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# **Learning constraint. Exploring nurses' narratives of psychiatric work in the early years of French community psychiatry**

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**Abstract :** This article uses narrative analysis to understand how mental health professionals working in a pilot experiment in community psychiatry in France between 1960 and 1980 made sense of their work experiences. Based on a collection of essays written by these professionals as part of their training as well as on other archival materials, the article explores writing practices in post-war French psychiatry as ways of constructing and negotiating moral commitments to work. The first three sections of the article give some background on mental health nursing in France in the immediate post-war period. The subsequent three sections examine how the professionals elaborated on their experiences in their writings, focusing on three different levels: first, the narrative voice used in the essays; second, the learning processes described by trainees; and finally, the ways in which they negotiated discursively the requirement to do emotionally well at work.

**Keywords:** History of psychiatry, Psychiatric nursing, Professionalization, Self narrative, Narrative analysis, Psychiatric reform in France

# Learning constraint. Exploring nurses' narratives of psychiatric work in the early years of French community psychiatry<sup>1</sup>

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This article uses narrative analysis to understand how mental health professionals working in a pilot experiment in community psychiatry in France between 1960 and 1980 made sense of their work experiences. The analysis is based on a collection of essays written by these professionals as part of their training in the *Association de santé mentale et de lutte contre l'alcoolisme dans le treizième arrondissement de Paris* (Association for mental health and the fight against alcoholism in the 13<sup>th</sup> arrondissement of Paris - ASM). Created in 1958, the ASM soon became a model for the organization of services promoted by the French Health ministry after 1960 as part of its new mental health policy, the so-called “*politique de secteur*” or “sector policy”. The sector policy aimed at creating territorial networks of mental health professionals working in a diversity of institutions, from psychiatric hospitals to community mental health centers, from nursing homes to day hospitals, in order to improve the flow of patients within the psychiatric system, to limit their stays in psychiatric hospitals and facilitate their social rehabilitation. But reformers were not just concerned by the deficiencies of a psychiatric system that condemned individuals suffering from severe mental illness to chronicity and permanent institutionalization. They sought to develop a new way of doing psychiatry that relied on a humanistic perspective on mental illness. A new vision of mental health professionals as moral agents was at the core of their project: in their view, psychiatrists and their coworkers should no longer be seen as repositories of a transcendent social norm to be imposed upon the mentally ill, who were considered as social deviants.

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<sup>1</sup> Unless specified, all translations from French are the author's.

Rather, they needed to develop new norms with their patients that were adapted to the latter's needs as well as to the contexts in which they lived<sup>2</sup>.

The essays kept in ASM archives are important testimonies of the ways in which mental healthcare paramedical workers understood these perspectives. In the essays, these professionals were asked to reflect upon the most salient aspects of their everyday work with patients in the various institutions that constituted the ASM system. These essays demonstrate how their authors tried to make sense of their daily experiences with mental illness. They also show them struggling to find a voice to talk about these experiences using techniques of discourse that were made available to them by their medical supervisors. In analyzing these essays, I am especially aware of what Paul Ricœur calls “the ethical implications of narratives” (Ricœur, 1990): as they recount experiences, narratives necessarily convey values that transform their readers' perceptions and actions. This property of narratives adds to the obviously ethical dimension of these essays, which conveyed explicit judgments about their authors' experiences. In the end, the essays did not simply demonstrate the moral commitment of their authors to their work; rather they were a tool in the hand of trainees to construct this commitment. To quote what Michel Foucault said on techniques of the self, in writing about their experiences, these professionals sought “to transform themselves, to change themselves in their singular being, and to make their life into an *oeuvre* that carries certain aesthetic values and meets certain stylistic criteria”. (Foucault, 1992:10-11)

The first three sections of the article give some background on mental health nursing in France in the immediate post-war period, and on the specific context of nursing within the ASM. In the subsequent three sections, I examine how trainees at the ASM elaborated on their experiences in their writings, focusing on three different levels: first, the narrative voice used in the essays; second, the learning processes described by trainees; and finally, the ways in which they negotiated discursively the requirement to do emotionally well at work.<sup>3</sup>

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<sup>2</sup> On this reform movement see: (Castel, 1982; Fourquet and Murard, 1980; Henckes, 2007). On the ASM, see: (Henckes, 2005)

<sup>3</sup> The analyses developed in this article are based on a research done in the archives of the ASM in 2004, as well as on the results of a wider research on psychiatric reform movements in post-war France. I thank Mr. Clément Bonnet, then director of the ASM, for allowing me to do this research.

## ***Reforming psychiatry, creating a new psychiatric nurse***

An essential dimension of the French psychiatric reform movement that emerged in the immediate post-WWII period was its insistence on the need to rethink the training of mental health professionals while simultaneously reforming the organization of the psychiatric system<sup>4</sup>. Most of the reformers involved in this movement were physicians working in psychiatric hospitals who were only too well aware of the necessity of having competent coworkers. Psychiatric nurses had always held a subaltern position among health professionals in France. Nursing had begun its professionalization in 1922 when a ministerial decree created a national diploma in nursing that became mandatory in 1946 for practicing nurses<sup>5</sup>. In the mental health field, a small number of nursing schools had been created within asylums beginning in the early 20<sup>th</sup> century. They were granted the right to prepare the national diploma by the 1922 decree, which also recognized a specialization in “mental hygiene”. To receive this accreditation, schools had to adhere to a program that followed ministerial guidelines, which proved to be difficult (Daumézon, 1935). In the late 1930s, health officials and psychiatrists recognized that the standards and expectations of the national diploma were too high for the mental health field. Given working conditions in asylums, any strenuous requirements in terms of qualifications would make it impossible to recruit the personnel needed to care for the approximately 100,000 psychiatric patients in the country.

