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3 WOMEN, MENTAL ILLNESS, AND PSYCHEDELIC THERAPY IN POSTWAR FRANCE

Zoë Dubus

Set and setting are central concepts in today's models of psychedelic-assisted therapy. However, this has not always been the case: set and setting are theoretical constructs that emerged from fierce epistemological debate.¹ Schools of psychiatry in some parts of the world have relied on it more than others. Researchers in France who engaged in experiments with LSD between 1950 and 1970 distinguished themselves by not employing this new technique. They did not even consider it.² As a result, the therapeutic results by early French psychedelic researchers were generally inconclusive, and patients routinely reported unpleasant experiences, which made the clinical findings even more unreliable.

Understanding why French physicians ignored set and setting models requires appreciating the context of postwar psychiatry in France. Conventional approaches downplayed the importance of patients' feelings, while the long-established French institutional system viewed psychiatrists somewhat distinctly first and foremost as scientists, not therapists. Moreover, during a period when psychiatry was still dominated by men, female patients were cared for and evaluated through a patriarchal lens.³ These contextual features help to explain how France developed its own psychedelic research culture, which ignored set and setting considerations in the psychedelic therapeutic context.

Two of the most influential French psychiatrists of the time studied the effects of LSD almost exclusively on women. By contrast, Erika Dyck and her colleagues gathered and transcribed over 1,000 patient observations at

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Hollywood Hospital in British Columbia and in three other clinics elsewhere in Canada, and she reported that only 27 percent of all recipients of psychedelic therapy were women.⁴ Consequently, it is crucial to examine how the experimental subjects' gender may have influenced the way that psychiatrists interpreted the phenomena caused by the psychoactive drug, as well as their disinclination to show care toward and support of their patients.

The first study of LSD in France began in 1951, when the psychiatrist Jean Thuillier at Sainte-Anne Hospital in Paris wrote to the Zurich-based Sandoz to request the drug “out of curiosity . . . to compare its effects to the delirium of certain types of psychosis.”⁵ At the time, Sainte-Anne was at the leading edge of psychedelic research; moreover, the hospital played an important role in training elite psychiatrists and broadly influenced French psychiatry as a result. This chapter is based on two archival documents resulting from research carried out by two “masters of French psychiatry”:⁶ Jean Delay (1907–1987) and Henri Ey (1900–1977). The first is a 1958 article published by the Sainte-Anne-based Delay and his intern Philippe Benda in the journal *Annales Médico-Psychologiques*,⁷ in which the authors present seventy-five patients, including seventy-two women who recently had been admitted to the hospital. The paper reveals some particularly horrifying sessions, which Ey, who worked at the Bonneval Hospital, noted both at the time and years later, saying that “Delay and Benda’s subjects were full of anxiety and said very little about states of euphoria.”⁸ As it happens, euphoric states were reported in the trials that used set and setting. To explore an early example of the clinical use of set and setting, therefore, it is useful to examine both Delay and Benda’s paper and Ey and colleagues’ unpublished report:⁹ were Ey’s nineteen female patients who were given LSD more inclined to report states of euphoria than those at Sainte-Anne?

THE THERAPEUTIC CONTEXT IN FRANCE

Between 1950 and 1970, at least eight research teams experimented with LSD on human subjects in France, but the drug never became part of a therapeutic process in any of these institutions. LSD remained an experimental substance, mainly used to induce temporary psychosis.¹⁰ In postwar

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Figure 3.1

Jean Delay, ca. 1960, Sainte-Anne Hospital, reproduced with the permission of Florence Delay.

France, neuropsychiatry was taught by academics who were rarely psychiatrists themselves. This curriculum was “almost exclusively theoretical [and it] was influenced by the neuro-biological medical tradition.” The careers were “quasi-dynastic,”¹¹ and knowledge and practices were passed from master to disciple. Delay was a member of this tradition of academic psychiatry and held the sole chair in mental illness in the entire country, at Sainte-Anne Hospital, the most prestigious institution of this time, from 1946 onward. He was part of what sociologist Robert Castel calls the “medical aristocracy,” who had a “technicist [vision] of his vocation: it was all about ‘treating cases’ rather than taking care of human welfare.”¹² Ey, on the other hand, was not working at Sainte-Anne: he chose to stay at the Bonneval public mental hospital south of Paris near Orléans (which now bears his name). However, from the 1930s onward, Ey traveled to Sainte-Anne’s on a regular basis to give psychiatry lectures. The approach at the great Parisian research hospital at this time was informed by biological psychiatry, which disregarded the

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patients themselves in favor of concentrating on the scientific study of the physiological and neurological aspects of mental disorders.

This scientific and biological paradigm was dominant when these two authorities became interested in LSD in the early 1950s. As such, their first approach was to integrate LSD into the conceptual framework of the psychiatric treatment in France at the time: shock therapy. At a time when anti-psychotic drugs were not yet available,¹³ the medical interventions resorted to lobotomy, electroconvulsive therapy (ECT), insulin shock therapy, and amphetamine shock treatment in their attempts to treat mental illness. The idea was to trigger a “dissolution of the [ailing] spirit,” which then could be reconstructed with the psychiatrist’s help—in a way, it was hoped, that would eliminate the pathology. Delay was highly involved in the research into such treatments.¹⁴ In fact, Thuillier described his approach as “too much science and not enough psychology; too much therapy and not enough analysis.”¹⁵ Hence, LSD arrived amid this therapeutic backdrop: the shock triggered by the experience must lead to the patient’s improvement.

