3

Before Deinstitutionalization

The United States and France Compared

The central empirical task of this book is to demonstrate that, all other things being about equal, alliances between the managers and employees of public mental health services shaped the trajectory of public policy in that area. That the United States and France meet this *ceteris paribus* condition might surprise some readers, who otherwise might view those two countries as far more different than the Scandinavian societies of Sweden and Norway. Moreover, the contemporary US and French mental health care systems appear to align with the general patterns of social provision in each country: limited and privatized on the one hand and generous and state-centric on the other. Yet these outcomes were less obvious prior to psychiatric deinstitutionalization in the second half of the 20th century. In fact, a midcentury observer might not have predicted that the supply of mental health in France would exceed that of the United States (see Figure 1.1 in Chapter 1). If anything, the opposite prediction could have been deemed more likely.

This chapter shows that the political-economic conditions that preceded French and US deinstitutionalization were broadly similar. At the close of the Second World War, both countries structured their social welfare and mental health care systems in comparable ways. They each began to experience the transformative period of economic growth and welfare expansion that rendered deinstitutionalization possible, and each approached that "Golden Age" with nearly identical blueprints for mental health reform. Of the two, though, the United States appeared to have the upper hand. The war had devastated mental health care provision in France: More than 40,000 patients had died of famine and dozens of hospitals had been bombed, closed, or otherwise requisitioned for military

purposes. Meanwhile, the supply of services in the United States remained in regular use and offered a more robust infrastructure for future expansion, to which legislators had explicitly committed.

One difference, though, stands out between the two countries: the possibility of coalition formation between workers and managers in public mental health services. On the labor side, French public sector trade unions acquired full legal rights after the war, but the maturation of their US counterparts was late, limited, and staggered across the states. As a result, French public employees gained their political-economic voice precisely at a turning point of welfare state formation, while American workers were absent from parallel discussions in the United States. The present study emphasizes the effects of this difference on mental health policy; but worth noting is that the same difference likely impacted other policy areas as well. Indeed, the postwar welfare workforce may have shaped the general patterns of social provision in each country in ways not yet fully appreciated.

On the management side, French public psychiatric managers were better equipped to enter into this coalition than their American counterparts. A series of conflicts in the 19th and early 20th centuries had led public psychiatric managers to organize independently of private practitioners in France: They formed the Trade Union of Psychiatric Hospital Physicians (Syndicat des médecins des hôpitaux psychiatriques, hereafter simply referred to as the Syndicat). The same conflicts were present in the United States, but actors settled them differently. Over time, a single representative organization for both public and private practitioners emerged: the American Psychiatric Association. These institutional changes command significant attention in this chapter, since the different organizational outcomes may have been related to structural factors in the political economy of mental health in each country. The existing historical accounts, though, attribute those outcomes to specific intra-professional conflicts.

My analytic emphasis nonetheless departs from the standard historiography with an alternative account of intra-professional conflict. Behind the animosity between hospital superintendents (originally called "alienists"), neurologists, office-based practitioners, and academic researchers, I find there were significant economic cleavages as well. While the interests of hospital superintendents were tied closely to their public employment and role as administrators, those of the other, non-state, actors often favored private provision. These differences may not have appeared to be the center of the controversy at the time, but as the following pages will reveal, they were fundamental to how different types of psychiatrists perceived themselves and their interests. Similar cleavages were present in both cases,

and for similar reasons, yet their settlements were negotiated and adapted in different ways in France and in the United States. As such, this analysis reveals the importance of political representation to the overall development of the psychiatric identity in each country, which in France became more aligned with public administration than in the United States.

By the end of the Second World War, similar conditions framed mental health care in the United States and France. One exception was that French public psychiatric managers had developed a unified and independent political voice they could ally with that of the newly legalized public sector trade unions. In contrast, American public sector managers had lost this unified and independent voice, and they also lacked a unionized coalition partner. These empirical differences hence lend evidence in support of the hypothesis articulated in Chapter 1: Provided the presence of labor rights, public labor–management coalitions are more likely to form when the organization of public managers is unified and independent of their private sector counterparts. Evidence for this chapter is drawn from secondary accounts of trade union and psychiatric history, authored primarily by area experts. Since few scholars have focused on the economic conflicts underpinning psychiatric history, however, primary sources also play an important role in the section on managerial organization. I have reviewed the academic journals and trade press of public and private psychiatric practitioners from the mid 1800s to just after the Second World War, in order to reinterpret key position statements and organizational rule-changes from an economic perspective. In France, these journals include the *Annales médico-psychologiques* (published from 1843 to the present), the *Rapports du Congrès des médecins aliénistes et neurologistes de France et des pays de langue française* (published from 1891 to 1957), and *l'Information psychiatrique* (published from 1945 to the present). In the United States, these journals include the *American Journal of Insanity* (1844–1920) and the *American Journal of Psychiatry* (1921 to the present). The chapter ends by reviewing potential confounding explanations, concluding that none offers a more convincing explanation for the eventual variation in mental health service provision across the two countries than the central hypothesis tested in this and subsequent chapters.

SIMILAR INITIAL CONDITIONS

For scholars of western welfare states, the Second World War was a critical historical juncture for social policy change. The same applies to mental health policy and the onset of psychiatric deinstitutionalization.

TABLE 3.1 *Similar initial conditions in postwar America and France (before psychiatric deinstitutionalization)*

	United States	*France*
Postwar economic growth and welfare expansion	"Golden Age"; Great Society	*Trente Glorieuses*; Laroque Report
Structure of social welfare provision, in general	Not universalized, occupation-based, dependent on local governments	
Structure of mental health care provision, specifically	Decentralized public administration of asylums	
Pressures to deinstitutionalize and blueprint for reform	Community mental health centers	Sectorization

A dramatic upheaval of international and domestic orders, the war (and its settlement) made new political opportunities possible (Capoccia and Kelemen 2007). The time was ripe for actors to make fresh public policies that would impact social life for decades to come. Efforts to reform mental health care, in particular, encountered similar political, economic, and social conditions in the French and American contexts. In fact, although public mental health care in France would eventually exceed that of the United States, these outcomes were hardly foregone conclusions in the early postwar period. Rather, the conditions listed in Table 3.1 rendered similar outcomes just as possible (Mahoney and Goertz 2004).

