Introduction: Just another turn? Practices, doing psychiatry and historiography

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Sociologists, historians and cultural studies scholars often diagnose another turn in the recent study and historiography of sciences, the 'practice turn' (Schatzki *et al.*, 2001; Soler *et al.*, 2016). Sociologists focus on practices in order to reconstruct routines in organisations and companies; historians analyse practices to grasp the meanings of social activities and their transformations over time; and cultural scholars engage with practices to understand how gender is performed or how (sub)cultures become apparent. Everyday practices, material cultures and the history of small things are currently in vogue, and scholars working on the history of psychiatry are beginning to take these objects and perspectives seriously. This collective volume aims at adding a multifaceted contribution, studying psychiatry in its making and unmaking in the second half of the twentieth century through some of the practices that contributed to its shaping: designing hospital buildings and rethinking more 'human' spaces of care; testing treatments and, ongoingly or exceptionally, employing those treatments; inventing new protocols and new relations to patients and users; opening up new fields of expertise and melding with other professionals. Far from just being a fashionable approach employed to renew historiography, engaging with psychiatric practices allows us to understand what psychiatry and mental health assistance were concretely made up of in a more nuanced and precise manner. They were not merely the result of great men and women's actions and discourses, nor a construct of modern society for the control and

isolation of deviant subjects, nor an outgrowth of technical and medical progress in the implementation of neuroscientific laboratory findings.

What we aim to show in the following chapters is the variety of practices covering and expanding the field of psychiatry in Europe after World War II, practices that contributed to shape and misshape the field, to redefine its core questions and to answer new ones. The idea of this volume is not to categorise (e.g. psychiatric, extra-psychiatric, anti-psychiatric) or evaluate (e.g. old-fashioned, avant-garde), but to analyse what psychiatrists and other actors of the field did in their daily work. Using selected case studies from across Europe,[1] we will explore how this 'doing' has changed psychiatry through the invention, routinisation and living of a variety of practices, and how these in turn have produced new methods, tools and even goals. The periodisation and spaces covered are vast, but the contributions for the most part adopt a local scale, allowing for a bigger picture to be drawn which highlights the international, national and local contexts, as well as the exchanges and circulations in terms of ideas and their concrete applications.

Psychiatry has experienced various kinds of disempowerment in the post-war period. Today, it no longer takes the form of a large institution in most European countries. Many of the walled-off, fortified bastions on the periphery of urban agglomerations are closed, empty or have been reused for other purposes. Likewise, the expertise of psychiatrists, which had long been in demand in society, politics and the courts, is being disputed by other professionals: educators, psychologists and neuroscientists, even ethicists and alternative practitioners, are competing for the power to determine the narrative in public discourse and private consultations. The territory of psychiatric diagnosis and therapy also has increasingly blurred borders, as we can see in the case of new terms like 'neurodiversity'. With every new edition of the Diagnostic and Statistical Manual (DSM), it is not only the number of diagnoses that grows, but also the reach of the psychiatric gaze (Frances, 2013). At the same time, some of the new "troubles" do not seem to require a psychiatrist to diagnose, treat or provide an expert opinion (for instance concerning child behaviour). Other professionals take over the job. Now that the institutional fundament, disciplinary contours and professional monopoly have been partly lost, it is becoming increasingly

difficult to find an adequate answer to the question: 'What is psychiatry and what does psychiatry do?'

We cannot provide an answer, but we can suggest a way to better understand what actually makes psychiatry what it is today. That is what this book aims to do. We do not seek to uncover the theoretical core of present-day psychiatry, to focus on the prominent and influential players, or to question concepts, institutions or academic representation. Instead, we aim to follow psychiatrists as they navigate the field, as they try to help suffering people, to make diagnoses, to counsel relatives, to provide treatment, to write expert reports, to guide policies and courts, to engage in public health services – in short, as they do psychiatry.

Psychiatry is what psychiatrists do? Psychiatry is the way in which psychiatrists do? This tautology is the argument of our volume? No kidding, what may look trivial at first glance becomes a methodological device as soon as we distinguish between doing and acting (Giddens, 1984). While by 'acting' we mean a directed action, with a clearly definable beginning and end of the executed movement, in the following we want to use 'doing' to refer to those habitual patterns of action or more or less ingrained ways of acting that are characterised by repetition, habituation and habitual customisation, in short: the practices of psychiatric doing as they manifest themselves in admitting or discharging patients, having exchanges with them or creating the conditions for broader relations with other patients or carers (for example, placing chairs in a circle and arranging group meetings), entrusting them to other services or professionals, note-taking, prescribing and so on. Such practices resemble invisible little tools or patterns that are present all the time. Their performance is usually understood by all participants sharing the same social sphere, which cannot be said of deliberate acts. The turn of our historical analysis to such practices should not be misunderstood as a 'reinvention'. Rather, it is an extension of the methodological arsenal necessary to devote adequate reflection to contemporary psychiatry.