Some medical doctors, including British and American therapists, soon realized that LSD was even more beneficial when administered as part of a positive experience. They therefore discarded the notion of “shock” and began to develop the concept of “set and setting,” a new approach that involved taking care to prepare the patient, creating a therapeutic alliance to give the subject a sense of trust and security in this relationship, and ensuring that the environment for the drug session was comfortable and cozy.¹⁶ This new method called into question the psychiatric medical practices of the time.¹⁷

For Western medicine, attention to set and setting was novel and stood in stark contrast with the French model of psychiatry. The historian Aude Fauvel (2013) has explained the discrepancy between French and Anglo-American therapists and how they accounted for patients’ feelings:

Indeed, English law already offered the guarantee of always being able to summon *habeas corpus* and to demand to be heard by the courts. However, this procedure, which is typically initiated under exceptional circumstances, was diverted by mental patients to bypass the silence of the asylum. To prevent

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this, there came a point in 1845 when the authorities even resorted to creating civil commissions to compile patients' complaints, without allowing doctors to oppose them. Because of this particular legislation, psychiatrists in Britain began to listen to the sick more than they did anywhere else.¹⁸

In contrast, consider the words of the French psychiatrist Paul Balvet, who said the following in 1950: "I admit it. I am my patient's enemy; in this way, I am the heir of the society that hates him."¹⁹ For Balvet, a sadistic current was running through all forms of psychiatric intervention until the point where therapists abandoned their subjective attitude toward their patients and developed an empathic bond with them. However, it was difficult to be empathetic when asylums were overcrowded, often unsanitary, and violent places.²⁰ In 1952, another French psychiatrist, Henri Baruk, described the astonishment of therapists who adopted a caring approach and realized that "behind the apparently extinct or dead masks of the 'insane,' [is] an individual with a vibrant personality, with feelings."²¹ He denounced the attitude of doctors who preferred to "take the easy way out" by avoiding "a daily effort of moral understanding," and instead were "destroying patients' reactions through trauma, shock, or brain destruction. The sick are thus transformed into apparently satisfied slaves, and all this is happening in a supposedly modern hospital."²²

DESCRIPTION OF THE PATIENTS AND OF THE THERAPEUTIC METHOD

Nothing is known about Delay's patients other than that they were recently admitted to Sainte-Anne (which implies that the hospital staff did not really know them), suffering from neurosis or psychosis, had limited education, and came from relatively poor backgrounds. Information about their age (including average age) is not available, and neither is there any other biographical information. The reasons for their institutionalization and how often they were admitted are also unknown, beyond the general diagnosis of neurosis or psychosis. Since there were usually unhelpful treatments for mental illness, patients went in and out of institutions throughout the course

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of their lives. All the patients in Delay's study were institutionalized in compulsory care at Sainte-Anne (i.e., without their consent).

The article only presents an account of the sessions carried out with the patients, without individualizing them: the aim for the authors is not to present cases, and the transcription of the recordings is only partial. There is no indication that the treatment had been explained to the patients or that they were aware of what they were going to experience. These individuals received little attention during their LSD experiences. Rather, in his report on the treatments, Delay describes various types of reactions to the drug and concludes that he perceived LSD's possible clinical applications to be negligible. The seventy-two women in his study were perfectly interchangeable, and no details were provided about them as individuals. Moreover, the authors mentioned "minimal observer interference." The use of the word "observer" reveals the medical practitioners' attitude toward the experiment: they were not actively supporting the patients but rather taking a scientific approach, coldly observing phenomena. Furthermore, the various reactions to LSD were referred to as "arrays," which they used to capture the range of states that the patients were observed to have experienced. The duration of the sessions varied greatly, from as little as a few minutes to as many as two hours, at which time Delay would inject them with chlorpromazine to stop the psychedelic reaction; on the other hand, Ey's sessions lasted between one and seven-and-a-half hours.

Both Delay and Ey described their methods of applying the drug in a fairly comprehensive way (method of administration, dosage, duration of the session, and other details), but the actual therapeutic method was not specified. In some cases, there are hints about the attitude of the health-care team, but no specific information describing the therapeutic framework or approach. For example, in Ey's department, the notes reported "[s]creams when we try to hold her down."; doctors "force her to get up and look at herself in a mirror." This was a recurring issue in most LSD studies in France at that time: faced with an absence of established therapeutic techniques, each research team essentially had to start all over again and struggled to develop their protocols. As the historian Sarah Marks has noted, the methodologies used in psychedelic therapy were very rarely reported in the scientific literature of the time: it was in memoirs written decades later that psychiatrists

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like Stanislav Grof and Milan Hausner provided details of their anaclitic therapies, which integrated the concepts of set and setting. Indeed, set and setting are a variety of techniques developed from the mid-1950s onward to improve the management of patients under the influence of psychedelics in order to promote therapeutically beneficial experiences. Therapists considered the patients' state of mind, prepared them for the experience that they were about to have, organized the room so it was comfortable, and adopted a supportive, encouraging, and comforting attitude when necessary. At the time, the medical profession was very reluctant to adopt such practices: some doctors "even advised against shaking hands with patients, fearing interference with the transfer process."²³

In Bonneval, Ey treated nineteen women with LSD, six of whom were institutionalized on a "voluntary basis," which in this case meant based on the opinions of the patient's relatives rather than what she herself wanted, and twelve were in an open ward attached to the mental hospital, which they entered of their own free will. Six of the women had received the most basic school education (*Certificat d'études primaire*), given between eleven and thirteen years of age, proving the student had acquired a basic level of knowledge. As with Delay's report, their intelligence was generally referred to as inferior. Table 3.1 summarizes both papers.

