION

Since the 1960s, the ideals that have inspired mental health care practices in the Netherlands have centered on notions of citizenship, in the sense that people with chronic mental disorders should be guaranteed the same rights and opportunities as other citizens. Patients have been moved out of psychiatric hospitals to enable them to participate in the community. Rehabilitation programs have been developed to support people with chronic psychiatric illnesses, to strengthen their autonomy, to find them places to live in the community, and to find jobs for them outside of the ''total institution'' (WHO 1996; Anthony et al. 1982, 1990; Watts and Bennett 1983). The question this article raises is who this citizen is. What kind of citizenship is aimed at for mental health care patients? I will analyze this question by studying the practice of washing in psychiatric nursing.

WASHING AND CITIZENSHIP?

At first glance, ideals of citizenship appear unrelated to mundane activities like washing. A shift from accentuating ideals of citizenship instead of those

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of cleanliness can be seen in the short history of psychiatric nursing in the Netherlands. Cleanliness and washing patients was part of good psychiatric nursing around the turn of the twentieth century. Mentally ill persons were hospitalized, provided with therapies, and just like any hospital patient, put to bed to get well. In those days, psychiatry tried to establish itself as a legitimate branch of medicine, signified by clean hospital wards and proper hygiene (Boschma 1997; 2003).

This is the type of hospital psychiatry that became the target of criticisms and reforms in the Netherlands. Care in the hospitals was judged to be repressive and generally of low quality while serving the purpose of surveillance rather than treatment (Boschma 1997; 2003). With the arrival of new ideals– first, the humanizing of hospital care, and later, the struggle for community care and citizenship–washing and cleanliness became old-fashioned themes in psychiatric nursing (Dankers and Van der Linden 1996; Tonkens 1999). Even more, attention to washing in order to achieve cleanliness became a symbol for the wrong type of psychiatric nursing, aimed at cure for patients rather than support for citizens.

But can washing and cleanliness so easily be separated from citizenship? Classic texts in cultural anthropology and sociology have drawn attention to how washing practices are embedded in culturally specific forms of social order. Mary Douglas (1966) describes ''rituals of cleaning'' as ways of positively shaping societies and presenting personalities. Dirt is the metaphorical ''matter out of place'' that does not fit into the categories people use to think about their society (see also Barrett 1998; Devisch 1985; Thompson 1985; Constantinides 1985). For Western societies, Norbert Elias (1976) argues that in modern times people have become increasingly reserved in matters regarding bodies, their excretions, display, and relation to other bodies. The changed interdependencies of Western people, he argues, have resulted in modern practices of etiquette, including privatization of bodily matters like washing. Alongside the civilized public interactions, these private interactions have brought into being a new private space (see also: De Swaan 1988: 139–40; Vigarello 1988; Gastelaars 1994; Twigg 2000).

Thus, even though Western washing is an activity that takes place behind closed doors, it is also an articulation of a specific social order. In political theory citizenship is conceptualized as the relations between citizens and the state. Relations between private and public sphere are complicated by the emergence of the market, as it is either seen as a new form of public sphere and a way of organizing citizens (Nauta 1992), or as a private sphere where individuals should be free to act without the interference of the state. Globalization and plurality further complicate neat distinctions between public and private spheres (Van Gunsteren 1991; 1992).

In this article I will sketch the 'theories' of citizenship as they find expression in daily practice in mental health care institutions in the Netherlands, without defining beforehand what a citizen is. One thing is clear, though: citizenship is connected to participation in the community. What form this participation takes, as well as which community is deemed relevant, varies with different care practices. Accordingly, distinctions between public and private, and what place the public or private spheres occupy, are sought *within* these practices, and not in philosophy books or policy documents. This might result in some surprising new conceptions of citizenship, in which washing has a specific, more or less valued place. What are these washing practices, who does the washing, and who are these citizens?

BACKGROUND AND METHODS

I studied nursing care and washing practices in the long-stay wards of two Dutch psychiatric hospitals and in five Dutch residential homes that provide housing for elderly chronic psychiatric patients. In both the psychiatric hospitals and the residential homes, I observed how psychiatric nurses perform "good care" (Pols et al. 1998; Pols et al. 2001). In the psychiatric hospitals, my aim was to describe the general ideals of rehabilitation by observing psychiatric nurses at work. How do ideals of rehabilitation gain substance when living outside the hospital is not an option? In the residential homes, the concept of "rehabilitation" was not used, though comparable ideals of developing citizenship and community participation were worked with (Chiu et al. 1999). Elderly patients did move from the hospital to residential homes that are meant to be more "community based," less stigmatizing, better equipped for physical disabilities, and closer to family and other relations.

My analysis of citizenship was inspired by the work of Boltanski and Thévenot, who asked "ordinary people" how they justify their actions (Boltanski and Thévenot 1991). Instead of just studying justifications, however, I focused on performances (Mol 1998) or "enactments" (Mol 2002) by observing actions of the psychiatric nurses and discussing these with them in interviews later. In their actions, the nurses and patients can be seen as bringing different social worlds into being (Garfinkel 1967). Making these worlds explicit made it possible to reflect on routines and sensitivities in care that were taken for granted by the nurses, but were nevertheless oriented towards different conceptions of citizenship. I will describe four repertoires of washing in psychiatric nursing, each containing a different ideal of citizenship. A repertoire brings together specific actions, ideals, and

knowledge, forming ''modes of ordering'' (Law 1994). A seemingly neutral activity like washing gets its specific meaning, value, and form of practice through its relation to an ideal of citizenship. The object of the washing, the place of mental disorders, and the specific problems encountered differ for each repertoire.

The four repertoires of washing that I separate out for analysis are not restricted to one institution, ward, nurse, or nursing team. Although some of the repertoires are dominant in one setting and absent in another, switches between repertoires can and are made with more or less difficulty. Some of the repertoires, however, conflict so much with one another that switches cannot be made and differences become a matter of explicit debate in practice. Spelling out repertoires, then, structures the messier complexities of daily life by articulating the often inexplicit patterns of values, knowledge, and actions.

FIRST REPERTOIRE: WASHING AS PART OF INDIVIDUAL PRIVACY

In the first repertoire, psychiatric nurses treat washing as part of individual privacy. Individual private space is not light-heartedly to be interfered with without the consent of the patient. How and how often washing occurs is left up to the patients. Nurses can, however, try to make use of the patients' preferences to facilitate washing. They can try to *seduce* patients to wash and make washing easier and more pleasant. To this end, they can try to arrange objects in a way that would gain a response. Does the patient prefer a washcloth or a sponge? A nice perfumed shower gel or good old plain soap?