In both the United States and France, the postwar period was one of significant economic and welfare state expansion, conditions that Scull (1984) found launched the initial decline of mental hospital residents by facilitating their access to income, health, and social care outside the asylum's walls. The unprecedented prosperity of the French *Trente Glorieuses*, or the "thirty glorious years" between 1945 and 1975, produced high productivity, high average wages, and high consumption. Inspired in part by the 1942 British Beveridge Report, the 1962 Laroque Report subsequently launched the expansion and development of France's social benefit system. Parallel developments occurred in the United States. The economic growth of America's "Golden Age" opened the door to numerous social policy reforms, including the landmark "Great Society" expansions of the 1960s. In short, the basic political and economic conditions of the two postwar countries laid the necessary foundation for deinstitutionalization.

Not only was deinstitutionalization probable but several factors suggest that the process could have taken a similar character in the two

countries. At the time, American and French social welfare policy operated according to a similar logic. Postwar health and social insurance schemes protected specific occupational groups, namely industrial, agricultural, commercial, and government workers. Although the two countries structured these schemes differently (with varied dependence on commercial insurance providers), their demographic impacts on public mental health care were comparable. Such coverage reduced the dependence of those occupational groups and, crucially, those retired from them, on mental hospitals. By the mid 20th century, mental hospitals in both countries (and elsewhere) also served as care homes for the elderly. Increased access to pension and health insurance schemes would facilitate the transition of older patients out of asylums and often into the burgeoning long-term care industry (Derrien and Rossigneux-Méheust 2020; Grob and Goldman 2006). Neither country, however, had universalized these benefits. As a result, care for the poor and destitute, the primary population of the mental hospital, depended on residual forms of welfare, which was largely under the purview of local governments.

As such, in both countries, subnational authorities – states in America, *départements* in France – managed a system of mostly public mental hospitals. From a legal perspective, the French system appeared more centralized than the American one. The American Constitution's Tenth Amendment left issues of health under the jurisdiction of state governments, while an 1838 French law required every *département* to supply an "asylum" (*Loi sur les aliénés du 30 juin 1838*). But French departmental councils, a local assembly of elected officials, set their own asylum budgets. While the central government provided the funds for these budgets (in contrast with the US approach), local authorities held significant control over the scale and distribution of care. As a result, budgets across *départements* could vary up to threefold (Chapireau 2022). Note also that the 1838 law did not finance asylum construction. As a result, *départements* constructed new public asylums in fits and starts, and only when economic conditions were propitious (Longin 1999). Moreover, many *départements* initially left this responsibility to the Church, a non-state actor (Goldstein 1987). Although public asylums gradually replaced religious institutions, the fact remains that France also relied on non-state mental health care.[1] This is

[1] Ben Ansell and Johannes Lindvall, "Mental Asylum History ≈ 1800–1939, England, France, Sweden, USA, Australia, Japan, Germany, Spain, Canada, Netherlands, Denmark, Norway, Ireland, Belgium, Austria, Switzerland, Italy, Finland and New Zealand." Unpublished draft text (accessed May 1, 2017).

perhaps another factor that could have biased France against the expansion of public mental health care after the Second World War.

The entwining issues of race and federalism could have posed additional constraints on the expansion of American public mental health care – though at the end of the Second World War, their possible effects were unclear. As scholars such as Robert Lieberman (1998) and Jill Quadagno (1994) have shown, powerful white Southern Democrats interested in maintaining a race-based and labor-repressive agricultural economy ensured that redistributive policy would not overturn that system, in part by reinforcing the tradition of local control. Ironically, however, the supply of mental health care in Southern states was often higher than elsewhere in the country (SAMHSA 1992, 50–51). Jim Crow-era laws concerning segregation produced separate, if highly unequal, facilities for Black patients (Edwards-Grossi 2021, 87). How the presence of these extra public facilities would affect the prospects for deinstitutionalization hence was unclear, especially since the carceral system had not yet begun to expand. As Anne Parsons (2018) has argued, not only did deinstitutionalization precede mass incarceration but deinstitutionalization was not the singular cause of mass incarceration, despite long-standing, simplified theories to the contrary (e.g., Penrose 1939).[2]

Both countries also shared a long tradition of private medical practice. In general, private providers delivered nonpsychiatric care. Reinforcing that pattern were the two countries' powerful medical professions. Codified in the statutes and founding documents of the main medical associations, the American Medical Association (AMA) and the Confederation of French Medical Trade Unions (Confédération des syndicats médicaux français, or CSMF), were firm commitments to direct price-setting between doctors and patients, fee-for-service payment, and market-based medical care (Dutton 2008). In both cases, therefore, the

[2] Less attention has been paid to the relationship between racialized political geography and welfare provision in France; so here, too, it is difficult to develop clear hypotheses about its effect on mental health care. France's overseas departments, most notably Algeria, may have shaped the distribution of metropolitan welfare in ways not yet fully explored in existing scholarship (though see Lyons 2013). The limited incorporation of Algerian Muslims into political institutions, for example, may have contributed to France's own fragmented, privatized approach to welfare at the time. Moreover, the war in Algeria (1954–62) and Algeria's subsequent independence triggered the formation of a more centralized Fifth Republic (Shepard 2008), which suggests that Algeria's presence in the French polity prior to that point may have played a similar role to that of the American South in the United States. As Lieberman's (2003) comparative work has explored, the very structure of French social policy may be related to the structure of the colonialist polity.

private sector preferences of the general medical profession could contest the public expansion of the mental health care system.

