Negotiating the limits of therapy. Patients', families' and nurses' perspectives on therapeutic failure in the aftermath of the psychiatric revolution,1970s–1980s

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Abstract: To a large extent, the history of psychiatric therapy is the history of incomplete cures, defeated hopes, and ever enduring chronicity. Yet while the historiography of psychiatry has paid much attention to the therapeutic successes claimed by psychiatrists, it has had only little to say about its failures. This article offers both a framework for analyzing therapeutic failure in the aftermath of the mid-twentieth century psychiatric revolution and an exploration of the ways in which it has been problematized in three corpuses of publications from families of people with mental illness, psychiatric survivors, and nurses, respectively. I suggest that failure should be understood as a situated concept that emerged, historically, from the complex set of transactions among psychiatrists, their clients, and the wider society. Specifically, I highlight three levels of analysis when addressing therapeutic failure. The first relates to the broader system of expectations surrounding medical practices. At the second level, failure emerges in the course of the administration of a given treatment from the observation that a cure or at least some relief has not been obtained for a given patient. At the third and last level, failure refers to the inability of a clinician to perform his prescribed role. The changing dynamics of treatment administration in the wake of the neuroleptic revolution, the evolving dangers of therapy, and the transformations in the relationship between therapists and patients is then highlighted to offer a broad understanding of failure as an experience and a concept for the various protagonists of the psychiatric drama.

Keywords: Therapy, psychopharmacology, the patients' view, families

Zusammenfassung: Die Geschichte der psychiatrischen Therapie ist weitgehend eine Geschichte unvollständiger Heilung, verlorener Hoffnung und langwieriger Chronizität. Während die Historiographie der Psychiatrie den von Psychiatern behaupteten therapeutischen Erfolgen viel Aufmerksamkeit geschenkt hat, hat sie nur wenig über ihre Misserfolge zu berichten gewusst. Dieser Artikel bietet sowohl einen theoretischen Rahmen für die Analyse des therapeutischen Versagens nach der psychiatrischen Revolution Mitte des 20. Jahrhunderts als auch eine Untersuchung seiner Darstellung in drei unterschiedlichen Textsammlungen (von Familien psychisch kranker Angehöriger, von psychiatrischen Überlebenden sowie von Krankenschwestern). Ich schlage vor, das Versagen als ein situiertes Konzept zu verstehen, das historisch aus den komplexen Wechselbeziehungen zwischen Psychiatern, ihren Klienten und der Gesellschaft insgesamt entstanden ist. Drei Analysebenen sollen bei der Analyse des therapeutischen Versagens genauer ins Auge gefasst werden: Die erste bezieht sich auf die Gesamtheit der Erwartungen in Bezug auf

medizinische Praktiken. Auf der zweiten Ebene tritt das Versagen im Verlauf einer verabreichten Therapie auf, indem vom jeweiligen Arzt beobachtet und festgestellt wird, dass bei einem gegebenen Patienten keine Heilung oder zumindest eine Besserung erzielt wurde. Auf der dritten und letzten Ebene bezieht sich das Versagen auf die Unfähigkeit eines Arztes, seine ihm zugeschriebene Rolle zu erfüllen. Die sich neu entwickelnden Dynamiken der Behandlung im Gefolge der neuroleptischen Revolution, die neu entstandenen Gefahren und Risiken der Therapie und die Veränderungen der Beziehung zwischen Therapeuten und Patienten werden hervorgehoben, um ein breiteres Verständnis von therapeutischem Versagen als Erfahrung und Konzept anzubieten.

Keywords: Therapie, Psychopharmakologie, Patienten Perspektiv, Familien

Therapeutic failure has been a neglected problem in the recent history of psychiatry. This was not the case in earlier periods. For anyone familiar with life in asylums in the late nineteenth and early twentieth centuries, failure was an all too vivid reality. It was personified by chronic patients, whose plight was caused by the devastating symptoms from which they were suffering as much as by the inability of psychiatry to relieve them, when not by its contribution to their aggravation. Therapeutic failure was a problem discussed at the political level, a motive for social and political action among those who sought to reform asylums, as well as an impetus for a variety of philanthropic initiatives.[1] It was also a burden for the psychiatric profession, which was highly aware of the limits of its interventions.[2]

Beginning in the 1950s, the advent of both psychopharmacology and the deinstitutionalization movement seemed to alter this familiar reality radically.[3] Chronic patients had not disappeared, but what chronicity meant became something much more complex.[4] Patients affected by chronic mental illness still faced a large array of detrimental difficulties that prevented them from living a normal life: repeated hospitalizations, social isolation, poverty and unemployment, multiple comorbidities, and a reduced life expectancy. Yet these problems were rarely seen as the consequence of failed treatment. Rather, among psychiatrists and the wider public, they began to be framed as the cost of therapeutic success. At first sight, failure seemed to be a residual problem belonging to the margins of psychiatric work.

[1] Scull (1993), Dowbiggin (1991), Rothman (1980), Grob (1983).
[2] Dowbiggin (1991).
[3] Healy (2002).
[4] Henckes (2011).

Treatment resistance is one of the phenomena that constitute these margins. More research is needed on the history of this notion and the way it has been used in psychiatry in the past 40 years.[5] What can be inferred from a review of the published literature is that it emerged with the need to find an indication for a class of treatments that were promising but presented a series of important risks for the patients. The first of these was clozapine, a neuroleptic drug developed by a Swiss pharmaceutical company in 1971, which seemed to be particularly effective but included the risk of agranulocytosis, a lethal condition if it is not monitored.[6] Treatment resistance came to be defined as the persistence of significant symptoms despite adequate treatment.[7] With time, it became the justification for a multitude of innovative treatments prescribed in an array of mental disorders, from transcranial magnetic resonance for hallucination to deep brain stimulation for depression, and a variety of drugs with psychedelic properties for a broad spectrum of conditions. Treatment resistance also framed specific consultations that were set up in the care of the patients concerned. The emergence of the concept exposed the crisis of therapeutic innovation in psychiatry in many ways—by definition, treatment resistance pointed to the limit of conventional treatment procedures and revealed the need being felt to find alternatives.

Anyone familiar with the world of psychiatric treatments would however probably challenge the idea that therapeutic failures in psychiatry consist solely of phenomena such as treatment resistance. In fact, they seem to encompass so much more than just the lack of effectiveness of drugs on given symptoms, including: relentless suffering and enduring disability; treatments with debilitating side effects; therapeutic violence; and the persistence of stigmatization.[8] What today is at the global level the most successful ideology of psychiatric care, namely recovery, which promotes the idea that psychiatric patients should be able to make sense of their lives despite the presence of persisting mental ills, may be the recognition of the preeminent fact that psychiatry is failing to provide its patients with adequate care.[9]

It is this tension between the all too visible limits of psychiatric treatments and the difficulty for the psychiatric profession and other participants to frame these limits that lies at the center of this article. I would like to explore the various meanings as well as the significance of therapeutic failure in psychiatry in the 1960s and 1970s. Based on an analysis of a series of writings by parents of

[5] Treatment resistance is currently the subject of the doctoral research at the Paris Descartes University being conducted by Alexandre Michel, whose master's research on electroconvulsive therapy also stimulated my work on this article.
[6] Crilly (2007).
[7] For a recent discussion of definitions of treatment-resistant schizophrenia, see: Howeset al. (2017).
[8] Moncrieff (2008), Dear/Wolch (1987), Estroff (1981).
[9] Braslow (2013).

psychiatric patients, by patients themselves, and by nurses, my objective is both to offer a framework for understanding failure as a social phenomenon and to demonstrate the varieties of ways in which the therapeutic failures of psychiatry were problematized and dealt with during this period by the various protagonists of the therapeutic drama.