Psychiatric nurse: Care used to be a group event, you went to the shower as a group, so to speak. In a huge institution such as this hospital, everything is centrally arranged. There's always the same food, always the same jam and cheese. And everybody has the same soap and shampoo. Then we said: ''Give us the money, we'll arrange it for ourselves.'' And then the clients realized: ''We can decide for ourselves what we want to put on our bread and what shower gel we like.'' And they learned to deal with a budget. If you buy ham or expensive shower gel, you can't buy something else. So they became aware of how to deal with money. And they really liked it!

Apart from citizenship, other gains associated with following personal preferences are mentioned in the quotation: tempted by good food and bathing preferences, the patients learn to deal with money and budgets, which enables and secures the possibility of pursuing their personal tastes. Knowing how to organize and deal with your personal preferences and interests is an important ability for the private individual in matters of washing and elsewhere.

Preferences and tastes are individual matters, but they can also reflect more general norms. The individual is a bearer of these norms, and the biography of a person's norms and habits is used to guide personal care. The question is: how did a patient perform washing in the past?

Diana: Yes, Mr. Siegel. He's unmanageable. Washing and dressing is such a fight, it's really terrible.
Leader of Team: Hmm. Are others having problems with Mr. Siegel?
Hazel: I don't have any problems with Mr. Siegel. I go to him in the morning, I give him clean underpants and I wash him. No problem. I just wash him.
Diana: But what about this unruly behavior!
Hazel: I have no trouble with him. I give him a "down-below," and he has a sense of humor too, this grumpy old man. I really like him.
Leader of Team: I don't think Mr. Siegel needs a down-below every day. He's not used to it. He's a person who went to the public bath once a week. He always did that. You shouldn't get into a fight with him. There's no need for him to get upset about washing. If he refuses, just let him be. [Discussion within the team of geriatric assistants]

By relating to a patient's history of washing, the activity can be tailored to what he or she is used to and prefers. People who washed once a week are not pressed to take a shower every day, but are encouraged to stick to their habits. Individually preferred objects and arrangements are important for nurses looking for clues to influence washing.

Preferably, there is a private individual space where patients can go about their washing alone. This is uncommon in psychiatric hospitals, however, where sanitary places are shared by patients living on the same corridor. The layout of hospitals and the lack of private spaces are thus the object of ongoing criticism. But even when there are no private spaces, nurses try to privatize washing as much as possible. The first step is to abolish the routine of the twice-a-week showering days. Although some of the patients stick to the old routines, others happily use their new freedom to reduce the number of showers they take. The nurses are cautious about interfering in matters of personal hygiene. They hold themselves back and give patients space to privatize washing rituals that other people so self-evidently perform alone.

The citizen defined by this washing repertoire is an individual who differs from other citizens, because each citizen has different tastes, interests, and norms. Individual preferences are (historically) contingent desires and habits. They are trivial most of the time: it is not a matter of debate whether a person prefers pinewood scented shower gel or jasmine shampoo. But based on the more trivial fancy for jasmine soap are more troublesome wishes, such as wanting to die, or refusing a treatment the doctor thinks is necessary. In all instances, though, the notion of individual freedom, and the ability to pursue one's desires and self-defined interests, goes along with

respecting privacy. Not being able to live out even trivial preferences would in this practice be an unacceptable and unnecessary restriction of individual freedom.

Psychologist: You can ask yourself: why didn't we do this before? It's so obvious. You deal with people, they may be a little bit ill, but they're people with tastes and desires. However ill you are, you can still appreciate the difference between, say, nuts and potato chips. There are always differences in taste. Everyone can understand that.

Permitting self-governance and allowing differences in norms and preferences implies a relative tolerance for dirt. The possible advantages of "being clean," if the person does not automatically take care of it, compete with the strong value of individual freedom. In some cases this can lead to persons and environments that look very dirty to visitors from the tidier outside world.

Monday morning, two cleaners are busy mopping up a huge pile of cigarette butts with a large rag. Burn marks are on every object that is capable of sustaining them. The common rooms are empty, except for ashes, cigarette butts, and coffee stains. The psychiatrist explains: "We are looking for a balance between clients' norms and pollution. We do not want a sterile and clean ward like elsewhere in the building."

The line the nurses draw between "dirty" and "too dirty" is guided by the preferences inferred from the practice of the patients living on the ward. Where individual privacy is an important value, dirt is much more acceptable than elsewhere. Dirt cannot be dealt with by professional authority, but needs consensus between nurse and client. Sometimes this leads to situations where all participants agree that dirt has become too dirty, and that something has to be done about it.

Nurse Jan says, grinning maliciously: "You sure missed out!" Lowie [a client who lives outside the hospital and is taken care of by the nurses of the ward] had a haircut and a shave. The barber refused to do it. "The barber does everything for money, but for this he couldn't be bribed," says Jan. He gestures to indicate that Lowie had an inch-thick crust on his head. Under the crust was eczema, and in between were lice. Very many lice. "The GP has seen a lot, but even he was impressed," Jan says. Lowie is under the shower, soaking, to make up for a year of not washing his hair.

This extreme example is typical for a practice where individual privacy is highly valued: the citizen should be left in peace unless he or she volunteers for a bath. There is a consensus between patient and caregiver, and the patient stopped by with his itching head to see if something could be done about it. Most people's limits will be reached much earlier, but from the perspective of individual privacy this is not a problematic situation.

Respecting individual privacy means allowing patients to be dirty if that is their choice or way of being. This seems to be Mary Douglas upside down: instead of cleanliness and cleaning being the way of creatively crafting order

and personality, dirt becomes an expression of an authentic self. Dirt becomes matter "*in* place," an acceptable individual wish. In Mary Douglas' analysis, however, this literal dirt would cease to be "dirty" and "polluting."

Psychiatric nurse: People can be who they are on this ward, with all their handicaps, with all their odd behaviors. That's our vision of rehabilitation. In principle, people are allowed to behave madly, as long as you can handle it on the ward. People are allowed to stay in bed for a day because they experience strange things. They are not obliged to get up and go to therapy. Let the people just be people to start with. They have so little left to themselves.

The tolerance for individual cleaning practices, with dirt being a private matter, includes admission of incurable anxieties and psychotic fears into this private sphere of preferences. As one of my more eloquent patient-informants told me, patients, including him, are anxious about showering and undressing.