In the post-war period, psychiatric reformers did not alter this position. But they sought to overcome these shortcomings by developing a series of standards adapted to both the competencies of nurses and the actual working conditions in psychiatric hospitals. In 1947, a figure in the reform movement published a manual of psychiatric nursing which developed a new vision of training for nursing (Bernard, 1947). The following year, a new school, *L'École supérieure d'infirmiers et infirmières des hôpitaux psychiatriques*, opened in one of the Parisian psychiatric hospitals to provide a model for training in mental health nursing. In 1949, under the impetus of a leading psychiatric reformer, a national organization was created to propose internships to non-Parisian psychiatric nurses so they could learn about occupational and milieu therapy, and a journal, *Vie sociale et traitements*, was created in 1954 to publicize this experience. Eventually, in the late 1950s, a series of regulations brought

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<sup>4</sup> The best account of the history of psychiatric nursing in France can be found in : (Jaeger, 1990; Jaeger, 1994).

<sup>5</sup> On the professionalization of nursing in France see (Collière, 1982; Kniebihler, 2008; Schultheiss, 2001)

uniformity to curricula in local psychiatric nursing schools, setting national standards for psychiatric nursing.<sup>6</sup>

In their writings, psychiatric reformers sought to develop a new vision of psychiatric care. They emphasized that psychiatric nurses not only had to deliver basic care and assist psychiatrists in administering biological treatments such as insulin therapies, electroshock and, from the 1950s on, chemotherapies, but should also contribute to creating a therapeutic atmosphere within institutions that favored recovery. To prepare nurses for this role, they proposed that they be taught normal and abnormal behavior and basic techniques in the management of interpersonal relationships. Rather than focusing on the pathophysiology of mental disorders, their training should emphasize the practical issue of how to behave with a person suffering from a mental disorder. As was summarized in a 1955 review article:

It seems that a specific effort should be made to give the nurse, not popular medical knowledge, but sound technique. The latter will be grounded on knowledge of pathological mental states (not disease), of the dangerous or harmful attitudes they create in an observer who is not prepared and of the well-adapted attitudes for which, on the contrary, one should strive. Furthermore, detailed study of rehabilitation and treatment techniques must lead to practices as rigorous as those of sanitization for general nurses. (Daumézon, et al., 1955:6)

While psychiatric reformers advocated for greater awareness among nurses of the therapeutic implications of their attitudes at work, they themselves disagreed on whether nurses' interventions could truly be characterized as a form of psychotherapy<sup>7</sup>. While some psychiatrists envisioned that nurses be trained in psychoanalysis in order to better prepare them for their jobs, others stressed that this would only add to the strain of working in a frontline position if nurses were to analyze every single aspect of their relationship with patients. During the 1960s, these discussions nevertheless fostered a movement toward self-recognition among nurses, which culminated in the post 1968 period with the creation of several committees or associations consisting exclusively of nurses, and aimed at promoting their profession<sup>8</sup>.

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<sup>6</sup> Eventually the training of psychiatric nurses merged with that of general nurses in 1994.

<sup>7</sup> This was the subject of an influential series of meetings organized in Sèvres, near Paris, in 1958-1959 by leaders of the psychiatric reform movement, which also saw psychiatrists develop a blueprint of sector policy. See: (Fourquet and Murard, 1980)

<sup>8</sup> For an account by a participant in one of these groups see: (Zilliox, 1976). Also see: (Turtle, 1981)

## ***Becoming a model nurse***

When the *Association de Santé Mentale et de lutte contre l'alcoolisme dans le Treizième Arrondissement de Paris* was created in 1958, it seemed all the more natural that it should have a role to play in the training of mental health professionals. ASM's mission initially was to coordinate the various players in the psychiatric field working in the 13<sup>th</sup> arrondissement of Paris. The Association's founder and first director, Philippe Paumelle, soon interpreted this mandate to include the creation of a series of psychiatric institutions that would serve as a blueprint for the new sector policy, to be promulgated by the Health ministry in 1960. During the next 15 years, he managed to attract an unprecedented amount of funding for a psychiatric organization and his association was able to open the largest array of psychiatric institutions ever seen in France. He began with the creation of a psychiatric hospital, which opened in 1963 in Soisy-sur-Seine, a rural city located 30 km south of Paris, followed in the next few years by three nursing homes, two therapeutic workshops, and a community mental health center that hosted various consultations and a home care service.

The ASM leaders' project to create a new mental health professional at the same time as they created a new mental health system was reflected in their opening a training center in 1963, the same year they opened the psychiatric hospital. A provocative dimension of the ASM leaders' project was their plan to attract professionals to the Association's institutions who were without previous experience working in the mental health field. When possible, they favored licensed nurses with the national diploma over those who did not have one but who had worked in other psychiatric institutions, and they decided to recruit qualified craftsmen to supervise patients' work in the therapeutic workshops of the Association. An internship of two or three days was organized to screen candidates. Those selected then entered into a training program that lasted two years. The 1963 annual report of the training center described the overall objectives of the training program as follows:

- to give healthcare personnel the elements that will allow them to involve themselves progressively and safely in their healthcare role;
- . to measure its extent and limits, that is:
- . to understand the patient they are caring for
- . to understand that the relationships developed with the patient through his care and the organization of collective life are important factors in the patient's evolution
- . to organize group life within wards or workshops and induce patients to participate in this organization, to do all of this as a team with others: nurse manager, male and

female nurses, occupational instructors, physicians, etc. by working at their side and by communicating with them. (Annual report of the Training center, 1963, ASM archives)

In effect, training sessions consisted of classes which took the form of “a series of seminars that left enough room for collaborative thinking and discussions” (Annual report of the Training center, 1963, ASM archives) and that trainees were required to attend along with their immersion in psychiatric work in ASM institutions. Classes addressed the issues of psychiatric semiology, group life in psychiatric institutions, relationships with patients, and nursing methods. The training ended with the writing of an essay that was the basis of an oral presentation in the presence of the director of the association and those in charge of the training center. The program was supervised by a psychiatrist and psychoanalyst, Myriam David, who had introduced case-work in France in the early 1950s and who later became a leading figure in French child psychiatry. She was assisted by a group of nurses trained in a private clinic in Switzerland and who also worked in the hospital.