If we take up this 'praxeological approach' and follow the psychiatrists, patients, other caregivers and expert figures involved in the psychiatric field, three advantages become apparent. First, the praxeological approach allows us to identify and provide a thick description of many practices that – for a short period of time or settling in as routines – contributed to the profound transformation of

psychiatry as an ensemble of institutions and as a discipline. Whether writing an epicrisis, organising the daily life of a therapeutic community or documenting one's experience through the spoken word, some psychiatric practices have apparently proven far more durable and stable than the institutions from which they once emerged. Other 'ways of doing' came from other disciplines or other institutions and were implemented in the psychiatric field as it expanded its skillset or sought new ways to answer old questions (how to cure, how to reduce the symptoms, how to deal with patients). At the same time, we observe that psychiatrists became involved in entirely new fields of activity, such as for example sex therapy (Lišková, 2018), which had little to do with the conception of psychiatry that once made the institution great. Moreover, new practices involved new professionals such as psychologists, psychotherapists, social workers and, more recently, peer support workers. At present, relatives' groups and affected persons' organisations are becoming part of psychiatric work and making their voices heard. If we take a closer look at such practices, we will probably attain a better understanding of what psychiatry has been about since the end of the classical institution and the loss of its power to determine the narrative.

Second, looking at such practices can show how existing structures enabled and mediated certain actions (e.g. forced medication or morning rounds) but, at the same time, how they were simultaneously established and structured by certain activities (e.g. talk therapy, patients' leisure time, use of space). In and through their actions, the actors involved (professionals, patients and relatives) in turn reproduced the conditions that make these actions possible (Giddens, 1984: 2). Power relations presented themselves as more fluid and malleable in such recursive loops. We can more easily trace how they became effective, how they were embedded in the daily lives of psychiatric patients and how they changed or were reshaped.

Third, analysing practices allows us to focus on and explore other fields of activity that have rarely been considered in the context of mental health issues. In this way, aspects reaching beyond institutionalised psychiatry (including facilities that emerged within the multifaceted post-war reform of psychiatry, such as out-patient care, day and night clinics and assisted living) become objects of analysis. Other elements also enter the picture of this renewed historical enquiry, such as public health policy, affected persons' organisations,

architecture and sociology. The multiple fields associated with psychiatry form an integrated network that is established and connected through common practices.

If one takes the practices seriously and observes how they are interwoven, how they solidify in routines and liquefy again, and how they occasionally emerge from a patchwork of different activities, it is not only a different history of psychiatry that emerges. Such a reconstruction certainly has implications for our understanding and conception of psychiatry. From a praxeological perspective, psychiatry presents itself less as a science grounded in theory or laboratory research than as an art of doing. Psychiatry can be understood as the outcome of practices and routinised habits. Psychiatry, even in the age of neuroscience, is not so much a science in the strict sense of the word, but a *techne* – a learned craft – characterised by those special skills that make psychiatrists, even today, sought-after professionals: experts who include social aspects, who see their own actions as having a rationale of social responsibility, and, finally, who develop solutions to problems that reach far beyond the threshold of the clinic or laboratory – in short, professionals who make the challenges of modern society manageable. How is that possible?

What all praxeological approaches have in common is that they concede or ascribe an intrinsic value to practices. This means that practices cannot be reduced to the mere 'application' of theoretical concepts, the execution of normative rules or the intentionality of actions. Nor is it sufficient to focus on the fact that theories, rules or norms are subject to some wear and tear or shrinkage in the mangle of practice (Pickering, 1991). Rather, practices are generative or productive, not in the sense of historical epistemology but in the sense of a 'resistance' or material constraint through which cherished habits, entrenched routines and formalised courses of action resist change. They become generative through unacknowledged conditions that produce unforeseen or unintended consequences, which can be articulated in new structures, rules and norms, but also new meanings, habits and routines.

The question remains: What is new about a history of psychiatric practices? Is this not merely a rewriting of the classical history of psychiatry? Are 'psychiatric practices' more than the regularities of action or regulated patterns of intervention whose description and explanation the historiography of psychiatry has pursued from

the beginning? Scepticism seems understandable at first glance, but there is a risk of underestimating the innovative value of a well-considered concept of practice. In fact, such a concept entails a changed understanding of what 'acting' is – and thus also of what 'actor' and 'subject' mean. At the same time, and above all, it changes our understanding of psychiatry.

What is the theory of practice?