I ask Gilbert if he has an idea why nobody likes to take a shower on this ward. He answers me solemnly: "Washing changes your body. Your skin and your pores. You have to undress, and that is unpleasant. These are fears. For myself, I do not undress when I go to sleep. Well, I take off my jersey, but not the rest. And I take a shower once a week, which is more than enough. You get a wash, change clothes, that's enough."

One lady was afraid her hair would fall out and her skin would come off if she took a shower. Another person associated the showers with torture-chambers, so he wisely avoided them. The nurses accept this and consider these arguments legitimate. They do not try to change the authentic self by training, learning, therapy, or interactions with the outside world, *unless* the individual makes this decision herself. Personal development is a private matter as well, as are incurable psychiatric symptoms that become part of the person's characteristic habits and particularities, like being dirty.

The nurses experience problems respecting privacy when consensus between nurse and patient is absent. Although they do not refrain from interfering, when they do so it is not to change the authentic self, but rather to put limits to conflicting forms of authenticity.

Nurse William says he could not stand the way Bill looked any longer, all dirty and with scabs on his face [he has a skin-problem]. They had tried "personal responsibility" and gentle insistence, even a prohibition to enter the common room in this dirty state, long enough, with no result. William ordered Bill out of bed, dragged him under the shower and scrubbed off all the scabs. "Harder!" Bill had called. He was in the shower for almost two hours. William put clean sheets on the bed and discovered about thirty empty cartons of apple juice behind it. Now Bill is in the common room, his head as red as a fire engine. Martha says there is ointment for it.

Because non-interference is valued and interference is suspect, when patients like Bill do not wash themselves, it is rarely clear when the point to do

something about it is reached. In the example cited a negotiation takes place about individual privacy: Bill can continue his behavior, but he is not allowed to disturb others by entering the common room. This allows Bill to be free and maintains the nurses' non-interference in Bill's privacy. Thus, individual privacy seriously restricts the possibilities for professional assertiveness in matters of washing.

When nurses do interfere without the invitation of clients, they sometimes justify this in terms of the intolerance of others. Other persons limit self-expression. Just as the individual is a private person, other people are equally private individuals with different, sometimes competing, interests and norms. By invoking (negative) rights (the right not to be disturbed unless harm is done to others), nurses also legitimate their interference in legal terms.

Psychiatric nurse: Well, you know, you are allowed to do that according to the law. We use the following phrase very often and very creatively: "to cause inconvenience to patients, roommates, or others." Then we get someone by the short hairs and see that it gets done. We have a few of those here. Gerald, for instance. Yeah, he looks nice enough from the outside, but when you bathe him you see that the front is yellow and the back is brown. And a change of clothes is badly needed.

Framed in this way, the relation of the individual to others (patients, nurses, family) is oppositional. Other persons restrict the liberty of the person living out his or her authenticity. It is hard to think of being clean as of value to a person who does not automatically do it or explicitly ask for help. At the same time, relations with others are not seen as of value to the individual (see also Atkinson 1998). The nurses construct relations between individuals in terms of conflicting interests.

A Private Wash for the Authentic Individual: The Private Citizen

Just what does this practice of washing tell about citizenship? In order to become a citizen in this care practice, an individual private sphere is needed. In this individual private sphere the "atoms" of public life can be developed: the authentic individuals. Authenticity in the individual private sphere can be lived without others interfering in it. The authentic individual has a specific form of autonomy, which is related to self-governance and freedom. The individual private sphere is needed to enable individuals to participate in a community of citizens that take care of their own interests and defend their authentic ways of being. Individual qualities and preferences need to be developed by the individual to be equipped for participation in a community where other individuals are equally autonomous, pursue their own goals, take care of themselves, and express their preferred way of living. Everyone

has a right to be a private individual, but specific competences are also necessary. Authenticity for these patients needs to be developed by providing material conditions and individual responsibilities. In this way, the patient is paradoxically regarded as already being a citizen, and as becoming a citizen.

From this it appears that the mind of a person is more private and individual than the body. The citizen is free to think and decide whatever he or she wants, either publicly or in an individual private space. But the body presents a more ambiguous part of the private sphere. On the one hand, the body is private, because people have the freedom to express their authenticity by making what use of it they like. But on the other hand, care practices clearly show that there is a limit beyond which nurses will interfere. At that point, the body is drawn into a social sphere of individuals with competing interests, or of caregivers with nagging feelings that something is wrong. Being dirty as a way of authentically living your body results in dirty bodies becoming a matter of public scrutiny. The hospital then becomes a social or public place, though not completely: the nurses' interference, however justified it may seem in a specific instance, is still seen as a transgression of the private boundary protecting individual freedom.

Thus, respecting privacy of individuals as a way of preparing for citizenship makes it very difficult for caregivers to interfere when patients pollute for whatever reason. Psychiatric nurses have to contain the feeling that "this goes too far" or equally unspecific legal rationalizations of hindrance. This inarticulate urge to interfere has to somehow overrule the larger principles of personal freedom and responsibility. (Not) washing brings a tension to the fore between what can be seen as private individual attributes that are of no interest to others (like color of skin or hair), and individual interests that affect (or harm) others.

SECOND REPERTOIRE: WASHING IS A BASIC SKILL

In the second repertoire washing is performed as a basic skill. As such, washing is not left to personal preferences. Washing skills are general skills, which should be learned or trained. Nurses often make an analogy with muscles and brain cells. You have to exercise them, or they will shrink and deteriorate: "use it or lose it." Armed with these athletic metaphors for bodily functioning, nurses do not take washing tasks from the hands of the patients. The trick is, as much as possible, to induce patients to perform the acts for themselves. This can help in *relearning* a skill one has lost, for instance because of hospitalization. A patient who never had to wash herself may not be able to do it anymore. Doing it yourself also serves the purpose of *keeping the skills intact*, trained and fit.