While the ASM certainly proved to be a stimulating environment, both for psychiatric work and for reflecting on this work, the training center nevertheless faced many difficulties over the years. One of them was related to the thorny issue of the nature of nurses’ knowledge and its relationship to psychiatric knowledge, a topic that, as was mentioned above, had been the subject of discussions among psychiatrists themselves since the post-war period. In 1968, the center was reorganized with the help of a Quebec nurse to encourage the participation of ASM nurses in teaching. The project entailed the creation of a system of supervisors and clinical instructors chosen among the most skilled nurses of the Association. The reform proved difficult to sustain in the 1970s and gave rise to numerous discussions until the training center was eventually closed down in the early 1980s.

However, the most enduring difficulty faced by ASM management lay in recruiting the workforce needed to run its web of institutions. Although ASM promised a stimulating work environment supervised by a highly motivated medical team, it could not guarantee better wages than other psychiatric institutions. Moreover, in the 1960s and 1970s, Soisy-sur-Seine was an isolated rural city without direct connection to Paris, and it could not offer much in terms of after-work activities for nurses who lived there. To these difficulties was also added the relative deterioration of working conditions in ASM institutions over time. In the early 1970s, the proliferation of the sector policy created a more competitive environment for ASM, which lost its pilot status and faced new financial constraints. A direct consequence of this



policy change was also an influx of chronic patients coming directly to the association from other Parisian hospitals where they had previously been hospitalized. At the same time, ASM could no longer avoid receiving a series of difficult patients that would have previously been sent to other Parisian institutions. ASM institutions now faced overcrowding, a problem that had plagued the French psychiatric system since its creation but that ASM management had hoped to avoid.

These changes fostered a new work atmosphere among ASM employees that contrasted with the optimism and entrepreneurship that had dominated the early years of the association and that its management sought to address with the creation of a series of specialized wards for patients that posed specific problems. In 1970, a locked ward had to be created within the hospital and in the next few years several wards were assigned to different categories of chronic patients: long-term patients, patients with “deficit psychoses”, elderly and demented patients and people suffering from mental retardation. While the medical team took pains to turn the dirty work in these wards into more gratifying experiences, the association nevertheless began to suffer from rapid turnover, leading its management to revise its recruitment requirements.

### ***The essays***

These difficulties are vividly reflected in the 198 typed essays of 7 to 40 pages by 145 women and 53 men trainees, kept in the archives of ASM. Most of their authors were licensed nurses or psychiatric nurses, and some were occupational therapists, physiotherapists or group coordinators. While a majority of the essays recounted work experiences in the ASM hospital in Soisy-sur-Seine, an important proportion were also based on experiences in other institutions within the Association – its day hospital, nursing homes, home care service, or therapeutic workshops. A few others drew on subsequent experiences in other settings after leaving the association. They also addressed a variety of situations involving a range of tasks with a diversity of people: distributing pills; giving a bath; visiting patients at home; looking after chronic, old or severely disabled patients; organizing a daily schedule; organizing leisure activities, etc.

The instruction given to trainees was to reflect upon their experience during their two years of training. They had to describe their discoveries, doubts and difficulties, the manner in which they found rewards in daily activities and coped with the most distressing aspects of their

work. As can be seen by a quick overview of titles, constraints imposed on patients ranked high among the concerns of these professionals: “Problems of authority towards the mentally ill faced by a nurse”; “Reflection on limits in a closed ward”; “Evolution of a nurse as she accepts and understands tolerance”; “Limits and frustration”; “I am working in a closed unit”; “The tolerance of the nurse toward the mentally ill and toward mental illness”; “The key”. But titles also allude to other sources of distress linked to the very difficulty of encountering severe mental illness: “Difficulties of caring for a psychotic patient in acute phase within a multidisciplinary ward”; “Practical life facing psychotic death”; “Chronicity”; “Facing destruction”; “Difficulties in recognizing and accepting the patient as he is”; “Contraception in psychiatry”. The essays thus show how ASM professionals learned to cope with a large array of distressing situations that entailed dealing with aggression, violence, passivity, death, degradation, decline and loss. In the remainder of the paper, I will be looking in greater detail at how ASM trainees discursively dealt with these experiences.

### ***Negotiated voices***

The fact it was difficult for trainees to find a voice to express their experiences at work is reflected in the many questions they raised throughout their essays. These questions give a speculative tone to the writings that is in contrast with the certainty usually displayed in medical texts (Atkinson, 1984). Some essays explicitly reflected on the uncertainties felt by their author in making sense of the reality they were dealing with. A nurse thus concluded his description of life in a nursing home in the following terms: “Personally, I find it very difficult to talk about daily life in the Foyer because it is made up of a thousand little things, small details in themselves but that, taken together, give hope. It’s inexpressible, a very real assortment of things but still subjective and subtle”. (#62, Male psychiatric nurse, 1978)<sup>9</sup> More fundamentally though, the pervasiveness of these questions throughout the essays also reflected a widespread perspective on psychiatric work in ASM institutions: caring for a mental patient involved engaging reflexively with one’s actions. As was recalled by a licensed nurse in 1980: “Whatever one’s function, part of psychiatric work consists in asking oneself a series of questions on how one is functioning, on challenging the behavior which one has adopted on a certain occasion or in the long run.” (#105, Female licensed nurse, 1980)

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<sup>9</sup> Throughout this paper, the essays are referenced by a serial number, the title of the author and the year of completion.

Trainees' questions had numerous dimensions and concerned many different issues. Some related to psychiatric or medical issues. Such was the case when trainees tentatively made a diagnostic or a psychopathological hypothesis to account for a patient's behavior, such as in this question asked in parentheses by a psychiatric nurse after describing the effect of a treatment sequence on a patient: "(May one speak of narcissistic revalorization?)". (#62, Male psychiatric nurse, 1978) Others referred to practical problems: how should the situation be organized to develop smoothly, who among team members should distribute pills, how should a nurse share her time between the numerous patients she has been assigned. However, many questions raised by ASM professionals had a more existential connotation: what should be done? Who am I in the presence of this patient? And who am I to take decisions that may impinge on this patient's free will? These questions asked by a nurse in the conclusion of her essay reflected the depth of such questioning:

I wonder whether being a nurse is not first of all having the ability to recognize the psychological reactions that patients provoke in us as being a mirror image of their own processes? Might this not also be an ability to 'welcome' the patient's 'madness' that makes it possible for us to find the resources necessary to 'invent', create moments and situations where we can represent the subject, through a process of identification, in the guise of the child that we imagine? Isn't this simply recognizing him as a person whose peculiarity we must bear for the moment? (#8, Female psychiatric nurse, 1980)

How should I act as a nurse and a person? was the main issue raised by this nurse. However, for the reader, other questions necessarily are: Whose voice is this? Who is the subject of the enunciation? The answers to these questions should be expressed at two different levels. At the first level, trainees addressed a generalized other who served as a distant witness of their commitment to self-analysis. They tried to draw lessons from their experiences at work which would be of universal significance – or at least, of significance for colleagues in the same position as theirs. Their questioning was in the form of a reflection that did not require immediate answers. However, behind this reflection, at the second level, also lay a message for the members of the pedagogical committee who would be the first readership of the essays. Many questions asked by trainees could be read as direct queries to this audience, anticipating discussions that would take place during oral presentations of their essays. At the least, trainees were seeking confirmation for the ways in which they framed their questioning. Some essays explicitly staged this dialogue, such as in the following warning comments made by a nurse: "I am deliberately staying in the background in this essay since we basically work

as a team, but in answering the questions you will ask, I will attempt to explain in more depth my experience as a care worker in the unit.” (#149, Female psychiatric nurse, 1975)

More generally, the narrative characteristics of the essays reflected the web of negotiations in which trainees were engaged on a daily basis within the institution. Some of these negotiations were required by the methodology that trainees had to follow to write their essays. The latter was described in the following way in an undated note from the early 1960s:

Candidates are required to regularly write a journal of their observations and to have discussions on a regular basis with a supervisor who will help them develop their thinking. Doing bibliographic research is advised, as well as documentary visits to people or sites that are of interest to the topic chosen by the candidate. (Undated note, ASM Archives)

As was suggested by this quote, the content of the essays had to be negotiated between trainees and a variety of supervisors and colleagues, who gave advice, organized the way trainees voiced their experiences and finally participated in shaping these experiences. Trainees would also build on a series of situations at work in which they had to talk about themselves. Such was the content of numerous meetings where staff members (including physicians) were invited to give voice to their feelings as part of the team management of patients. Another dimension of the intertextuality of the essays lay in references made to other writings produced by ASM institutions. The ASM was the site of an array of writing practices that probably had few equivalents in other psychiatric settings in France at the time. Among these were clinical records, hand-over notes, minutes of meetings, medical theses and research reports. Clinical cases reported in the essays were probably similar to those in other writings. At least this is the case in a series of essays concerned with a group of patients diagnosed with severe mental retardation and that also were at the center of a number of publications by ASM co-workers throughout the 1970s, including a book in 1978 (Eberentz, et al., 1978). More generally, many essays made explicit references to theories developed by medical members of the association. Among these was the concept of mothering developed by psychoanalyst Paul-Claude Racamier to account for a certain way of caring for schizophrenic patients and that was widely used by nurses to describe their own work. Another important theory relied on the opposition between reality and imagination, which shaped nurses' understanding of the way they opposed what they deemed irrational behaviors. As a result, many essays demonstrated an awareness of the fact that they discussed meanings that had been created by others. A nurse thus reflected on the fact that she, as a nurse, could not interpret a psychiatric phenomenon without help from more qualified workers, although her essay was probably among those that

developed the most sophisticated interpretations of patients' behaviors: "As a nurse, I am excluded from theorizing about psychiatric practice, which is usually reserved for others: psychiatrists, psychologists, psychoanalysts" (#33, Female psychiatric nurse, 1980)

Trainees thus had to master a series of references in order to be able to make sense of their experiences in the specific framework that was taught to them during training. But they also had to master the very form in which they shared these experiences. The essays belonged to two well-defined literary genres. A first group of essays could be read as clinical case presentations. They were centered on patients and displayed all the features that have been analyzed by sociologists of medical discourse: de-personalization, use of the passive voice, deletion of the author, a time frame adjusted to its author's vision of the patient (Anspach, 1988; Atkinson, 1995). A second group of essays corresponded to another literary genre which is less often encountered in medical writings: the autobiography. These essays used the first person singular and the narrator was the main character of the narrative. They often described scenes in vivid detail, reporting dialogues in direct speech and making extensive use of exclamation and question marks, thus reflecting the emotional state of their author. These essays could often be read as true confessions<sup>10</sup>. Trainees admitted their weaknesses; they reported their dilemmas and recognized where they did, or did not do, well. Clinical cases were turned into stories of friendship. Since these autobiographies served to measure their personal development, trainees demonstrated their understanding of the meaning and consequences of their actions and the sense of responsibility they had acquired throughout their internship. For instance, a 1982 essay by a male psychiatric nurse described a fight with a patient, which ended when the nurse beat the patient who was subsequently sedated by the team with an injection. The narrator concluded his story by the following comment on how he had learned from his violence: "the punch given to Mr. W. acted as a boomerang. I was too self confident and thought that I mastered the situation, without really realizing that I could be physically aggressed, which was the case". (#64, Male psychiatric nurse, 1982)

The deep moral commitment displayed in these narratives contrasted sharply with the blurring of responsibilities that has been shown by medical sociologists to be characteristic of the discourse of clinical case presentations. For trainees, turning to the impersonal voice was often clearly a way to limit their personal commitment to the situation they described.

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<sup>10</sup> Beginning in the 1970s they could also refer to a series of autobiographical writings published by diverse professionals. Among those directly concerned with psychiatric nursing are: (Roumieux, 1974; Zilliox, 1976).