With this analysis I suggest that failure cannot be reduced to the systems of evaluations set up to assess the effectiveness of treatments. Failure has to be understood within the broader belief systems that shape the expectations of psychiatrists, mental health professionals, patients, their families, and the wider public regarding what a good life is meant to be. It must be located in the very texture of psychiatric work. Success and failure are concepts negotiated in complex choreographies—what counts as a success or a failure is ultimately what the participants in the psychiatric drama accept to see as such.

Eventually this article intends to be a contribution to the ever growing historiography that has responded to Roy Porter's invitation to explore the worlds the worlds of medicine "from below" thirty five years ago.[10] My interpretation of this invitation differs however from a dominant scholarship that has set to highlight the "culture" or the "discourse" of patients seen as a whole as a cohesive, repressed group.[11] Rather, inspired by Adele Clarke's interpretation of philosopher George Herbert Mead's concept of perspective[12], I insist that "below" is a location where multiple perspectives come to play to constitute social situations as negotiated and constructed. In that sense it is in the multiplicity of the voices of the protagonists of psychiatric therapy that I seek to locate the daily experience of therapeutic failure.

The first section of the article frames failure as a problem for historians of psychiatry. I then present the three corpuses on which my analysis is based: the bulletin of the main French association of parents of people suffering from mental illness; the journal of a French group of survivors of psychiatry; and a collection of essays written by nurses working in a pilot community psychiatry experiment near Paris. The last three sections of the article look at the ways in which failure is framed in all three corpuses.

Identifying therapeutic failure in historical contexts

Therapeutic failure is a tricky concept for historians of medicine and particularly for historians of psychiatry. For one, the history of psychiatry has long concentrated on its successes. Unsurprisingly,

[10] Porter (1985). Also see: Condrau (2007).
[11] This is notably the case of the recent collection of essays edited by: Bacopoulos-Viau/Fauvel (2016).
[12] Clarke (2005).

psychiatrists converted to history have usually focused on the achievements of their discipline.[13] The existence of competing visions of progress among different segments of the profession explained that what was seen as successful practices meant various things for authors with divergent inclinations, yet ultimately the failures of the discipline rarely emerged as a problem that merited attention among these psychiatrists historians, even when it was recognized that they formed the bulk of past experiences with therapy.[14]

While acknowledging the limits of this historiography, recent researches on psychiatric therapies have nevertheless still concentrated on the successes claimed by the profession.[15] A central tenet of this literature is that what effectiveness meant at a given historical moment reflected the meanings attributed to therapy within a given system of evaluation.[16] Success, as a result, is seen as a construction that cannot naturally be derived from the inherent merits of a given technique. Some of this research by critically inclined historians endeavored to debunk the therapeutic feasts of psychiatry to show their inherent limits and to demonstrate the enduring failure of the discipline.[17] In this line of research, a large amount of work has concentrated on past therapeutic procedures that came to be seen as failures by psychiatrists themselves, though they might have been considered as successful in their own time.

At this stage, Jack Pressman's lessons in his magisterial book on the history of lobotomy may be recalled.[18] As he argued, what counted as success depended on the broader conditions of practice at the time. The goal of medicine has always been less to cure disorders than to solve the problems that were thought to originate in them. The reason why lobotomy worked in the 1950s and no longer did 20 years later was that it provided a solution to the most pressing question of the time, namely the management of hundreds of thousands of patients incarcerated in substandard institutions. Yet Pressman concentrates on lobotomy as a success story and he says remarkably little about its later failures. Other researches have examined the crises of confidence that have shaken psychiatry's vision of its therapeutic means at various times, including the mounting critique of asylums at the turn of the twentieth century and recognition of the dependence created by the use of

[13] See notably: Thuillier (1981), Healy (1997), Healy (2002).
[14] The various meanings of successful practices are discussed in Henckes (2016).
[15] Important examples are: Rasmussen (2008), Pieters/Snelders (2011), Swazey (1974).
[16] Pressman (1998), Braslow (1997).
[17] Moncrieff (2013).
[18] Pressman (1998).

benzodiazepine in the 1970s.[19] They do not, however, say much about the ordinary failures of clinical work.

Failure might have been either too visible or too invisible a phenomenon. On the one hand, the inability of psychiatry if not to cure, at least to provide relief to an enormous proportion of its patients is just compelling evidence of its failures; on the other hand, what counted as failures for clinicians, patients, and their families usually remained concealed behind the closed doors of medical offices and homes.

In this regard there is more to say on the relationship between success and failure from Pressman's history of lobotomy.[20] In one of the most fascinating chapters of his book, Pressman shows how the success of psychosurgery was predicated upon the failure of psychiatric therapy in general. Lobotomy did not so much work as a cure than it was meant to salvage individuals who otherwise would have been irremediably lost to incarceration in an asylum. The point is that these patients were not to be lost to incarceration—indefinite incarceration of the mentally ill had become an intolerable perspective for psychiatry, the patients, and their families as well as the larger society. Something had to be done, even at the cost of mutilation. Failure, in a way, was not an option. One might paraphrase here the observation by the French philosopher and Canguilhem's student François Dagognet in his seminal dissertation, *La raison et les remèdes* [Reason and remedies]: "Nowadays, pharmacology has transformed and ennobled the medical attitude: what is born from this move is a must-do."[21]

As suggested by these remarks, therapeutic success and therapeutic failure cannot be seen as objective concepts. They should be conceived as negotiated and situated judgments emerging in the transaction involving psychiatry, patients, and the wider public. They are shaped at the crossroads of specific work dynamics and broader social expectations.