Perhaps the most notable commonality between postwar French and American mental health policy is that leaders in the two countries intentionally borrowed ideas from one another. Although the academic and social movement to deinstitutionalize the mentally ill would not gain prominence until the late 1960s and 1970s, by the 1950s the World Health Organization (WHO) was promoting global mental health reform among policy elites. In addition to convening regular meetings of its Expert Committee on Mental Health (over half of whose members were either French or American), the WHO also provided funds for participants to visit the psychiatric hospitals and clinics of other countries (Henckes 2009). When psychiatrist Maurice Despinoy returned to France from his WHO-sponsored American tour, for example, he brought with him the concept of the "day hospital" (Henckes 2007), an idea that later became integral to the expansive French public mental health care system, if not the more limited American one.

These meetings also contributed to the two countries' shared blueprint for reform. Geographically defined catchment areas – of about 60,000–70,000 people in France and between 75,000 and 200,000 people in the United States (Coldefy 2007, 23; Foley 1975, 92) – would provide a range of outpatient services for patients formerly cared for in mental hospitals. Hospitals, though, would continue to play an important role. Members of the Expert Committee, for example, viewed the average number of psychiatric hospital beds in western countries – about 3 per 1,000 inhabitants – as the new norm (Henckes 2009). Outpatient programs would supplement, not wholly replace, that inpatient care.

Closing the hospitals was by no means off the table. Although psychiatrists had begun to rethink its role, the institution remained an important part of psychotherapeutic treatment. Both "institutional psychotherapy" in France and "milieu therapy" (and to some extent "psychodynamics") in the United States viewed the hospital environment and its social life as an active form of treatment (Grob 1994, 226; Robcis 2021). Moreover, even the budding critiques of the asylum did not conclude that hospital care was destined for failure. For example, Albert Deutsch's proposed policy solution in his 1948 *The Shame of the States* called not for an end to the asylum but rather for additional public funding to hospitals to address the "twin diseases" of overcrowding and understaffing.[3]

[3] Note that the most influential public advocacy efforts tended to come from journalists like Deutsch, rather than the patients themselves. During the asylum period, especially,

Deutsch's policy prescriptions call attention to two factors that gave the United States an upper hand in implementing the above vision of reform. First, the overcrowding of postwar American hospitals stands in sharp contrast to the opposite development in French hospitals. Between 40,000 and 45,000 patients in French psychiatric hospitals had died of famine and neglect during the war (von Bueltzingsloewen 2007). Such devastation significantly reduced the utilization and contemporary relevance of psychiatric hospitals. Table 3.2 uses data from the previous chapter to compare patterns of hospital residency and supply in the two countries before and after deinstitutionalization.[4] Note how the population-adjusted rate of institutional residency in France is nearly 30 percent less than that of the United States in 1955, and how that relationship flips dramatically in 1985. Moreover, although the supply of hospitals is somewhat lower in the United States compared to France in 1955, it drops even further over the course of deinstitutionalization while the French levels remain the same.

These diverging outcomes are surprising for a second reason: American policy-makers committed more concretely to expanding mental health provision. Deutsch's call for additional funding, then, was not ignored. On the contrary, and as Chapter 4 will illustrate, the US Congress moved to enact the 1963 Community Mental Health Center Act, which provided funds for the construction and expansion of outpatient mental health centers.[5] In contrast to this landmark "bold new approach" heralded by President Kennedy in 1963, the French sectorization policy was born of a mere administrative circular drafted in 1960.[6] In effect, postwar policy-makers in the United States appeared more committed to expanding psychiatric services than their French counterparts, and yet the opposite would eventually occur.

In sum, French and American deinstitutionalization emerged out of broadly similar contexts. In both countries, the end of the Second World

there was relatively little effort to support clients who sought to exercise their political voice on their own. The early 20th-century French and American "mental hygiene" movements, for example, aligned themselves with the patient perspective but both were directed by psychiatric professionals (Grob 1983; Henckes 2007).

[4] Moreover, the likelihood of institutionalization in France plummeted from 230.5 in 1935 to 155.3 in 1945 (author's calculations, see Chapter 2). In effect, in 1955 France had only just rebounded from this decline.

[5] Mental Retardation and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88–164, 77 Stat. 282, codified at 42 U.S.C. ch 33. subch I–V.

[6] John F. Kennedy, "Mental Health Programs: Address to the Congress of the United States," *Journal of the Senate* (February 5, 1963), 108–13.

TABLE 3.2 *Mental health care supply in the United States and France before and after deinstitutionalization*

	1955		1985	
	United States	France	United States	France
Residents per 100,000	338.19	231.72	46.67	145.37
Hospitals per 100,000	0.17	0.22	0.12	0.22

Source: Comparative Deinstitutionalization Data Set (Chapter 2; Appendix)

War was followed by a period of economic growth and welfare state expansion that rendered deinstitutionalization possible. Several factors suggested that the process could have unfolded in a similar way in both countries as well. Fragmented, occupation-based social protection facilitated the transition of elderly residents from mental hospitals and into long-term-care facilities, while care for the poor and destitute mentally ill depended on the generosity of local public authorities. These decentralized government institutions could not count on the powerful medical profession for support, as nonpsychiatric physicians advocated for private sector solutions to health care challenges. Policy elites, however, did have an interest in expanding public services in psychiatry, and even shared a transatlantic vision for reform. A midcentury observer, moreover, might have bet on the Americans' capacity to implement that reform over the French. The United States had developed a firm legislative commitment to expanding community services, while France found itself devastated by the tragic loss of patients during the war. What follows, however, points to one area that would benefit French reform ambitions in ways unavailable to Americans: the possibility for a public labor–management coalition in mental health care.

DIVERGING POSSIBILITIES FOR A PUBLIC LABOR–MANAGEMENT COALITION

Despite these similar initial conditions, public mental health workers in postwar France were much more likely to form a political coalition with their managers than their American counterparts. This difference – the central divergence of the supply-side policy feedback model presented in Chapter 1 (Figure 1.2) – increased the likelihood that France would observe positive supply-side policy feedback in the longer term. Meanwhile, the cards were stacked decidedly against that option in the

United States, where public sector labor unions had not yet gained significant organizational and legal rights to voice their demands. Debilitating workers further, public psychiatric managers organized with private managers, the hypothesized obstruction to this coalition. In France, however, public sector workers gained legal recognition and rights just after the Second World War, and public psychiatric managers organized independently of private managers. The following pages review these chief differences and then addresses potential confounders.