Instances of these changes were noticeable in essays dealing with what appeared to be difficult situations. A nurse thus recounted a difficult interaction with a patient who did not comply:

We try to give her a framework, she reacts violently. She finds work during a leave in Paris, she is discharged. New failure, she is back to the hospital, very depressed. She is asked to conform to the life and to the rules in the ward, she accepts but she starts getting excited again. She has to be put alone in a locked room. (#22, psychiatric nurse, 1970)

The transition from the first person plural to the passive voice in this quote is a vivid example of the way nurses faced the moral quandaries of administering constraint in psychiatric practices. However, discourse on responsibility in trainees' autobiographical essays also needs to be read at another level, in reference to a scientific genre that could be traced back to practices of self-analysis in 19<sup>th</sup> century introspective psychology and in contemporary psychoanalysis (Danziger, 1980; Mayer, 2001). In this perspective, trainees' confessions were clearly not aimed at making amends for what had gone wrong. Rather, they sought to demonstrate that they mastered the rhetoric of moral self-awareness deemed indispensable for working in the ASM.

Most essays in fact conformed to both genres and articulated them with variable success. They usually began with autobiographical notations using the first person and then included a clinical case often written in an impersonal mode. Nevertheless, some essays displayed less skill in using these different modes. Such was the case of an essay written by a psychiatric nurse in 1980 that took the form of a third person autobiography: the narrator was absent from the narrative and referred to a character, "the nurse", which obviously was the author himself. (#32, Male licensed nurse, 1968) This essay gives the impression that its author is both absent and present, unable to find a place within his own discourse<sup>11</sup>.

### ***Precarious journeys***

The tension between the personal and the impersonal voices displayed at the formal level in the essays can also be analyzed in the personal journeys which they recounted. To portray and establish themselves as professionals, trainees typically told a coming of age story, one that should be compared to Olesen and Whittaker's classical analysis of professional socialization

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<sup>11</sup> This essay should be compared with the examples of autobiographies at the third person given by Philippe Lejeune (1977) in his classical analysis.

(1968). The daily life of the institution provided a series of encounters with patients and colleagues that served as material for scenes described in detail. Some of these encounters developed into disturbing experiences, causing disillusion and sometimes leaving the narrators wounded. Others remained true to the murky everyday reality of life on a ward. All induced the narrators into thinking over their maturation and readjusting their expectations toward work in the ASM. As they progressed, they learned to differentiate between their actions and reactions as a person and as a mental health professional. In the end, the narrators reflected on how their experiences had changed them.

The essays typically began by recalling the sense of confusion and chaos felt by their authors, whatever their background, as they came to the ASM. An occupational instructor without previous experience of work in a medical institution described in blunt terms: “Believing myself to be at ease, I recall that my first attitude toward patients was that I did not understand why they were there; they seemed to be just as like everyone else.” (#2, Male occupational instructor, 1974) The same impression was expressed by a psychiatric nurse who had previously worked for years in a public psychiatric hospital: “As soon as I came to [the ASM hospital], I wondered why I was there, and why patients were there, and how we could help them get out and acquire responsibilities outside the hospital.” (#59, Male psychiatric nurse, 1968) Some trainees recalled their disappointment in facing the banality and unspectacular nature of mental illness, contrasting it with their expectations of rich encounters with extraordinary individuals. A psychiatric nurse who was assigned to the care of impaired patients described herself as distressed and felt that it was her first real encounter with the reality of a psychiatric hospital, although she had several years of experience in a public psychiatric hospital behind her. (#41, Female psychiatric nurse, 1978) A few essays mentioned how this encounter with the ASM meant a loss for them of the world they had left behind. A licensed nurse recalled with nostalgia the schedule and sense of practicality he had had when he used to work in a general hospital. (#164, Male licensed nurse, 1980) A former jeweler hired as an occupational instructor confessed in less elaborate terms: “Of course, from time to time, I was nostalgic for the normal world where my former buddies from the workshop remained. But I had chosen to work with crazy people, I had to accept the consequences and get through the situation the best way I could.” (#6, Male occupational instructor, 1967)

These statements were not just rhetorical pronouncements made by enthusiastic trainees. They set the stage for what would be trainees' apprenticeships in the ASM. They participated in a narrative strategy that aimed at demonstrating how two different kinds of discoveries they would make were in fact profoundly tied together. At one level, trainees would discover the specific way of doing psychiatry in the ASM, which contrasted with both the coercion and routine that plagued asylum psychiatry and the technicality and coldness of somatic medicine. At another level, they would also go through a series of very personal experiences, which comprised the content of this psychiatry. In the essays, the convergence of these two levels was made clear in descriptions by narrators of finding their way by themselves to this art of caring for patients. This reflected a requirement made by the pedagogical team: trainees had to find out how to "create relationships" with patients by themselves. Their early confusion was brought on by the difficulty of determining how to act in the face of this requirement. Describing her initial irresolution concerning this requirement, a licensed nurse evoked a sense of paralysis: "I was upset by the void that surrounded me, by the lack of practical, concrete action. In one word, I did not know what to do or how to organize my day." (#34, Female licensed nurse, 1978) Another nurse described her impressions during her first days in the day hospital: "I feel like I am doing nothing (especially not my job as a nurse), like I am left behind by the team". (#62, Male psychiatric nurse, 1978) Two nurses mentioned the "panic" they felt upon arriving in the ASM faced with what seemed to be a meaningless experience. Another described herself as a "spectator" of life on their ward. What was needed was an understanding of the situation in which they were immersed. Learning to decipher their relationship with patients meant learning to uncover the true significance of the latter's requests or behavior, beyond their immediate meaning.

Only a sincere attempt to demythologize mental illness should motivate our action toward these patients. After having carefully observed them, we should try to detect what their needs are: what does the patient mean when he is acting this way, what is he trying to make me understand, what does he want to express, what needs is he expressing through his behavior? (#26, Male licensed nurse, 1970)

In recounting how they found their way out of this initial state of indecisiveness, trainees typically described two different attitudes. The first was to use "their (work) technique" to do something that seemed to be both useful and meaningful: technique, in these statements, referred either to the specific acts of nursing that nurses had learned before coming to the ASM, such as giving a bath, preparing pills, or organizing a packing therapy session; or, for occupational instructors, it referred to the specific craft they had learned and practiced in their



former position as professionals. A nurse thus commented on how “When I arrived, I could only find my place as a nurse, with respect to distributing the drugs I had to deal with. For me, the pill I had to give enabled me to find my place and to respond to the patient – according to my abilities – who expressed his fear, his anxiety or his symptom to me.” (#164, Male licensed nurse, 1980) As this quote suggested, technique seemed retrospectively to provide only a limited definition of competence. In using their techniques with patients, trainees had discovered that something else was at stake in the relationship and that their interactions had other meanings.

