

RESEARCH ARTICLE

A Discipline Like No Other: Marginalized Autonomy and Institutional Anchors in French Public Psychiatry (1945–2016)

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Abstract

Research on psychiatry in the United States has shown how, since the 1980s, the discipline has sought to increase its prestige and preserve its jurisdiction by embracing biomedical models of treatment and arguing it is a medical specialty like any other. While this strategy is consistent with what the literature on professions would expect, this paper analyzes an alternative case: French public psychiatry, which has remained in a position of marginalized autonomy, combining low status and economic precarity with state recognition of its specificity. Drawing on Bourdieu's theory of fields, I analyze how the persistence of specialized psychiatric hospitals in France—most of which have closed in the United States—has shaped the conflict between psychiatrists favoring autonomy and actors in university hospitals and the Ministry of Health seeking to reduce it. These specialized hospitals have functioned as *institutional anchors* that contribute to maintaining the discipline's autonomous position in the medical field in three ways: by socializing psychiatrists into viewing themselves as a distinctive branch of medicine, linking psychiatry to powerful actors in the state interested in maintaining the discipline's distinctive role in social control, and concentrating a population of chronically ill persons not amenable to traditional medical interventions. This analysis expands on the literature on professionals and field theory by emphasizing the role of institutions in structuring the reorganization of jurisdictions and relationships between fields.

Keywords: Psychiatry; professions; fields; hospitals; institutional anchors; Bourdieu; France; marginalized autonomy

Existing research has shown that professionals restlessly seek to expand their jurisdiction and increase their status (Abbott 1988; Freidson 1973; Menchik 2021; Starr 1982). In the United States, since the 1980s, psychiatrists have sought to enhance their prestige, ensure payments from insurance companies, and defeat challenges to their jurisdiction from psychologists and social workers by insisting that they treat “diseases of the brain” with scientifically validated, biologically

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oriented interventions (Horwitz and Grob 2016; Strand 2011; Whooley 2019). Scholars have documented how this biomedical approach has been increasingly adopted by the psychiatric profession worldwide (Fernando 2014; Lakoff 2006; Watters 2011).

This paper addresses the divergent trajectory of French public psychiatry. As elsewhere, the discipline has faced pressure from both within psychiatry and from the state to move away from providing psychoanalytically inspired interventions in specialized, segregated hospitals and toward delivering pharmaceutical treatments in more culturally valorized, general medical settings. Yet French public psychiatry remains a world apart: it has a unique system of financing, distinctive organizational structure, and legally defined role in ensuring social control it shares with no other French medical specialty. Leading professional organizations have fought vigorously to maintain this specificity, even though it reproduces public psychiatry's continued low status within medicine and ongoing erosion of funding for its work.

This paper approaches this case through the lens of Bourdieu's field theory. Fields are discrete meso-level social orders within which a set of actors compete for a particular set of "stakes" (Bourdieu 1988; Buchholz 2016; Steinmetz 2017)—in this case, the legitimate way to organize treatment for people with mental illness and the resources attached to doing so. French public psychiatry is divided between "heteronomous" practitioners (often in university hospitals) seeking to align themselves with other medical specialties and "autonomous" ones defending their discipline's specificity (Bourdieu 1988; 1996a; Maton 2005). The relative success of the latter has created a situation of *marginalized autonomy*: a discipline operating on principles distinctive from the rest of the medical field, which are nonetheless difficult to transform into prestige and resources within the broader "field of power" (Bourdieu 1996b).

Why and how have public psychiatrists reproduced marginalized autonomy? My explanation hinges on the role of specialized psychiatric hospitals as *institutional anchors*. Although scholars have long theorized how institutions reproduce the social order (Berger and Luckmann 1966; Friedland and Alford 1991), their role is underdeveloped in the study of fields. I specify three ways in which specialized psychiatric hospitals have structured conflicts within psychiatry. First, they provided a site of *socialization* into an autonomous vision of psychiatry that those so socialized fought to protect. Second, specialized hospitals *constructed* the core stakes over which public psychiatrists struggled: a group of chronically ill patients which autonomous psychiatrists were better positioned to manage. Third, hospitals provided a *bridge* between psychiatry and actors within the state, like the Ministry of the Interior, which typically played little role in the medical field. Through these linkages, psychiatry lost a degree of autonomy over a specific set of practices (involuntary hospitalization), while gaining support and resources for the field's autonomous logic more broadly. Hospitals thus served as anchors because they helped stabilize public psychiatry in a peripheral position within the social space of medicine, despite the efforts of powerful actors in prestigious university hospitals and the Ministry of Health to reduce the discipline's marginalization while submitting it to processes of economization and standardization.

In the first empirical part of this paper, I examine the 1960s and 1970s, when psychiatrists, long relegated to administrative roles in asylums, agitated for a position of "parity without assimilation" vis-à-vis other medical specialties. Public psychiatrists incorporated specialized hospitals into a reformed mental health

system, which sharply differentiated French public psychiatry's trajectory from that of the United States. In a second section, I chart efforts in the 1980s and 1990s by heteronomous psychiatrists, often based in university hospitals, to increase the discipline's prestige by aligning its principles and practices with other medical specialties. They allied with actors in the Ministry of Health, who saw reducing public psychiatry's autonomy, partly by shifting care out of specialized hospitals, as key to better managing and regulating it.

The third empirical section, covering the 2000s and 2010s, examines how major professional organizations fought to maintain public psychiatry's autonomous place within medicine and the specialized institutions in which it practiced. I show how hospitals functioned as institutional anchors, using case studies of attempts to create common financing mechanisms between psychiatry and medicine, to eliminate policies and regulations specific to psychiatry, and to merge psychiatric with non-psychiatric hospitals into a single administrative unit. In my conclusion, I reflect on how this paper responds to calls to reincorporate institutions into field theory (Goldstone and Useem 2012) and contributes to better understanding the structure and constraints of professional conflict.

Literature Review: Marginalized Autonomy and Institutional Anchors

Professional Autonomy in French and American Psychiatry

Professions are occupational groups with exclusive control over a specific set of tasks requiring specialized knowledge to perform (Abbott 1988; Freidson 1973). Individual professions exist in a broader system marked by ongoing conflict over the boundaries of each profession's "jurisdiction," or state-sanctioned monopoly over addressing certain problems (Abbott 2005; Dobbin and Kelly 2007; Starr 1982). Maintaining a jurisdiction requires constant demonstration of professionals' expertise and recognition of it from their clients, other professionals, and the state (Craciun 2016; Eyal 2013; Menchik 2021).

This focus on jurisdictional struggle as the "real ... determining" (Abbott 1988: 2) force in professional life provides a useful framework for understanding the transformation of psychiatry in the United States. In the 1970s, the discipline faced an anti-psychiatric movement challenging the moral and scientific legitimacy of its approach to mental illness (Staub 2011). Meanwhile, social workers and psychologists argued that they, too, could perform the tasks over which psychiatry had claimed a monopoly, such as providing psychotherapy or managing community clinics (Mechanic, McAlpine, and Rochefort 2014). Simultaneously, insurance companies sought to rein in spending that had ballooned as psychiatry expanded its jurisdiction to more psychological states and life problems (Luhmann 2000; Strand 2011).

Psychiatry's response in the United States conforms to how we would expect a profession to solidify its hold on a jurisdiction. In the 1980s, reformist psychiatrists rewrote the Diagnostic and Statistics Manual to reframe mental illnesses as "discrete disease entities analogous to the conditions that other medical specialties treated" (Horwitz 2011: 45). By roping itself to science and biomedicine, the discipline buttressed its "cultural authority," or the recognition among laypeople that its "abstract knowledge" was "valid and true" (Starr 1982: 13). Psychiatrists also recentered on the task over which they, but not psychologists and social workers,

could claim unique expertise: medication prescription (Whooley 2019). The result was that the discipline's practices and principles moved much closer to those of other medical specialties.

French public psychiatry has faced fewer challenges from other professions to its jurisdiction, owing to a more rigidly defined medical hierarchy (see Abbott 1988). It has, however, faced critiques of its expertise from an anti-psychiatry movement, as well as decades of pressure from university psychiatrists and key actors in the central state to move closer to medicine. Yet today, public psychiatry remains idiosyncratic: unlike the rest of the French medical system, where public hospitals and private practitioners are sharply divided, public psychiatry integrates both inpatient and outpatient care into a single administrative unit. Compared to most other developed countries, a greater proportion of inpatient psychiatric care is delivered in specialized (rather than “general”) hospitals that contain only psychiatry (figure 1). French psychiatrists are comparatively numerous (figure 2), which reflects that they do more than prescribe medication, but also deliver therapy and coordinate social services (Brossard 2013; Jacqueline 2006)—roles transferred to psychologists and social workers in the United States.

French psychiatry is also devalORIZED. Psychiatry attracts students who performed poorly on national medical exams.¹ In one survey, 40 percent of French medical residents believed that psychiatrists were “not real doctors” because they trucked in “treatments judged ineffective” and “maladies considered incurable” (Leboyer and Llorca 2018: 102). Public psychiatry has been harder hit by budgetary austerity than the medical system writ large.² Practitioners themselves have described their discipline as in “great suffering” and becoming “hell.”³

Yet even as some public psychiatrists have sought to pursue an American-style path toward raising the discipline's status through alignment with mainstream biomedicine, others have mobilized to maintain their discipline's specificity. These dynamics are difficult to account for within the literature on professions, with its focus on inter-professional jurisdictional struggle based on strategic attempts to increase prestige via claims to scientific expertise (Menchik 2021; Starr 1982). Indeed, they seem to diverge from a global pattern of the increasing adoption of U.S. models of biomedical psychiatry (Fernando 2014; Lakoff 2006; Watters 2011). I argue the dynamics within French psychiatry can better be explained by reconceptualizing struggles over psychiatric specificity within the framework of field theory.

From Jurisdictional Struggles to Field Autonomy

In the sociology of Pierre Bourdieu, “fields” are “space[s] of conflict and competition” in which participants compete via a particular set of “rules of the game” and using a

¹ Michel Laforcade, 2016, *Rapport relatif à la santé mentale*. Paris, France: Ministère des affaires sociales et de la santé, 37.