Nurse Rose has helped Mrs. Brisbane out of bed, out of her nightgown, into the wheelchair, and has wheeled her to the bathroom. Rose turns on the taps, puts a washcloth in front of Mrs. Brisbane and says: ''Put your hand on it. Okay, now wet it. Now go ahead and wash your face.'' ''No,'' says Mrs. Brisbane. ''Come on, it's nice if you can do that for yourself!'' Rose says. ''No,'' says Mrs. Brisbane. But she starts washing her face anyway. And I see she is perfectly able to do it. ''Your ears too!'' Rose calls from the other room, where she is making the bed. ''Yes,'' says Mrs. Brisbane, but I can see that she isn't doing it. Rose returns to the bathroom. ''Now the upper part of your body, with soap. Put some soap on the cloth, okay now.'' Mrs. Brisbane fiddles with the soap and with an efficient movement Rose puts soap on the cloth. Mrs. Brisbane starts washing her chest while Rose gives directions. ''Your armpits too!'' Mrs. Brisbane washes her armpits. ''And under your breasts!'' Mrs. Brisbane obediently lifts the left breast and washes the skin underneath. ''Very good,'' Rose says, ''Now the other breast. Otherwise you'll get a rash, you have it a little bit already.'' Rose helps her. Now Mrs. Brisbane is finished and she puts the washcloth in front of her. Rose rinses the cloth and says: ''Put your hand in again. Just to rinse off the soap. You're doing great!'' And the ritual repeats itself.

Although it is doubtful that Mrs. Brisbane will ever wash herself without assistance, the acts she does engage in herself serve the purpose of keeping her fit and keeping some of her basic motor skills intact. The nurses and geriatric assistants explained that this way of washing a person is much more demanding than just taking over. And the result is often less satisfying to them in terms of cleanliness. Caregiver and patient perform the act together. The nurse gives verbal cues, and acts as a ''prosthesis'' by performing the parts the patient cannot do so as to enable what she can do.

Where learning and maintenance of skills is the goal, ''functional diagnosis'' becomes important in psychiatric nursing: what can a person do, what can't she do, what can he learn? Assessment and planning are tools in nursing care with a basic skills perspective. Care plans become necessary props, and a smooth exchange of information in the nursing team is organized. All members of the nursing team should know what a patient can and cannot do, where assistance is needed, and what goal the training aims for. Every nurse should approach the person in the same way, especially because the training is not always without a struggle, as I will show below.

The goals of the training are written up in care plans, and the nurses write reports on the progress made and trouble encountered. The training of skills implies improvement; evaluations can and should be made. Not surprisingly, this brings in an element of optimism in care for severely disabled persons, because a new form of progress is defined: not the removal of symptoms, but the development of skills. The body is active in its striving for independence.

This type of care is associated with rehabilitation. It is assumed that the individual would like to be independent in order to be able to live in the community. Washing oneself contributes to this ideal of living with as little

dependence on professionals as possible: if you learn to do for yourself what you can, you will be less dependent on supporting professionals. On the other hand, the image of physical fitness and learning makes basic skills fit in as well with medical formulations of treatment. Training skills can be seen as a therapeutic goal that, once reached, implies a return to a normal, civil life.

Positing washing oneself as a basic therapeutic aim and as a source of freedom gives the nurses the authority to force individuals to do it. This authority is not perceived as problematic, because it is implicit that the person also *wants* to be independent: either you *have* the skills and you would want to use them, or you do not have the skills and you would be happy to learn them. Passivity is to be avoided from the point of view of basic skills training, because it would cause skills to deteriorate.

But why are washing skills regarded as *basic* skills? This is because, excepting serious physical handicaps, washing is a skill that everybody has and that must be practiced before any other activity is attempted or skill is learned. Having a diagnosis of, say, schizophrenia does not damage washing skills (although it might be thought of as damaging motivation to use them, see below). This disconnection of physical skills from mental illness provides an opening for turning the patient into an active and autonomous citizen. Because the skill is basic, everybody *should* wash him- or herself. On this basis, other skills and activities can be built.

Geriatric assistant: I have the feeling that they, well [searches for the right word] they felt more *grandeur*. They decide for themselves when they will wash. For some of them the whole morning ritual changed. First they went to breakfast in their dressing gown, and afterwards they went to their rooms to have a shower. Instead of: seven-thirty, call everybody and wash immediately. Some people got a much larger territory; they became interested in different things. They began to get involved in setting the table.

Regarding washing as a basic skill is closely linked to theories of hospitalization. Taking activities and responsibilities out of people's hands will make them passive and will cause skills to disappear. It is also related to the idea that hospitalized and socially excluded people should learn skills in order to get around in the community. Making telephone calls, budgeting, and filling out forms all are important skills for the citizen-to-be. But washing is the most *basic* skill; it comes before filling out forms. It is lowest in the pyramid of self-management and is practiced also in care where training is not otherwise important. As the geriatric assistant says, changing caregiver routines also changed client routines. Clients' new assertiveness in other areas supports the idea of washing as a basic skill, from which other activities can be developed.

So, from a professional point of view, it becomes imperative to practice or learn skills. This can lead to disputes with patients who resist doing the washing themselves.

Geriatric nurse: Most of the residents are psychiatric. This requires a specific approach. You see, Mrs. Albert, she can help herself. She can wash herself, she can walk. However, she will *never* say that she can. "I can't do anything," is what she keeps saying. And if you give in to this, you take away all her independence. It's a fight, over and over again, every morning, to get her to do it herself. Just to dress herself and walk over to the living room. So, despite the fact that you don't have to do much work with this woman in the way of actually helping her, she's got a morning's work cut out for you, supervising her.

The geriatric nurse argues with Mrs. Alberts so that she will not lose her washing and dressing skills. Although Mrs. Alberts denies being able to do it herself, her statement is not credited, because the nurse sees no physical handicaps. Mrs. Alberts' objections are seen as a consequence of her psychiatric problem, not as a "real" (physical) impairment. Psychiatric disorder is not seen as a valid reason to leave responsibility for one's personal care to others. This frames the person with mental illness as irrational and unpredictable, or even as sabotaging or manipulating care.

Sandra [geriatric assistant] tells me that she deputized on the other ward with less severely disturbed clients. She thinks it's a world of difference. "You could think: this is the psychiatric ward, so you have to work harder, now and again. But that's not the point. Of course the people here are physically in need of more care, but that isn't the point either. The work gets hard when someone doesn't *co-operate*. When you say: ‚Put your hand through this sleeve,' and she doesn't do it. Take Mrs. Best. She's a small person, but she doesn't co-operate at all. So sometimes you help her with a good wash-up, get her dressed, and you say: ‚Come on, I'll walk you to the living room.' And she refuses, she says: ‚I can't walk.' So then I think: ‚Okay, I'll let her be alone in her room for a minute, I'll come get her later.' And when you come back, she's shit her pants. She does that, I told you before. So then you have to put her under the shower again."

Seeing the refusal to practice basic skills as sabotage is a consequence of the specific way in which skills and learning define a person's autonomy and normality in this care practice. Autonomy is found in activities that enable decisions or freedom afterwards. To be a citizen is to act independently. To refuse to do so is not a serious position in a basic skill repertoire. Mrs. Best is treating her body not as a citizen-to-be, but as a disturbed person.