Technique, in this perspective, was contrasted with a personal bias toward others that was the basis for creating relationships. In statements which recall a wider critique of technology in the France of the 1960s and 1970s, a few trainees suggested that techniques tended to delete the personality of their practitioner. A psychomotor therapist thus commented on how she had hidden behind her technique to describe her work experience: “I am not deceived by this technique, which I do not always master anyway; indeed, the most important thing is my reaction in dealing with the patient and his illness, and no technique is enough if I do not add to it a reflection on feelings, thoughts, and fantasies that come to me in facing these patients.” (#66, Female psychomotor therapist, 1980) However, others alluded to a more complex way of using technique to elicit personal attitudes in themselves and in patients. A psychiatric nurse thus wrote: “Technical skills and theory have not entirely solved my concerns, my feelings, my hopes dealing with the patient”. But he then commented on his accomplishment: “As my daily feeling of authenticity was revived by my technical skills, both became inseparable” (#89, Male psychiatric nurse, 1975)

In other essays, the narrators would follow another pathway to competence. They would engage in a close relationship with patients, whom they would literally adopt, spending hours with them, deploying vast amounts of energy to satisfy their needs. The narrators would then recall moments when they found themselves identifying closely with patients, both of them becoming isolated from the rest of the ward. In some cases, this relationship would be encouraged by colleagues who would find relief in the fact that they would care for patients who were otherwise difficult. In other cases, colleagues would have sent warning messages that had not been understood or followed. Then as the relationships unraveled, the narrators typically understood that they had gone too far and that something else was at stake behind the immediate gratification they found in these relationships. In other essays, a disturbing

encounter with patients would have opened their eyes and they would then begin to communicate with colleagues. At this point, they would understand the value of teamwork.

The insistent discourse on teamwork in the essays was no more than proper tribute paid to what was probably one of the strongest dimensions of the philosophy of care in the ASM. The justification for teamwork was drawn from an adaptation of psychoanalytical theory. While in neuroses, cure came from a resolution of the transference neurosis of a patient toward his or her therapist, in psychoses, transference was considered to be so “massive” and provoked such strong counter-transference phenomena in therapists that it required teamwork to master its potentially destructive effects. In the essays, the discovery of teamwork included both the fact that one could talk about one’s emotions and feelings as well as the fact of accepting that one’s colleagues may have other perspectives on a given patient that could justify different ways of caring for him or her. Teamwork was consistently described as one of the most difficult dimensions of psychiatric work, as it meant taking into account the judgment of others:

The most difficult thing upon arriving at (the ASM hospital) was to work in a team, to take into account the person opposite me, to no longer be alone with the patient but to use the personality, the practices, the knowledge of each team member in a common care plan, and also to have one’s own qualities accepted, which is not always easy in an institution where many imagine they alone possess “knowledge” in psychiatry. What was the most difficult when I came to (ASM hospital) was to work within a team, to recognize the other facing me, to no longer stay alone with the patient but to use the personality, the practice, the knowledge of each staff members in carework done together, and also to make others accept my own knowledge, which is not always obvious in an institution where lots of people think they possess the “truth” in psychiatry. (#65, Female psychiatric nurse, 1977)

In the essays, teamwork eventually gave trainees a sense of both participating in a dedicated and supportive community and of belonging to a profession. One essay vividly demonstrated the process by which its narrator had been integrated into her team and the change in perspective it had meant for her. (#132, Female psychiatric nurse, 1971) It described two clinical cases from two different moments of her career, one at the beginning of her internship, the second at the end. The first case was the story, told in the first person singular, of a solitary nurse trying to cope with the strain of working alone with a difficult patient. Eventually, she found help when she dared ask the resident and her colleagues for support. The second case recounted the collective handling of a patient by the team, using primarily the first person plural and turning to the first person singular only to demonstrate how the actions of the narrator fit well into a broader scheme of action.

Relying on techniques and working in a team were thus both characterized, in different ways, as methods for trainees to distance themselves from their personal biases. The ideal result of training was conceived of by trainees as an ability to both be themselves, while at the same time reflectively engaging with themselves to maintain the right attitude toward patients. The term “distance” was widely used to account for this skill. A nurse who devoted her essay to consideration of “the phenomenon of distance in psychiatry”, contrasted this notion of “distance” – which she said was more specific to nursing – with that of “benevolent neutrality”, which, according to her, characterized physicians’ attitudes. (#188, Female psychiatric nurse, 1981) Distance needed to be adjusted according to patients’ needs, while neutrality was a general behavior. In this account, the idea of “limits” served to characterize both the way trainees had to maintain distance from patients – that is to refrain from identifying with them, to master their emotions and to not try systematically to help them at the expense of their own well being – as well as to the necessity of learning how to forbid things to patients or even to use constraint and coercion on some occasions. In other words, trainees had to develop “an awareness of their own limits” (#4, Female licensed nurse, 1968) in order to be able to impose limits on patients. An occupational instructor wrote quite eloquently: “Psychosis often carries within itself a terrible death of the mind. As caregivers, we can over-protect ourselves from the anxiety of this death and become hardened, become guardians of a sanctuary of shadows, and become shadows ourselves. But we can also try to live each day – in spite of the patients and by taking into account our limits – and sort out this difficult but fascinating dialogue between needs that we must learn to listen for, to hear, to discover and our response, which implies a long and honest apprenticeship in sincerity.” (#2, Male occupational instructor, 1974) Many essays thus developed a complex dialectic that was not always easily mastered by their authors. The same occupational instructor also wrote:

Getting involved in a relationship is our daily work, but we need to learn to disinvolve, to take distance in our work in order to better understand what we do, to work on our answers and temper our wish to cure at all cost. The love we think we give to patients is not enough; being a care worker involves learning techniques, we need to learn to use ourselves, but also to be ourselves, to rely on colleagues, but also enable colleagues to rely on us. This work never ends, and I believe this essay is only one step in the long journey I still have to make. (#2, Male occupational instructor, 1974)