² Alain Lopez and Gaëlle Turan-Pelletier, 2017, *Organisation et fonctionnement du dispositif de soins psychiatriques, 60 ans après la circulaire du 15 mars 1960*. N°2017-064R. Paris, France: Inspection générale des affaires sociales, 23.

³ Catherine Bégu Vincent, “La très grande souffrance de la psychiatrie française,” *Le Monde*, 18 July 2020 ; Daniel Zagury, “La psychiatrie publique est devenue un enfer,” *Le Monde*, 12 June 2018.

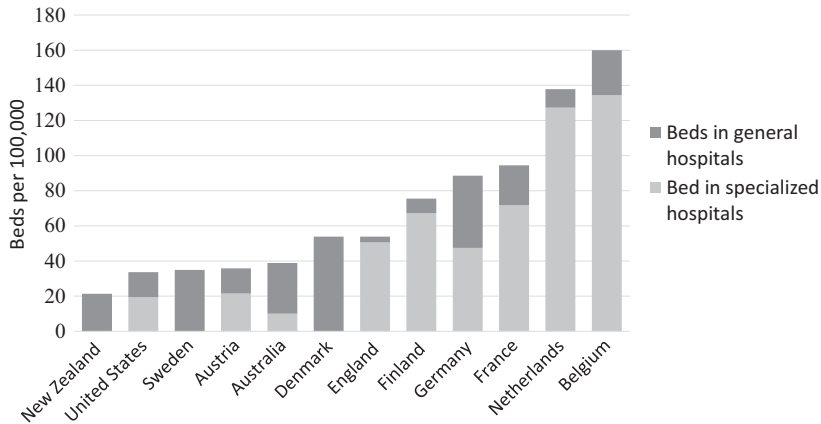


Figure 1. Psychiatric Beds in General Hospitals and Psychiatric Hospitals (2011). Source: WHO Mental Health Atlas.

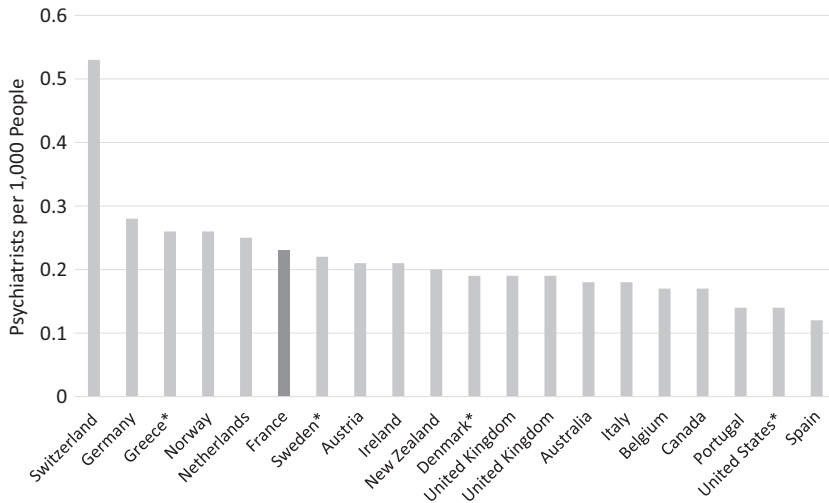


Figure 2. Psychiatrists per Capita (2020). Source: OECD Health Stat. *Data from 2019.

given set of resources, or “capital” (Wacquant and Bourdieu 1992: 17).⁴ From this perspective, professions are themselves “internally heterogenous and divided” (Steinmetz 2017: 477) rather than unified wholes.⁵ The stakes of conflict in a field are not just material resources and prestige, but the very definition of the field itself (Bourdieu 1975: 23). Conflicts within psychiatry, then, concern both the control of treatment and whether mental illness itself is fundamentally similar to or different from other illnesses.

⁴Bourdieu’s is not the only iteration of field theory, but he shares with others a definition of fields as meso-level social orders organized around a set of stakes and constraints on how competition for them should take place (Fligstein and McAdam 2012).

⁵Such a shift follows other recent scholarship advocating for more attention to internal divisions within the medical profession (Jenkins 2020).

While each field is a “relatively autonomous social microcosm ... with a logic and a necessity that [is] specific” (Wacquant and Bourdieu 1992: 97), competition within them is shaped by the way they are nested within a broader “field of power.” In this meta-field, the actors who are dominant in a given field compete with other fields’ dominant actors to convert their field-specific capital into economic resources, cultural status, or political influence (Bourdieu 1996b). Actors within a given field can be differentiated by their orientation toward this field of power. At one pole are those advancing an “autonomous principle looking inwards to the ostensibly disinterested activities of the field,” and at the other are those holding to a “heteronomous principle looking beyond the field’s specific activities and towards economic and political success” (Maton 2005: 690; see also Krause 2018). For example, French academia was long divided between those who sought to dominate the field based on autonomous “scholastic” capital—knowledge validated by other scholars internal to their field—and heteronomous “academic” capital—recognition from the outside world (Bourdieu 1975; 1988).⁶

This distinction between heteronomy and autonomy is useful because it allows us to better articulate the trade-offs of distinctive professional strategies. Strand (2011) points out that, in the United States in the 1980s, psychiatry was polarized between a once-dominant autonomous pole of psychoanalytic psychiatrists and a heteronomous one that modeled psychiatric care after biomedicine. Heteronomous actors gained control of the field partly because they created alliances with other actors in the field of power, like insurance companies or government regulators. Yet in so doing, they submitted themselves to greater economic rationalization and administrative oversight (Luhmann 2000).⁷ Field theory helps us conceptualize French public psychiatry as in an inverted position of *marginalized autonomy*: its autonomous pole continues to organize the field based on a distinctive *nomos*, or “fundamental law” (Bourdieu 2000: 96; Buchholz 2016: 37), that is specific and distinct from other medical specialties. Yet autonomous psychiatrists have faced difficulties in transforming that dominance into economic resources or cultural prestige within the wider field of power.

However, neither the profession’s literature nor field theory can fully account for this latter case. Within the sociology of professions, the destination of lower-status professions (like paralegals or nurses) is often a shrunken domain of expert tasks or subordination to higher-status professions, not a stable and autonomous jurisdiction (Abbott 1988). Field theory, on the other hand, helps articulate why French public psychiatry would seek autonomy, but has limits in explaining why those efforts were successful. Bourdieu (1996a: 60) does show how, in the nineteenth century, French writers oriented toward “art for art’s sake” partly liberated themselves from “submission to the forces of power or to the market” (namely the bourgeois patrons who insisted on the production of certain kinds of work). This autonomy, however, was founded on the fact that artists had inherited economic capital to sustain themselves (Bourdieu 1996a: 81), even as their seemingly economically disinterested attitude won them social prestige.

⁶The rise of think tanks tied to external political and economic forces in the United States similarly represents the ascendance of a heteronomous logic in the field of knowledge production (Medvetz 2012).

⁷Garland gives a parallel example, describing how the field of criminal justice from the 1990s benefited from a new injection of resources from policymakers, but at the cost of forfeiting professionals’ autonomous focus on rehabilitation towards serving heteronomous social demands to punish and incapacitate (2001).

Public psychiatry has neither these independent resources nor the broader social valorization of autonomous writers. Indeed, in his later work, Bourdieu (1999) perceived a growing dominance of heteronomous actors across scientific, legal, and academic fields, which were increasingly penetrated by the state (itself progressively subservient to the market). How, then, have French psychiatrists reproduced their marginalized autonomy?

Institutional Anchors

My explanation centers on a set of institutions, specialized psychiatric hospitals, which have been both a key stake in these conflicts and helped reproduce public psychiatry's autonomous *nomos*. The role of institutions in promoting stability is long-theorized in sociology (Berger and Luckmann 1966; Friedland and Alford 1991; Powell and DiMaggio 1991). However, they have received less attention in the literature on professions and Bourdieu's theory of fields, which focus instead on the strategic actions of individuals or groups (Lagroye and Offerlé 2011: 22).

I conceptualize specialized hospitals as *institutional anchors*, keying off the concept of "cultural anchors" developed by Ghaziani and Baldassarri (2011). Cultural anchors are common symbolic reference points in a complex field of conflicting and cooperating social movements that "promote stability among inevitable flux" (ibid.: 180). In the same way, institutional anchors shape and constrain struggles, rather than resolving them; they create a "tendency towards equilibrium rather than durable consolidation" (Tournay 2011: 2; see also Lagroye and Offerlé 2011).

I focus on institutional *anchors* to analyze, specifically, the role of institutions in a world of professional "ecologies" (Abbott 2005; Liu and Emirbayer 2016) conceptualized in spatial terms: whether as a domain of tasks and problems divided up into jurisdictions or a field in which actors are distributed between heteronomous and autonomous poles. The institutional anchors I study, psychiatric hospitals, provide physical structure to that space: they group together expert tasks in specific places and cluster individual professionals together. In so doing, they help anchor a particular organization of social space by stabilizing an existing balance of power between poles within a profession. In turn, they maintain the distance between a profession and specific external powers (like the state or market) seeking to transform it. I show how psychiatric hospitals function as institutional anchors via three mechanisms:

Institutional Anchors as Sites of Socialization. Competition in fields is constrained by *habitus*, or an engrained set of dispositions that give a "feel for the game" (Bourdieu 1988). For public psychiatrists, specialized psychiatric hospitals serve as "institutions ... through which autonomous principles of vision and division become ingrained" (Buchholz 2016: 38). Like the cafés and salons frequented by Parisian writers (Bourdieu 1996a: 51), psychiatric hospitals in France fostered "a shared understanding about who the group is and what its practices are" (Fligstein and McAdam 2012: 218). In particular, they inculcated an embrace of psychoanalysis that differentiated psychiatrists from other medical specialties.