Some further distinctions are required for a full appreciation of the significance of therapeutic failure. First, failure should not be confused with error, though it might take the form of what the sociologist Charles Bosk called "normative error," that is the failure by a professional "to discharge the obligations of his role conscientiously."[22] In that sense a failure is a breach of professional competence and has to be evaluated against the standards and expectations of what it means to be a

[19] Asylum critique is discussed in: Dowbiggin (1991), Goldstein (1987), Rothman (1980).
Discussion of benzodiazepine dependence can be found in: Gabe/Bury (1991), Tone (2009).
[20] Pressman (1998).
[21] Dagognet (1964).
[22] Bosk (1979). See too the sociologist Donald Light's analysis of suicide as the ultimate form of failure in 1970s psychiatric practice: Light (1972).

professional. A therapeutic intervention might however fail without an error being made but because of its inherent risks. In this case the evaluation of the situation might depend on the appropriateness of the risk taken given the severity of the condition being treated. An individual failure might be the cost of collective progress or, on the contrary, an illustration of the collective failures of medicine. The "courage to fail," to quote the sociologists and historians Renee Fox and Judith Swazey, is a dimension of professional competence.[23]

Following on these observations, we need to distinguish three levels of analysis in thinking about therapeutic failure. The first relates to the broad system of expectations surrounding medical practices. Failure, at this level, derives not solely from the limits of the armamentarium of psychiatry in the face of complex severe disorders, but also from the expectation that, despite its limited therapeutic power, psychiatry should be able to provide its patients with a cure. At the second level, failure emerges in the course of the administration of a given treatment from the observation that a cure or at least relief has not been obtained in a given patient. At the third and last level, failure refers to the inability of a clinician to perform his prescribed role. In this third sense failure does not derive from the limits of therapies, but rather from the limits of a professional as a person. With these remarks in mind, we can now turn to the three corpuses on which my analysis is based.

Negotiating failure in three corpuses

The 1960s and 1970s were a significant period for a history of psychiatric failures. In the first years after the advent of neuroleptics in the early 1950s, the discourse that psychiatry was entering a new era of therapeutic success seemed irresistible.[24] Psychotropic drugs were not only more effective on mental disorders, including in chronic cases, than any other available treatment. The multiplication of products with similar effects also seemed to expand, indefinitely, the therapeutic capacity of the profession. If a given treatment did not work for a patient, another molecule or a new combination of different molecules could always be tested. In this sense, failure was only temporary, and relief if not cure was the horizon for most if not all patients with mental illness.

This discourse began to lose strength in the early 1960s. On the one hand, even forceful advocates of psychotropic drugs had to recognize that chronicity remained a challenge for many patients.[25] Patients were relapsing despite treatment, and after years of medication they still presented symptomatic tableaus that were often only marginally less disabling than what had been observed earlier. On the other hand, recognition that the prolonged administration of certain drugs had a

[23] Fox/Swazey (1974).
[24] Henckes (2016).
[25] Deniker (1963).

series of detrimental and apparently irreversible effects caused a breach of confidence among mental health professionals and service users. Two major crises particularly shook the psychiatric profession: the first resulted from the observation that neuroleptic treatments may cause a series of severe neurological symptoms called tardive dyskinesia; and the second derived from the recognition of dependence behavior in users of benzodiazepines.[26] In the United States, both crises ended up in legal actions against psychiatrists and the pharmaceutical industry, and they also had as a consequence declining prescription rates in the 1980s.

Among advocates of psychopharmacology, however, these crises did not fundamentally challenge the notion that mental illness could be managed with appropriate maintenance treatment. The idea expressed in 1975 by the French psychiatrist Pierre Lambert, both a pioneer in psychopharmacology and a noted psychoanalyst, that chronicity had to be seen as "deferred healing," conveying this optimism.[27] In contrast parents, patients, and nurses were all highly aware of the limits of this optimism. For all three groups, failure was not a theoretical option. Rather it was an almost daily experience and in any event a risk. Critical ethnographic studies from the early 1980s insisted on the sense of resignation expressed by patients who had to live lives devastated by illness and the effects of treatment, as well as social suffering.[28] The antipsychiatry crisis of the 1970s might be seen to a large extent as a reaction to the false promises of psychiatry.

Following, I explore these attitudes in three corpuses of writings from all three groups. The first is the bulletin of UNAFAM, the French association of parents of people with mental disorder. Set up in 1963 in Paris under the impetus of a small group of families and with the help of psychiatrists from the French *Ligue d'Hygiène Mentale* (Mental Hygiene League), the objective of the association was both to foster mutual support among families of people with severe mental disorders and to promote the making of legislation and services that would help improve the situation of their children. Published from the early days of the association, its *Bulletin* played a role in socializing parents to what was called "the job of parents."[29] It published different genres of writings: transcripts of lectures and meetings with psychiatrists; articles by psychiatrists, social workers, or lawyers on the organization of the psychiatric system and its reforms; testimonies and advice by parents; as well as publicity for and reports on specific facilities. As I have shown elsewhere, these texts developed a dual discourse on hope: on the one hand the articles promoted the idea that a form of professionalization could help parents develop the right attitude toward their children and help them

[26] For a discussion on tardive dyskinesia see: Brown/Funk (1986). For a discussion on benzodiazepine dependence see: Tone (2009), Gabe/Bury (1991).
[27] Lambert/Midenet (1975). See too Henckes (2011).
[28] Estroff (1981).
[29] In the following the Bulletin of UNAFAM will be quoted as: BLUNAFAM.

get better; on the other hand these parents also developed a quasi-eschatological discourse framing hope as a virtue that they had to cultivate in order to cope with the difficulties of their situation.[30]

The second corpus consists of the journal of the *Groupe information asiles* (GIA) [Asylum Information Group]. The group was formed in 1972 by students and mental health professionals along the model of the *Groupe Information sur les Prisons* [Prison Information Group], a group meant to circulate information on the situation of prisoners, which had itself been initiated in 1971 under the impetus of Michel Foucault. The *Groupe information asiles* then became the first group ever led by psychiatric users in France.[31] The group aimed to organize and unitize the people they called *psychiatrisés* in order to foster counter-reaction to psychiatric power, to unite with other dominated groups, including disabled people and workers, as well as to gather information on psychiatric treatments.[32] In the early 1970s GIA members had been close to Maoist movements, a dominant social and cultural force among young intellectuals in post-1968 France, and their rhetoric bore strong traces of this influence.[33] The GIA published a bulletin titled *Psychiatrisés en lutte* from 1974 to 1979, which comprised reports on the actions led by the group and others, testimonies by *psychiatrisés*, as well as analyses of the nature and mechanics of psychiatric power that were written collectively by leaders of the group.[34] By the end of the decade, the GIA took a strategic turn and focused on contesting arbitrary commitment before the courts. Eventually the association would play an important role in the reform of French legislation on this issue in the 1990s and 2010s.