Science studies and the history of science were the first historical disciplines to adopt praxeological approaches (Lynch, 1993; Buchwald, 1995; Pickering, 1995). By asking what researchers actually do in their laboratories and how scientific facts are produced, the hitherto popular notion of intentional rational experimentation was reduced to absurdity (Knorr Cetina, 1984; Latour and Woolgar, 1986; Fleck, 1993). Many studies in the history of science have been able to show – by reconstructing the practices involved, the constant tinkering with the equipment, the incessant changes in the experimental set-up and the apparent game of trial and error – how a scientific finding emerges, is stabilised and disseminated, and finally accepted. In contrast, the history of medicine understood practice for a long time as the locus where medical treatment was performed, or even the performative dimension of such activities itself. Only under the influence of ethnological considerations has that aspect been problematised which today is at the centre of all praxeological approaches – namely the mediation and production of meaning.

Praxeological approaches feed from quite different disciplines, ranging from anthropology and sociology to philosophy, as well as the already mentioned science studies. For Max Weber, who always understood social sciences as part of cultural studies (*Kulturwissenschaften*), 'no cognition of cultural processes is conceivable other than on the basis of the meaning which the always individual reality of life has for us in specific, individual relationships' (Weber, 2006: 745).[2] Therefore, all cultural expressions are merely a 'finite section of the senseless infinity of the world events, which is considered with meaning and significance'. These considerations have brought the anthropologist Clifford Geertz to the much-quoted formulation

that culture is to be understood as a 'self-spun web of meanings' (Geertz, 1973: 5), in which the human being is always entangled.[3]

According to Claude Lévi-Strauss (Lévi-Strauss, 1962), a given practice can be seen as a bricolage, a patchwork created by various elements of action and rules of combination. The early Pierre Bourdieu, drawing on Noam Chomsky, extended this model of a generative grammar of action to the whole field of social practices (Bourdieu, 1977). A finite number of established and routinised elements of action in the psychiatric field (dressing the ill, dispensing medication, patients' work therapy) and an equally finite number of pairings (free choice/uniform (dressing), self-reliant/forced (medication), paid/unpaid (work)) generate and enable, through their recombination, both new possibilities for action and other practices. On this grammar of action, Bourdieu built his theory of practice to establish the concept of habitus and link the microanalysis of individual behaviour with the macroanalysis of society. A praxeological analysis of psychiatric practices can show, for instance, how a traditional element of psychiatric diagnosis (the 'sick person's handwriting sample') combined with a likewise established element of ambulatory psychiatric approaches (the 'talking cure') acquired a dazzling ambiguity through the routine of writing a daily report in a socialist setting, carrying both emancipatory and disempowering meanings. Even the use of hypnosis, formerly considered obsolete, could suddenly appear as a resistant mode of action in a politicised setting.

It is, of course, possible, as many sociologists and philosophers suggest, to specify each individual act in at least one of these respects: purpose, intention and motive. However, this does not yet determine a practice; rather, it conflates the designation of agency with the description of separate purposes (Giddens, 1984). In Giddens's words, any purposive action is not composed of a set of separate intentions, reasons and motives. In practice, each individual action is embedded in a constant flow of conduct. It cannot be separated from its social context of time and space. There are former and subsequent actions. Repetition, practice and habituation not only transform the execution of actions into a practice, they also charge this practice, so to speak, with the context of the original activity, and give the practice a meaning that goes beyond its mere purpose or intention.

This is easier to understand from a historical distance which alienates us from the 'naturalness' of recent patterns of practice. To

give an example: the purpose of dressing newly admitted patients in uniforms was to provide each of them with functional, safe and egalitarian clothing. It also served hygiene and was intended to prevent the spread of germs and unwelcome parasites. Over the decades, if patients were redressed upon admission, repetition and habituation inscribed further meanings on this action beyond its original purpose, which were in turn conveyed with each performance of the practice – the undressing, accompanied by the deprivation of personal effects, contributed to the humiliation of the patient, taking away some material expressions of his or her identity, defining him or her as an inmate of a total institution. Defined as purposive acts, practices, including psychiatric practices, reveal themselves to us only incompletely and thus remain underdetermined. They may be theoretically grounded, scientifically justified and rationally legitimated, however, practices are neither adequately described nor even sufficiently understood by theory, science and reason. Rather, they lead – metaphorically speaking – a life of their own, which only opens up to historical analysis if one understands practices as meaning-mediating and meaning-generating, and includes these meanings in the analysis. In this way, the ceremony of dressing newly admitted patients took on a meaning that was presumably not intended, and certainly not adequately reflected or rationalised.