In the end, trainees had not only learned how to work in the ASM, but also how to conduct themselves on a personal level. Encounters with patients were rich experiences which helped them formulate truths about themselves as both professionals and as persons. An occupational therapist recounted how her cases enabled her to gain fuller insight into who she was. “Nadine

helped me to think upon the why of my work in psychiatry and to deepen my knowledge of my own personality; she pushed me beyond my limits as a healthcare worker and looked at me as a person. I could not show myself other than how I was; she made me understand that we, as healthcare workers, were not sheltered from mental illness since we could sometimes feel the anxiety of existence in all its horror.” On a second patient, she reflected: “Dominique will remain someone whom I like a lot, who taught me about herself and what other patients could live through. She taught me that the most important aspect was not in technical skills, that they were a tool, but that sometimes one had to accompany the patient, as a human being who could reestablish in him or her a feeling of existence.” (#140, Female occupational therapist, 1980)

However, if they were profoundly committed to self-examination, trainees revealed disappointingly little about themselves. A reader outside the ASM does not learn much about their authors’ life outside work or even their basic social characteristics. Age could not always be inferred from what trainees chose to disclose of their personal identities – and the same would probably have often been said of gender had the essays been unsigned. The essays rarely reported indications on personal commitments to explain the authors’ attitudes toward their profession and mental illness. Some alluded to personal questions asked by patients – but never reported their answers; others mentioned reasons for identifying with given patients in a shared characteristic – typically, having both a young child. But I could find only one trainee reflecting on how a personal life event had interfered with her professional commitments. In a unique instance of self unveiling, a nurse recounted how, an afternoon, she came back to work after lunch feeling “depressed for personal reasons”:

Right after I came back, Mrs. V. rushes on me, crying, in a state of extreme anxiety. It is a true call for help: “Come along, I can’t stand it, I am not well, please, I need to talk to you”. She cannot know that, at this point, I am tempted to despair with her, and to let myself go, like her. (#189, Female licensed nurse, 1967)

### ***Constrained experiences***

The lack of personal commitment shown by trainees in writing about themselves might explain why they may produce a remarkable sensation of uniformity in their readers. While the essays certainly described very personal experiences had by their authors throughout their two years of training in the ASM institutions, they did so using strikingly similar narratives. Only a few of them seemed to be driven by a personal voice and not rely heavily on clichés.

Some essays even made a case for their limited inventiveness. A nurse thus began her piece with the following caveat: “The trajectory and thinking that I am about to recount here are not particularly original.” (#152, Female psychiatric nurse, 1978) Not only did many essays describe the same situations and episodes but, in the end, they also used many of the same expressions to convey what they had understood about the ASM concept of nursing.

Recent scholarship in the sociology of nursing has emphasized the ways in which contemporary healthcare work is becoming commodified and standardized as healthcare organizations are more and more subject to market forces. (Pine, 2011; Theodosius, 2008) Following on Arlie Hochschild’s pioneering work on emotional labor, it has been demonstrated how the requirement for nurses to perform emotionally well at work was an aspect of this process. The multiplication of guidelines is meant to provide nurses with a repertoire of adequate responses to both the emotional burden and moral demands of their work. In reaction to these trends, it has been argued that one should pay more attention to the everyday practice of ethics by nurses, which are rendered invisible and often more complicated by such regulations. (Bolton, 2000; Brodwin, 2013; Chambliss, 1996; Pols, 2006)

Much of this discussion has concentrated on the changing face of nursing in times of neoliberal reform, and many authors appear to regret a time when nurses’ self-expression was less subject to constraint. Yet nursing as a profession always comprised a definition of how nurses should behave both personally and morally. The abandonment of the vocational model of nursing in favor of a new model based on learning in the post-war period meant nothing else than a shift in the regulation of nurses’ behavior. (Bradshaw, 2001; Kniebiehler, 2008) The way ASM nurses had to publicly expand upon their experience during the numerous meetings organized in the institution was but one of the instruments introduced at the time for regulating their presentation of self. It was part of a process of shaping subjectivities, directed by the medical leadership of the Association, which aimed at producing model professionals. The uniformity of their narratives testifies to the standardization of self-talk that was produced in such settings. However, a close reading of these essays also demonstrates that one needs to be sensitive to the diversity of attitudes among nurses toward what they were required to do. Some enthusiastically participated in the ASM system of meetings and supervision in which they clearly found rewards. But many trainees also reflected on the strain they were under by the requirement to continuously disclose their inner feelings.

Many essays thus recounted the difficulties nurses had in complying with ASM leaders' requirements to actively participate in meetings and repeatedly unveil their self in front of colleagues and the medical hierarchy. A male nurse recognized that meetings were "engrossing" but he stressed the fact that they were: "difficult as they continuously questioned my acts vis-à-vis the team and patients". (#150, Male psychiatric nurse, 1977) Another nurse reflected on his difficulties in speaking in meetings: "I often thought: will I come across OK, or on the contrary will I not seem ridiculous or naïve? I was especially afraid to be evaluated by people who were more experienced than I was."(#164, Male licensed nurse, 1980) Describing the meeting system in which he had to participate, a nurse also explained that: "The care worker who comes here to talk about the patient has a duty to the others in the team; it is a reciprocal debt and it is right to bare oneself often, to highlight countertransference." But he went on: "But it is very difficult to report our behavior with the patient to the healthcare team." (#89, Male psychiatric nurse, 1975) Talking about oneself clearly was a strain for many of these nurses. It required an ability to reflectively engage with oneself that was probably not possible for all of them. The impersonality of many essays might well have been a way of escaping this requirement.