The last corpus is a collection of essays written between 1960 and 1980 by nurses from a pilot experiment in community mental health in Paris under the aegis of the *Association santé mentale et lutte contre l'alcoolisme dans le treizième arrondissement de Paris* (ASM13) [Association for Mental Health and Struggle Against Alcoholism in Paris's Thirteenth Arrondissement].[35] The essays were a requirement for the training program the nurses followed when they were hired by ASM13. 198 of them have been kept in the association's archives. In these essays nurses were asked to elaborate on their work experience and to reflect on their difficulties in performing their care role.[36] As I have

[30] Henckes (2013).
[31] On the history of GIA see: Hoch (2008), and: Aperçu historique du GIA de 72 à 92 (entretien avec Philippe Bernardet) (2008). My appreciation to André Bitton for sending me an exemplar of Emmanuel Hoch's research. On the context of the creation of GIA in the history of French psychiatry, also see: Coffin (2005), Turkle (1978).
[32] Throughout this article I have kept the French term *psychiatrisés*, which might be translated by "psychiatrized" and may be seen as the French equivalent of psychiatric survivors. *Psychiatrisés* insisted on the ways in which these were transformed, as persons, by psychiatry, which is reflected by the grammar form (past participle) used in this denomination.
[33] Hoch (2008).
[34] Psychiatrisés en Lutte shall be abbreviated as PEL in the following.
[35] On ASM13 see: Henckes (2005).
[36] Throughout the article the essays will be referenced by a serial number, the title of the author and the year of completion.

shown elsewhere, these essays are a vivid expression of the twofold difficulties with which these nurses were confronted: the hardship of daily work with patients with severe psychiatric disorders; and the requirement to use appropriate discourse to reflect on their experience.[37]

The following analyses will address two different sets of questions to the three corpuses. First, how did members of the three groups describe the situations they characterized as failures? What vocabulary and metaphors did they use to characterize failure? How did they understand the situations that evolved into failure? What was the role of the various protagonists in these failures? Second, how did the members of these three groups understand their own involvement in these failures? What did these failures imply for themselves? To what extent and in which ways could therapeutic failures be their own failure?

For all three groups therapeutic failure had both existential and political dimensions. Although the risk for psychiatric users of failed therapy was usually not death, they, their families, and the mental health professionals who took care of them had much to lose in the therapeutic encounter. In an age of economic expansion, a new norm of social participation, consumption, and active living was taking ground in France. For people with mental illness, failure to conform to this norm meant stigmatization, social exclusion, and ultimately failed lives. The expression “social waste” used by both parents and *psychiatrisés* to characterize the situation of their children or their own situation reflected the bitterness of this experience. Suicide or premature death was also a highly frequent horizon for many of these patients. Nurses were not less affected by the failures of their patients, which directly called into question their professional calling. This awareness stimulated, however, vastly different attitudes among the three groups, including criticism of the limits of mental health policies among parents, vocal opposition to psychiatry among survivors, and the leaving of nurses.

Eventually, the three corpuses also reflect the emergence of new voices and the shift in power on the psychiatric scene. As families, patients, and nurses were playing an increasing role in defining what mental healthcare should be and how it should be delivered, they also expressed views on these issues that often contradicted psychiatrists’ perspective. In this sense, the weight given to failure in their publications contrasted with the rhetoric of success that dominated psychiatrists’ discourses. In complex and ambivalent ways this contrast might have been an indication of the limits of their empowerment. Let us now turn to the analysis.

[37] Henckes (2014).

Failure or sacrifice? Families and the difficult negotiation of hope

UNAFAM families understood therapeutic failure at the two first levels identified above. Failures, in their discourse, emerged from both the limited capacities of the psychiatric profession at large and the limits of treatments on given symptoms. Psychiatrists were usually credited for doing their best in the face of what was described as a devastating experience. In this sense families saw therapeutic failure as an unavoidable fact of psychiatry, a fact with which they had to cope. As we shall see, it is at this level that they assessed their own success and failure.

Perhaps more than for *psychiatrisés* and nurses, for the families of psychiatric patients failure was an integral dimension of the experience of mental illness. As the length of stays in psychiatric hospitals was decreasing, parents had come to play an increasing role in the care of their children. While hospitalization was still an unavoidable stage in the trajectory of severe mental illness, families were usually required to take care of their relatives once these were released. The lack of community care facilities, such as nursing homes and outpatient consultations, meant that parents were left alone with this charge. Families were then front-stage witnesses of their children relapsing to mental illness. Parents were also more sensitive to the personal failures of their children than were the professionals and even the patients themselves. Mental disease was destroying the hopes and ambitions they had for their children and this loss was all the more painful for families who generally came from the upper middle class and were aspiring to social elevation for themselves and their children.[38]

The *Bulletin* eloquently records the burden represented by this situation for families. The limits of therapy affected them specifically in two different forms. The first was the fact that patients were usually not cured, but only "stabilized" (*stabilisés*), when they left hospitals. Protest against what parents described as premature hospital releases was among UNAFAM's most bitter mobilizations. Parents had to take care of a relative who not only still experienced symptoms, but who was also deeply shaken by the experience of both mental illness and psychiatric treatment. Moreover, they were left with little information on the condition of their children and without any guidance on the attitude they had to adopt, the ways in which they should react to the bizarre or affected behavior of their children, and how they could help them truly recover. The *Bulletin* depicts the numerous instances of tension between families and their children, and the burden of this tension for the parents. Such instances included for example the ways in which an apparently insignificant motif in the wallpaper could feed the obsessions of their children, the torments of family meetings when the success of a brother or a cousin shed light on the failure of a sick child, divergences between the

[38] On the management of hope among families of people with mental illness, see: Karp (2001).

parents on the attitude to adopt toward their son or daughter. Mundane activities recalled the plight of disease and the failure of recovery. A column from 1966 thus eloquently described the effect that television programs had on a child that was very aware of his condition of being "social waste":

> Those who are aware that they are a part of this waste rejected by a society "that does not want to know" are positively mentally tortured by this television set that forcefully sends out songs of joy speaking of love, the sun, spring, on music that they used to love, played to chords on which they may have once danced, which is now for them, with all the rest, like the noisy echo of a world they have left for the hell in which they are now prisoners. [39]

The second limit was that patients would often soon relapse and that the partial cure that had been obtained during hospitalization would then be lost. The experience of severe mental illness was made of a repetitive cycle of disease, treatment, (partial) recovery, relapse, and again disease. This cycle seemed irreversible—the hope families had had that their children would be able to live a good life despite the disorder were almost systematically defeated by its recurrence. Failure was unavoidable in trajectories that comprised more downs than ups; one had to go through some form of failure to find one's way through madness. In a discussion with UNAFAM members reported in the *Bulletin*, a psychiatrist described in the following terms how parents ought to apprehend this experience:

> You just mentioned repeated failures, which also led to a "breakdown" (*fragilisation*) and eventually to relapse. We see here a sort of limit into which we run; we cannot guarantee that someone will never relapse, just as someone who has never been ill can certainly become ill one day. . . . Our goal is definitely to reduce the risk of failure, to reduce the risk of suffering, but we cannot hope to annihilate this risk. If we never took any risk, there would be no rehabilitation. . . . Relapsing is not a disaster; someone who has managed to get out of a difficult situation once will do so once again.[40]

For psychiatrists, failure was a contingency in a trajectory of recovery and a necessary risk on the path to progress. For parents, on the other hand, the perspective that their children would relapse was perhaps a greater source of concern than their residual symptoms. When relapse occurred, families not only had to endure the torments of a new mental health crisis—including conflict and often violence, the intrusion of a mental health team or sometime of the police into their home and privacy, and the humiliation of having to return to the hospital. They also lost the hopes they may