The observations of the LSD experiences recorded in the two reports are dominated by fear (mainly of going mad), shame (of not knowing how to answer the questions or being laughed at by observers), and silence (during the session or in the days afterward). Neither Delay or Ey mentions any approach to guiding or assisting the women during their experiences. Ey repeatedly refers to a "depressive tone" (*tonalité depressive*) in the majority of the experiences, but not whether he had adopted a particular approach to help the women he treated navigate these difficult moments.

Childhood or adulthood trauma often lay behind the problems, ranging from depression to psychosis, that brought these women to the hospital. Early childhood abandonment, being an illegitimate child brought up by people other than her parents, the absence of affection during childhood, and physical violence were typical. During adulthood, heartbreak, domestic conflict, dread of the prospect of a new pregnancy, problems pertaining to

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Table 3.1
 Comparative descriptions of the LSD sessions carried out by Jean Delay and Henri Ey

| | Delay and Benda (1958) | Ey and Colleagues (1959) |
|--------------------------------------|--|---|
| Gender | 72 women—3 men | 19 women |
| Age | Unknown | Average age: 30 years old Between 17 and 59 years old |
| Education level | Limited | 6 with Certificat d'études primaire 1 with a more advanced diploma 4 without Certificat d'études primaire 8 with no curricula mentioned (education deemed as "bad") |
| Social background | Modest to poor | Modest to poor |
| Preparation | Unspecified | Very basic, not systematic |
| Number of sessions | Several sessions in a quarter of the cases Unspecified number | Sole session, save for one patient |
| Dosage | Between 1 and 2 μg per kilogram of body mass | Between 75 and 150 μg 10 = 100 μg / 8 = 150 μg / 1 = 75 μg |
| Administration | Mostly injection Oral = 10 | Injection = 16 / Oral = 4 (one patient had two sessions) |
| Duration | 1 to 2 hours | Between 1 and 7.30 hours |
| Chlorpromazine to end the session | Systematic | 12 cases 8 unspecified cases |

sexuality, and physical and sexual violence were also regularly mentioned. Hence, although in some cases the memories discussed under the influence of LSD were positive—"I saw the boarding school park; I saw flowers, I picked purple violets. A perfect life, these flowers that smelled good"²⁴—their content much more often reflected pain, fear, and stress: "It seemed to me that he was there, I was overcome by fear"; "Her mother pushed her away when she wanted to comfort her"; "I saw my own rape and it was terrible"; "I thought about the sad child I was, with no mom." Several women shared the same symbolic experience about the meaning of colors: for instance, red symbolized "maternal hemorrhaging." In addition, the trauma of the war years was still firmly embedded in people's memories: the color green was reminiscent of the uniforms of German soldiers. Memories of the war surfaced on a regular basis in both Delay's and Ey's patients. Delay and Benda

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reported: “Corpses piling up like in 1940. I saw Daddy again with lots of little worms all over him.”²⁵

In 1950s France, psychiatrists were unconcerned about notions of patient consent regarding the treatments that they carried out. In Delay’s and Ey’s departments, preparation for the session was either nonexistent or extremely rudimentary. As far as follow-up after the sessions went, Delay reported that the patients talked to each other about the psychic phenomena they experienced and openly questioned the efficacy of their treatments, which strongly suggests that nobody had explained to them the purpose and potential value of their experiences. Ey’s Bonneval report is unclear about whether each patient was forewarned of the effects of LSD, but it seems clear that she was often informed *after* the injection. The details were finally provided at the eighteenth observation: the patient was told that she was going to experience “feelings of cenesthesia, dry mouth, and blurred vision. In order to avoid the possibility of suggestion, no additional details were given.”²⁶ This insufficient preparation partly explains the distressing tone recorded in the transcribed sessions, given that the patients had no idea what their experience of LSD would entail. In addition, several accounts in Ey’s report mention doctors coercing patients into accepting the treatment, as in the observations of a twenty-seven-year-old nurse named Mireille F., who had been suffering from pangs of paroxysmal anxiety over the previous two months: “Anxious and recalcitrant. Only reluctantly accepts the injection.” She received an injection of 100 μg .²⁷

Regarding the issue of the presiding doctors and attendants and the patients establishing a therapeutic alliance, the Sainte-Anne patients were new to the institution, so they were likely unfamiliar with the ward staff or the doctors. Moreover, institutionalized mental patients at that time saw doctors only on rare occasions, which prevented them from establishing a genuine bond. The two reports indicate that the therapists placed a great deal of distance between themselves and the patients, and in some instances they displayed behavior designed to induce fear and anxiety in the patients during the session with LSD. In 1950, the journal *Esprit* published an issue devoted to the study of the ethics of psychiatric interventions. One paper called into question the notion of “personality rape,” which patients undergoing

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narco-analysis²⁸ were subjected to in order to break their resistance and force them to tell their secrets against their will.²⁹ Yet from the 1940s to the end of 1960, Delay, Ey, and their French colleagues were particularly fond of this technique. They used LSD within a therapeutic model in which the patient's consent was deemed irrelevant. With LSD, Ey expresses his satisfaction at having been able to learn information that a patient "had never revealed" and other things that she had "concealed." In reaction, in the reports of both therapists, some patients refer to the substance as a "truth serum."