Public Sector Unionization in Postwar America and France

Compared to those of their midcentury French counterparts, the legal and organizational rights of American employees of public mental health services were limited. Although private sector workers had gained collective bargaining rights at the national level in 1935, decisions about those rights for public sector workers were left largely to individual states.[7] As a result, as Alexis Walker (2020, 5) writes, "public sector employees had to fight for legal recognition in every state and locality, which progressed slowly." That the overall trade union movement had suffered under the Taft–Hartley Act in 1947 only weakened the public unionization movement further, even if much of the bill did not directly apply to government workers or their supervisors.[8] Not until the 1960s and 1970s, after deinstitutionalization was well underway, did government employees begin to gain substantial political voice and legislative momentum. Furthermore, as Walker shows, this divided labor law not only repressed the representation of public employees but also weakened the overall trade union movement by fragmenting its membership. American public employees were thus politically weak and therefore absent from discussions about mental health and other social welfare policies in the period immediately following the Second World War.

Although midcentury public sector workers in France faced their own set of complex and varied challenges, many more were able to join unions. As of 1946, these workers could even strike under certain circumstances, a right almost unimaginable to American public employees at the time. As Chapter 5 will explain, mental health workers in France

[7] Federal employees, meanwhile, did not gain official recognition until a 1962 Executive Order and, even then, their collective rights would (and still do) vary by agency and work classification. Exec. Order No. 10988, 27 Fed. Reg. 551 (January 19, 1962).

[8] Labor Management Relations Act of 1947 (Taft–Hartley Act), Pub. L. No. 80–101, 61 Stat. 136, codified at 29 U.S.C. ch 7 § § 141–97.

became a more active player in mental health care after 1968, when public employment expanded overall and in outpatient services in particular; however, their access to political voice was far more straightforward than in the United States. In effect, the employees of French public mental health services were better equipped to express their demands to managers throughout the postwar period.

How Public Psychiatric Managers Organized in the United States and France

Meanwhile, if the hypothesis laid out in Chapter 1 is correct, French public psychiatric managers also were better equipped to enter into a coalition with workers than their American counterparts. By the end of the Second World War, French public psychiatric managers had formed a distinctive organization, in fact a trade union itself: the Syndicat des médecins des hôpitaux psychiatriques (i.e., the Syndicat). In contrast, American public psychiatric managers formed just a part of the umbrella American Psychiatric Association (i.e., APA), which included a rapidly growing number of private practitioners. The first organization would help to amplify the political voice of public managers while the second muted it, as subsequent chapters will show (and as I have demonstrated elsewhere, e.g., Perera 2022). This difference would allow the Syndicat to act in accordance with the interests of the public sector more readily than the APA.

The political formation of these two organizations deserves special attention. Unlike the differences in national-level public sector labor rights just outlined, these alternative managerial organizations were particular to mental health care. As such, one might wonder about endogeneity. Did something about the existing mental health system bias American and French managers toward each of these representative institutions? Such concerns are less relevant to differences in public sector labor organization, insofar as the provision of different public services varies within each case (regardless of the overall political strength of their employees). Managerial interests, however, were more explicitly tied to the particularities of mental health care. To that end, scholars have not traditionally interpreted these physician associations as managerial organizations, yet the administration and management of services were (and in many ways still are) a crucial element of psychiatric practice.

Next, I trace the historical development of both the French and American managerial organizations. I draw on both the secondary

source histories of the psychiatric profession in each country and primary source statements from the actors themselves. In so doing, several points become clear. First, administration and management have long been a core component of psychiatric practice, especially in the public sector. These economic and political interests, furthermore, shape the politics of the profession in ways underemphasized by the existing historiography. Finally, a series of gradual institutional changes produced the alternative organizational forms. Faced with similar political and economic challenges, actors in each organization adapted differently. Over time, managers in France slowly exerted their independence from private practitioners, even as American managers began to draw closer to private practitioners. This process of "conversion" – wherein new groups are incorporated to an institution and in doing so alter its form, role, and meaning – is especially evident in the American case, in contrast with the evolution of the French case (Mahoney and Thelen 2009; Rocco and Thurston 2014; Thelen 2004).

Both the APA and the Syndicat can trace their roots to the mid 1800s, when the modern psychiatric profession began to emerge. As "alienists" (*aliénistes*), physicians of the mind attended to mental "aliens" (*aliénés*), those patients whose psychological state isolated them from societal functions and norms. Treatment in an "asylum" (*asile*) was thought to ameliorate (or otherwise manage) the condition, so alienists also found themselves directing these proto-hospitals, overseeing their staff, administering their accounts, and, of course, representing their interests to the government authorities who often financed them. The psychiatric profession, in short, was as managerial as it was medical. Over time, alienists would become "psychiatrists," aliens would become "patients," and asylums would become "hospitals," but the link between the profession and public service administration would remain.

That this link emerged during a key moment of modern state formation is no coincidence. Alienists on both sides of the Atlantic were closely aligned with their respective postrevolutionary state-building enterprises. Not only did the new government institution of the asylum provide a secure income for the sons of the emerging *petite bourgeoisie*, the profession itself also offered an identity rooted in science, rationality, and impartiality. Such were the core values of these two newly enlightened republics. Trained in nascent medical schools, alienists soon rejected "spiritualism" (which emphasized the role of spiritual and metaphysical factors on illness) for "science" (which focused primarily on the functions of the body) and instead looked to statistical methods and other emerging

technologies to understand both the medical and the managerial aspects of their profession (Dowbiggin 1991; Goldstein 1987; McGovern 1985). In doing so, they also upheld and reinforced state attempts to maintain social order, a central government objective in both the United States and France during the turbulent 19th century.