Practices are thus understood as temporally extended events or processes, as both Anthony Giddens (1984) and Joseph Rouse (2018) describe them. However, while for Giddens a practice is characterised by repetition, habituation and routinisation (as opposed to the act as an element of action), Rouse, in a more traditional way, emphasises the rule-governed and normatively set or legitimated constructivity of such practices. In this way, however, rules and norms again become primary. Nevertheless, the normative approach opens up a thought-provoking perspective, since Rouse sees actors themselves (and their actions) as constituted by practices. As a result, practices are the essential mode of interaction with the world through which human action is mediated.[4] Giddens, on the other hand, sees the reflexivity with which actors themselves track, evaluate and correct their actions as the crucial factor for a rationality of action. Some of Geertz's cultural anthropology comes into play when Rouse depicts practices as meaningful configurations of the world – i.e. as the weaving and

spinning activity which fabricates that cocoon in which the human being – as a social and cultural being – is trapped.

The conclusion that Bourdieu, Giddens and Rouse draw from their praxeological considerations seems more important for us: practices are a prior or at least more important category than subject and action. The study of practices avoids or defers the inevitable questions of professional historiography, from which the history of psychiatry has emerged over the last decades: Who did this? What is the driving force? Beyond all theoretical differences, we hold that it is more important to consider for which questions a particular praxeological approach can be operationalised, for which sources it is suitable and which pitfalls of previous historiography of medicine and science it helps to avoid.

State of the art

More than a decade ago, it was noted that the history of twentieth-century psychiatry lacked strong narratives comparable to those that have helped us to understand the psychiatry of former times, that is, those produced by historians, cultural scholars, psychiatrists and other professionals (Hess and Majerus, 2011). Instead, the historiography of contemporary psychiatry is still intertwined with the legacies of the nineteenth century, especially in German-speaking countries (Weindling, 1989; Faulstich, 1993; Hohendorff *et al.*, 2010; Fangerau *et al.*, 2017). What is needed, so the programmatic claim, is to take into account new actors and spaces, different methodologies and fresh perspectives. Indeed, the last decade has seen many approaches that transcend the disciplinary narrative while retaining a sense of the dynamics of silencing, the wilfulness (*Eigensinn*) of actors and the rare forms of resistance (Gijswijt-Hofstra *et al.*, 2005; for case studies see Meier, 2007; Lamb, 2014; Göhlsdorf, 2015). Many studies have also overcome the narrative of the single institution while retaining an awareness of the advantages of the micro-level approach (Majerus, 2013) and deconstructed the insane asylum as the only space where psychiatry could develop (Beddies and Dörries, 1999; Henckes, 2011; Beyer, 2016; Klein *et al.*, 2018). Recent research has finally examined the multiple manifestations

of psychiatric practice in respect to the places, techniques and activities of doing, particularly for the post-World War II period (Crossley, 2006; Skålevåg, 2006; Eghigian, 2015; Kritsotaki *et al.*, 2019).

Many studies have been carried out on the relation between war and psychiatry. Wars have been seen as an important trigger of mental troubles, which led to innovation in the field of mental health in the military system as well as in civil medicine and society. War brought a rise in new diagnoses like the ancestors of PTSD (post-traumatic stress disorder) and a decline in older ones like neurasthenia and hysteria (Lerner, 1996; Gijswijt-Hoftstra and Porter, 2001; Crouthamel and Leese, 2017; Schöhl and Hess, 2019); the bible of psychiatry in the USA, the DSM (Diagnostic and Statistical Manual of Mental Disorders), was a veritable child of military medicine (Mayers and Horwitz, 2005; Horwitz, 2021). The international mental hygiene movement is being scrutinised in its national and local developments as one of first systematic expressions of the will to deinstitutionalise mental assistance and to make it penetrate the social fabric (Fussinger, 2011; Kritsotaki *et al.*, 2019). Psychiatry's expertise went beyond the asylum walls: homes were visited to detect mental (as well as familial and social) misfunction (Kölch, 2001; Fuchs *et al.*, 2012; Bakker, 2021); dispensaries distributed psychiatric care in urban areas; day clinics extended the former asylum into urban spaces (Hess and Ledebur, 2012); and preventative strategies and counselling developed into new fields of activity with which psychiatry entered the realm of normal everyday life (Henckes *et al.*, 2018; Kritsotaki *et al.*, 2019). While recent psychiatric history now largely agrees on the historiographical evaluation of heroic therapies, the pharmacological revolution remains a challenge (Schmuhl and Roelcke, 2013; Greene *et al.*, 2016). Thus, the apologetic progress stories about the introduction of psychotropic drugs have now given way to a certain thoughtfulness.[5] Although it is indisputable, there has not yet been sufficient research on whether the psychiatric reforms of the post-war decades, especially the de-hospitalisation of psychiatric patients and reduction in inpatient length of stay, were greatly aided by the psychopharmacological revolution (Pieters and Majerus, 2011). However, its consequences, especially the economisation of psychiatric treatment and close collaboration between psychiatry and big pharma, are now viewed

more critically (Healy, 1997, 2013).[6] This is also due to the fact that the success of psychopharmacotherapy is by no means as convincing in historical analyses as it is in the accounts of the psychiatrists involved (Majerus, 2019).