Yet the pressure described by these nurses was echoed in a few other essays that pointed out how the meeting system of the ASM fell short of stimulating the atmosphere of participation that was showcased by the association's leaders. A licensed nurse who had come to the ASM after having worked in the operating room and in an ICU, hoping that she would find more gratifying work experiences there, complained in length about the "silence" that dominated most meetings: "I mentioned in my introduction the void that I had felt my first months here. It was everywhere: we didn't say much between care workers; between patients, they all seemed to ignore each other somewhat; between patients and care workers, one fled the other to a certain extent." She went on:

There is no doubt that meetings serve as barometers to measure the atmosphere, sketch a portrait of the group or life on the ward. But this silence, what is it for? What does it hide? In this milieu, which I thought was open to discussion, precisely where the art of speaking, of listening was in good standing, well no! It seems that people are afraid to express their thoughts, that something prevents them from creating constructive relationships. What? I don't know! (#34, Female licensed nurse, 1978)

This nurse emphasized her isolation at work, but one of her colleagues expressed her disappointment with the ASM meeting system in even more vivid terms. While these were

supposed to support reflexivity, autonomy and self reliance, she found that they in fact had the effect of deferring responsibility:

Didn't we ourselves sometimes act so as to be reassured by the institution? Did we act responsibly and independently on a daily basis or were we completely dependent on a hierarchy that decided globally according to the Law? How did the team function? Was it a place for sharing, allowing each one to participate in open discussions on improving activities, to dynamically resolve conflicts, or was it a place where rules were perpetuated? (#152, Female psychiatric nurse, 1978)

She then went on by stressing that: "for a majority of care workers, any intervention on behalf of patients was always subjected to an examination of the Rule, as we asked our hierarchies for authorization to act."

These reports also invite us to pay more attention to the many ambiguities of trainees' self-presentation. While writing was certainly an exercise in composure, the essays revealed moments of true distress, which a confession could not heal. A few trainees had to admit the continuous strain put on them by their work in spite of the support provided by teams. A nurse noted, with rather low spirits: "In conclusion I would say that, as in every hospital, the patient has to suffer to recover. But here, more than elsewhere, the nurse participates in this suffering, as she has to accept the failures and disappointments, and sometime without any personal gratification." (#124, Female licensed nurse, 1969) Recounting his experience in the locked unit of the hospital, another psychiatric nurse also mentioned that "the elements that constitute our personality are subjected to permanent aggression" He then described at great length the strain that was put on him by a job which required that he constantly exert control over patients, even though he was supported by colleagues: "The simple act of closing a door with a key, knowing that there is a human being behind it who sometimes protests, makes me reflect each time, and sometimes I even now feel a terrible pang." This troubling experience was accentuated by the fact that some patients were sent to the locked ward for the wrong reasons, because of overcrowding in other wards: "sometime we feel that we are seen as a small prison, a place where agitated, dangerous or unbearable people are locked in." (#89, Male psychiatric nurse, 1975)

As in these essays, many others displayed an ambiguous if not ambivalent stance towards the emotional commitment that was required by the ASM team. Trainees would often reveal much about themselves despite their attempts at showing a professional face. An essay

entitled “Facing destruction” was a long and moving account by a male psychiatric nurse of the care of a 29-year-old alcoholic patient. (#45, Male psychiatric nurse, 1980) Eventually the patient died alone at his home, a few days after leaving the hospital against the advice of the medical team. The comment that followed on the story was a long and evenhanded reflection on the subtle art of managing hopes and frustrations in care. The narrator commented on the necessary neutrality and distance that a nurse should keep in regard to his patients. He stressed the need to refrain from imagining a brilliant future for patients who would not easily recover. While this comment demonstrated how its author was able to manage the limits of his commitment, he concluded his paper with a strong sense of defeat: “This perpetual struggle becomes exhausting. I remember that very often I had to tell him that I was there to prevent him from destroying himself, despite my doubts about the efficacy of my talk. I often felt helpless. Despite everything, I have always thought that it was possible to achieve greater wellbeing for Mr. C. He did not give us time to do this.”

Trainees were required to be straightforward. Yet silence was a way to avoid the duty of self-reflection. And it also was a way to avoid confrontation with the hierarchy. How their working conditions added to their physical and emotional burden was not to be mentioned. Rare were the trainees who were as critical as this nurse who, recounting a long and difficult case, commented: “it is at these precise moments that I wondered if there was not something ridiculous about the way we treated our young psychotics.” (#23, Female nurse, 1979) Evaluation was to remain at a personal level.

## **Conclusion**

An implicit argument throughout this article was that reform movements in twentieth-century psychiatry should not only be analyzed at the social, political and medical levels, but that they also had a narrative dimension. Reformers did not only – and perhaps not primarily – invent new ways of doing psychiatry and of organizing psychiatric practices. They also invented new ways of talking about these practices, which eventually created new ways of understanding oneself as a mental health professional. The essays written by ASM trainees are just a vivid example of how this way of talking about oneself was understood and adopted by practicing healthcare workers. In analyzing these narratives, one could then quote what Bakhtin said of the *Bildungsroman*. In these essays “(man) emerges *along with the world* and he reflects the historical emergence of the world itself. He is no longer within an epoch but on the border



between two epochs, at the transition point from one to the other. He is forced to become a new unprecedented type of human being.” (Bakhtin, 1986:23)

In this article, I have tried to highlight the narratives of mental health professionals working with people suffering from severe mental illness in 1960s France in order to show how they learned to discursively deal with the many strains that resulted from their daily life at work: the emotional strain of caring for difficult patients as well as the strain brought about by the requirement made by their supervisors to publicly regulate their emotions. I have shown that trainees displayed a variety of attitudes toward these pressures and that they used a variety of strategies to find their way through this maze, at times contradicting what was required of them. There certainly was not just one way of conceiving of oneself as both a professional and an individual in facing the many requirements of psychiatric care. What adds to this complexity is that there also were diverse ways of articulating both these identities.

What acting ethically meant in this setting, then, is not straightforward. The medical team of the ASM had sought to create a series of discursive techniques to regulate their subordinates’ ethical behaviors. Narrating oneself to others was meant to confront and find a solution to the ethical quandaries of everyday work. Yet it may be argued that it is precisely in maintaining a distance toward these techniques that trainees also were able to maintain self-continuity. As for other dimensions of psychiatric work, working with these techniques required skills that were unevenly distributed. Trainees demonstrated these skills by playing with the rules given to them by their supervisors. In the end, ethics emerged in the loopholes of practical regulations.

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