This socializing function of specialized hospitals anchored public psychiatry in two ways. First, it led professionals to reflexively counter-mobilize to maintain those hospitals when heteronomous psychiatrists sought to close them down. They sought to defend these autonomous-if-marginalized institutions where psychiatrists felt like a "fish in water" whose *habitus* matched institutional context (Wacquant and

Bourdieu 1992: 127). Second, they created a mismatch between the practices of public psychiatrists and other doctors, which became apparent when psychiatrists moved into general or university hospitals. The result, in some cases, was a mutual rejection that reaffirmed public psychiatrists' commitment to specialized hospitals.

Institutional Anchors as Constructing Stakes. Actors in fields seek not just to control their material and symbolic stakes, but to strategically redefine those stakes themselves (Buchholz 2016). Institutional anchors limit this redefinition by creating a set of enduring problems or tasks with which any group seeking to dominate the field must cope. As Goffman (1961) classically pointed out, asylums did not just collect people with mental illness under one roof. They also transformed them into a population of chronic patients who were disconnected from the outside world, dependent on the hospital itself, and had social and material needs as well as health problems that biomedical treatments could not address.

American psychiatry largely abandoned this population as practitioners migrated to private practice (Whooley 2019). However, the French state—unsurprisingly, given France's universalistic health system—expected public psychiatry to continue to manage this population, which specialized psychiatric hospitals themselves had partly constituted (Barnard 2019). This construction of the stakes of the conflict made it difficult for heteronomous psychiatrists to transpose the model of short-term, scientifically validated biomedical interventions from the rest of medicine into psychiatry. Autonomous psychiatrists were consistently better at representing themselves to the state as committed to these stakes, but this yoked them to a population whose failure to be successfully treated and released reinforced the discipline's marginality.

Institutional Anchors as Bridges. The outcomes of struggle between heteronomous and autonomous actors depend on their linkages to specific actors in the field of power. For most medical specialties, those key relationships are with market actors (like insurance) and the welfare-oriented “left hand” of the state (Bourdieu 1999), like the Ministry of Health. Psychiatry is a more complex case, however, because its role in social control has historically placed it in interaction with the coercive “right hand” of the state, such as the police or courts.

Institutional anchors function as *bridges* when they link fields that are otherwise distant in social space. A bridge facilitates cross-field transactions without transforming the underlying logic, or *nomos*, of each (see Mora 2014). In the case of French public psychiatrists, specialized psychiatric hospitals served as a bridge to the powerful Ministry of the Interior. This linkage meant psychiatrists lost autonomy over one set of practices—particularly, involuntary hospitalization of patients deemed a threat to public order—but gained resources for hospitals and support for the field's autonomous *nomos* more broadly.

To summarize, this paper frames the evolution of French public psychiatry as a struggle between an autonomous pole that envisioned psychiatry as a medical discipline *not* like any other, and a heteronomous pole modeling itself on other medical specialties. In the 1960s and 1970s, the autonomous pole became dominant as public psychiatry reformed (rather than closed) specialized psychiatric hospitals. In the 1980s and 1990s, the heteronomous practitioners rooted in university hospitals and allied with key actors in the Ministry of Health pushed to close these facilities and to align psychiatric organization with the rest of the medical field. Since 2000, however, specialized psychiatric hospitals have functioned as institutional anchors, by constructing a population for public psychiatry to manage, serving as sites of

professional socialization, and creating a bridge with arms of the state that were otherwise disinterested in a broader, heteronomous reconstruction of psychiatry. The reproduction of psychiatry's marginalized autonomy and the persistence of specialized hospitals were thus mutually reinforcing.

Data and Methods

I assembled evidence for the continuing specificity of French psychiatry from comparative data on hospital beds, financing, and psychiatrists from the World Health Organization and the Organization for Economic Cooperation and Development. I collected historical data on the number of psychiatric beds in France from the French National Statistical Yearbooks, cross-checked with figures included in over thirty national reports.

I identified the general themes of conflicts over psychiatric autonomy drawing on 266 laws, circulars, decrees, and orders which dealt directly with “psychiatry” or “mental health” or which included provisions specific to psychiatry, published since the 1930s (cataloged by Ascodocpsy). I coded these documents to determine the main issues they addressed, such as professions or financing. As figure 3.1 shows, the question of psychiatry's autonomy presented itself directly in the 1960s as psychiatrists fought to be recognized as doctors and for asylums to be classified as hospitals. Figure 3.2 demonstrates how in more recent decades the issue appeared indirectly in discussions of psychiatric financing, involuntary care, and planning. My conceptualization of psychiatric hospitals as institutional anchors results from identifying patterns in how hospitals created opportunities for certain resolutions to these problems and made others seem unworkable.

To understand the conflicts in the first period (1945–1980), I reviewed government reports, memoirs of prominent psychiatrists, and articles published in *L'Information psychiatrique*, the professional journal of the Union of Hospital Psychiatrists. I also consulted contributions to the conference *Journées psychiatriques*, held in Paris from



Figure 3.1. Laws, Decrees, and Circulars Specific to Psychiatry: Hospitals, Professionals and Planning (1930–Present). Source: Ascodocpsy.

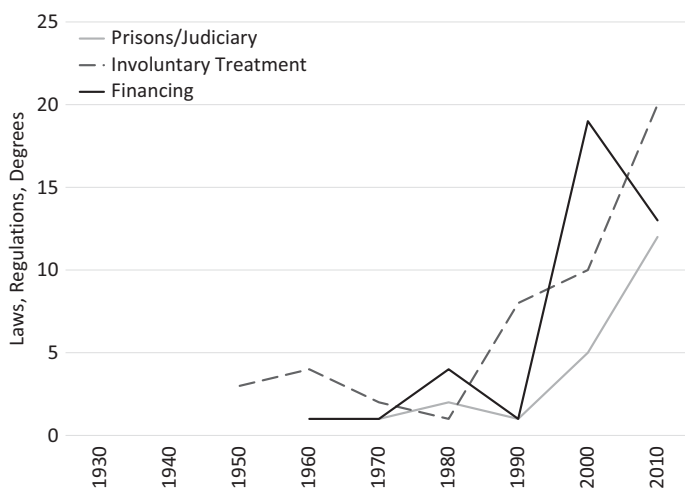


Figure 3.2. Laws, Decrees, and Circulars Specific to Psychiatry: Prisons, Involuntary Treatment, and Financing (1930–Present). Source: Ascodocpsy.

1965–1967, which was a key moment in deciding the future of French psychiatry. I have placed primary sources in footnotes to differentiate them from the French and American secondary literature, cited in the text.

For the period from the 1980s forward, the data also include the archives of the French Ministry of Health, the Technical Agency of Information on Hospitalization, and the Institute of Research and Documentation in Economics and Health, as well as transcripts of parliamentary debates on reforms to the health system in 2009 and 2016. I also rely on professional communiqués and press releases from psychiatric unions and media articles mentioning “psychiatr*” in LexisUni, which covers the key newspapers *Le Monde* from 1990 to the present and *Le Figaro* and *Libération* from 1995.

My analysis also draws on fifty-nine interviews I conducted in 2015 and 2016, plus six follow-up interviews in 2021. Interviewees included nearly all of the referents for psychiatry in the Ministry of Health and Regional Health Agency of Ile-de-France, as well as in government agencies such as the Public Health and Health Statistics Agencies, six leaders of psychiatric professional organizations, and three hospital directors. Interviews lasted between 45 minutes and two-and-a-half hours.

Psychiatric Autonomy within the Medical Field (1945–1985)

Psychiatric Profession: “Parity without Assimilation”

French psychiatry emerged in the nineteenth century hand-in-hand with a set of specialized and segregated institutions in which psychiatrists would work. France’s 1838 “Law of Madmen” declared that each sub-national department “is obligated to have a public establishment, specially designated to receive and treat ... exclusively this genre of illness.”⁸ Most asylums were built in rural zones where psychiatrists

⁸Beaudouin and Beaudouin 1967.

served primarily as administrators; their work was “in truth ... very far from medicine” (Gauchet and Swain 1980: 282). Despite its distance from the medical field,⁹ public psychiatry was far from autonomous. The majority of asylum patients were placed there involuntarily at the demand of the state, and as such, “medical activity was subservient to [the] administrative power”¹⁰ of the Ministry of the Interior (Pinell 2012).

The period between World War II and the 1980s saw a transformation in public psychiatry that firmly established it within the medical field, albeit with a distinctly autonomous *nomos*. A key impetus for reform came from the death of nearly one-third of asylum patients during the German occupation, which sparked an effort from psychiatrists themselves to humanize hospitals (Henckes 2010). Under the aegis of “institutional psychotherapy,” psychiatrists sought to make the hospital “play a role analogous to that of the psychoanalyst”: helping patients heal their subjectivity and relationships with others via their participation in the life of the institution (Robcis 2016: 218). French psychiatrists responded to anti-psychiatry critiques of the asylums not by abandoning these institutions, but by reframing them as a tool for patients’ emancipation.¹¹ They made psychoanalysis into an “administrative” as much as therapeutic approach (Castel 1981: 100).

Yet, at the start of the 1960s, “doctors of [public] psychiatric hospitals” were civil servants, not medical specialists recognized by the Ministry of Education (Pinell 2004: 3).¹² Within medical schools, one review of psychiatric training observed, the “zones of contact with psychiatry ... are very limited.”¹³ Nearly all university positions were held by state-recognized neuro-psychiatrists (Dargelos 2005: 57). Neuro-psychiatrists were self-consciously heteronomous: they juxtaposed themselves against asylum psychiatrists by emphasizing biological models of illness and pharmaceutical, not psychoanalytic, treatments.¹⁴

Psychiatrists in specialized hospitals began what Bourdieu would call a “classification struggle,” mobilizing against their “absence in the official classification” to “get [themselves] noticed and admitted, and so to win a place in the social world” of medicine (Bourdieu 1984: 480–81). The final communiqué from a major 1967 conference of public psychiatrists specified that they wanted to be considered an “autonomous medical discipline,”¹⁵ with “parity” in status (and pay) without “assimilation.”¹⁶ They couched this demand by noting the “volume of its [public psychiatry’s] tasks” and its “extension beyond the medical field,”¹⁷ referencing the variety of administrative roles psychiatrists continued to play in psychiatric hospitals.