The organizations representing American and French alienists also identified firmly with the statist side of the major sociopolitical divides of the period. In the United States, an emerging independent bureaucracy sought to counter patterns of heavy-handed patronage (Carpenter 2001; Skowronek 1982). The Association of Medical Superintendents for American Institutions for the Insane (hereafter, the American Superintendents' Association), founded in 1844, defined itself in opposition to these patterns. The appointment of alienists to head insane asylums, they believed, should be based on merit, not partisan connections. The American Superintendents' Association was aware that political skills were crucial to their profession, especially in an environment where bureaucratic imperatives remained subordinate (McGovern 1985, chap. 4). Nonetheless, in 1848 the American Superintendents passed a resolution that "deprecated" attempts to appoint alienists "through political bias," instead backing the "best men irrespective of every other consideration" (quoted in McGovern 1985, 143–44). Aspiring to nonpartisanship and meritocracy, American alienists hence rejected the politics of patronage in lieu of a more Weberian identity.

Meanwhile, in France, a sharp Church/State conflict was seething. Religious authorities oversaw many asylums, which rendered these and many other social services targets for anti-clericalists (see, e.g., Ansell and Lindvall 2020; Morgan 2006). In fact, the 1838 asylum law was a result of this tension. The *Doctrinaires* – a powerful segment of the political elite of the July Monarchy (1830–48) – were critical of the Church's influence on political, social, and economic affairs and sought to establish *département*-level asylums to compete with the religious ones. The move expanded the number of alienists and strengthened their link to the state (Goldstein 1987). For reasons similar to those of their American counterparts, French alienists were beginning to view themselves as rational, scientific, and bureaucratic actors (Dowbiggin 1991). Finding favor among the *Doctrinaires*, the alienists began their first professional association, the Société Médico-Psychologique, in the 1840s. Although both the tumult of the 1848 Revolution and French law restricted their ability to host regular, public meetings, the initial members of the French Société – like their counterparts and frequent interlocuters, the American

Superintendents[9] – also emphasized the profession's managerial, financial, scientific, and public sector orientation (Dowbiggin 1991, chap. 4; Goldstein 1987, 339–42). Despite their parallel origins, however, the organizations that represented public sector psychiatric managers in the United States and France slowly began to evolve in different directions over the following century.

Between the late 1800s and the Second World War, though, the organizational representation of psychiatric managers evolved differently in the United States than it did in France. American public managers eventually came to organize together with private practitioners, even though the original commitment of the American Superintendents' Association to the public sector was unquestionable. In fact, the group was founded in part to advocate for state funding of insane asylums, especially those built according to the therapeutic architecture designed by Dr. Thomas Kirkbride. The massive "Kirkbride asylums" required a parcel of land of at least 100 acres and significant government support for their construction.[10] Membership of the Association, furthermore, was restricted to "medical superintendents," a term that underscored both their clinical and their managerial responsibilities, as well as their predominantly public employment. Although a few directors of non-state hospitals requested to join the organization, only one ever served on a committee and only three ever delivered papers at annual meetings in the mid 1800s (McGovern 1985, 136–37). In fact, when Dr. Edward Jarvis delivered a paper in 1860 on "The Proper Functions of Private Institutions or Homes for the Insane," discussants Dr. D. T. Brown and Dr. MacFarland observed "very great prejudice" and a "drift of sentiment on the part of the Association" against "an institution of private character."[11] The Superintendents' Association, in short, firmly rejected private practice.

Yet, by the late 1800s, as industrialization took hold in the United States, the Superintendents' Association found itself facing conflict on

[9] A simple review of the cumulative index to SMP's journal, the *Annales Médico-Psychologiques*, during this period makes the frequency of contact between the two organizations clear. Leading figures from the American Superintendents (e.g., Dr. Isaac Ray) and innovative states (e.g., Pennsylvania, Massachusetts) even receive their own entries. See Baillarger, Cerise, and Lunier, *Annales médico-psychologiques: table générale et alphabétique 1843–1878* (Paris: Victor Masson et Fils, 1868).

[10] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* (Philadelphia, 1854).

[11] See Jarvis, Brown, and MacFarland in "Proceedings of the Fifteenth Annual Meeting of the Association of Medical Superintendents of American Institutions for the Insane," *Journal of Insanity* 17–18 (1860), 17–35.

several fronts. Rapid technological development had shifted the structure and orientation of production, reorganizing society with it. The economic crisis of the 1870s had left asylums underfunded as well as overcrowded (Barton 1987). The massive immigration wave of the late 1800s, increasing rates of older patients suffering from senile dementia, and rising numbers of alcoholics and opium addicts expanded the resident population of state hospitals, which lacked the funds to humanely accommodate them (McGovern 1985, 150–51). As the quality of asylum care declined, public criticism increased too. Former asylum patients such as Elizabeth Packard and Clifford Beers became anti-psychiatry and anti-asylum activists, raising the national profile of their abusive experiences and prompting public investigations of asylum conditions (McGovern 1985, 156). These criticisms significantly tarnished the Superintendents' public image, so much so that another organization, the National Association for the Protection of the Insane and Prevention of Insanity, was mounted in direct opposition to them in 1880, though the diversity of opinion among the membership of this rival organization meant it was short-lived (this likely led to its rapid disassociation in 1883).[12]

Neurologists, newly emerged professional and economic competitors, perhaps posed the most important challenge to American alienists. "Your hospitals are not our hospitals; your ways are not our ways," sneered the neurologist S. Weir Mitchell at a turn-of-the-century conference address to the American Superintendents Association. Their specialties, though linked, were in fact different. If the alienists' "real specialty [was] insane-hospital management" for "wretched and neglected" psychotic patients, as one attendee of that conference put it, neurologists specialized in clinical care and research for "nervous diseases" or "neurosis" among the more affluent. The discipline had emerged after the Civil War, when postbellum academic researchers began to investigate the effects of gunshot wounds to the brain and nerve tissues (McGovern 1985, 158; see also Barton 1987, 52–44). By the late 1800s, neurologists had established themselves in urban universities and private offices, catering to a growing patient base from the middle and upper classes (Grob 1994, 50–51; McGovern 1985, 158). Unlike the insanity and psychosis that were prevalent among the poor and destitute living in asylums, nervous diseases

[12] *National Association for the Protection of the Insane and the Prevention of Insanity* (Boston: Tolman & White, 1880); *Papers and Proceedings of the National Association for the Protection of the Insane and the Prevention of Insanity, at the Stated Meeting Held in New York City* (New York: G. P. Putnam's Sons, 1882).

were viewed as mild conditions, unthreatening to the social order and more permissible among the upper strata of society. The economic preferences of neurologists therefore were distinct from those of the alienists, a difference underemphasized in the existing historiography, which instead tends to highlight their professional and therapeutic differences. While the alienists required public funds for their profession, neurologists benefited from private affluence.