[39] Brunel, Georges, Entretien au coin… de nos communes difficultés, BLUNAFAM, (1966), 3.
[40] La remise au travail du malade mental. Conférence dialoguée faite par le Docteur Cl. Veil. BLUNAFAM. (1968), 2–3.

have had that mental illness would be behind them and that a new normality was within their reach. Part of this loss was related to the future they had envisioned for their relative. Relapse usually meant that he or she would stop going to school or to work, that he or she had to abandon independent housing, and sometime marriage plans. This column published by a mother in 1968 vividly captured the depth of emotions felt by parents who had to go through this experience:

> But here comes the first relapse, the second. Each time your wound is reopened. You feel like you are falling down a bottomless pit, on a staircase with shaky steps. And yet each time, hope comes alive again. Each time the fall is more painful. This is when you are tempted by despair. Leave it all, lie down, wallow in this nirvana, that nothingness. Abandon a useless struggle. Pull out this weed that is fallacious hope.[41]

Two further dimensions are added to the bitterness of this experience for families. The first is their own role in the failures of their children, both because they were unable to prevent relapse and sometimes thought they had contributed to it, and because of their potential contribution to the origins of mental disease in their children, parents necessarily felt they had some responsibility in their situation. What made the case perhaps even more complex was the fact that families were the target of contradictory discourses among psychiatrists. On the one hand, both psychodynamic and genetic theories insisted on the ways in which madness circulated within families. On the other hand, psychiatrists had to reassure parents in order to gain their trust. In a lecture to UNAFAM members, a visibly embarrassed psychiatrist had to confess his helplessness in the face of theories that seemed to generate difficulties more than anything else:

> Of course there are hereditary factors, and we cannot deny that they are very important. But what can we do about it? We are therapists. You are parents. Transforming the genetic equipment of our grandmother is out of the question. There's nothing we can do about it. We are what we are, and we must accept ourselves as such.[42]

The second dimension was the isolation felt by the parents. A major motif in the UNAFAM discourse was the unintelligibility of the experience of mental illness for those who were not concerned, including friends or even relatives. Not only was the behavior of a sick child beyond the understanding of anyone not having an intimate relationship with mental illness, the moral strain felt by a family who had to live with the child was also invisible to the outside.

[41] Entretien au coin… de nos communes difficultés. Du fond de l'abîme. BLUNAFAM. (1970), 4.
[42] Conférence de Paul Sivadon, Quatrième assemblée générale de l'UNAFAM. BLUNAFAM. (1966), 4.

A dimension of this isolation was related to the lack of communication with medical teams. A column published in 1968 titled "The respect due to families" reported in detail the ways in which families were often mishandled by psychiatric teams.[43] Parents were not able to meet with their child's psychiatrist, for instance, or were given too little information on his or her condition. In the face of this mistreatment, the official line of UNAFAM was to blame the lack of resources in psychiatry for the scarce time given to families rather than to criticize psychiatrists. Yet, like this father, some parents unrestrictedly expressed criticism of the brutality of medical communication:

> Tactless questions on the father or mother's behavior, sweeping appraisals, suggestions on how to behave with the family circle, advice given to assert the patient's personality in this direction, all of this with no prior contact with the parents and based only on the information given by an individual whose health condition makes said information doubtful at the very least, all of this brings even greater difficulties to a place where these are already big.[44]

In the face of these difficulties UNAFAM members developed two responses. The first was to support the reform of psychiatric hospitals and to call for better services to care for their children, especially after hospitalization. In the late 1960s UNAFAM opened a nursing home near Auxerre in northern Burgundy intended to serve as a model for such services, and in the following years it joined other disability movements to ask the government for better services for disabled people. The outcome of this mobilization was the vote in 1975 of legislation that set up a framework for the sort of services called for by families. This measure caused an uproar among psychiatrists, who saw these services as a direct attack on their professional jurisdiction, and in the following years they managed to overturn the legislation.[45]

The second response by UNAFAM members took the form of a sacrificial rhetoric, which they promoted as a personal ethic. Parents were to accept their children's illness and be able to exalt their own pain by enjoying the simple joys of life and by helping others. The following moral was drawn from the column quoted above on the unavoidability of failure:

> Do not refuse what life offers you in its humblest, most mundane dimensions: a ray of sun playing on a leaf, the song of a bird soaring into the sky, the smile of a child. Get interested in your relatives. Try to relieve the distress that someone brought to your attention. Looking at others' misfortunes will make yours seem less harsh.[46]

[43] Entretiens au coin… de nos communes difficultés. Le respect dû aux familles. BLUNAFAM. (1968), 4.
[44] Entretiens au coin… de nos communes difficultés. Le respect dû aux familles. BLUNAFAM. (1968), 4.
[45] See Henckes (2012)
[46] Entretien au coin… de nos communes difficultés. Du fond de l'abîme. BLUNAFAM. (1970), 4.

In this regard, for UNAFAM members the ultimate form of failure was the inability of parents to publicly acknowledge the diseased condition of their children. This position was best expressed in the reaction to a letter sent to the association by a desperate father whose son had committed suicide.[47] As UNAFAM had been unable to bring him support when he had needed it, the father wrote to expose his sense of betrayal and announce that he was withdrawing his membership. In the commentary following the published letter, an anonymous editor developed a long meditation on the meaning of what he described as a collective failure.[48] The mission of the association was to break through the hostility that surrounded mental illness. Parents who were unable to accept their children's illness were also unable to help other afflicted parents. If UNAFAM members had failed on this occasion, it was because the shame of having a sick child had made them unable to hear this father's sufferings. Breaking the circle of silence and shame was the only appropriate response to the plight of mental disease.

Fighting over failure. *Psychiatrisés* and contesting psychiatric power

For UNAFAM families, therapeutic failures were at once a personal destiny and the product of an ignorant and brutal society. The second corpus gives a rather divergent perspective on the issue. *Psychiatrisés* from the *Groupe Information Asiles* saw failure as a structural dimension of psychiatric practices. It was directly related to the role psychiatry played in the political economy of capitalistic societies and expressed the moral corruption and the ineptitude of its professionals. If failure was unavoidable, in that sense, it was because the entire psychiatric profession failed to adequately perform their prescribed role. This radical vision expressed an ideal in which psychiatric care was inseparable from political practices. It is also at this political level that *psychiatrisés* evaluated their own success and failure.