⁹In 1817 the Paris Faculty of Medicine began offering courses for specialists in “mental medicine.” After the 1838 law, universities began refusing to train psychiatrists, because the decision to admit someone to an asylum was not a medical determination (Goldstein 1987: 122, 347).

¹⁰Murard and Fourquet 1975, 31.

¹¹I am grateful to Baptiste Brossard for this point.

¹²For clarity, I refer to this group as “public psychiatrists,” even though they were not formally relabeled as “psychiatrists” until 1969.

¹³Green, Martin, and Sivadon 1965, 22.

¹⁴Losserand 1965, 185.

¹⁵Société l’évolution psychiatrique 1967, 149.

¹⁶Ayme 1995, 142.

¹⁷Green, Martin, and Sivadon 1965, 74.

Within this classification struggle, reformed psychiatric institutions themselves were a key bargaining chip. Public psychiatrists argued that they, rather than neuro-psychiatrists, deserved state recognition because of their existing jurisdiction over the population in specialized psychiatric hospitals (Pinell 2004: 6). After all, in 1968, 710 public psychiatrists managed over a hundred thousand beds in specialized hospitals, while fifteen hundred neuro-psychiatrists controlled only three thousand in university and general ones.¹⁸ The role of psychiatric hospitals in social control gave the doctors practicing within them leverage. Several times in the 1950s and 1960s, the Union of Doctors of Psychiatric Hospitals (later the Syndicat des Psychiatres des Hôpitaux, or SPH) went on “strike” by refusing to fill out the certificates necessary for the state to hospitalize patients involuntarily—psychiatrists’ primary role under the 1838 law.¹⁹

These arguments by the hospital psychiatrists proved compelling. The state saw social control of the mentally ill as an essential role for psychiatry but recognized that “certain *maladies* ... cannot be treated, as a result of the gravity of their illness, in a service of neuro-psychiatry,”²⁰ operating on heteronomous principles that emphasized short-term medical treatment over longer-term management. In 1968, the state recognized public hospital psychiatrists as hospital practitioners.²¹ The year after, it created a single “Certificate of Specialized Study” in psychiatry, effectively eliminating neuro-psychiatry.²²

Psychiatric Hospitals: Integration and Specificity

Public psychiatrists were successful not just in upgrading their own status within the medical field while maintaining their autonomy, but also in doing the same for the institutions where they worked. In the 1960s and 1970s, the government made major investments in expanding hospital capacity. Although new psychiatric beds were added both to specialized psychiatric hospitals and psychiatric units within “general” or university hospitals, specialized institutions accounted for the lion’s share.²³ This reflected the unique linkages that specialized hospitals, serving as institutional bridges, had to different levels of the state. As the national auditing office in 1976 observed, local governments demanded psychiatric hospitals because they “had the advantage of being situated outside of urban agglomerations and thus favor the creation of employment in rural zones.”²⁴ As already noted, the central state also recognized that general and university hospitals—which could not take involuntary

¹⁸ *Annuaire statistique de la France*, 1955–1998, <https://gallica.bnf.fr/ark:/12148/cb34349577d/date> (retrieved 2 Jan. 2019).

¹⁹ Ayme 1995, 74, 135, 164.

²⁰ Ministère de la santé publique et de la population, *Circulaire relative au programme d’organisation et d’équipement des départements en matière de lutte contre les maladies mentales*, 15 Mar. 1960, 11.

²¹ République Française, *Loi No. 68-690 portant diverses dispositions d’ordre économique et financier*, 31 July 1968.

²² Ministère des affaires sociales, *Création d’un certificat d’études spéciales de psychiatrie*, 7 Jan. 1969.

²³ As France’s hospital system finally reached the apogee of its growth in the mid-1970s and psychiatric beds began to close, there was little shift in the proportion of beds in specialized versus general hospitals. Belliard, “L’hôpital psychiatrique,” 78.

²⁴ Cour des comptes, *L’organisation de la lutte contre les maladies mentales*, 1976, 595.

patients under the law of 1838—were a poor match for psychiatry's role in social control.²⁵

Despite strategically leveraging these linkages, public psychiatry also sought to limit the “right hand” of the state's influence. The development of community services and humanization of hospitals allowed psychiatrists to treat most patients voluntarily rather than via internments.²⁶ By 1982, only 1.9 percent of hospital admissions were made at the demand of the prefecture.²⁷ With psychiatrists holding key positions in the departments of the Ministry of Health responsible for mental health, and a reduced role for the Ministry of Interior in the functioning of hospitals, the discipline's governance became increasingly aligned with public psychiatrists' vision of an autonomous discipline *within* the medical field.

Consistent with this transformation, a 1970 law recognized the shifting role of psychiatric hospitals by subsuming them into the statute of “acute-care hospitals,” but shortly thereafter rechristened them as “Specialized Hospital Centers”²⁸ (*Centres hospitaliers spécialisés*, or CHS). Staffing these hospitals required a drastic expansion of the public psychiatric corps. Public psychiatrists argued that, since university hospitals had until recently been dominated by neuro-psychiatrists, they had an “evident incapacity ... to ensure the training of specialists.”²⁹ Behind public psychiatrists' hostility was the discipline's attachment to institutional psychotherapy and psychoanalysis, which public psychiatrists claimed could only be taught within a CHS (and which, in turn, provided a justification for those institutions' continued role). In 1968, the Ministry of Health decided to allow psychiatrists to have their residencies in non-university hospitals and for psychiatrists without a formal university post to train them (Pinell 2004: 10), a situation that existed nowhere else in French medicine.

In short, this period placed both public psychiatric hospitals and psychiatrists in a homologous position: recognized as part of the medical field, but autonomous within it. This was reflected in the large number of official government decrees around both, published in the 1960s and 1970s (figure 3.1). This integration-with-autonomy reached a high-water mark in 1985, when the state finally assumed the full costs of public psychiatric care from local governments.³⁰ Under a policy of “sectorization,” the country was divided into catchment areas of around seventy thousand people, each of which would have a single psychiatric team providing both inpatient and outpatient care.³¹ This linkage sharply differentiated the French trajectory from the United States: as one French psychiatrist explained, “[in the United States] the divorce is maximum between the community and hospitals.... The *secteur* is the

²⁵Ministère de la santé publique et de sécurité sociale, 18 Jan. 1971, *Circulaire n° 148 relative à la lutte contre les maladies mentales*, 5.

²⁶Société l'évolution psychiatrique 1967, 156.

²⁷Zambrowski 1986, 31. Similarly, psychiatrists pushed to return to prisoners who had been placed in hospitals by the courts subsequent to a finding that they could not be held responsible for criminal acts (Collectif Contrast 2016: 435).

²⁸Ministère de la santé publique, 6 Dec. 1972, *Décret No 72-1078 relatif au classement des établissements publics et privés assurant le service public hospitalier*.

²⁹Société l'évolution psychiatrique 1967, 153.

³⁰République Française, *Loi No 85-1468 relative à la sectorisation psychiatrique*, 31 Dec. 1985.

³¹The idea of sectorization was actually introduced in a 1960 *circulaire*, but its development was limited until National Insurance assumed financial responsibility. Murard and Fourquet 1975.

union of the community and the hospital.”³² Funds for the *secteurs* would be managed by hospitals. Since in 1985 85 percent of psychiatric beds were in CHS, this meant de facto that they would “drain the majority of resources in public psychiatry.”³³

The historical record from this postwar period shows few challenges to public psychiatrists’ jurisdiction over severely mentally ill people from other professions or from the private sector. Instead, conflicts played out within the discipline, as public psychiatrists struggled for “parity without assimilation” against heteronomous university-based neuro-psychiatrists. Public psychiatrists became dominant, albeit through attaching themselves to institutions that had little prestige and were marginalized by their continued role in caring for a chronically ill population.³⁴

Heteronomous Transformations in Psychiatry (1986–2000s)

Starting in the late 1980s, heteronomous psychiatrists mobilized to increase their status by reducing the discipline’s specificity. As stated by a 1986 report by a psychiatrist charged with health policy for the center-right governing party (a stark contrast to most public psychiatrists’ affiliation with the political left), “The discipline of psychiatry can no longer be considered a closed world, a separate enclave from the rest of the healthcare system.”³⁵ Already in the 1980s, psychiatry began to lose its unique status, including the end of separate psychiatric residencies and to a requirement to pass the same national examination as other specialists had to.³⁶ Both changes gave more power to university psychiatrists.

Indeed, psychiatrists in general and university hospitals were overrepresented among those advocating for more heteronomy. They aligned themselves with the tradition of neuro-psychiatry, which had sought “to make mental illness an illness like the others, which can be cured” (Leboyer and Llorca 2018: 46). One university psychiatrist stated in an interview, “I don’t believe at all that there is a specificity of psychiatry”³⁷ and insisted he would fail any student who thought otherwise. Another decried the “mistrust towards experts, towards universities” among psychanalytically trained psychiatrists, who resisted the imperatives towards evaluation and evidence-based practices sweeping the medical field.³⁸

Reformers focused particularly on the bastions of an autonomous public psychiatry: specialized psychiatric hospitals, or CHS. Institutional psychotherapy, the approach that had legitimated reforming rather than closing the asylums, was, according to one university psychiatrist, just ineffectual “psychoanalysis with walls.”³⁹ Reformers explicitly linked the low status of psychiatric places,

³²Ibid., 219.

³³Belliard 1990, 78.

³⁴As an example of this marginalization vis-à-vis the rest of medicine, in 1976, the Order of Medicine attacked sectorization because it gave public psychiatrists a role in providing outpatient care, whereas in all other domains care outside of hospitals was delivered by private practitioners (Ayme 1995: 295).

³⁵Zambrowski 1986, 15. The report also called for eliminating the special diploma for nurses working in psychiatry, which was established in 1973. The state stopped granting this diploma to new trainees starting in 1993 (Jaeger 2012: 154).

³⁶Ayme 1995, 347.

³⁷Interview, University Psychiatrist, 23 Sept. 2015.

³⁸Ibid., 9 Nov. 2015.