Deinstitutionalisation has proved to be probably the most enduring buzzword for a new narrative that may do justice to the post-war history of psychiatry. Even if deinstitutionalisation, according to the accounts of its protagonists, often seems to have fallen out of history, given the radical calls in the 1960s and 1970s for an end to the asylum, the beginnings of deinstitutionalisation can be traced back to more or less isolated practices at the end of the nineteenth century (Schmiedebach and Priebe, 2003; Klein *et al.*, 2018; von Bueltzingsloewen, 2020). Thus, it remains topical to ask what deinstitutionalisation meant in concrete terms and how one can analytically grasp and conceptualise those areas of psychiatric action which, beyond the 'boundaries of the institution', resurrected it in a new form – in the form of forensic psychiatric hospitals, institutions for the disabled or homes for the elderly (Brink, 2010; Coché, 2017). Much more intriguing, however, are the attempts to explore the fringes of psychiatric activity since World War II: transcultural psychiatry (Ellenberger *et al.*, 2020; Antic, 2022), sex therapy (Lišková, 2018) and the transformation of psychiatric treatment services into a lifestyle and consumer item (Ehrenberg and Lovell, 2000; Donald, 2001), to name just three examples. Ideological boundaries are also being brought into view. In addition to class and social origin, recent studies have shed light on the role of gender, race and geographical origin in shaping disciplinary assumptions and concrete relations in the field of psychiatry (for instance Studer, 2016; Edwards-Grossi, 2022; Scarfone, 2023).

Greg Eghigian's call for a deinstitutionalisation of the historiography of psychiatry has fallen on receptive ears (Eghigian, 2011; von Bueltzingsloewen, 2015; Guillemain, 2020). However, recent studies have rarely questioned the boundaries of the subject and the academic discipline; instead, they have mostly described the fragmentation and specialisation of knowledge. For one, recent research has 'decentred' a long-held focus on the psychiatric department and identified other spaces and places where psychiatry was also practised or where the actors' actions and activities were guided by the goals and tools of psychiatry. For another, more recent approaches closer

to cultural studies are readily adopted to explore the materiality and performativity of institutional practices with an interdisciplinary or even artistic approach (Ankele and Majerus, 2020).

The scene of psychiatry has been enriched by new actors whose invisibility was marked in previous research. Besides psychiatrists, other professionals from the field of care are being considered, from nurses and social workers to psychologists and psychoanalysts (Henckes, 2014; Rzesnitzek, 2015; Tornay, 2016; Marks, 2017; Balz and Malich, 2020; Smith, 2020). Psychotherapy began to play an important role in urban facilities, where social and medical aspects of treatment were dealt with simultaneously, as for instance in drug abuse policy or in the therapeuticisation of 'total institutions' like jail or school. Here, beside the prescription of drugs and other treatments, some of the carers began to devote their time to considering the patients' words, as psychology and psychoanalysis proposed. During the post-war reform of psychiatry, psychoanalytic insights gained a place in some psychiatrists' training and in their approach, not only to patients, but also to institutional issues. The French movement of 'institutional psychotherapy' (Oury, 2016; Robcis, 2021) – at the core of the 'refoundation' of some psychiatric hospitals – is an example of this trend.

Furthermore, psychologists began to perform tests, on which the psychiatrists' diagnostic work in part relied, both in psychiatric hospitals and in other facilities. Through paper technologies and the materiality of the psychologists' tools and tests retrieved from the archives, the professionalisation of psychologists and their integration in public mental health become tangible. Nurses' roles were reshaped as well: to adjust to treating mental patients, they could follow special trainings, as at the *Association de Santé Mentale du 13ème arrondissement* in Paris or at the Heidelberg Psychiatric University Clinic (Henckes, 2007; Prebble and Bryder, 2008; Henckes, 2014; Borsay and Dale, 2015). The social worker, after a shy appearance in the interwar period, became a figure of mediation between the medical sphere and other spheres of the everyday life of mentally affected people, a means of tentative integration in these spheres: self-sufficiency, work, welfare and administrative procedures (Borsay and Dale, 2015; Dickinson, 2015; Nolte and Hähner-Rombach, 2017). Speech and language therapists could also accompany the global care of some psychiatric patients, as could occupational therapists and

ergotherapists, who were involved in redesigning the environment within which one evolves and in rehabilitative processes (Mitchell, 2002).