Psychiatrisés en lutte developed a thorough analysis of how psychiatry produced the wasted lives that were necessary for the market economy. In a series of articles that had both antipsychiatric and Marxist undertones, GIA leaders explained how the condition of people under psychiatric treatment had its source in a form of social alienation. Unemployment caused by wider economic forces was the reason for the inability of people to adapt to society. Since no one was willing to change the social reality that caused their problems, these people were transferred from one social service to another until they fell into the hands of psychiatrists. The latter in turn reduced these peoples'

[47] Courrier de nos adhérents. Ce que nous pouvons, ce que nous ne pouvons pas. BLUNAFAM. (1967), 4.
[48] This was certainly Georges Brunel, the indefatigable leader of UNAFAM from its institution until his death in 1971, and its president from 1967 to 1971. A civil servant at the French Parliament, he was also the author of the autobiography of a youth suffering from mental illness published by the French Ligue d'Hygiène Mentale in 1966: N: Je suis un schizophrène. Toulouse, Privat 1966.

problems to a series of psychological and biological phenomena, which they treated as private matters. Through this "individualization" process, *psychiatrisés* were isolated from the rest of the working class and lost the possibility of acting politically.

> For the bourgeoisie, psychiatrizing certain workers amounts to dividing the working class and its allies: farmers, employees, and craftsmen. For psychiatrized workers, mental health care generates interests that differ from those of their class, interests on which the bourgeoisie relies to exploit and manipulate them as it pleases.[49]

Psychiatry was thus seen as a "drive belt" or a "hinge" between production and repression that served to help keep the exploited class at work.[50] A special issue of the journal published in 1977 showed how psychiatrists penetrated workplaces to help manage the workforce. Psychiatric treatments were also massively used in administrations and factories that put their workers under stress.[51] In turn, *psychiatrisés* reduced to waste by psychiatric treatment were left with as the only solution unskilled jobs and joining an expanding subproletarian class. At the end of the day, being mad was the only position that remained accessible to people whose lives had failed.

In these publications, psychiatric therapy was uniformly characterized as mistreatment. At best, it was a diversion. Far from helping *psychiatrisés* to regain a meaningful life, drugs and psychotherapy were treating the external manifestations of their personal problems; they anesthetized their consumers and prevented them from rebelling against their condition. Ultimately they only served as justifications for treating *psychiatrisés* as mentally ill people.

At worst, psychiatric therapy produced the symptoms and alienation they were supposed to fight. The debilitating effects of therapies such as drugs or shock treatment, as well as the stigma attached to psychiatric treatment in general and to hospitalization in a mental institution in particular, resulted in that *psychiatrisés* were even less able to adapt to society after treatment than before. In the end, *psychiatrisés* necessarily had to return to psychiatric treatment and could not escape the spiral of failure and self-destruction that marked the path of a life with mental illness.

For *psychiatrisés*, madness was thus at once a social destiny and a sort of self-fulfilling prophecy. The analyses and testimonies published in *Psychiatrisés en lutte* can be read as a bitter critique of the false promises of psychiatry. *Psychiatrisés* lucidly and pathetically acknowledged their condition of social waste. Throughout the 1970s, GIA leaders encouraged *psychiatrisés* to relate their personal

[49] Ambiguïtés dans le titre : Psychiatrisés en lute. PEL. 7–8 (1976).
[50] L'infirmier, son fou, et la lutte contre la psychiatrie. Gardes Fous. 4 (1974), 29.
[51] Dossier travail et psychiatrie. Psychiatrisation des travailleurs des villes et des champs. PEL. 9-10 (1977).

trajectories in narratives that were published in the bulletin in order to help the thinking on the individualization process. These autobiographical self-narratives read like inversed *Bildungsromans*. Rather than documenting the emancipatory trajectory of individuals who were finding a proper position in society, they illustrated the ways in which *psychiatrisés* were progressively dispossessed from their capacity to act meaningfully as their projects were systematically defeated by wider economic, repressive, and medical forces. Between two stays in a hospital or a prison, *psychiatrisés* felt the worthlessness and anomy of lives that no longer had a goal. As they described the irresistible force that seemed to endlessly drive them back to the hospital, their narratives displayed a deep sense of helplessness. As a *psychiatrisé* vividly wrote in the conclusion of his own story: "We often don't get far, and sometimes we are quick to return."[52]

In contrast with the testimonies collected in the UNAFAM *Bulletin*, the *psychiatrisés*' narratives insisted on the repression their authors had suffered from psychiatrists, their families, and other agents of social control. *Psychiatrisés* were not only victims of psychiatry, they also had to face imprisonment as well as other forms of coercion. In their accounts, they made almost no distinction between the various institutions of social control that they had had to face, and some *psychiatrisés* insisted that being in prison had allowed them more freedom than being in hospitals.

While these narratives expressed an almost desperate pessimism, this feeling was offset by the conviction displayed in many articles that adequate help at the right time could have put an end to their difficulties. Only incompetence had prevented psychiatry from delivering the needed help. "It should be known that if I had had just one form of competent, tangible, and moral help, all these problems would have lasted a much shorter time," wrote a *psychiatrisé* in the conclusion of his self-narrative.[53] As for GIA leaders, they thought *psychiatrisés* could defeat psychiatric power and regain control over their condition by both joining the wider social movement and organizing resistance at their individual level. Like other health movements of the 1970s, the GIA insisted on the role of knowledge in achieving this end.

The GIA's knowledge politics took several forms. On the one hand, the organization developed a thorough analysis of the ways in which *psychiatrisés* could resist medical power in their daily interaction with it. Large sections of *Psychiatrisés en lutte* were also devoted to circulating information on mobilizations in hospitals and beyond. Since the strategy was to break the isolation of *psychiatrisés* in their fight against dominant social forces, the journal systematically reported on

[52] Processus d'individualisation. Itinéraire de Michel. PEL. 2 (1975).
[53] Voici comment ça peut vous arriver à vous aussi. PEL. 13-14 (1978).

mobilizations as diverse as those of disability groups and antinuclear movements.[54] This also explained why the group accepted individuals who had not experienced psychiatric treatment among its members; a note explained in 1974 that it was important for the organization to expand membership to other dominated groups so as to foster cooperation and mutual support among all. On the other hand, the GIA also sought to develop its own expertise on psychiatric treatment. In 1974 the organization established three commissions to produce analyses and recommendations on psychotropic drugs, occupational therapy, and involuntary commitment in hospitals, respectively.

A major theme of the analyses published by all three commissions was to demonstrate how activities that psychiatrists described as therapeutic served, in fact, other purposes. Occupational therapy was thus described as a dimension of an oppressive system that maintained workers in a subordinate position. In the 1970s, occupational therapy often consisted of work done for local industries in exchange for a small reward. An article published in 1975 under the title "A slave trader speaks out" reported an interview conducted with the manager of a small corporation that outsourced part of its production to psychiatric hospitals.[55] The article commented at length on the ways in which local enterprises calculated the benefits they could derive from work performed by the inmates of mental hospitals and prisons. Such practices led the GIA to demand that the work done by *psychiatrisés* be paid at its true value. *Psychiatrisés* were to create a work relationship with psychiatrists and break the circle of domination that was generated by the discourse on the therapeutic value of work.