These interconnected threats of financial strain, public backlash, and the economic competition of neurologists forced the American Superintendents to reconsider their political commitments to public institutions for the poor. How should alienists revamp their image? What alternate sources of funding could support their profession? Should they beat or join their rivals, the neurologists? Responses to these questions emerged slowly, in a series of subtle changes to the organizational rules governing membership of the Superintendents' Association.

Between 1885 and 1921, the Superintendents' Association gradually opened the doors of membership to private practitioners; so much so that, by the middle of the 20th century, private practitioners constituted the overwhelming majority of the Association's members (Grob and Goldman 2006, 17). The first small shift occurred in 1885, when the association changed its membership rules to include assistant physicians, not just the superintendents of public asylums. A younger crop, that had been exposed to neurological training and not yet carrying managerial responsibilities, these new members began to shift discussions at meetings away from administrative concerns and toward more scientific ones (McGovern 1985, 159–61). In 1892, these junior (nonmanagerial and neurologically trained) physicians gained admission, if not the right to vote, in the temporarily renamed "American Medico-Psychological Association" (Grob 1983, 69). Here, too, the composition of attendees and the subjects discussed at annual meetings continued to shift away from the public sector. In time, private practitioners began to attend meetings with the intention of recruiting psychiatrists out of public practice.[13] The organization came to fully embrace this practice, and these new members, by the time it adopted its new name in 1921: the American Psychiatric Association (APA).[14] By 1940, private practitioners composed more than a third of the APA's members. Following an increase

[13] Pierce Clark, "Extra Asylum Psychiatry," *American Journal of Insanity* 74 (1918), 425–29.

[14] "Constitution and By-laws," *American Journal of Psychiatry* 78 (1921), 247–52.

in dues, making it difficult for practitioners with lower wages (such as those in the public sector) to join, membership of private practitioners jumped to over 80 percent by the mid 1950s (Grob 1991). As a result, the majority of the mid 20th-century APA was "neither knowledgeable about nor sympathetic toward their institutional brethren" (Grob and Goldman 2006, 17). This stands in sharp contrast to the orientation of its mid 19th-century ancestor, the Superintendents' Association. Now, the interests of the organization's public sector members became secondary, and furthermore these public sector members had no association of their own to join.

In France, meanwhile, alienists faced the same challenges as their American counterparts had in the late 1800s and early 20th century, except their organizational evolution differed. Like the American Superintendents' Association, the Société Médico-Psychologique also initially sought to unite the community of public alienists and represent their economic interests. As the historians Ian Dowbiggin (1991) and Jan Goldstein (1987) have found, publications by key members in the early 1840s made these twin objectives clear (see pages 76–78 and pages 339–41, respectively). The French Société would seek "the improvement of insane asylums," wrote B. A. Morel (1845), and "powerfully promote [these] demands … to the government in the interest of this unfortunate class of society entrusted to our care," added Honoré Aubanel (1846). Such political-economic ambitions aligned closely with alienists' social-professional identity, for "financial questions … were the material representation of [alienists'] doctrines," as Émile Renaudin (1846) put it (cited in Dowbiggin 1991, 77 and Goldstein 1987, 340–41, respectively, their translations). Ironically, while the clarity of these commitments among members of the French Société blurred more quickly than they did among members of the American Superintendents, it was French, not American, public psychiatrists who ultimately redefined their independence from private practitioners.

Almost immediately after it was founded, the French Société faced conflicts similar to those of their American counterparts. Following the 1848 Revolution, French alienists lost their liberal, anti-clerical *Doctrinaire* supporters and instead found themselves attempting to appease the more conservative, monarchical Bonapartists. As a result, they faced criticism from both political camps. The political descendants of the *Doctrinaires*, the liberals, launched a massive newspaper campaign that accused alienists of infringing on civil liberties and denounced them as "miserable slaves of power, police assassins" (Regnault cited in Goldstein 1987,

353; translation hers). Meanwhile, the Bonapartists adopted strict surveillance measures to control and repress any suggestion of anti-religious sentiment within the group (Goldstein 1987, 355–56). Such constraints limited the French Société's ability to defend itself and, over the following decades, led to widespread public accusations against the perceived arbitrary incarceration of patients to asylums. Even while this allegation was truer of the profit-seeking private sector than it was of public institutions, it was nevertheless primarily framed as a charge to public sector practitioners (Dowbiggin 1991, 95). That French public asylums, much like American ones, faced financial constraints and overcrowding as industrial production waxed and waned did little to improve their tarnished image (Dowbiggin 1991, 167–68).

In addition, the neurological challenge to public sector alienism was just as forceful in France as it was in the United States. In fact, at the time France was home to the internationally renowned Jean-Martin Charcot, who is still celebrated today as the "founder of modern neurology" (despite his controversial research on hysteria). Charcot (and his circle of fellow students and researchers), much like his American counterparts, tended to practice in urban university centers (especially Paris) and cater to the affluent. The treatment of mild *névroses* (neuroses), furthermore, mainly took place in *maisons de santé* ("health homes"), private clinics where aristocratic families interned their mentally ill relatives (Goldstein 1987, 338).[15] The 1838 law mentioned earlier in this chapter, moreover, had protected these *maisons* precisely to avoid handing "a virtual monopoly over a lucrative market" to the alienists (Goldstein 1987, 400). By the late 1800s, these private sector competitors posed a significant political and economic challenge to the initial public sector identity of the French alienist.