A Skilled Wash for the Independent Body: The Independent Citizen

Where washing is a basic skill, washing is an explicit competence to be learned by the aspiring citizen, who must be independent to live among other independent citizens. Autonomy is characteristic of this citizen, but

before freedom and choosing comes 'doing.' Being autonomous is doing things oneself as much as possible. If you can do that, you can organize your life as you like. Skilled bodies provide the conditions for free choices.

Washing is not optional: everybody has to do it. Bodily activity is of importance to a skilled person striving for independence. It is assumed that the patient wants to become an independent citizen. Citizenship involves freedom of mind, but not of bodily actions, because freedom of mind is obtained through specifically trained body skills. The independent person can function in the community by being self-supportive. Professionals, like psychiatric nurses, provide temporary support; by successful training, they have to make themselves superfluous. In this way, they try to equip the citizen-to-be with the necessary competences. Nurses do not define themselves as part of a public sphere, but as providers of "therapies" (training programs) that enable patients to become competent to leave the hospital and go back to the community "out there."

"Psychiatric disability" does not disrupt the skill itself. Psychiatric problems might damage co-operation with goals that nobody in their right mind would question. People with a mental illness are able to wash and they should be pushed to do so, just like everybody else. Being dirty is not an option. It is the reluctance to wash that has to be overcome. Objecting to a basic skill scenario would be an objection to citizenship and a choice for patienthood. This leaves patients not many possibilities to propose alternative ways of becoming a citizen. Their psychiatric disabilities are not the object of care, yet they are still treated like patients in order to become skilled citizens.

THIRD REPERTOIRE: WASHING IS A PRECONDITION

This repertoire of washing is complicated, because it is not about washing. Even though it is "not about washing," however, it establishes certain conditions for washing. In this repertoire, washing and getting dressed are preconditions for doing things in life that really matter. One simply needs to be washed and dressed to be able to go to work, get around in the community, use services, get an education, or re-establish one's contacts with family. These are goals for professional nurses, to help a person develop the project of his or her life. Much in line with the historical change mentioned in the introduction, washing is not seen as a part of professional nursing aimed at developing citizenship.

In a life project, being clean and well dressed is not considered an important thing in itself but is taken for granted. It would be best if the

person took care of these matters herself, just like everybody else. If problems arise and a person cannot do this, help can be arranged, for instance by hiring professionals specialized in washing people. It is seen as a practical problem that needs a pragmatic solution. If a person looks a bit different, this is not of great importance when measured against the challenges that await him or her in the real world. But offensive smells or dirt are of no help, either. It is not questioned whether or not washing should be done, but rather who should take care of it.

In this way, the performance of washing is more a matter of organization than of specific techniques. Hiring the residential homes' geriatric assistants is a way of doing this. In the psychiatric hospitals, there are mixed teams of geriatric assistants and psychiatric nurses in wards for the elderly. There were, however, no washing professionals on the wards with younger persons in the psychiatric hospitals I studied. The psychiatric nurses had to assist if necessary.

The care where washing is a precondition aims at citizenship by "self-actualization:" psychiatric nurses help the patient to develop and sort out their priorities and help them to develop the project of their lives. This is resonant with humanistic psychology (Rogers 1961; Maslow 1970). Self-actualization is a specific form of rehabilitation in psychiatric nursing. The focus is on personal growth, not on symptoms or pathology. Patients can discuss pathology with the psychiatrist if they specifically want to put it on the agenda. Development of a life project, however, is the main task of the nurses, a way to turn patients into clients and citizens.

Psychiatric nurse, team leader: You know, they de-patientize if you see what I mean. Specific disorders or deviations exist, but you don't have to act on them. You just have to take care that nobody is bothered by it, especially not the person suffering from it, that he can get along with it in a pleasant way. And if you are coaching people and want to get to know them, patient records are not the first things you need.

For the self-actualizing citizen it is important to explore individual goals and projects for the future, one that holds the promise of the fulfillment of personal potential and leads to a development of a respectable place in the community. People pursuing their personal goals and strengths are of benefit to society as a whole. Skills can also be trained, but in quite a different way than as a basic skill. While it is obligatory to practice basic skills, there is no need to have specific skills for self-actualization. The skills to be developed have to be meaningful to a person's life project.

Psychiatric nurse, team leader: Well, yes, we do try to let people keep their independence as much as possible. And that is something different than wanting people

to function as independently as possible. In that case you will teach people to do tricks. Everybody does the dishes; everybody cleans his own room, and so on. While here, we look at the person and ask: ''Is it meaningful to them, does the person benefit from it, can the person handle it, and do things get messed up if he doesn't do it.'' It has to be an improvement for someone's life.

Autonomy in care for self-actualization is a matter of developing and choosing rather than doing things oneself (basic skills) or being free to decide on one's individual private life (privacy). The question of what skills should be learned is left to the discretion of the individual. The nurses do not push the individual to learn or practice specific skills, as would be done in a basic skill care practice. And they do not leave it to individuals to privately decide on their goals, but actively engage in helping them articulate these decisions, and assist them in realizing their individual projects.

Clients, however, are not often explicit about what they perceive as meaningful to their life project. After years of hospitalization they have learned to keep their dreams and stories to themselves, and have lost track of options existing outside the hospital. Deciphering hints and looking for clues are part of a nurse's job, in order to support individuals in discovering what they value, and to help them to develop their lives.

When geriatric assistants are hired to support patients with washing, however, the splitting of mind and body by a division of labor among professionals becomes problematic.The psychiatric nurses are critical of the routinized and authoritative way that geriatric assistants wash their clients (see for this practice of washing Pols 2006). Precondition and life projects turn out to be more substantially connected: care for preconditions cannot take just any form. Notwithstanding the division of labor, routinized and systematic washing appears to contradict ideals of self-development and setting priorities. Routinized washing might be appropriate in dealing with patients suffering from dementia and incontinence, but it is unacceptable for psychiatric nurses who are trying to encourage their patients to develop their own potentials. At this point, a solution can be that professionals concerned with self-actualization take up the washing and dressing themselves. This way, they adapt the washing to their own practice and values of good care: washing has to become part of a life project.

When this occurs, psychiatric nurses try to stimulate the development of a life project by making patients choose and consider even little things that are important to them. It seems inconsistent to help patients go to the local community center, but not to give them the opportunity to choose their own clothing and decide on their own shower time. It can also be the case that a patient has specific reasons to refrain from washing. This strategy includes

washing and dressing in the person's project; hence, these activities regain importance.