In the same spirit, the GIA sought to demonstrate that drugs did not help to treat *psychiatrisés* but that instead, they served to maintain them in a situation of dependence, thus reinforcing psychiatric domination. One dimension of the critique focused on the collusion between the psychiatric profession and pharmaceutical companies. In order to help *psychiatrisés* resist prescriptions, the GIA sought systematically to collect information on the nature and effects of drugs. In 1978 it published a first summary of the various effects of psychotropic medications and a longer version circulated in the form of a leaflet in 1979.[56] *Psychiatrisés en lutte* also sometimes published a column analyzing prescriptions sent to the journal by *psychiatrisés* with a view to unveil the logic behind the various drugs mentioned in them.[57]

In these descriptions, psychotropic drugs were reduced to a long list of debilitating and often life-threatening effects. The effects against given symptoms—such as hallucinations or sadness—

[54] For instance : PEL. 9-10 (1977).
[55] Un négrier parle… PEL. 3-4 (1975-1976).
[56] Les principaux effets de la chimiothérapie. PEL. 13-14 (1978). La commission médicament du GIA national: Du côté de la pourriture psychiatrique. La vérité sur les médicaments. 1979
[57] Les groupes de quartier du GIA et le problème des médicaments. Gardes Fous. 1 (1974), 19.

described in medical publications or claimed by the industry were never mentioned. The GIA did not contest that some drugs could be of use for some *psychiatrisés*, and some publications even mentioned how they could be useful in preventing hospitalization.[58]

> The point is not to adapt to a dog's life, but to find a way to change our lives. Drugs can help us do this as long as we, *psychiatrisés*, control the dosages, not a doctor who is supposed to know and does not have the same interests at stake.[59]

What the GIA fought was the massive and indiscriminate use of drugs in hospitals. It claimed a right for *psychiatrisés* to be given thorough information on their treatment as well as to refuse it, and it demanded that prescriptions be written clearly, and that the various effects of the drugs be indicated by psychiatrists to their patients.

The GIA's vision of psychiatry left little room for the possibility that psychiatry could be in any way successful. In this sense, psychiatric therapies were reduced to their failures—not only were they unequivocally inefficient when not dangerous, but moreover, psychiatrists were considered as not having any real scientific knowledge or technical skills. Their only function was repression.[60] The failures of psychiatry were those of a corrupt discipline unable to take into account its patients' interests. While these analyses resonated with wider criticism of psychiatric power, including by psychiatrists themselves, they gathered little momentum in psychiatric institutions. By the late 1970s the organization was suffering from a lack of mobilization among its members, a problem that was not specific to psychiatric movements but which was particularly difficult for the GIA. By the 1980s, the GIA's critical work would leave the field of therapy to focus on the legal dimensions of psychiatric work. In many ways the GIA's mobilization against psychiatric therapies was also, itself, a failure.

The failures of pedagogy: Nurses and the disenchantments of professional training

Questioning the therapeutic nature of psychiatric practices might seem the expression of a particularly critical approach. It was also an important dimension of the writings of nurses from ASM13 however. Like *psychiatrisés* they were highly sensitive to the part played by mental health professionals in the failures of their therapeutic endeavors. Contrary to them, however, they did not locate the origins of these failures at the social and political levels. In their view, these unequivocally called into question the professionalism of clinicians. As a result, when nurses from the ASM13 were

[58] For instance, "[T]his does not mean that drugs should be thrown into the garbage insofar as they can prevent the emergence of symptoms that will get us committed or that they can prevent us from doing what we would like to do." Les groupes de quartier du GIA et le problème des médicaments. (1974)
[59] Les groupes de quartier du GIA et le problème des médicaments. (1974).
[60] Le GIA et son histoire, sa participation aux assises. PEL. 3-4 (1975).

involved in a failed action they could not gloss over their own responsibility in the situation. More generally failures had deep personal meanings for professionals who were asked to use their emotions and personal skills as therapeutic tools. The pervasiveness of failure in daily psychiatric work also resonated strongly for individuals who often came to the ASM13 with the hope that they would find there an opportunity to live stimulating personal and professional experiences. The only way out was to learn how to find the right distance vis-à-vis successes and failures.

Like the other two corpuses, these essays document the omnipresence of failure in psychiatric work and vividly reflect the burden it represented for these nurses, who were at an early stage of their careers. As beginners, the nurses were usually asked to work in the less rewarding positions, notably in wards for chronic patients, demented people, or people suffering from mental retardation, three categories that represented a large share of the patients in psychiatric hospitals at the time and in which only limited progress could be expected. In this context, there was often little room for success in their daily experience of care. Yet nurses working with acute patients whose hospital stay was usually not endless also had to experience failure on an almost daily basis, and even what seemed to be success stories were considered with caution given the risk that all too soon they would turn into failures. A nurse who had been devoted to two cases that she saw as successes thus concluded her essay as follows: “But I think that in this domain we talk enough of failure and that we can sometimes talk about it with a little more optimism” (#126, 1970).

The specific experience these nurses had of failure was shaped by ASM13’s approach to therapeutic work. Therapy, at ASM13, resided in the ability to establish a therapeutic relationship with the patient. What a therapeutic relationship implied, however, was a tricky issue, which was at the core of the training program at ASM13 but to which nurses had to find a solution on their own. “Methods: there were none,” wrote one of them (#175, 1968). Nurses had to navigate in a world of signs and meanings in which each attitude or action could mean something other than it seemed at first. An aggression might be a demand, repeated demands might call for more distance, and compliance might be less a sign of progress than of over-adaptation to life in the hospital and chronicization. The essays related the ways in which nurses made their way through this maze and learned something about the right attitude with the help of colleagues and the medical team. Meetings and informal discussions helped more than formal teaching. Failures and mistakes were a necessary step in this process, and the ability of nurses to acknowledge and analyze their own failures was a core aspect of the pedagogy. In this sense the essays were a writing genre approaching religious confession.

Therapeutic failures took two different forms in these accounts. The first occurred when a nurse could not establish an adequate therapeutic relationship with a patient or with a group of patients.

This was the case when the patients or groups of patients were not behaving as expected, when a nurse did not respond to a patient's behavior in an adequate way, when a nurse felt manipulated by a patient or did not know what to do with him or her. In this context, nurses experienced failure in the form of a feeling of frustration, which alerted them that something was going wrong. A nurse commented on her failed relationship with a patient suffering from bipolar disorder: "I feel helpless in front of her and have the feeling of uselessness" (#5, 1968). The same patient would put her "in situations in which [she had] to refuse what she was asking for." She also observed, helplessly, how the patient developed a rivalry with the woman who shared her room in order to attract her attention. In the same vein, an occupational therapist reported his impression that he had failed because he could not get his patients to work properly in his workshop (#6, 1967). In yet other cases, nurses reported on group activities that patients did not attend. For these nurses, ultimately failure referred to a feeling of being useless in their care of patients. What they had to learn was to adapt their own expectations and behavior such as to modify their therapeutic relationship with them.