While their reports indicate that there was little emphasis on set, both Delay and Ey paid more attention to the setting. The room where Delay's experiments took place was filled with plants, with artwork displayed on the walls. The drawings and pictures were not just decorations; they were considered part of the experiment. Music was also occasionally played in Delay's sessions. In Ey's experiments at Bonneval, there was no music, but the room was painted sea green and decorated with a drawing and a plant. However, these tentative steps into issues of setting do not appear reflected in the way that the session was guided, which left much to be desired: in addition to the distant attitude and coldness of the observers, patients complained that they were often left alone, even when they were having a bad experience with LSD.

RESEARCH ANALYSIS

The first doctoral dissertation on the therapeutic use of LSD in France was carried out in 1957 by Daniel Widlöcher under Delay's supervision. Widlöcher was the first French psychiatrist to consider LSD as an adjunct to psychotherapy, and he used it with at least nine female patients in Sainte-Anne; he noted:

In our observations, anxious and depressive reactions were more apparent among the patients who were hospitalized in open wards, where they could routinely criticize the appropriateness or the results of the treatment. On the other hand, among those who were institutionalized, for whom such problems were rather irrelevant compared to the issue of their institutionalization and of the duration of their stay, the experience was much easier to endure.³⁰

Widlöcher tacitly admitted that institutionalized patients were less inclined to criticize and comment on the merits of their treatment, and more submissive and cooperative in order to be treated better and thus allowed to leave sooner. Because they were less inclined to rebel, the doctors did not give as much thought to how they were treated. The status of these women alone—that of patients often locked up against their will—does not explain their relative lack of resistance: gender played a key role in this instance. Discretion and submission were fundamental qualities for Frenchwomen in the postwar era.³¹ From the perspective of institutional psychiatry, to go against this supposed “nature” was a transgression that could be interpreted as a worsening of the individual’s mental state, and thus may lead to more stringent conditions of confinement. Within the asylum, women had more to lose than men if they resisted treatment: for the latter, unyielding and resistant behavior could be understood as a sign of recovery: the patient was beginning to recover his virile, “manly” qualities. In the words of the sociologist Joan Busfield (1989), “it would be impossible for any institution to escape the sexism that is endemic to society.”³²

GENDER, DISTANCE, AND A LACK OF EMPATHY

A wealth of scholarship now underscores a clear link between the oppression of women in society, particularly in connection with birth management and the onset of mental illness.³³ Several of Bonneval’s patients were institutionalized for depression: most of them had suffered numerous and repeated pregnancies, late miscarriages, and difficult deliveries resulting in the death of the child. These tragic events were often what lay at the root of their mental distress. One of the women’s valid fears was about getting pregnant again. In addition, the traumas that they experienced significantly affected their married lives and sexuality³⁴ and could lead to domestic violence. (It is important to note that in France, access to contraception was authorized only in 1969, via a law that did not enter into force until 1972.)

The way that the doctors judged these women is clear from their notes in Bonneval: thirty-six-year-old B., who had eight children in ten years, saw her third child die in childbirth, which triggered her first psychotic episode.

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Her patient file reads “household neglect”—in other words, a pathological disorder linked to not keeping a tidy home. They noted her apathy, “with a general air of sadness”; her “impulsive runaways”; and her “oddities.” B. no longer fully conformed to the female roles assigned to her by society. Her behavior was therefore interpreted in pathological terms according to a process that Phyllis Chesler analyzed in her 1972 book *Women and Madness*.³⁵ She described what a feminist way of caring for these women would look like: “A feminist therapist believes that a woman needs to be told that she is ‘not crazy,’ that it is normal to feel sad or angry about being overworked, undervalued and underpaid; that it is healthy to harbor fantasies of running away when the needs of others (aging parents, needy husbands, demanding children) threaten to overwhelm her.”³⁶

In French mental institutions, and in society more generally, gentleness, compassion, and empathy were attitudes typically ascribed to women. They were perceived as inherently “feminine,” and therefore potentially pejorative. In a psychiatric context still dominated by men, these qualities were provided, in the best-case scenario, by female nurses.³⁷ Psychiatrists, for their part, needed to maintain a cold, stern manner when faced with suffering. For example, although the doctors realized that loneliness disturbed their patients, the latter were often left alone for the duration of the experiment. One of them “begged not to be left alone,” while another called for help: “You have to help me, you can’t leave me.” According to the notes, thirty-six-year-old Ms. A “throws herself to the ground, tries to rip her clothes off and screams—it is impossible to get through to her.” However, a few minutes later, Ms. A was left alone. The doctors noted that “her demeanor and her face show panic.” In fact, Delay and Benda entitled one of their subsections “torture,” in which seven of their subjects exhibited similar terrors. They transcribed a patient as saying: “Everything is hostile around me, nothing is familiar, stop torturing me,” and “I don’t understand how you can make people suffer like that.” This transcript is not followed by any comment about advice aimed at helping the patients, who clearly begrudged the doctors for their cold manner: “an expressionless face. The closer I wanted to get to him, the more distant he seemed”; “You just stood there motionless, without a humane gesture. Instead of comforting me, you did nothing”;

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“You have a nasty look”; and so it goes on. As for the psychiatrists, they simply mention the “benevolent neutrality of the observers.”