If washing is put back on the agenda of the psychiatric nurses, however, self-actualization seems to end and transform itself into something else. For nurses for whom washing is a precondition, the goals associated with washing and getting dressed are typically not seen as very challenging. They remain in a way 'precondition matters' that should come before the development of citizenship.

Psychiatric nurse: I applied for this project [a psychiatric ward in a residential home] with the idea that we would coach people to live independently in the residential home, away from this ward. Or even outside the residential home! That was my main motivation to come here. For those people who would keep on living here, I thought of them as a bonus. But in fact, they make up the majority. And it takes a lot of time to help them with washing and dressing. So I am not sure yet if I will continue working here or if I will move on to another project.

The coaching this nurse had hoped to engage upon sets goals related to community life: living on one's own, choosing a place to live, and talking about what is needed for domestic life. It is not about things as mundane as washing.

A Preconditional Wash for Life Project Developers: The Self-Actualizing Citizen

The citizen for whom washing is a precondition is one who engages in community life by developing his or her personal potentials. By developing their strong points, they can become participants, for instance by getting a job, by traveling, or by establishing contacts. Nurses help patients realize they can have goals, help them decide which ones to pursue, and help them to reach these goals and become a citizen.

Again, autonomy is important for the would-be citizen. In this repertoire it is related to choosing which potentials (however buried or flattened by hospitalization) to develop. Developing strong points, abilities, and possibilities helps a person find a satisfactory way into the community. Psychiatric nurses take an active approach in care, but because of their mission (developing the life project of the client), they do not have the authority to decide which goals are worthy of pursuit. These are, after all, personal matters.

The agenda of the psychiatric nurses, however, makes care for washing less attractive to them than the more publicly appealing goals that relate to community life. Taking washing tasks upon themselves means that ideals of self-actualization are brought back inside the house from outside, or brought from the top of the pyramid of needs to its base. This does not seem

to work easily: a qualitative difference between precondition (including washing and medication) and self-actualization persists. People having trouble with washing do not seem to be people who are on the verge of participating in society. Dealing with washing seems to imply a step back from helping clients to become citizens, to seeing clients as patients again. They remain in the hospital or in the residential home, and do not develop towards community life. Apparently, washing is a precondition after all.

FOURTH REPERTOIRE: WASHING IS A RELATIONAL ACTIVITY

In this repertoire of washing, relations are purposefully developed as the goal of care. Of course the other repertoires of washing are also about organizing relations, but this is not perceived as the goal of the care practice. Establishing a relation between caregiver and patients is a central aim here, and also a means to other ends: without good relations, everything stops. Because the relation, and not a specific (form of) activity is central, washing becomes an activity like any other. It is neither a basic skill, nor a precondition for "higher ends." There are different aims or activities, and washing is one of them. This also implies that it is not of primary interest that the patient performs the washing herself, whether or not she is capable of doing so.

Psychiatric nurse: For most people living here, it is important to build up their independence and self-management, starting with the ADL [Activities of Daily Life, such as washing and getting dressed]. But OK, we help Mrs. Smith. This is a choice we've made. We help her with ADL because physically she is in bad shape. She has a heart and lung condition, and she gets oxygen on a regular basis. So you can say: "You have to do it yourself," but then she's laid up for the rest of the day. She'd sit in her room, staring at the television. She was simply too exhausted to do anything else. And look at her now: she's hardly in her room, and she has lots of contacts.

At first Mrs. Smith found it strange to be assisted with washing, because she was still able to do it by herself. But here washing is not a basic skill, neither is it a private activity to be done alone. Although it could be seen as a precondition, it isn't, because Mrs. Smith has the choice to wash herself or to have more contacts, and the nurses help her with washing without questioning if this should be their task or not. There is no hierarchy between activities. The person who does the washing can change: it can be the caregiver or the patient, whichever is more convenient, pleasant, or effective. You-must-do-it-yourself is not as important as you-may-do-it-yourself. Assisting a person with washing can be a way of doing things together; it can also be that washing a person serves the purpose of pleasure.

The image of the patient/ citizen is not so much an image of an individual; rather, it is about ''living together'' with others. The proposed self is a social self: to exist, it must relate to others. Relations make the citizen more or less integrated. The nurses help to develop the patients' social network as a way of becoming part of a community, which is not ''out there,'' but ''right here.'' Family, friends, even ''arranged friendships'' with volunteers, community centers, and so on are thought of as more important for citizenship than trying to improve or change patients by therapy programs directly acting on the individual level (skills training, making decisions for yourself). Nurses help their clients to establish stable relations with their family members.

The nurse herself, however, is an important member of the network: she forms a first link to citizenship or a life in the community. More than trying to change their clients, nurses live with them. Being there for birthday parties and other festivities is part of their job, just as assistance with washing can be.

What kinds of relations make a citizen, then? Negotiations are very important in this form of care. There are no fixed positions, with one person imposing norms on another. Rather, there is give and take, which is influenced by moods and changes over time. There is no clear strategy that always works in dealing with other people.

Psychiatric nurse: I think these things aren't plannable. On one day you can say: ''Hey, Ben, come on, time for your shower!'' And I think ''That's nice, I can talk to him in an informal way.'' Another day I think: ''Ben, today I am not going to ask.'' There is no standard that is always successful. Some other time I would probably say: ''Ben, you can do it on your own.'' Or he would say: ''I don't want to.'' I think it is very hard to lay down rules about how to do these things.

The shifting positions make it hard to prescribe general rules for behavior. The relationship must accommodate different moods and uncertainties. A nurse should be flexible and able to adapt to new situations. The best bet for some stability is to establish a relation with the patient; after that, she has to react when the time is right. Any techniques are allowed, as long as coercion is not used. Violence is not a part of relations between citizens. No professional authority could replace negotiations; neither does the patient dictate what has to be done. The result of the flexibility can be that some patients are a little dirtier than they would have been if they were routinely washed. It can also mean that stubbornly refusing patients become far dirtier than the nurses would like.

Psychiatric nurse: Mr. Jones has lived here for four years without taking a shower.
Interviewer: Really? And he doesn't smell?