Moreover, the family, relatives and milieu in a broader sense have also found their place in the complex mosaic of the history of psychiatry. They are no longer reduced to their role in the admissions and discharge processes. Rather, they are taken seriously as actors in the patient trajectory, who offer a different perspective on the illness, develop different ways of dealing with it and ultimately have to bear the consequences for the family and the workplace. The patient, too, is given a proper place in this picture. Admittedly, the claim of a history from below cannot be realised in the way some once imagined (Porter, 1985; Condrau, 2007).

The sick person is no longer seen as the more or less passive bearer of a label or conceptualised as the victim of stigma. Instead, there is an attempt to do justice to him or her as the actor of a life of his or her own. More recent histories consider the integration of the patient in treatment as a peer support worker and attempt to grasp their social networks and reconstruct the web of shared experiences in order to gain a more detailed perception of their lives beyond authority: their hardships, but also their joys and freedoms (see Ankele, 2009). This new attention to everyday-life aspects of mental illness beyond the institution sharpens our view of the causes and consequences of social precarity, also as a consequence of migration and discrimination (Nellen, 2007; Guillemain, 2018).

Roy Porter's demand to give importance to the patient's perspective has produced narratives from the bottom up, made possible by a more sensitive way of approaching the archive, which enables the historian to not only see paper technologies as deployed by the psychiatric staff, but also observe the appropriation of these technologies in their dimension as tools of expression. The archive is somehow more stratified, more complex: the now classic clinical files are articulated with interviews, made and registered in the past decades or conducted by the historian nowadays with witnesses or actors (Bruzzone, 2021), with material objects or with spaces and atmospheres (Ankele and Majerus, 2020). A growing importance is given to media, the audiovisual and visual technologies that furnish both new objects of inquiry and precious sources to question how psychiatry represented itself (Berton *et al.*, 2018).

These multiple turns contributing to diversify, decentre and enrich the gaze of the history of psychiatry – the patient's turn, the spatial turn, the visual turn, the material turn – have been taken as an invitation to consider new actors, new perspectives and new sources. The practical turn could be applied likewise to writing the history of mental health. However, this collective volume suggests a slightly different way, because the many turns that the history of psychiatry has endorsed also raise more fundamental questions, especially about the relationship between theory and practice, everyday life and science, the profession at large and experts, and so on. A praxeological approach, this volume argues, contributes to providing insightful answers to these questions through the thick description of experiences.

Of course, practices cannot be observed historically in the field as their actual deployment can be through the immersive ethnological methods of observation and participation. But we can retrieve the traces they have left in the more or less classical material we deal with to write history. In most cases, these traces are not intentionally handed down, but are inscribed in the materiality of the surviving sources, such as arrows, notes and crossed out elements on the cover of a medical record that once steered its way through an institution (Hess and Schlegelmilch, 2016; Hess, 2018). We can also trace the repetition and carrying out of actions that, in their processualism, ground a practice. And we can, finally, reconstruct their meaning and purpose by embedding them in an analysis of the historical context of their development, which once gave them meaning and mediated their purpose.

Outline of the volume

Practices come to life and are performed in very different dimensions: productive, experimental, reflexive or transgressive. In and through practices, new ideas are articulated or visions take shape, but they also open up new options for action, sometimes even new worlds waiting to be realised. Practices are also the acid test in which new concepts prove themselves or become concrete. Reflecting on practices can itself become a self-reflective practice. After all, practices do not adhere to institutional or disciplinary boundaries; on the

contrary, they often form the hinge that articulates very different areas of our modern wider world. These dimensions – visions and dreams, experimentation, reflections, crossing boundaries – organise the volume.

The section 'Visions and dreams' focuses on experiences that have been viewed, lived and narrated by the very protagonists as unique and utopian. The four cases presented here cover different spaces and temporalities – from 1980s Greece to 1960s Italy, from 1970s Germany to post-war England. These ways of doing psychiatry are linked to the spaces where they took place as much as to the initiators of these 'groundbreaking' practices. They represent a reformist impetus determined to break with previous entrenched frameworks. The character of novelty assigned by the actors to their creations and experiences is here also seen through the eyes of the patients, as far as the sources allow one to read and interpret how the latter saw these activities and apparatuses primarily addressed at the well-being of each individual, rather than at refreshing discipline and its therapeutic and architectural expressions in se (extraverted sensing). New ethics for mental health professionals – for doctors as well as nurses and new collaborating professions – appeared: democratisation, the exchange of views (of roles in the most extreme cases), reducing distance, allowing empathy to emerge. The newly conceived spaces in the post-war period seemed to reflect these ambitions too.