³⁹Ibid., 22 July 2016.

professionals, and patients: as a 1992 report on “An Open Psychiatry” commissioned by the Ministry declared, so long as the discipline was based in the CHS, psychiatric *secteurs* would remain stigmatized “place[s] of exclusion and rejection [by society].”⁴⁰ The report went on to lament, “In the eyes of the public, working in a hospital is mostly gratifying ... unless it’s in a specialized establishment in psychiatry.”⁴¹

The report’s central recommendation was to shift psychiatry into general medical hospitals. The proposal had significant support from both the Ministry of Health and the Ministry of Finance. Indeed, the two ministries were increasingly unified in pushing a heteronomous logic for psychiatry, as economists and administrators replaced physicians in the key bureaus for mental health (Benamouzig 2005). A major planning document promulgated in 1990 declared that “the attachment of psychiatric sectors to general hospitals is a priority in national policy.”⁴² The goal of integration, a member of the Minister of Health’s cabinet put it, was to “change the image” of psychiatry and “make them accept the connections that unite them with other doctors, and accept to work at their side.”⁴³ Addressing public psychiatry’s low status might rectify a growing problem: while in the 1960s and 1970s posts in public hospitals offered an appealing level of economic stability to graduates, by the 1990s two-thirds of new psychiatrists were going into private practice, leaving the public sector understaffed.⁴⁴

Moving away from specialized psychiatric hospitals entailed reimagining the purpose of hospitalization itself. General hospitals would abandon the CHS’ costly role as providers of long-term social welfare for chronically ill persons. One ministry official explained, “There’s a financial aspect here. If you have to rationalize spending on hospitals, you need to focus on crises. And as soon as it’s no longer a crisis, you no longer belong in a hospital.”⁴⁵ The Ministry of Finance intervened in hospital reforms in 1991 and 1996 to ensure that they granted no special status to psychiatry and instead “privilege[d] the medical and technical elements of care” (Philippe 2004: 324). These policies had real effects: from 1989 to 2000, the state closed thirty thousand beds in CHS but only twenty-five hundred in general hospitals, drastically altering the proportion of each in the overall inpatient mix (see figure 4).

Other interventions reduced the power of psychiatric unions, historically key advocates for autonomy. At the start of the 1990s, psychiatry was overseen by a National Commission on Mental Illness that grouped together professional associations, which reflected the unique “importance of the public sector” in psychiatry.⁴⁶ Yet in 1993, the Ministry’s Director of Hospitals declared himself

⁴⁰Massé, Gérard, *La psychiatrie ouverte: une dynamique nouvelle en santé mentale: rapport*, Ministère de la santé et de l’action humanitaire, 1992, 204.

⁴¹*Ibid.*, 274.

⁴²Ministère de la solidarité, de la santé, et de la protection sociale, *Circulaire relative aux orientations de la politique de santé mentale*, 14 Mar. 1990.

⁴³Laurence Follea, “Réconcilier les chapelles de la psychiatrie française,” *Le Monde*, 10 Feb. 1993.

⁴⁴Laurence Follea, “Les psychiatres publics s’inquiètent des demandes liées à la crise sociale,” *Le Monde*, 12 Mar. 1998, https://www.lemonde.fr/archives/article/1998/03/12/les-psychiatres-publics-s-inquietent-des-demandes-liees-a-la-crise-sociale_3652863_1819218.html (retrieved 27 Mar. 2023).

⁴⁵Interview, Direction général de l’offre de soins, 28 July 2016.

⁴⁶Direction générale de la Santé, “Note pour Monsieur le Ministre Délégué à la Santé,” 5 Aug. 1991, box 2009/037/3.

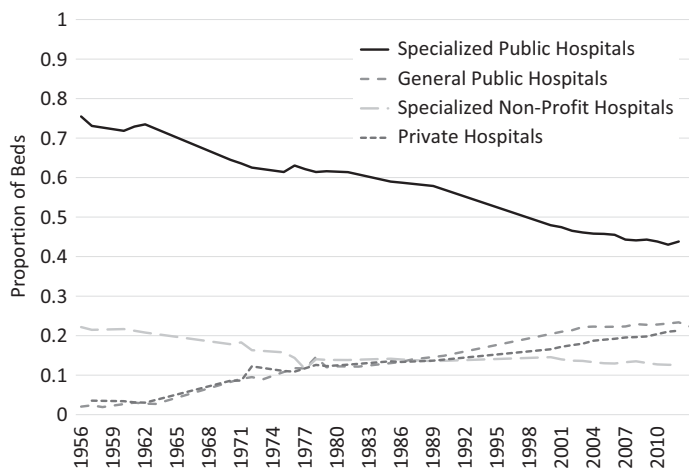


Figure 4. Psychiatric Beds by Facility Type (1953–2012). Source: Annual Statistical Yearbooks of France.

unfavorable to renewing the Commission because “doing so only for the discipline of psychiatry will inevitably incite demands of the same nature from numerous organizations representing other disciplines: emergency medicine, cancer, chronic renal disease, surgery, etc.”⁴⁷ By 1998, the sub-direction of the Ministry for Mental Health itself declared that the commission should be subject to the “decree on the suppression of useless consultative bodies.”⁴⁸

These changes benefited not just university psychiatrists, but some private ones. A 2003 report recommended integrating public and private psychiatric hospitals into a single system.⁴⁹ As the author (a private-sector psychiatrist who had served under a center-right Minister of Health) explained, doing so would elevate private practitioners who were experimenting with new pharmaceutical treatments and cognitive-behavioral therapy and thus “at war with the psychoanalysts.”⁵⁰ These parallel initiatives reflected the same heteronomous logic being asserted in American psychiatry at the same time (Strand 2011): bringing psychiatry closer to medicine would benefit patients with more technically-advanced care, valorize psychiatrists with the aura of science, and facilitate cost controls. The number of official texts dealing directly with psychiatric professionals and psychiatric hospitals plummeted by 2000 (figure 3.1).

As was the case for the postwar period, these conflicts are notable for the lack of large-scale jurisdiction struggles across professions. Social workers and psychologists rarely challenged public psychiatry’s primacy over people with severe mental illness. Nor could these conflicts be reduced to a fight over expert “tasks and problems” (Eyal 2013: 364). Both autonomous and heteronomous public psychiatrists largely agreed that their clinical role centered on prescribing medication for severe mental illness

⁴⁷Direction générale de la Santé, “Création d’un conseil supérieur de santé mentale,” 20 Oct. 1993, box 2009/037/3.

⁴⁸Direction générale de la Santé, “Comité consultative de santé mentale et réflexion dans le domaine de la santé mentale,” 12 June 1998, box 2009/037/3.

⁴⁹Cléry-Melin, Pascal, and Kovess-Masféty 2003, 27.

⁵⁰Interview, private psychiatrist, 16 Oct. 2015.

(not, for example, delivering psychotherapy). The debate, rather, was over the field's fundamental *nomos* (or underlying logic—see Bourdieu 1996a: 61): whether psychiatrists prescribed medication as doctor-administrators attempting to alter patients' subjectivity and social relationships or as specialists treating biomedical symptoms (see Jacqueline 2006). Heteronomous reformers embraced the latter approach, even if increasing the discipline's prestige meant "submission to the forces of power ... [and] market" (Bourdieu 1996a: 60): biomedical standardization and fiscal rationalization.

Defending Autonomy, Reinforcing Marginalization (2000s–2016)

Over the course of the 2000s and 2010s, public psychiatrists' unions and professional organizations mobilized to defend their discipline's specificity within the field of medicine. As in previous eras, a segment of public psychiatrists linked their own autonomy with the maintenance of specialized psychiatric hospitals. Hospitals, in turn, functioned as *institutional anchors* which helped reproduce psychiatric autonomy in conflicts over financing, involuntary treatment, and hospital planning, which became objects of specific legislation and regulations beginning in 2000 (figure 3.2). Yet these successes reinforced the discipline's marginalization within medicine.

Constructing Stakes: Financing for a Special Population

Public psychiatrists first successfully reasserted their autonomy vis-à-vis attempts to transform psychiatry's financing. In this conflict, reformers from the Ministry of Health and university hospitals had to grapple with how the CHS *constructed* a distinctive population of patients in the *secteurs*' care. By shaping the stakes of the field, hospitals anchored the discipline by making it difficult to rationalize financing along the lines of the rest of medicine.

Many psychiatrists saw the "global budget" granted to psychiatry in 1985 as a crucial recognition of and support for its autonomy. Unlike elsewhere in medicine, where largely-public inpatient and largely-private outpatient care relied on separate funding, psychiatric hospitals received a lump sum to cover both as part of a single administrative unit, the *secteur*. This budget financed seemingly non-medical activities like community "prevention," managing "therapeutic apartments," or helping patients find work (Barnard 2019). It thus fit well with an autonomous logic of psychiatry inspired by psychoanalysis' focus on the relational and social dimensions of care. Yet while a global budget allowed the state to cap expenses, one official explained, it was nonetheless problematic because "it separates psychiatry from the rest of medicine" and "is difficult for the management of hospitals."⁵¹

As pressure to address a deficit in the National Insurance budget mounted in the 1990s (Palier 2005), the state turned to a new financial model for hospitals: payment by the activity ("*Tarification à l'activité*" or "T2A"). This system required expanding the use of electronic medical records and analyzing that data to identify the average cost of an episode of treatment for a certain pathology. Hospitals would then be paid based on this average, incentivizing them to modify their activities to avoid over-

⁵¹Interview, Agence Régional de Santé—Ile-de-France, 28 Feb. 2016.

spending on a particular patient (see Juven 2018). T2A favored heteronomous practitioners and hospitals administrators willing to orient their activities toward the market, attracting certain kinds of patients and optimizing treatment approaches.