Both documents show a clear lack of empathy on the part of the therapists. Indeed, the Bonneval report reveals sessions dominated almost entirely by terror and suffering; yet it is clear that the physicians had their share of responsibility in leading the sessions in this direction, as the following example illustrates. Twenty-four-year-old Mrs. D. was given LSD orally five days after arriving at Bonneval. The session lasted seven hours and fifteen minutes: “Very strong levels of anxiety. We have to insist to make the patient agree to drink water containing 150 μg of LSD. Only *then*³⁸ do we warn her of the likely course of events.” Two hours and forty minutes into the session, the doctors tried to make her believe that the water they had made her drink “contained no medication.” It is hard to understand why doctors would suggest something so terrifying—namely, that the patient’s disturbance was organic to her rather than drug induced. Moreover, the doctors later recorded that “the patient stubbornly and continuously refuses to admit the hypothesis put forth to her, she clings onto the conviction that she has been drugged, it is a link that connects her to reality. To deny the existence of this link is to admit her insanity!”

Another alarming session involved seventeen-year-old Simoneis, described as a “pervert” who had been prosecuted for a crime against decency. The doctors once again tried to upset their patient by making her believe something that they knew would disturb her: “The patient is very vigilant and she retains her self-control perfectly. However, she seems to panic when she is told of the prosecutor’s (fictitious) visit.” In addition to these attempts to destabilize the patients, members of Delay’s team came in and out of the room, asking questions. In seven instances, the patient became aware that she was being laughed at and that the observers were laughing at the situation: “Please, Madam, this is not funny. I didn’t think it, I can see it; they laughed, they laughed at me; it must be fun to watch the interrogation.”³⁹

Whether the doctors or the nursing staff were actually mocking her or not—though the quoted remarks by several patients suggest this possibility—is irrelevant: what I aim to demonstrate here is that there was a major difference between the emerging class of psychedelic therapists in other jurisdictions, who paid attention to the set and setting, and the French doctors, who did

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not. The former would have sought to avoid situations that could lead to patients having a bad impression of their experiences. In France, the classic shock therapeutic model created an environment of unease and paranoia in these early LSD treatments; the fact that these sessions were more experimental than therapeutic led the doctors to test their patients' reactions, with no regard for their feelings.

SYSTEMATIC EROTICIZATION

One of the reasons for doctors keeping their distance—beyond mere training, which recommended very minimal physical contact with patients—was in the systematic eroticization of the behavior of these vulnerable women. While scientists, especially Anglo-American researchers, very quickly noticed and recognized that individuals under the influence of LSD as part of a therapeutic process needed contact and had to be carefully looked after,⁴⁰ the patients' attempts to get close to the doctors in both Bonneval and Sainte-Anne were seen as “erotic pantomimes.” For example, during sessions at Sainte-Anne, one patient attempted to lean on the doctor's shoulder and another tried to take his hand and apologized for the lack of respect. Delay and Benda, however, were aware of the need to establish physical contact with patients who were seeking support, given that they cited the psychiatrist Ronald Sandison's recommendation to that effect in their introduction. They also noted, “Various prompts from the observer interfere with the spontaneous behavior” of the patients, such as interjecting to encourage them to lie down. Instead, the doctors simply recorded observations about the patients' actions throughout the session be published in the reports. Indeed, one patient refused to lie down because she thought that her behavior was being interpreted as erotic: “I will not lie down, because they said that I was masturbating.”

In Ey's ward, one patient was “forever holding the physician's hand. She strokes it in a manner which is unambiguous. . . . The patient can't stand it if the doctor moves away from her. It appears that this physical contact, in addition to its erotic nature, is also a way of ‘orienting’ herself.” Another woman asks the doctor to “sleep” with her in order to “watch over [her] and

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keep [her] company.” She adds: “I don’t want to be alone” (this patient was in a terrified state throughout the entire session), which Ey understood to be a “furtively erotic demeanor” rather than a sign of fear. It should be noted that at that time, the word “sleep” was still commonly used to mean “lie down,” and it did not suggest an obvious sexual connotation. Upon examining a third patient, who had been raped and was reliving the experience while on LSD, the doctors describe the young woman’s actions using sensual words.