As in the United States, the responses of French public alienists to these challenges involved a series of minor and gradual organizational adjustments. Following the 1848 Revolution, the French Société refounded itself in 1852. This time, its by-laws emphasized scientific purposes over economic ones.[16] To be sure, the Société's membership base remained with the public alienists and generated concern for economic

[15] This is not to say that nervous conditions were not diagnosed among the lower class in France. Goldstein (1987, 333–36) cites a study by Briquet, published in 1859, that found that "popular classes were more susceptible to hysteria than their betters." The study helped to supply more clientele to asylums, but after a series of intellectual battles, ultimately failed to associate the study and practice of neurology with the public sector.

[16] *Nouveau règlement de la Société médico-psychologique* (Paris: Martinet, 1852), 3–11.

issues, so much so that it founded an insurance plan for disabled alienists and their widows and orphans (Goldstein 1987, 342). But in principle the Société welcomed the participation of mental scientists from all disciplines, including neurology. After the Revolution-era legal restrictions on corporatist associations, guilds, and trade unions loosened in subsequent decades, the Société gained ministerial permission to hold regular, large public gatherings. According to the available records, the first "International Conference on Mental Medicine" (Congrès international de médecine mentale) took place in 1878 in Paris.[17] Article 3 of the by-laws of the Congrès notes that its membership was open to those in the Société but also "all those interested in questions related to mental alienation," for a reduced fee, no less.[18] After about 1890, the Société renamed the event the "Conference for French and Francophone Alienist Physicians and Neurologists" (Congrès des médecins aliénistes et neurologistes de France et des pays de langue française). By that point, therefore, public sector alienists and their private sector competitors regularly attended scientific gatherings together, even though their political organization remained ambiguous.

Over the next two decades, this ambiguity became an increasingly sensitive issue that began to pry open the divide between public and private practitioners in France. "Dividing the army of workers into two separate groups, one concerned with nervous conditions and another with mental illnesses is completely artificial," implored M. Stéhelin, the prefect (head) of a French *département*, at the 1896 conference. "They should not be separated," he added.[19] His plea for unity laid bare the tensions between private physicians of "nervous conditions" and public alienists of "mental illness." In fact, as soon as M. Stéhelin's speech ended, a group of public practitioners left to discuss the subject of creating a Union of French Alienists.[20] This union did not immediately materialize, for reasons that I

[17] Like the American Superintendents' Association that counted both Americans and Canadians among their membership, the French Société and its conferences were also transnational. It often hosted conferences across borders, in cities that included Paris, Geneva, and Brussels. The fact that the Congrès met in these cities, as well as in France's smaller capitals such as Bordeaux and Toulouse, is perhaps a sign of both its attempts to build a cosmopolitan scientific community and its attentiveness to the practical concerns of provincial alienists.

[18] *Rapports du Congrès internationale de médecine mentale tenu à Paris du 5 au 10 août 1878*, 3.

[19] "Septième session tenue à Nancy du 1er au 5 août 1896," *Comptes rendus du Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, 9.

[20] Ibid., 13.

only can speculate. On the one hand, the limited organizational rights of civil servants at the time favored the development of informal *amicales* ("friendly societies") instead of professional associations or trade unions (Siwek-Pouydesseau 1989).[21] On the other hand, the public alienists did not yet face a direct challenge from private practitioners.

By 1907, the situation had changed. Just before that year's conference, the directors of private *maisons de santé* had formed their own group "in defense of their own professional interests."[22] In response, the alienists announced the Association amicale des médecins des établissements publics d'aliénés (Friendly Society of Public Asylum Physicians) with an eight-page spread in the profession's leading journal, the *Annales médico-psychologiques*.[23] Although both groups attended their joint conference, public and private practitioners had now formed separate interest organizations.

While the Société would continue its scientific initiatives and joint conferences of alienists and neurologists, the splintering society of alienists would eventually produce the Syndicat of public psychiatrists over the next half-century. The path was slow and winding. Nicolas Henckes (2007) has documented how the group strengthened and solidified its independent identity in rich detail. For example, he writes about how, during the interwar period, one member, Édouard Toulouse, launched a movement to expand and develop the treatment of milder conditions and neuroses outside of the existing public asylum system, incidentally inspired by the contemporaneous trend in the United States. It took ten years for the friendly society to expel him and clarify its commitments to public practice (Henckes 2007, 148). Toulouse's League for Mental Hygiene, along with an emerging trade union of "nervous system" physicians, would eventually become a chief competitor of the public practitioners (Henckes 2007, 377–80). Later, during the Second

[21] For most of the 19th century, professional associations in France were all but illegal. The 1791 Le Chapelier Law, a product of the first phase of the French Revolution (1789–99), forbade guilds and outlawed the right to strike, in the interest of promoting free enterprise and banishing the *Ancien Régime* practice of corporate favoritism. But even beyond guilds, the Napoleonic Code (effective as of 1804) stipulated government surveillance of any association with more than 20 members. It was not until the latter part of the century that these rules were relaxed, first with the 1884 Loi Waldeck-Rousseau, which authorized working-class unionization. Physician unionization was finally permitted via a more comprehensive law passed in 1892.

[22] "Association amicale des médecins des établissements publics d'aliénés," *Annales Medico-Psychologiques* 5–6 (1907), 221–27.

[23] Ibid.

World War, Nazi occupants forced the friendly society to rename itself the Professional Association of French Psychiatric Hospital Physicians (Association professionnelle des médecins des hôpitaux psychiatriques français). It was not until after the Liberation – and the expansion of public sector organizing rights – that the Syndicat was established in 1947.