The first essay of this section is Despo Kritsotaki's, on a facility in Athens that pursued socially and politically oriented mental healthcare in post-dictatorship Greece, combining the models of group analysis and the therapeutic community. Here, the political dimension endorsed by the protagonists contributed to making the project a utopian microcosm. Democratising psychiatry – through emancipation, the absence of hierarchy, equal participation and respect of everyone's personality – was the aim, as well as the ideological and practical framework in which therapeutics and relations were deployed.

Marica Setaro's chapter looks at the general assemblies that took place in the therapeutic community implemented in the 1960s in the psychiatric hospital of Gorizia (Italy). Insofar as it brought together doctors, patients, nurses and volunteers, it presented itself as a democratic tool, a space for non-hierarchical exchange and

discussion. However, the chapter shows a cleavage between this stated ambition and its perception by some of the inmates – as a supplementary space for the doctors to scrutinise patients' attitudes and a place where requests remained unanswered. Giving an account of the Gorizia experience – classically described as the departure point of the reform trajectory that led to the closing of mental hospitals in Italy at the end of the 1970s – from a multifocal perspective, this chapter balances visionary intent with more concrete aspects.

Gundula Gahlen's text focuses on the Department of Social Psychiatry and Rehabilitation at the Heidelberg Clinic in the 1960s and 1970s. Here, practices included less systematic use of drugs and shock therapies; an awareness of the importance of patients' expression; daily meetings of medical professionals, staff and patients; new roles, responsibilities and attitudes for the nurses; and continuity in the path of care, from inpatient to outpatient, from bringing people back from acute phases to rehabilitation and reintegration into social life, through work, education and multiple activities in outpatient facilities. Unique and somehow visionary at the beginning of the 1960s, those practices later become routinised here and elsewhere and part of what was expected in a psychiatry ward.

These three chapters focus on visionary ways of doing psychiatry through the development of renewed relations to inmates, the aspiration to democratise and de-hierarchise, and the support of social reintegration paths for the mentally ill. The fourth deals with visionary ways of materially preparing the ground and equipping the space for a renewed psychiatry. Christina Malathouni's chapter is about architectural transformations of psychiatric facilities in 1950s England. It takes the admission unit of a psychiatric hospital situated in what is today Oxfordshire as one of the first examples in which aspirations to reform psychiatric practices and their environment merged with architectural and spatial arrangements through the reflection of a new generation of architects on these topics. The chapter highlights the place that some professionals, who are not psy-specialists, can take in providing the best possible solutions, in a somehow utopistic way, to some aspects of psychiatric doing – namely the spaces, the environment and the atmosphere.

The section 'Experimentation' focuses on some specific cases – one from 1970s Finland, another from 1950s France and the third from post-1956 Hungary – whose protagonists were aware that they were

trialling new ways of doing. These have not necessarily become mainstream, but contributed to shaping new frameworks of therapeutic intervention or allowed for feebler protocolar procedures and eclectic appropriations.

Katariina Parhi's chapter captures the functioning of two Helsinki outpatient facilities for the treatment of young drug users. The chapter highlights the experimental character that these non-profit, non-governmental organisations for the prevention of substance abuse embodied. On the one hand, they refused the alcohol abuse model of assistance – namely the imposition of strict rules, as well as the prescription of medication. On the other hand, they tended to abolish rigid ways of understanding sociopsychological mechanisms. In this way, previous psychiatric ways of doing were overturned, making space for non-hierarchical experimentation in the emerging field of the care of young drug users, where psychiatry worked shoulder to shoulder with social work. Experimentation here meant dealing with a new problem – the substance abuse among the youngest – and distancing from the classical hierarchical and prescriptive ways of correcting these styles of life. It also meant giving new value to non-authoritarian expertise, coming more from a place of exchange than imposition, more from listening than redressing.

Florent Serina's chapter is dedicated to the implementation of psychosurgical techniques in the University Psychiatric Clinic of Strasbourg over a decade, from the end of the 1940s. It shows how that innovation was used, routinised and finally excluded from the arsenal of available treatments. The chapter covers experimentation in two ways. Firstly, as a locally situated and locally observed setting up of a technique experimental in se, through an ensemble of actors and what can be retrieved of procedures, mostly from paper technologies, related to the implementation of that technique. Secondly, it focuses on the phases that composed something that remained of the order of the experimental: uncertain beginnings, the peak of uses with a kind of routine, the reduction in the number of operations performed and the growing caution around them.