Colette is eighteen years old and was diagnosed as follows: “Severe neurosis with hysterical tendencies.” She had recently been raped by a fifty-year-old man. The doctor observing her became the object of transference, a psychoanalytic term meaning the displacement of feelings, thoughts, and behavior onto someone other than the one from whom the original feelings, thoughts, and behavior had arisen. She mistook him for her rapist and tried to slap him. She shouted, “You have broken me” and lifted her skirt. The doctor commented, “Very erotic attitude—raises her skirt—rubs her thighs—violent gestures toward the doctors—repeats the words: bastard, disgusting . . . ‘Doing that with men, it’s too much’.” Her attitude was repeatedly described as erotic and ambivalent. At the end of the session, the doctors nevertheless concluded that “the patient did not relive the traumatic rape experience. . . . The main thing which became apparent was a latent eroticism, combined with marked aggressiveness.” The observations, which run over three pages, are quite explicit about her reliving the rape and make for particularly difficult reading. In addition, the aggressiveness that was mentioned earlier continued for several days, directed toward her presiding doctors, which they took to be proof of her transference, as well as her resentment toward them for making her relive her rape.

As mentioned here, many patients were afraid of being left alone and tried everything to convince the doctors to stay with them. Their pleas were often desperate, but the doctors tended to interpret them as erotic. For instance, thirty-two-year-old Jacqueline was prone to severe anxiety. She first called for her mother, then sobbed, and finally she thought she was going to die. The doctors noted that her anxiety was “extreme,” and that she repeatedly made known that she did not want to be left alone. Then, they reported: “Erotic attitude, smiles, attempts to caress and grope, cuddly

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attitude. . . . Very rapid thymic oscillations ranging from the most intense anxiety to eroticism tinged with the fear of being abandoned.”⁴¹

Physical contact between therapists and patients was indeed challenging in these institutions. As the historian Véronique Fau-Vincenti has shown, some female inmates were not shy about writing passionate letters to the interns they liked or walking around naked when there were men on the ward.⁴² However, what is noteworthy here is that every attempt to make contact during both these LSD studies was systematically interpreted in erotic terms.

COMMUNICATION BREAKDOWN

At the end of the day, how could female patients properly share their life stories to facilitate therapy under such circumstances? Under the gaze of a male psychiatrist, some patients felt embarrassed and ashamed of their behavior and the image they presented. It should also be noted that one observer on Ey’s team remarked that a patient who was “still young” had a “well-groomed” appearance. Because women were used to being assessed by what is now referred to as the “male gaze,” patients were concerned about their appearance: “What a show I am giving you”; “I must look silly, unkempt. I feel belittled, ridiculous, I don’t know what to do with myself”; “You are watching me, I don’t like being watched”; “I must look like a dimwit.”

The shame and embarrassment expressed by patients indicate that they did not feel safe; this was not an environment where they could be themselves. On the one hand, they were still weighed down by social conventions: for example, they had to try to look their best to maintain their femininity. If they did not, that would immediately be seen as a form of pathology, as previously shown. Yet the fact that they were being examined by men of higher social standing, who were better educated and had authority, who occupied the role of experts in relation to them, and who had control over their diagnosis and the duration of their institutionalization was particularly problematic. The doctor’s power over these women was effectively almost absolute: he could decide to keep them in the asylum or allow them to be released, give permission for visits, or state that a particular kind of behavior deserved

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punishment. Thus, being worried about what the psychiatrist might find about you against your will (the idea behind the “truth serum” mentioned by Delay’s and Ey’s patients), as well as knowing that the scrutiny accompanying such discoveries could lead to an indefinite institutionalization due to your “madness” was not the ideal set and setting.

Nowadays, the inability to let go during the psychedelic experience is recognized as a major source of anxiety for subjects.⁴³ As early as 1959, the Canadian anthropologist Anthony Wallace had demonstrated the influence of certain parameters on the LSD experience. One of these factors was whether, from a cultural perspective, those experiencing a psychedelic session should fear being punished for their hallucinations.⁴⁴ In the Western world, this question was answered in the affirmative, and since the nineteenth century, it had been coupled with a pathological dimension. The female patients in question were aware of this fact and would sometimes strategically repress psychological symptoms for fear of an even more severe psychiatric diagnosis, or they would feel particularly helpless and terrified at the appearance of such symptoms which, for them, confirmed the diagnosis of madness. These women also assimilated the idea that if they expressed strong emotion, they would inevitably be seen as mad and as deviants from their femininity.

The treatment was aimed neither at psychotherapy nor specifically at reliving, processing, and accepting painful memories. The shock method was predominantly part of the context of biological psychiatry, using LSD as a form of shock therapy. After the chlorpromazine injection, which put an end to the session, the patients were once more left on their own. Yet it was sometimes precisely during this period, when the effects of LSD were waning and the patient was coming back to her senses, that she most needed to verbalize and analyze her experience. As one patient noted, “I would have liked to express my feelings.” This reflection was noted in the paper but not commented upon.⁴⁵

For Delay and Benda, it all just amounted to patients’ complaints. The word “complaint” is used seventeen times in the first part of their paper; not only does this mean that the description of LSD’s effects was expressed in purely negative terms, but also that these comments became tiresome for the doctors. It emphasizes the stereotype that women complain all the time. Yet

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the comments that are actually reported reveal that many statements alluded to a state of euphoria: one patient commented on the shape-shifting lines by saying, “It’s funny”; another saw a plant and cried, “How pretty!” The way that these remarks were interpreted by supposedly neutral observers was in reality highly biased, even condescending.