In 1995, the ministry constituted a working group to devise a method for implementing T2A in psychiatry. From the beginning, they recognized that finding an average cost for a hospitalization was difficult because, as the working group's minutes observed, "the specificity of psychiatric care is that it is associated with an often-long period [of hospitalization] with numerous modes of treatment."⁵² This was particularly true of CHS, where the average length of hospitalization was three times that in general hospitals.⁵³ The results of a first experiment in developing useable typologies of treatment episodes were disappointing. The variables in patients' medical records could only predict 22 percent of variation in costs, dropping to 10 percent for schizophrenia.⁵⁴ A subsequent report from the Ministry's economics department concluded, "The coding [in the medical record] does not always translate into the reality of certain types of care ... [because] certain hospitalizations stem more from medical-social problems than pathologies in a narrow sense."⁵⁵ The agency responsible for the experiment concurred that economic modeling was difficult because of "a large variability in care ... created by the characteristics of medical structures" themselves.⁵⁶

The ministry pressed on, announcing in 2001 that electronic medical records in psychiatry would become obligatory in 2004 and "used for the allocation of resources" by 2006.⁵⁷ Unions of public sector psychiatrists, rooted in the CHS, overwhelmingly opposed the initiative. The leader of one union reported that 80 percent of his membership voted against the proposed shift.⁵⁸ For them, the obligation to use standardized diagnostic categories in a medical record destined for researchers and ministry consultants, who would transform the data into tools for fiscal management, would be the "death knell of the *secteur*, of our discipline, of psychoanalysis, and public hospitals."⁵⁹ Some public psychiatrists deliberately exacerbated the technical challenge of implementing T2A by declaring a "strike against statistics" in 2004, coding cases into the electronic health records reviewed by the ministry as "F99: psychic troubles without other indicators" (Béart and Dembinski 2012: 162).

In 2005, the national agency for regulating hospitals conceded that their new methodology explained only 6 percent of variation in costs of hospitalizations, even

⁵²L'Agence Technique de l'Information sur l'Hospitalisation (ATIH), n.d., "L'activité psychiatrique: deux modalités envisagées," *Archives phase expérimentation psychiatrie*, <https://atih.sante.fr/lactivite-psychiatrique-deux-modalisations-envisagees> (retrieved 20 Feb. 2020).

⁵³ Belliard 1990.

⁵⁴ Odier 2007, 543.

⁵⁵ Valérie Paris, Thomas Renaud, and Catherine Sermet, *Des comptes de la santé par pathologie: un prototype sur l'année 1998*, Direction de la recherche, des études, de l'évaluation et des statistiques, 2002, 6–7.

⁵⁶ L'Agence Technique de l'Information sur l'Hospitalisation, "Trajectoires de soins: description du modèle," *Archives Phase Expérimentation Psychiatrie*, n.d., <https://atih.sante.fr/trajec-toires-de-soins-description-du-modele>, (retrieved 20 Feb. 2020).

⁵⁷ Ministère de l'emploi et de la Solidarité, *Circulaire DHOS/E3/2001/N°625 relative à la mise en place du PMSI en psychiatrie*, 19 Dec. 2001.

⁵⁸ Interview, Syndicat des psychiatres d'exercice public, 3 Aug. 2016.

⁵⁹ Hélène 2006, 549.

less than the previous attempt.⁶⁰ The government report rolling out T2A for other hospital-based specialties concluded that “the T2A in psychiatry poses methodological problems that are not resolved” and left the discipline out of the project.⁶¹ Psychiatry’s victory ensured that it would continue to have a global budget that would allow it to focus on the chronically-psychotic population which many public psychiatrists saw as their core constituency.⁶² The CHS’ very failure to successfully treat and return to the community this group favored public psychiatry’s continued autonomy. Even government officials who preferred a more heteronomous discipline admitted that “private psychiatry, or even university hospitals, won’t take responsibility for an entire population ... [they] refuse the nasty, dirty *malades [sic]*” crowding the CHS.⁶³

Psychiatry’s exceptionality had both symbolic and material costs. Chronic, institutionalized patients were precisely those that did not allow psychiatrists to demonstrate the technical acumen that serves as the foundation for medical authority (Menchik 2021). Under T2A, other disciplines could increase their revenues by picking certain kinds of patients, concentrating on more lucrative procedures, or leveraging statistics on their activity to demand changes in funding schemes (Juven 2018). Meanwhile, an official working for the National Insurance agency explained, psychiatry “has a difficulty of representing the costs of psychiatric illnesses, quantitatively, compared to cancers.”⁶⁴ The ministry slowed growth in the global budget of public psychiatry down to 1.9 percent per year between 2005 and 2015, versus 3.0 percent for general medicine.⁶⁵ Psychiatry thus maintained autonomous financing within medicine only to see its relative resources decline.

Bridging Institutions: Involuntary Treatment and Psychiatric Governance

In their push to integrate psychiatry with the rest of medicine, university psychiatrists would seem to have been favored by their heteronomous orientation towards the field of power: namely, their ability to convert their commitment to providing acute care and biomedical treatment into favorable regulations and resources from the Ministries of Health and Finance. However, in the 2000s CHS created a bridge between public psychiatrists and the Ministry of the Interior. The latter wanted to manipulate a subset of psychiatric practices as a tool of social control, but this linkage ultimately facilitated the discipline’s broader autonomy.

Health policy itself under President Nicolas Sarkozy (2007–2012) was inauspicious for psychiatric specificity. In discussions of the 2009 Law on

⁶⁰L’Agence Technique de l’Information sur l’Hospitalisation, “Recueil complémentaire: résultats et enseignements,” *Archives phase expérimentation psychiatrie*, 19 Oct. 2005, <https://atih.sante.fr/trajec-toires-de-soins-description-du-modele> (retrieved 20 Feb. 2020).

⁶¹Jean-Marie Rolland, *Rapport sur la tarification à l’activité dans les établissements de santé*, no. 3265, Assemblée Nationale, 2006, 21.

⁶²In 2014, one-quarter of psychiatric beds in France were occupied by people who had been hospitalized for more than a year. Of them, 80 percent were in specialized psychiatric hospitals. Coldefy and Nestrigue 2014.

⁶³Interview, Agence Régional de Santé—Ile-de-France, 4 Aug. 2016.

⁶⁴Interview, Caisse régionale d’assurance maladie—Ile-de-France, 17 Feb. 2016.

⁶⁵Alain Lopez and Gaëlle Turan-Pelletier, 2017, *Organisation et fonctionnement du dispositif de soins psychiatriques, 60 ans après la circulaire du 15 mars 1960*. N°2017-064R. Paris, France: Inspection générale des affaires sociales, II, 84.

Hospitals, Patients, Health, and Territories, one member of the National Assembly commented that “the future of [public] psychiatric hospitals should be discussed” because “their mode of functioning is different from the general hospitals.” The Minister replied that “the subject of mental health does not figure in this law”⁶⁶; that is, its provisions (focused on increasing marketization of the system) would apply to psychiatry, but psychiatry itself would not be specifically recognized. The 2009 reform eliminated Regional Commissions on Mental Health, one of the last distinctive governance bodies for psychiatry.⁶⁷

The state is not a monolith, however, and actors across the bureaucratic field held distinctive positions about the merits of psychiatric specificity. While the Ministry of Health clearly favored heteronomous psychiatry, Sarkozy’s Ministry of Interior was introducing new and specific directives and policies around psychiatry’s role in the criminal justice system and involuntary care (figure 3.2). It resisted attempts to realign French psychiatry in keeping with changing international psychiatric norms, which frequently entailed reducing psychiatry’s unique role in forced care. In 2004, a Ministry of Health delegation participated in a project from the Council of Europe to issue common recommendations around “psychiatry and the rights of man.” The archives show numerous instances where the Ministry of Interior intervened to ensure the delegation protect the “particularities of our system of involuntary hospitalization,” notably the right of the prefecture to demand a hospitalization based on someone causing “troubles to the public order.”⁶⁸

After a murder by an escaped patient in 2008, Sarkozy delivered a speech inside a psychiatric hospital, declaring that “the potentially dangerous sick need to be submitted to a special surveillance.”⁶⁹ Sarkozy pledged 70 million euros for hospitals’ “securitization” (Velprey and Eyraud 2014). Even psychiatrists hostile to this framing of patients as “dangerous” recognized the opportunities this attention offered, especially for the specialized hospitals that held a disproportionate share of involuntary patients.⁷⁰ Under Sarkozy’s administration, France went from having four hyper-secure “Units for Difficult Ill-Persons” (“Unités pour malades difficiles,” or UMDs) to ten. All of the new facilities were attached to CHS.⁷¹ As one article noted, “by the end of the 90s, the [CHS] saw its future darken. Asylum-like sites no longer made any sense.” But, explained one psychiatrist, when the CHS built an UMD, “it gave [the hospital] life-insurance. We don’t close UMDs.”⁷²

In 2010, the government introduced a law that would give the central state more control over involuntary hospitalizations. Preparatory reports concluded, contrary to the arguments being advanced by the Minister of Health in the 2009 Health Reform,

⁶⁶Commission des affaires culturelles, familiales et sociales, “Examen (Articles) du Projet de loi HPST.” *Assemblée Nationale*, 3 Feb. 2009, http://www.assemblee-nationale.fr/13/dossiers/reforme_hopital.asp (retrieved 1 Mar. 2020).

⁶⁷Durand 2013.

⁶⁸Direction générale de la santé, “Projet de recommandation relative à la protection des droits de l’homme et des libertés fondamentales des personnes atteintes de troubles mentaux,” Direction générale de la Santé, 10 Mar. 2004, 2009/037-3.

⁶⁹Nicolas Sarkozy, “Déclaration du Président de la République sur la réforme de l’hôpital psychiatrique,” 2 Dec. 2008, <http://discours.vie-publique.fr/notices/087003805.html> (retrieved 20 Feb. 2020).

⁷⁰Coldefy and Neindre 2014.

⁷¹Association Psycom, “Unités pour malades difficiles,” 28 May 2015, <http://www.psycom.org/Espace-Presse/Sante-mentale-de-A-a-Z/Unite-pour-malades-difficiles-UMD> (retrieved 11 Aug. 2020).