The second form of failures involved the collective management of a patient. These failures occurred when patients were durably disturbing the order and discipline of a ward, when they disregarded the rules repeatedly, when their symptoms did not improve or even got worse, or when they kept returning to the hospital after their release. In at times ambiguous ways, these failures reflected the inadequacy of a care plan or the inability of a team to implement this care plan. They could be the consequence of lack of communication within the medical team, of a staff shortage preventing the team from working properly, of a poor evaluation of the situation, or of an accumulation of mistakes, for instance when teams reacted with aggression to a patient's aggression. They were also sometimes directly caused by patients who manipulated teams or whose symptoms resisted to treatment. A nurse thus concluded the case of a patient whose management had proven impossible:

> I feel that there is a relationship here which despite its richness, its intensity, did not enable her to resocialize, which leads me to think that the relationship is clearly useful, but that it is not almighty in the face of omnipotence. In some cases, we need to admit our powerlessness, long-term patients need structures that would help them live as a function of their degree of autonomy. (#162, 1982)

In their essays, the nurses produced insightful analyses of the sequence of actions and reactions that produced both sorts of failures. In contrast with the families or *psychiatrisés*, they underscored the agency of the protagonists of the therapeutic relationship. Rather than referring to an impersonal process of waste production, they explained these failures by two personal processes. On the one hand, some patients seemed to be the object of an irresistible force that pushed them into physically

destroying themselves and others. Suicide, self-inflicted violence, drug consumption, or violence against their entourage or environment were the manifestations of this drive, which could often barely be prevented. On the other hand, some failures occurred when patients rejected the psychiatric team, other patients, or were rejected by them. A nurse described in the following terms a situation that seemed to have no solution: “The patient absorbs and rejects us in the same movement. The patient is constantly making demands and rejects us as incapable of caring for him. He continually gives us the feeling of failure produced by his refusal to accept treatment, to collaborate with any therapeutic action.” (#69, 1967)

In these accounts, the failures display a fundamental ambiguity—it proved difficult to disentangle what was caused by the pathology, and what by the patient himself or by the medical team. Some nurses expressed these ambiguities eloquently, such as this nurse who concluded a case history with this observation, “The mentally ill person, facing the fact of living, of earning an income, of loving a buddy or a woman, refuses this for himself and erects the disease as an impossibility” (#22, 1966). In many cases they hesitated between seeing these failures as their own problem or their patients’.

For these nurses, the ultimate form of failure was their inability to distance themselves from their patients’ sufferings and failures. One nurse explicitly expressed this idea when she explained how she understood her failure when she got personally involved in her patient’s inability to adapt to the life of the ward: “I experienced failure as my failure” (#181, 1971). Another nurse provided a vivid report on how the failure of her therapeutic relationship resulted in her identifying with her patient:

> My unbearable powerlessness before Janine is the equivalent of her own desperate psychotic sentiment: “no one can do anything for me.” Her aggressiveness toward the world is also my aggressiveness against the physician. I do not admit that this stage in the evolution of her disease, which seems to me a privileged one, is not used to begin a new therapeutic approach. (#190, 1967)

The right attitude was to be detached and able to feel distanced from a patient’s difficulties. One nurse explained:

> I have accepted the idea that some of the mentally ill are incapable of wanting to be free. I must confess that I feel detached from any desire to cure such people. Now my care is given in a lighter spirit: patient, available, finally ready to help them meet their desire and no longer listening to mine. (#43, 1982)

Many essays displayed in their narrative strategies developed by the nurses to find the correct attitude toward failure. An essay titled “Facing destruction” strikes its reader with the sense of

inexorability that pervades its narrative (#46, 1980). After the suicide attempt of a patient with whom she had a close relationship on a day when she had not visited him, another nurse wondered: "Did he want to make me fail?" Another nurse reported a sense of defeat, because of her identification with the patient, in what would have been seen by all accounts as a success story (#91, 1980).

While most essays thus demonstrated the ways in which their authors successfully managed the strain of failures, a fair number demonstrated the limits of the coping strategies available to them. A few nurses had a critical take on the failures of their institution. Some regretted the disorganization of teams and the lack of support from the medical teams, criticism which would be particularly virulent during the May 1968 strikes. Another nurse wondered whether she had the adequate tools to deal with her patients:

> I add that for both of them I felt their hospitalization to be failures. This did not cast doubt over the work I had done but made me wonder whether another care technique in the community could not have been developed for these patients for their more difficult episodes. (#177, 1968)

At another level, the high turnover and difficult recruitment, which remained a major problem for the association's management during the whole period, testified to the hardship of work at ASM13 and the limited rewards the organization was offering its personnel. Aspects of the problem were the low wages as well as limited recognition from the hierarchy. While most nurses who quit the association did not leave any indication of their motivations, a few might have shared the sense of betrayal expressed by this nurse who had quit another alternative psychiatric community in western France and had voiced his opposition to the methods he had witnessed there in a column published in *Psychiatrisés en lutte*:

> Little by little, I slipped into a position of marginality and latent conflict with "the institution," until I found myself facing a choice: to submit… or get the hell out. Submitting would have meant giving up any desire to excel, of coherence, of sincerity. It would have meant playing the game with cynicism, acting only in my interest, working joylessly on a strategy of social escalation, and giving up.[61]

* * *

[61] Cliniques Laborde et Chailles dénoncées par un moniteur. PEL. 5-6 (1976).

In this paper I have argued for a closer examination of the range of phenomena that shaped failure as a negotiated experience for the various protagonists of psychiatric therapy in the aftermath of the "psychiatric revolution." While families, patients, and nurses all felt the limits of therapeutic practices deeply, my analysis reveals a series of profound ambivalences at the heart of their experience. The first relates to the relationship between the therapeutic process and its outcome. While the failures of psychiatry were highlighted by the failed lives of its patients, the extent and the ways in which a connection should be made between both dimensions was and still remains a disputed issue. An aspect of this tension lay in the starkly heterogeneous nature of both experiences, that of a failed action and that of a failed life. While there might have been an agreement over the characterization of lives with mental illness as wasted lives, being accountable for failed psychiatric practices proved to be a burden that no one really wanted to share.

The second ambivalence involved the assessment of the respective contributions of collective and individual action to the failures of the therapeutic process. While in the end success or failure was necessarily assessed at the individual level, most of the protagonists were enormously seduced by the idea that its origins were to be found in systemic dysfunctions. While this tension certainly played a role in the success of the critique of psychiatry, it resulted in the protagonists' difficulty to transform this critique into collective action.

Therapeutic failure emerges from this analysis as an elusive notion. What failures meant and how they should be evaluated was almost never stabilized, and the different actors of the therapeutic process had rather different views on the subject. What was perhaps an even bitter dimension of this experience was the sense of inexorability among all the actors. Despite, or perhaps precisely because of the success of the rhetoric of success among advocates of the psychiatric revolution, the idea that failure became an integral dimension of psychiatric practices was both unavoidable and inexpressible. This is not the smallest of paradoxes.

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