Finally, these women found it impossible and frustrating to talk about their experiences when faced with psychiatrists who came from a very different social and cultural backgrounds. The patients at Sainte-Anne and Bonneval came from poor socioeconomic backgrounds, both economically and culturally. This created yet another barrier between the therapists and their patients, who were ashamed and conscious of the fact that they had difficulty expressing their feelings. They feared that words would fail them and they would be laughed at if they used expressions that were perceived as stupid. Many found solace in silence and refused to answer questions—in some cases, this lasted for several days after the experience, thus rendering any form of psychotherapy impossible. Their silence may indicate that some of these women attempted to resist treatment that they regarded as a form of brutality.⁴⁶

CONCLUSION

Patriarchal and patronizing relationships between male psychiatrists and female patients is a key factor explaining the complex phenomenon of the systematic inattention to the notion of set and setting in early psychedelic therapeutic contexts in France. From a broader perspective, an intersectional frame of analysis could be used to focus on the impact of class on patients’ lived experiences, and on the ways that therapists supervised—and neglected—those experiences. For example, in a fascinating book, the sociologists Claudine Herzlich and Janine Pierret demonstrate very clearly that people from lower social classes are considered tougher and better able to endure pain than those of higher social class. This implies that the medical profession is less interested in alleviating the suffering of the poor, whether physical or mental.⁴⁷ These women are therefore subjugated on three fronts: as patients facing doctors, as women facing men, and as proletarians facing a social and cultural elite.

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Henri Ey and Jean Delay, as luminaries of the psychiatric profession of their time, had a decisive influence on steering subsequent French therapists interested in LSD away from considerations of set and setting. French researchers, particularly Delay, were pioneers in research into neuroleptics—drugs that lead the subject to experience indifference or ataraxia, reverse action mechanisms of LSD, which tends to evoke deep meaning and connection. With this drug model in mind, the psychiatrist’s involvement was seen as unnecessary during such treatments—so much so that the French psychiatry professor Yves Pélicier explicitly referred to “the relational and psychological abandonment of the patient”⁴⁸ that resulted from this type of medication. It would seem that from their emergence in the 1950s, psychedelic theories were at odds with French psychiatry.

NOTES

1. Ido Hartogsohn, *American Trip: Set, Setting, and the Psychedelic Experience in the Twentieth Century* (Cambridge, MA: MIT Press, 2020).
2. Zoë Dubus, “Marginalisation, stigmatisation et abandon du LSD en médecine,” *Histoire, médecine et santé*, no. 15 (2020): 87–105.
3. Phyllis Chesler, *Women and Madness* (New York: Doubleday, 1972); Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830–1980* (New York: Penguin Books, 1987); Lisa Appignanesi, *Mad, Bad and Sad: A History of Women and the Mind Doctors from 1800 to the Present* (London: Virago, 2009).
4. Erika Dyck, “What about Mrs Psychedelic? A Historical Look at Women and Psychedelics” (lecture, Breaking Convention, University of Greenwich, London, August 17, 2019): <https://www.youtube.com/watch?v=T04atyEQqUk&t=112s>.
5. Jean Thuillier, “Ma rencontre avec Albert Hoffman, l’inventeur du LSD,” *Bulletin de L’Association des Amis du Musée et du Centre Historique de Sainte Anne* (October 2006): 1.
6. Alain Ehrenberg, *La fatigue d’être soi: Dépression et société* (Paris: Odile Jacob, 2008), 68.
7. Jean Delay and Philippe Benda, “L’expérience lysergique. LSD-25. A propos de 75 observations cliniques,” *Encéphale*, no. 3/4 (1958): 169–209; 309–344.
8. Henri Ey, *Traité des hallucinations* (Paris: Masson et Cie, 1973), 568.
9. Henri Ey, Claude Igert, and Gabrielle Lairy, “Etat des recherches portant sur les hallucinogènes et les hallucinolytiques effectuées en 1958” (Avant rapport semestriel, Bonneval, mai 1959), no. 380 in Fonds Ey (7S), Archives municipales de Perpignan.
10. See, for instance, the research by Pinchas Borenstein, MD, in Villejuif, France: Pinchas Borenstein, Philippe Cujo, and Claude Olievenstein, “Epreuve à la iethylamide de l’acide