Even at this stage, the Syndicat could have reconciled itself to private practitioners and developed an association that resembled the American Psychiatric Association.[24] In fact a leading member of the Syndicat, Georges Daumezon, advocated as much. Between 1945 and 1947, furthermore, the Syndicat contemplated whether it should affiliate with the main medical association, the CSMF. This umbrella organization represented most French physicians, which included many of those in private practice. The French public psychiatrists, however, voted against joining the Confederation. The Syndicat also voted against joining the central, communist-led General Confederation of Labor (Confédération générale du travail, or CGT), as well as the unions and organizations representing civil servants. French public psychiatrists instead sought complete autonomy.[25] Their independent political voice, as Chapter 5 will demonstrate, hence rendered them important partners for public mental health employees in the following decades.

CONFOUNDERS

In sum, by the end of the Second World War, the political economy of mental health in the United States and France shared many similarities, save one key difference. Employees and managers of American public mental health services were far less likely to form a coalition than their French counterparts, who enjoyed both greater legal rights and a unified, independently represented managerial organization. This difference, as shown in subsequent chapters, played a crucial role in the two countries' diverging paths to postwar deinstitutionalization, rendering the United States less likely to expand public mental health services during that period than France. Before moving to that period of diverging paths, however, it is important to consider potential confounders: that is, whether other factors that influenced the likelihood of a coalition could

[24] Georges Daumezon, "L'American Psychiatric Association," *Information psychiatrique* 23:7 (1947), 203.

[25] See the issues of *L'Information psychiatrique* between 1945 and 1947. For a key article on the topic, see P. Sivadon, "Médecins ou fonctionnaires ?," *L'Information psychiatrique* (1946), 7–9.

also have influenced the trajectory of mental health care. Here I consider a few candidates, though none gains enough traction to outweigh the central importance of the public labor–management coalition.

Perhaps France and the United States started off with different rates of public employment and a different propensity toward work in that sector? Did the strong French state simply have more public employees who advocated for unionization earlier there? Not quite. In 1960, total public employment (as a percentage of the working age population) was not significantly higher in France compared to the United States: 11.79 percent and 8.85 percent, respectively (Cusack 2004). It would be difficult to argue that this three-percentage point difference would so radically alter the trajectory of deinstitutionalization in the two countries. Moreover, as Siwek-Pouydesseau (1989, 11) writes, of the one million public employees in postwar France, about a quarter were teachers, not health care workers.

On a related note, it was not necessarily the case that employment in public mental health services was more prestigious in France than it was in the United States. Although it is true that civil service employment in France generally carries great prestige, the employees of public mental health services were not Parisian "fonctionnaires" (bureaucrats). French public psychiatrists in fact complained of the hostility toward their profession.[26] As Henckes (2007) has documented, the social status of those employed in the public mental hospital was far less prestigious than that of the university hospitals or private clinics (331–34). The relative unpopularity of working in French public mental health services, therefore, made it unlikely to drum up the support of its employees for the sake of protecting any perceived prestige.

Turning more specifically to public psychiatric managers, even while the structure of medical interest representation and training may have reinforced the gradual organizational changes made by psychiatrists in the United States and France, it is not clear that it also shaped their mental health policies. Since the 1840s, American medical labor has become more integrated than its fractious French counterpart. In the United States, physicians chose individually whether to affiliate with the primary representative of the medical profession, the American Medical Association (AMA), and/or a specialized representative (in the case of psychiatrists, the APA). This arrangement has not only allowed many

[26] G. Daumezon, "Situation actuelle de la psychiatrie, ses perspectives d'avenir," *L'Information psychiatrique* 22:3 (1945), 7–8.

American private sector psychiatrists to elect to join both the APA and the AMA (kindling the political affinity of the two organizations); it has also made it more difficult for American public psychiatrists to establish an independent political voice. But these changes coevolved and in fact cannot be assumed to bias American physicians toward private practice. As Peter Swenson (2021) has shown, the AMA was especially progressive during the early 20th century but later became more conservative. Moreover, the US structure of medical interest representation has not prevented the establishment of some public health services for vulnerable populations, such as Indigenous and veteran Americans.

The development of medical organization and training in France, by contrast, contributed to the isolation of public psychiatrists, if not necessarily the expansion of their services. The confederal structure of French medical labor has resulted in highly factionalized physician interests, often down to very granular levels. A single medical discipline can be broken down into multiple syndicates (representing, for example, academic physicians, subspecialties, salaried physicians, medical students, etc.). Indeed, the French Syndicat is a good example, especially since it was able to exercise its option not to affiliate with the medical confederation. Moreover, French psychiatric education required a period of training at public hospitals. This difference may have contributed to the independent identity of French public psychiatrists; however, and as shown in Chapter 5, they did use the medical training system as a tool to expand public employment – but only after they formed the Syndicat. More importantly, neurologists completed the same training. Unlike many other countries, the disciplines of psychiatry and neurology did not formally split in France until the 1960s, that is, students of each field shared coursework and training. This close association between the two disciplines makes their divided political representation all the more surprising.

Perhaps the most obvious potential confounder is the relative strength of the political Left and labor in general in France compared to the United States. The postwar period hardened this difference. McCarthyism was weakening the American Left precisely as the Liberation sought revenge on Nazi collaborationists on the French Right. But it is not clear how that difference might have shaped public mental health services. As noted in Chapter 1, mental health care does not tend to gain in electoral importance. Political parties and trade unions, therefore, have little reason to advocate for more mental health services (though see Rogers 2022 on how they can shape the philosophy that guides provision). In addition,

and as I discussed in the opening of this chapter, the same reformist enthusiasm for more humane treatment existed in both countries.

In Chapters 4 and 5, I turn to this shared blueprint for mental health care reform in both countries. Chapter 4 documents how the absence of a public labor–management coalition in the United States prevented the enactment of mental health care reform and Chapter 5 shows how its presence in France enabled it. Revising standard narratives about the development of psychiatric deinstitutionalization in the United States, I explain why the rise of public employment in America did not manage to maintain its large state mental health infrastructure. On the contrary, the absence of a coalition led to weakening support for these services. Deinstitutionalization proceeded dramatically, with devastating results for people with mental illnesses in that country.