⁷²Favereau 2019.

that: “Psychiatry cannot simply be subsumed into the common organization of medical care. Its specificity is inherent to the pathologies to which it treats.... Mental illness can lead to a person ‘troubling the public order’ and the organization of the health system must contain measures taking this into account.”⁷³ The opposition from psychiatric unions was ferocious: “It’s the only time I’ve ever seen the discipline united, against the idea that the sick person is a dangerous one,” one psychiatrist told me. Sarkozy seemed to be threatening the field’s overarching *nomos*.⁷⁴

While the 2011 law passed over many psychiatrists’ objections, it nonetheless set in motion a process that indirectly met some of their demands for special treatment within the medical field. A 2005–2008 government plan for psychiatry and mental health had lapsed without replacement, victim of a “lack of institutional measures for its implementation” and “insufficient leadership,” according to the main government accountability office.⁷⁵ Yet the archives show that the government reversed course in 2011 and decided to elaborate a new plan in order “to respond to critiques concerning the law around involuntary care.”⁷⁶

When Sarkozy was defeated for re-election in 2012, the Conference of Presidents of the Medical Committees of Specialized Psychiatric Hospitals—a weighty professional organization, owing to the persisting size of the CHS—seized on the opportunity. They wrote to the new socialist health minister requesting “to go beyond the law of 2011 [on involuntary treatment] ... to a law specific to psychiatry and mental health.”⁷⁷ Paradoxically, the unions representing public psychiatrists knew the easiest way to argue for a dedicated law was to invoke their role in providing social control. A communiqué argued that a new law should adapt to the “particularities of [psychiatry’s] mission,” the first of which was “the need to ensure ... care without consent.”⁷⁸ In 2014, the Minister of Health went to a CHS in Paris, where she announced that “the world of psychiatry was mismanaged and stigmatized by the previous government.”⁷⁹ Although the discipline would not receive an entire law to itself, it would be the object of a dedicated article in the government’s 2016 reform to the health system.

Why did the Minister of Health overrule the actors in her own ministry who were still favoring a heteronomous organization of public psychiatry? First, as a member of her cabinet explained, they knew that, historically “movements of discontent in public hospitals” often “begin in the [CHS].”⁸⁰ They thus included the article to

⁷³Couty 2009, 17.

⁷⁴Interview, Direction générale de l’action sociale, 14 Oct. 215.

⁷⁵Cour des comptes, *L’organisation des soins psychiatriques: les effets du plan ‘Psychiatrie et Santé Mentale,’* Rapport publique thématique, 2011, 75.

⁷⁶Direction générale de l’offre de soins, “Note à l’attention d’Annie Podeur: démarches en cours sur la santé mentale,” 2011, box 2014/011/3.

⁷⁷Conférence Nationale des Présidents et Vice-Présidents de Commissions Médicales d’Établissement des Centres Hospitaliers Spécialisés / Fédération Nationale des Patients en Psychiatrie / Union nationale de familles et amis de personnes malades et /ou handicapées psychiques], “Communiqué sur Rapport Couty,” 5 Mar. 2013.

⁷⁸Godet, Pierre François, “Projet de Loi de Santé peut-il réconcilier la psychiatrie avec les réformes?” *Syndicat des Psychiatres des Hôpitaux*, 11 Nov. 2014, <https://sip.sphweb.fr/2014/11/19/le-projet-de-loi-de-santa-peut-il-raconcilier-la-psychiatrie-avec-les-raformes/> (retrieved 28 Feb. 2020).

⁷⁹Touraine, Marisol. “Politique de Santé Mentale et de Psychiatrie,” 24 Sept. 2014, <https://www.vie-publique.fr/discours/191558-declaration-de-mme-marisol-touraine-ministre-des-affaires-sociales-et-d> (retrieved 20 Feb. 2020).

⁸⁰Follea, “Les psychiatres.”

“keep psychiatry from descending into the street”⁸¹ and, eventually, bringing other restive doctors with them. Second, after the terrorist attacks in Paris in 2015, even the socialist Minister of Interior envisioned “mobilizing psychiatric hospitals against the terrorist threat.”⁸² The 2016 law ultimately reaffirmed the unique organization of public psychiatry into *secteurs* and charged public psychiatry with ensuring care for “the entirety of the population ... notably for patients with particularly complex trajectories ... including hospitalization without consent.”⁸³

Did psychiatrists preserve a degree of autonomy from the caring “left hand” of the state only to be dominated by its coercive “right hand”? The Ministry of Interior was narrowly focused on patients who were subjected to hospitalization at the demand of the prefecture, which concerned only 0.9 percent of public psychiatry’s caseload in 2015.⁸⁴ The archival record shows the Ministry of Health’s frustration at “not being informed of the development of new legislation” by the Ministry of Interior, which accentuated the specificity of psychiatry while ignoring broader, heteronomous reforms to the psychiatric field.⁸⁵ Psychiatric hospitals thus provided a bridge to wings of the state that demanded control over a subset of psychiatric practices, while in turn providing badly needed resources. These conflicts indirectly facilitated the reinscription of psychiatry’s autonomous *nomos* into the law.

But while public psychiatrists asserted that fighting for their autonomy meant defending humanistic, psychoanalytic principles, in practice it meant also accepting that part of their role would be that assigned to them in 1838: interning mentally ill people at the demands of the state. Even if it concerned a minority of patients, this linkage with coercion and control undoubtedly had both reputational and therapeutic consequences. Noted one hospital director, “Going to a psychiatric hospital is much more complicated than going to a general hospital. It would be an enormous step in terms of the stigmatization of mental illness ... if psychiatric care was more diluted with the rest of medicine [in a general hospital].”⁸⁶ But such a “dilution” was precisely what many psychiatrists feared, as emphasized in the next section.

Socializing Institutions: Specialized Hospitals and Psychiatric Training

At the core of the push for a heteronomous psychiatry in the 1990s and 2000s was the goal of transferring care away from CHS towards general and university hospitals. Yet in the 2011 National Plan for Psychiatry and Mental Health, this objective disappeared.⁸⁷ Indeed, the shift to general hospitals virtually ground to a halt by

⁸¹Interview, Cabinet Member, Ministère des affaires sociales et de la santé, 25 June 2016.

⁸²David Gourion, “Terrorisme: ‘les psychiatres n’ont pas vocation à collaborer avec le ministère de l’intérieur,’” 21 Aug. 2017, https://www.lemonde.fr/idees/article/2017/08/21/les-psychiatres-n-ont-pas-vocation-a-collaborer-avec-le-ministere-de-l-interieur_5174728_3232.html.

⁸³République Française, *Loi N° 2016-41 de modernisation de notre système de santé*, 26 Jan. 2016.

⁸⁴Coldefy, Fernandes, and Lapalus 2017.

⁸⁵Direction générale de la santé, “Modification de la Loi n°90-527 du 27 juin 1990 codifiée relative aux droits et à la protection des personnes hospitalisées en raison de troubles mentaux et à leurs conditions d’hospitalisation,” 4 May 2004, Direction générale de la Santé, box 2009/037/1.

⁸⁶Interview, Hospital Director, 26 Apr. 2016.

⁸⁷Direction générale de la Santé, 2012, *Plan Psychiatrie et Santé Mentale, 2011–2015*; Ministère des Solidarités et de la Santé, 2018, *Feuille de Route: Santé Mentale et Psychiatrie*.

2010 (figure 4). The state stopped collecting data that differentiated general and specialized public hospitals in 2012. This section considers how the CHS, as a site that socialized psychiatrists into an autonomous self-understanding, contributed to maintaining that specificity and specialized institutions themselves.

In some cases, the barrier to moving psychiatry into general hospitals came from other doctors, who perceived a mismatch between their *habitus* and those of psychiatrists. In other disciplines, the system of payment by the act pushed doctors to become managers and marketers as they competed with one another to get more patients with less costly conditions (Juven 2015). These doctors felt public psychiatrists resisted this imperative. As one official in the Ministry's Direction for Mental Health explained, "The general hospitals have had to really reflect on how to optimize their medical activities, analyze it, reflect in terms of the market, because their financing depends on their medical productivity. They have to develop a brand. And they have the impression that psychiatry has just avoided all this effort of restructuring and optimization. They [hospital directors] say, 'The psychiatrists can't explain what they do.'"⁸⁸ For example, a group of somaticians in Toulouse wrote the minister opposing the transfer of psychiatric units from a CHS to their hospital, arguing that the "proximity of psychiatric patients risks shocking and distancing our normal patient population."⁸⁹

Concerns about their treatment by other practitioners only explains part of psychiatrists' reticence to enter general hospitals. The CHS where many psychiatrists trained were places where they were "like a 'fish in water'" in a world of autonomy that they could "take ... for granted" (Wacquant and Bourdieu 1992: 127). Noted one official, "I get that going into a general hospital is de-stigmatizing, but it's clear that there is an impoverishment of the training when people are no longer in a psychiatric hospital, and are just trained like other doctors. You lose an entire culture."⁹⁰ With older private psychiatrists who practiced psychoanalysis retiring in droves (in 2020, over 50 percent were over age sixty),⁹¹ CHS were one of the last redoubts of a therapeutic eclecticism that combined psychoanalysis and institutional psychotherapy with more contemporary behavioral and biological approaches. Within the CHS, psychiatrists were both medical practitioners and implicated in hospital administration, a role they lost in facilities they shared with other specialists. Revealingly, while vacant posts were a problem across the public system, the situation was worse in general hospitals.⁹² "All the *secteurs* based in general hospitals say they want to return to psychiatric hospitals," a Ministry of Health official lamented.⁹³

⁸⁸Interview, Direction général de l'offre de soins, 11 July 2016.

⁸⁹Motta, Philippe, "Le transfert d'un hôpital psychiatrique divise les Médecins," *Le Figaro*, 18 Mar. 2002.

⁹⁰Interview, Caisse nationale de solidarité pour l'autonomie, 18 Jan. 2016.

⁹¹Assurance Maladie, 23 Feb. 2022, *Psychiatres et Neuro-Psychiatres Libéraux*, https://assurance-maladie.ameli.fr/sites/default/files/2020_fiche_psychiatres-et-neuro-psychiatres-liberaux_1.pdf (retrieved 4 Apr. 2023).

⁹²Coldefy, Le Fur, Lucas-Gabrielli, and Mousquès 2010, 59.