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- lysergique (LSD-25) et thérapeutiques psychotropes: étude électro-encéphalographique," *Annales Médico-Psychologiques* II, no. 2 (1965): 237–246.
11. Jean Garrabé, "Les chaires de clinique des maladies mentales et des maladies nerveuses à Paris," *L'information psychiatrique* 88, no. 7 (2012): 551.
 12. Robert Castel, "Genèse et ambiguïtés de la notion de secteur en psychiatrie," *Sociologie du Travail* 17, no. 1 (1975): 57–77.
 13. Anne Caldwell, *Origins of Psychopharmacology from CPZ to LSD* (Springfield: Thomas, 1970).
 14. Edward Shorter and David Healy, *Shock Therapy: The History of Electroconvulsive Treatment in Mental Illness* (Toronto: University of Toronto Press, 2007).
 15. Jean Thuillier, *Les dix ans qui ont changé la folie* (Paris: Robert Laffont, 1981), 25.
 16. Maria Mangini, "Treatment of Alcoholism Using Psychedelic Drugs: A Review of the Program of Research," *Journal of Psychoactive Drugs* 30, no. 4 (1998): 381–418.
 17. World Health Organization Study Group on Ataractic and Hallucinogenic Drugs, in *Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry & World Health Organization*, vol. 152 (Geneva, Switzerland: World Health Organization, 1958)
 18. Aude Fauvel, "Cerveaux fous et sexes faibles (France, 1860–1900)," *Clio Femmes, Genre, Histoire* no. 37 (2013): 54.
 19. "Médecine, quatrième pouvoir? L'intervention psychologique et l'intégrité de la personne," *Esprit* 18, no. 165 (1950): 387.
 20. Nicolas Henckes, *Le nouveau monde de la psychiatrie française. Les psychiatres, l'Etat et la réforme des hôpitaux psychiatriques de l'après-guerre aux années 1970* (Paris: EHESS, 2007); Adeline Fride, *CHARENTON ou la chronique de la vie d'un asile de la naissance de la psychiatrie à la sectarisation* (Paris: EHESS, 1983); André Roumieux, *Je travaille à l'asile d'aliénés* (Paris: Champ libre, 1974).
 21. Henri Baruk, "La Psychochirurgie frontale peut-elle se justifier?" *Revue PhiloFranceue de la France et de l'Étranger* 142 (1952): 393.
 22. Baruk, "La Psychochirurgie frontale peut-elle se justifier?" 420–421.
 23. Sarah Marks, "From Experimental Psychosis to Resolving Traumatic Pasts: Psychedelic Research in Communist Czechoslovakia, 1954–1974," *Cahiers du Monde Russe* 56, no. 1 (2015): 70.
 24. Delay and Benda, "L'expérience lysergique," 202.
 25. Delay and Benda, "L'expérience lysergique," 208.
 26. Ey et al., "Etat des recherches portant sur les hallucinogènes et les hallucinolytiques effectuées," 64.
 27. Ey et al., "Etat des recherches portant sur les hallucinogènes et les hallucinolytiques effectuées," 30.

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28. In this method, the patients were subjected to high doses of barbiturates, plunging them into a daze in which they unwittingly provided personal information. This in turn allowed the psychiatrist to undertake psychotherapy.
29. Juliette Boutonnier and Léon Michaux, "Le complexe de viol," *Esprit* 18, no. 165 (1950): 491–495.
30. Daniel Widlöcher, *Le diéthylamide de l'acide lysergique: Étude de psycho-pathologie expérimentale* (MD diss., Paris, 1957), 84.
31. To illustrate the way that sexism has permeated part of the French medical order, see André Soubiran, *Lettre ouverte à une femme d'aujourd'hui* (Paris: Albin Michel, 1967).
32. Joan Busfield, "Sexism and Psychiatry," *Sociology* 23, no. 3 (1989): 345.
33. See the literature review in Busfield, "Sexism and Psychiatry."
34. See this horrific account: R., "Moi, j'ai peur," *Les Temps Modernes* 12, no. 134 (1957): 1561–1567.
35. Phyllis Chesler, *Women and Madness* (New-York: Doubleday, 1972): 56.
36. Phyllis Chesler, "Twenty Years since 'Women and Madness,'" *Journal of Mind & Behavior* 11, no. 3/4 (1990): 318.
37. See, for instance, R. Sandison, A. Spencer, and J. Whitelaw, "The Therapeutic Value of Lysergic Acid Diethylamide in Mental Illness," *Journal of Mental Science* 100, no. 419 (1954): 491–507. For an analysis of the gendered relations among health-care professionals in the time of shock therapy, see Coline Fournout, "L'imaginaire thérapeutique des chocs à l'insuline." *GLAD! Revue sur le langage, le genre, les sexualités*, no. 12 (July 13, 2022): 1–16. <https://doi.org/10.4000/glad.4437>.
38. My emphasis.
39. Delay and Benda, 1958, 75 observations, 321.
40. See, for example, Joyce Martin, "L.S.D. Analysis," *International Journal of Social Psychiatry* 10 (1964): 165–69.
41. Ey et al., "Etat des recherches portant sur les hallucinogènes et les hallucinolytiques effectuées," 68–71.
42. Véronique Fau-Vincenti, "Des femmes difficiles en psychiatrie (1933–1960)," *Criminocorpus* (2019).
43. Max Wolff et al., "Learning to Let Go: A Cognitive-Behavioral Model of How Psychedelic Therapy Promotes Acceptance," *Frontiers in Psychiatry* 11 (2020): 1–13.
44. Anthony Wallace, "Cultural Determinants of Response to Hallucinatory Experience," *A.M.A. Archives of General Psychiatry* 1, no. 1 (1959).
45. Delay and Benda, "L'expérience lysergique," 327.
46. Erving Goffman, *Asiles* (Paris: Éditions de Minuit, 1968), 358.

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47. Claudine Herzlich and Janine Pierret, *Malades d'hier, malades d'aujourd'hui* (Paris: Payot, 1984).
48. Yves Pélicier, "Neuroleptiques et modification des modes de prises en charge," *Tribune médicale* (1985): 414.

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