The last chapter of this section, Gábor Csikós on Hungarian child psychiatry following the 1956 insurrection and repression, focuses on one single treatment case, through which some developments of this young discipline are highlighted. With the backdrop of the political conditions, the chapter considers the question of the

difficult differential diagnosis of mutism, the fitting of electroconvulsive therapy with Pavlovian theories and the therapeutic eclecticism at the practical level. In the young boy's story, hypnotherapy is applied when ECT and other biological therapies do not seem to be successful. This constitutes a shift from active therapies to psychodynamics, although of course hypnosis was considered more in line with Pavlovian principles than 'bourgeois' Freudianism.

Entitled 'Reflections', the third section aims at showing how the actors were called to think about the practices in which they directly or indirectly took part and how they gave them meaning. This reflective habit questioned the very role of doctors. It was conducive to a closer empathic and therapeutic exchange with patients, as in Marietta Maier's chapter, and to the potential role of other professionals, like the sociologists rethinking the asylums' atmosphere and relations in Monika Ankele's chapter. It also appears in the patients' perception of a particular way of treating them and of asking them for a personal written reflection on daily life within the ward, as in Henriette Voelker's chapter.

Through medical records and treatment protocols filled out in the Burghölzli clinic in Zurich in the early 1950s, Marietta Maier gives us access to how a psychotherapeutic trial took place which intensively involved a team of professionals and a selected number of patients. A thick description of the new practice is offered: the time they spent together, the patients' improvement and deterioration and the critical reflections that doctors and nurses began to have about themselves, their work and the social role of psychiatry. Here we can see how the psychiatric self – the self-perception of one's very role in clinical, professional and human terms – was changed by experiences. These contributed to place attentive observation, regular exchanges with the patients, and reflection on day-to-day actual and mainly relational psychiatric doing at the core of the professionals' practice. The following chapter by Monika Ankele shows how sociology became a tool for social criticism and for sociopolitical change in the years when new ways of doing psychiatry were sought after. With the aim of observing daily life in the hospital – living conditions for patients and working conditions for nurses – the empirical research carried out at the main Vienna psychiatric hospital in the 1970s resounded with the political will to reform

psychiatry. Although a reflective attitude is palpable here on the sociologists' and decision-makers' side and, further, instilled in psychiatric professional actors, the patients' voices and reflexions remain inaudible in the critical sociological practice. In the last chapter of this section, by Henriette Voelker, we can see how dynamic group psychotherapy practice aimed at empowering patients in socialist East Berlin. Avoiding authoritarian guidance, patients were invited to write reports on their daily experience of this experimental therapeutic milieu. The writing practice, both intimate and relational, resulted in a combination of self-analysis, interpersonal communication and further reflection by therapists on their own role, on the practices implemented and on the efficacity of the therapies for each patient. As a brick in the larger construct of reformed ways of doing psychiatry, this practice tended to make the patients protagonists of their cure and responsible for their attitude – in the spotlight of a medical 'reading gaze'.

The last section, 'Crossing institutional boundaries', shows how disciplines and fields of action other than psychiatry have borrowed practices that were characteristic of psychiatry and how psychiatric expertise has played a central role beyond the treatment of mental diseases, namely in the field of sex reassignment in 1970s Norway and in youth redressing institutions in 1960s Belgium.

Ketil Slagstad's chapter analyses the role of psychiatric expertise in transgender healthcare. In a decade when sexology gained autonomy and public credit, the Oslo Health Council began to offer standardised assistance and accompaniment for trans people. Here, psychiatry crossed the borders of its classic diagnostic and therapeutic terrain to take charge of issues concerning medical transition. In Benoît Majerus and David Niget's chapter, we can see how the use of psychotropics crossed the borders of the psychiatric field, as they were used within the Belgian youth guidance institution of Saint-Servais between 1959 and 1975. 'Difficult' girls were closely observed in the 'Special Section', to which 'troublesome elements' were sent when they disturbed the normal course of life in the pavilions. The quantitative and qualitative analysis shows an entanglement of disciplinary and curative objectives and the ways to achieve them, through the significant – though almost unnoticeable in individual files – use of neuroleptics.

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Notes

1 In contrast to Doroshow, Gambino and Raz (2019), who studied mostly the USA context.
2 Translation ours.
3 The (retranslated) German translation of Geertz is much more vivid than the original phrase: 'that the man is an animal suspended in webs of significance he himself has spun' (Geertz, 1973: 5). For the German translation see Geertz, 1983: 9.
4 Koo 2017: 95; see also 'practice' in the *Oxford English Dictionary*.
5 For success stories see: Swazey, 1974; McCrae, 2006; in contrast: Speaker, 1997; Greenslit, 2005; Jenkins, 2010; Balz, 2010; Balz, 2011; Tornay, 2016. For patients' perspectives on biological therapies: Majerus, 2019; Guillemain, 2020.
6 For case studies see: Hess, 2015; Meier, König and Tornay, 2019; Wagner, 2019; Hottenrott, 2021.

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