PN: Of course he smells. But there is a difference; some people don't attract dirt, so to speak. Take Jensen: if he can, he'll escape the shower as well, but he doesn't look dirty. But people like Ger and Frank: put them under the shower, and after half an hour you would like to advise them to go wash themselves. They seem to attract dirt, and their shirts hanging out of their trousers doesn't look so smart. Others dress so nicely that they camouflage whatever you would find if you looked or smelled underneath. But with Mr. Jones it took four years. Booming psychosis. They took him once to put him under the shower and he really thought: I am going to the gas chambers. I will never forget that, it was so intense, the way he screamed. Dear God, that was a heart-rending cry. Then you wonder: Should you do that? In the crisis ward they would have picked up a person much earlier. But that's not our way. We try to negotiate, be flexible, and talk. That has its limits, of course. But I always think it's fascinating: these people are really ill, really disturbed. But you can establish some form of relation; you can communicate in certain ways. You can understand them and you will always discover that there is some place from which to work. But you have to be patient, put in a lot of effort, and be happy with very small changes.

Relational care also means that patients can refuse to wash at a given moment. Because establishing and keeping relations is the objective, however, the nurse is much more assertive than could be the case when washing is seen as a private activity. She is not stopped by her own scruples, but by the resistance of a patient, or by the impossibility of establishing a relationship by means of which she can reassure a patient that showers are not gas-chambers. Her input in the relation is legitimate: opinions can be given, suggestions can be made. The caregiver just has to be clever enough to get things her way, or know the patient well enough to see what she will respond to. The same conditions obviously apply for the patient, who does not have the final word either. The essential thing is to be sensitive to the contingencies and particularities brought by every new day.

Citizenship seems to begin with personal relations. Ideally, there is give-and-take between citizens and, consequently, between nurses and patients. Each brings with them their specific differences, personalities and changing moods. To establish relations, these differences are appreciated and acted upon. A coordinated, unified team approach, which is favored in practices that emphasize development of basic skills, would be bad nursing here. And washing, just like any other activity, can help to establish the relation.

Psychiatric nurse: I like to do it [washing and dressing of clients] with people. It's a much more relaxed way of making contact; you have a very clear goal. And the rest just comes with it. It's a simple way of communicating, very informal. Because, see, if you talk to someone, you don't have the same conversation the next day. After a while, you get to *know* Jeannie, if you see what I mean. With dominoes, too, you've played that game for days on end. These people are not really able to make contact or keep themselves occupied. [...] So when you come in one day, and you're not all that motivated, or there's not much to discuss with a certain patient, you still have this caring for washing and dressing. And while you do that, it's possible for

something to happen that deepens communication or that enables you to do something extra for the person.

As this nurse shows, communication is not always easiest by ''talking.'' On the contrary, he perceives verbal communication as often difficult. Washing creates an alternative situation for communication. There is a clear task at hand and ''the rest comes with it.'' The situation is not determined by conversation alone.

The idea of citizenship advanced here does not bring with it many prescriptions. There is no pre-set hierarchy of worthy or less worthy goals: goals are subject to change, and they should function to support relations with others. With the re-valuation of washing, other types of ''non-heroic'' communication are also valued more.

Psychiatric nurse: You should simply see that you work with people–that's what it's all about. It's a terribly stupid profession, being a nurse. What matters is that you can empathize with other people. To learn that, you go to school for four years, see what I mean? I don't want to downplay the profession, but I do want to put it into perspective. Because it's about investing in people, and getting something back. And it doesn't matter if this is about washing, dealing with voices [hallucinations], or moving to another place. If you can work it out together, you can really do a lot. Then you can cheer up the craziest nutcase.

This informant questions the professionalism of relational care. Elements of friendship enter the relation from the active attitude adopted by the caregiver, who makes comments and gives unsolicited advice out of a sense of commitment or concern. But there are also elements of professionalism: the professional relation guarantees the continuity in ''cheering up nutcases;'' talking about psychiatric problems is a part of the job, and this, just like assisting a person with washing, can be more difficult to do for a friend or neighbor or in some intimate relations, for instance, between parent and adult child (see also Borgesius 1988; Borgesius et al. 1988).

A Relational Wash for Getting Along Together: The Relational Citizen

When washing is a relational activity, to be a citizen is to be connected to other people. It is not of central importance to be autonomous; instead, the citizen has to establish and maintain relations with other people. Friendships and personal relations are ways into the community. Living in an institution does not automatically imply a marginal position. There is no pre-set spatial division between what is inside or outside the community. A lack of good relations would marginalize an individual, so this is where the psychiatric nurses begin their work. They start by making the caring relation more personal and more balanced. The nurse becomes part of the social network.

There is no autonomous self to be defined as apart from others; the self is variable and inconsistent. This is true for nurses as well as for patients. Flexibility and improvisation become important qualities for citizens. They can be active, but they have moods, styles, and inconsistencies that must be taken into account. Washing, as well as other matters, is framed from this perspective. There is no hierarchy of activities, nor is preference given to matters of bodies or minds. These will have to be dealt with on a day-to-day basis.

Establishing living together in a convenient way as the goal of this care practice means downplaying professional claims of psychiatric nursing. Caring is unpredictable; it is not easy to prescribe 'methods' or rules of how to act. Caregiver and patient will have to work it out together. Instead of a clearly outlined *citizen*, this practice of washing presents us with a way of *negotiating* or *practicing* citizenship.

DISCUSSION: CIVILIZING THE WASH

The establishment of ideals of citizenship in psychiatric nursing aims to achieve the (re-) integration of persons with mental disorders into community life. Patienthood should be traded for, or at least complemented with, citizenship. As a result of this paradigm shift in mental health care, washing was rendered tacit, as it ceased to be part of "good mental health care." Although tacit, it never stopped being a part of daily care. Practices of washing and promoting citizenship merged in complex ways, resulting in the different repertoires of washing.

But not only washing is rendered tacit. The different ideals of citizenship are also not discussed. Analyzing citizenship through washing practices poses questions about what norms, (bodily) conditions, competences, and barriers there are to being or becoming a citizen. Of course it would not be fair to analyze citizenship on the basis of washing practices only, because some care practices that aim at citizenship for patients do not claim to solve washing problems. Some notions of citizenship seem to be tacitly displaced when they became attached to washing. But despite these reservations, specific points about citizenship can be made.

WASHING THE CITIZEN

Certain remarkable characteristics of citizenship can be made explicit by looking at the four washing repertoires described. It is striking that in the

first three repertoires of washing, but not the fourth, the ideals of citizenship share as a characteristic the fact that they structure social relations by developing different forms of *autonomy* for the patient. To become an autonomous citizen is to cultivate individual interests (private citizen), to become independent (independent citizen), or to develop one's potentials (self-actualizing citizen). Community life consists of autonomous individuals living among other autonomous individuals, and the services and goods they use. These individuals can be more or less in competition with one another, yet they are the atoms of social life. The ''bourgeois,'' with specific interests, competences, and projects, is promoted rather than the ''citoyen'' who has responsibilities for the common good (Nauta 1992).