⁹³Interview, Direction général de l'offre de soins, 5 Oct. 2015. More broadly, salaried positions in the public sector have attracted more psychiatrists than private practice in the last decade. Erwan Alix, "Six graphiques pour mesurer la situation de la psychiatrie en France," *Ouest France*, 26 Apr. 2023, <https://www.ouest-france.fr/sante/psycho/six-graphiques-pour-mesurer-la-situation-de-la-psychiatrie-en-france-011657ac-debc-11ed-8876-51122d90141b> (retrieved 20 May 2023).

A more modest attempt to strike a balance that preserved CHS but obligated them to act in a more heteronomous fashion came in the 2016 health law (introduced in the previous section). The law mandated that public hospitals and outpatient providers work together in “Territorial Hospital Groups” (*Groupements hospitaliers de territoire*, or GHTs) to create a “common medical project” for people living in a given area. Participating in the GHTs, the leader of one psychiatric union admitted, might actually help underfunded CHS survive by allowing them to share costs with larger general hospitals and better financed university ones.⁹⁴

Yet major unions in psychiatry immediately demanded a special exception that would allow psychiatric hospitals to be left out of GHTs. Unions evoked the existing specificity of psychiatry to advocate for maintaining it: noted one communiqué, “We cannot ignore that psychiatric practice depends on a distinctive organization and planning ... [Psychiatric institutions] are still financed by a global budget, not T2A ... which allows them to fulfill the multiple missions of the *secteurs*.”⁹⁵ Public psychiatrists feared that their fungible global budget would be “eaten up” by more prestigious university hospitals if it was placed in the same administrative unit.⁹⁶

For interviewees in the Ministry of Health, resistance to the GHTs seemed to reflect little more than an instinctive insistence that a distinctive discipline required autonomous institutions.⁹⁷ Yet that circularity had a self-perpetuating character. As one Senator noted in discussions of the 2016 law, “There still exist enormous psychiatric hospitals, which show the extent to which psychiatry must be considered on its own terms.”⁹⁸ The Ministry’s reticence to antagonize public psychiatry led it to ultimately accede to psychiatry’s demands, including allowing specialized psychiatric hospitals to create their own, psychiatry-only GHT or to ask to be left out of the GHTs entirely. By 2017, one-third of CHS had requested to do so.⁹⁹

The administrator charged with psychiatry for a regional health authority observed the consequences: “The services of psychiatry over there [in the CHS] they’re going to die a slow and lonely death, gasping out, ‘I would never want to work there [in a general hospital], I don’t want to cooperate.’” Yet, even though, to him, the CHS were a “millstone” around the neck of psychiatry, they were necessary to train new psychiatrists: “The psychiatrists in university hospitals are not very numerous. And why? Because they are all working in CHS.”¹⁰⁰ These examples capture the underlying role of a collective *habitus*: that actors are socialized to act in ways that “reproduce the objective structures” (Bourdieu 1990: 61) that had produced their own professional dispositions—even as those objective structures were economically (and, in officials’ eyes, therapeutically) failing.

⁹⁴Interview, Syndicat des psychiatres d’exercice public, 3 Aug. 2016.

⁹⁵Godet, Pierre François, “Les GHT spécialisés en psychiatrie : une absolue nécessité!” *Syndicat des Psychiatres des Hôpitaux*, 2 June 2015, <https://sip.sphweb.fr/2015/06/02/les-ght-spacialises-en-psychiatrie-une-absolue-necessita/> (retrieved 28 Feb. 2020).

⁹⁶Interview, Public Psychiatrist, 3 Feb. 2016.

⁹⁷Interview, Cabinet—Ministère des affaires sociales et de la santé, 25 June 2016.

⁹⁸Sénat, 18 Sept. 2015, “Compte rendu integral,” 8638.

⁹⁹Interview, President—Conférence Nationale des Présidents de CME de CHS, 12 May 2017.

¹⁰⁰Interview, Agence Régional de Santé—Ile-de-France, 4 Aug. 2016.

Conclusion

This paper has examined why and how professional groups accept and reproduce a position of marginalized autonomy: relative independence in organization and practices, coupled with limited cultural valorization and a precarious economic position. My explanation has centered on the role of *institutional anchors* in maintaining the existing structure of the field, even in the face of heteronomous demands to transform it. French public psychiatry reformed, rather than abandoned, the psychiatric hospital in the 1960s (Coffin 2005; Henckes 2010). These hospitals created a population of institutionally-dependent patients that university psychiatrists were ill-equipped to manage. Specialized hospitals provided social control through involuntary hospitalizations, which meant losing autonomy to the state with respect to a subset of practices but ultimately reinforced the discipline's distinctive organization and governance. Finally, hospitals functioned as a site of socialization that reinforced its lack of integration with the rest of medicine.

Psychiatric hospitals may not be the only institution anchoring French psychiatric specificity, which speaks to the flexibility of the concept. The fragmented, confederal organization of French interest groups have allowed public psychiatrists to pursue their autonomy independently of increasingly heteronomous private practitioners, who were more dominant in the centralized American medical interest group system (Perera 2022). French universities offer no clinical training to social workers and French national insurance does not pay for treatment by psychologists, and both of these factors limit the direct challenges psychiatrists faced to their jurisdiction. The persistence of specialized psychoanalytic training centers may also have helped keep an autonomous logic of psychiatry as a uniquely relational, subjective discipline alive, despite psychoanalysis' declining cultural prestige (Iftimovici 2017).

Nonetheless, my specific focus on psychiatric hospitals as anchoring an autonomous public psychiatry is congruent with the negative case of the United States. For over a hundred years, when critiques of psychiatric expertise mounted, state asylums provided "refuges to which psychiatrists could retreat" (Whooley 2019: 29). Yet even before de-institutionalization closed 90 percent of public hospitals' beds, psychiatrists left: from 1945 to 1960, public hospitals went from employing two-thirds to less than one-fifth of the members of the American Psychiatric Association (Grob and Goldman 2006: 16). Once in the community, psychiatrists faced challenges from psychologists and social workers. Unable to fall back on a low-prestige but state-guaranteed role providing chronic care in state hospitals, psychiatry had to buttress its cultural authority by embracing putatively scientific, biological models of illness (Strand 2011). They turned to the one practice they still monopolized—medication prescription—which in turn aligned with the heteronomous demands of managed care insurance companies (Luhmann 2000; Mechanic, McAlpine, and Rochefort 2014).

This argument has broader theoretical implications for the study of professions, fields, and institutions. The literature on professions imagines a horizontal world of professional groups and jurisdictions (Liu and Emirbayer 2016), whereas field theory focuses on the internal hierarchies of polarized fields and their vertical nesting within a broader field of power (Bourdieu 1996b; Buchholz 2016). In both, the role of institutions in structuring this topography is underdeveloped (Goldstone and Useem

2012).¹⁰¹ Bourdieu (1988, 1996b) at times overlaid individuals and institutions in his mapping of fields. But he offered little theorization of these institutions' independent effects or of how autonomy persists in the face of heteronomous actors endowed with symbolic and material resources from the field of power (cf. Bourdieu 1996a).

By developing the concept of institutional anchors, this paper goes beyond the truism that institutions tend to reproduce themselves. It instead emphasizes the role of institutions in a world marked not by consensus and inertia, but strategic action and conflict, in which institutions are both a stakes and a tool of struggle. Anchors weigh actors down, constraining the strategies professionals will adopt to expand their jurisdiction. They also pin them in place, providing a potentially independent source of power in addition to the status or "capital" that competing groups bear.

The three functions of institutional anchors I have identified help explain how. First, they are the source of persistent, durable problems that can limit how fluidly professionals can shift to claiming expertise over a different set of tasks. "Challengers" in the field of criminal justice, for example, must do more than just advance new principles for the operation of the field; they must also deal with enormous prisons with budgets, employees, and inmates. While neo-institutional theorists emphasize institutions as cognitive phenomena (Berger and Luckmann 1966; Meyer and Rowan 1977; Powell and DiMaggio 1991), institutions also have physical instantiations that, much like an anchor, limit movement in social space. Second, institutions operating as bridges can throw a lifeline to otherwise marginalized professional groups. Nurse practitioners, for example, have carved out a measure of autonomy by clustering in low-status specialties like geriatrics or in rural clinics, in exchange for a stable, if limited, flow of funds from public insurance (Trotter 2020).

Finally, analyzing institutions as sites of socialization helps us move beyond Bourdieu's focus on atomized agents to see how competition in fields also involves groups with a collective *habitus* (Fligstein and McAdam 2012: 218). This might lead them to reflexively take positions that are out of sync with what would seem to be their individual interests. This point speaks to the endogeneity of institutional anchors: as the French "sociology of institutions" argues, institutions are not self-perpetuating but require ongoing reinvestment from the people socialized within them (Lagroye and Offerlé 2011; Tournay 2011). Sociologists might, for example, firmly reproduce their own discipline's low status within the social sciences based on a conception that "the social" is too complex an object to be understood with the more parsimonious and socially valorized models of economists (see Bourdieu 1975). French psychiatrists' insistence that "mental illness" cannot be reduced to symptoms or biomarkers follows a similar logic.

Bourdieu offered a "critical and mournful" account of the loss of field autonomy, lamenting the marketization of universities and the subsumption of social programs to the financial strictures of neo-liberalism (Krause 2018: 9). In the case of psychiatry, though, whether heteronomous and autonomous strategies best serve people with mental illness is an open question. In the United States, "declining mental health exceptionalism" (Frank and Glied 2006: xii) has coincided with the dominance of a heteronomous pole of psychiatry. This may have increased psychiatry's prestige, but it has required largely abandoning care for people with the most severe illnesses

¹⁰¹For example, scholars of expert work, Freidson (1973: 88) argues, have paid more attention to professional work than to their work-settings (cf. Jenkins 2020).

(Mechanic, McAlpine, and Rochefort 2014; Whooley 2019). In France, public psychiatrists have instead clung to their role as the “natural defender” of people with severe mental illness, confident that their “fates are linked.”¹⁰² They have kept both patients and professionals at the margins of the health system.

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¹⁰² Ayme 1995, 9.

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