But relating citizenship to autonomy leads to certain problems with regard to the political goal of community participation of these patients. A first problem is the sociality of the autonomous citizens. It is unclear how the autonomous individuals can relate to one another, apart from not hindering each other. The private citizen has to be protected from others; the independent citizen has to take care of his or her own affairs regardless of what others do. It is subtler with the self-actualizing citizens, because they may develop relations as part of their life project and the preconditional nature assigned to washing signifies an awareness of the importance of dealing with others. Yet in all three cases the first thing to be strengthened and developed is individuality and specific individual competences, so that the individual may become sociable later. ''Participation in the community'' seems to imply the addition of new individuals who are taught how to behave, leaving the community ''out there'' to function as before. The care practices directed at autonomous citizenship seem to promote conditions and competences for the individual to survive outside the hospital or residential home. The new citizens do not make connections or argue for changes that make it easier for them to be accommodated in the community, but instead have to adapt themselves to its conditions.

A second problem with the concept of autonomous citizenship is that the hospital or the residential home does not seem to be the place to practice citizenship in relation to other citizens. There are not many ''real'' citizens around (with the exception of the residential homes, where ''normal elderly'' live and relatives live close by). The patients are ambiguously seen as citizens or citizens-to-be (they are being taught to be citizens). Individual competences are to be learned in hospitals or residential homes, by those ''excluded,'' and are to be practiced ''out there,'' in order that the ''excluded'' may be ''included'' in the community. Autonomous citizenship locates psychiatric services outside of the community.

In this spatial division between being inside or outside the community, with psychiatric services being outside, the nurses take a remarkable position regarding their own autonomous citizenship. It seems that they are there to promote the citizenship of their patients, without acting as autonomous citizens themselves. Instead of arguing for their own interest or taking care of themselves, they are professionals helping others to become citizens. By doing so, they bracket their own citizenship to support patients, which is not part of the definition of citizenship but is part of their professionalism (unless they see nursing as self-actualization). Their citizenship, like that of the patients, seems to start outside the hospital doors.

A third problem is that the three notions of autonomous citizenship try to create citizens who are *equal* to other citizens in their rights, obligations, and competences. If someone deviates in an unconventional way, for instance by not washing, this is hard to deal with in terms of autonomous citizenship. As became clear in the analysis, the perception of washing as a private activity, a basic skill or a precondition, runs into problems when patients pollute, do not want to wash themselves, or experience trouble with washing. The notions of autonomous citizenship make these problems hard to deal with for the nurses. Washing ceases to be a private matter, the wish to be independent is challenged, or washing becomes a central issue rather than a precondition.

For that matter, psychiatric disorders are also marginal to the notions of autonomous citizenship (see also Estroff 1995). Psychiatric handicaps can organize or categorize "patients" as a group. To the autonomous citizen these handicaps are private particularities, leave skills and independence untouched, or are irrelevant to self-actualization. They are not relevant to the definition of autonomous citizenship, which is about the equalities (and normalities) of citizens rather than their differences. With the entrance of the citizen, the patient seems to disappear. Troubles for patients are privatized or delegated to other professionals in the precondition repertoire. In the repertoire where washing is a basic skill it is even more complicated: although psychiatric symptoms are not seen as disruptive for the skills themselves, the development of skills is approached in a therapeutic way.

So using autonomy as a concept to define citizenship leads to certain problems in thinking about participation in the community for these patients. Community life demands changes for "newcomers," but does not support them by adapting its standards; spatial divisions between private and public locate professionals, patients, and mental health care conceptually outside the public sphere; and differences between citizens are hard to reflect upon or to deal with because autonomous citizenship stresses

equality with other citizens, and this defines differences–however unsuccessfully- as private or irrelevant.

Are these problems inescapable? The notion of relational citizenship seems to avoid them. Relational citizenship is developed by building constructive and helpful relations with others through negotiation or mutual accommodation. It implies a form of sociability in which the citizens acknowledge their dependence on others. In this way, it is not only the *patients* who have to be or to become citizens, but the nurses as well. By being part of the network of their patients, they enact the citizenship they proclaim. Both nurses and patients shape citizenship through their relations, notwithstanding differences such as professionalism, patienthood, or hospitalization.

The concept of relational citizenship does not imply equality or the exclusion of deviance. Psychiatric problems are as susceptible to negotiation and accommodation as are problems associated with washing, or questions about applying for a place in the community center. Multiplying differences implodes ''equality.'' Not only can preferences differ from person to person; they can also differ in the same person from day to day. Divisions do not run between the mad and the sane, the private and the public, the patient and the citizen, the autonomous and the dependent, the clean and the dirty, but between *situations* with specific characteristics. Spatial metaphors of private and public spheres do not hold for relational citizens. Relational citizens move through *time* in differing and changing connections from one place to another, in and out of the hospital and even to the bathroom. In doing so, the citizens establish new norms together. ''Normality'' in relations between citizens does not refer to norms that are given (such as autonomy); the norms have to be performed, refreshed, and re-established in each situation (see Winance 2001, 2002). In the interaction not only the patients change in order to become citizens, the ''other'' citizens take their part in defining new norms as well. Everyone is responsible for civil relations, it is not just a matter of acquiring the same competences and skills. One can react to strange behavior in an even stranger way, or try to accommodate it and thus ''make it normal.'' In order to welcome newcomers on the labor market one can try to train them to become ''normal employees,'' or competitive demands of the working situation can be adapted. The notion of relational citizenship implies opportunities for two-sided political action and critical reflection on what is the common good, approaching the ideal of the ''citoyen'' who has responsibility for others. One can argue that the concept of relational citizenship also links citizenship to ''the good life'' or ''being human'' (see Foucault 1985, 1986; Withuis 1990).

The concepts of autonomous citizenship inferred from washing practices bring out tensions to which the notion of relational citizenship provides solutions. Practicing relational citizenship allows for relations and situations that enable different groups to participate on mutually acceptable terms. Yet the relational notions of care and citizenship have a hard time surviving the actual focus on professionalization and planning in Dutch psychiatric nursing. Patient autonomy is the key-word nowadays, notwithstanding its specific limitations for conceptualizing community participation for marginal groups.

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