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BEYOND THE WALLS

Cross-Referencing Psychiatric Records, Reconstructing Biographies: Case Studies from Belgium

In 1963, Anton D. and Marie M. were admitted to the Institute of Psychiatry in Brussels.[1] The records produced during their stay document the conditions of their hospitalization and also reveal the many institutions they interacted with throughout their lives. While not all of these institutional connections left archival traces, some generated valuable records. By cross-referencing these sources – medical, administrative, police, and judicial – we can enhance their archival corpus and reconstruct their trajectories over time. Once gathered, these materials shed light on their individual paths and also provide insights into the long-term transformations of psychiatric care practices. With this article, I aim to demonstrate the potential of biographical reconstructions through the combination of such different materials, offering a closer understanding of the historical experience of psychiatric deinstitutionalization.

Deinstitutionalization is one of the most significant narratives for the history of psychiatry in the second half of the twentieth century. The term refers to the process of reducing or closing large psychiatric institutions in favor of community-based mental health services and treatments that help to reintegrate patients into society, respect their rights and enhance their quality of life. The causes of deinstitutionalization are complex, including such factors such as the reduction of public expenditure, the trauma of

1 The *Institut de Psychiatrie* was founded in 1932. It is attached to the Brugmann General Hospital, located in the north of Brussels, and, like the latter, depends on the *Université Libre de Bruxelles* and the *Commission d'Assistance Publique* (CAP) de Bruxelles, a municipal body whose aim is to alleviate and prevent poverty and organize medical assistance services. The institute can accommodate over a hundred patients, divided according to gender (men and women), condition (agitated or calm), and placement in closed or open sections.

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World War II, the advent of new therapeutic approaches, an emphasis on prevention, outpatient support, suitable residential alternatives, the assertion of human rights, and the critique of institutional practices.[2] While deinstitutionalization initiatives have been widespread across the Western world, the timing, modalities, and intensity of such reforms have differed between countries.[3]

In Belgium, a mandatory insurance system implemented in 1963 transformed traditional asylums into medicalized psychiatric hospitals that met general hospital standards. This shift transitioned care from ›custodial‹ to ›acute care‹ and redirected traditional asylum populations to specialized facilities without reducing their numbers. A decade later, in 1974, Belgium revamped its mental health system, replacing old service indices with new ones for better-structured neuropsychiatric services. However, significant deinstitutionalization and reduction of psychiatric beds only occurred after reforms in the early 1990s, which established special care homes and assisted housing.[4] Despite these efforts, the psychiatric bed rate *per capita*, which had remained extremely high during the second half of the 20th century, is still high even today. Belgium is the country with the second most psychiatric beds *per capita* in the OECD after Japan. Historian Benoît Majerus has hence questioned whether the deinstitutionalization paradigm can be used for describing psychiatric care in Belgium.[5]

A more detailed analysis that takes into account regional variations reveals a more nuanced reality. Brussels and its hinterland differ significantly from Flanders; while the former has seen a transformation in the provision of psychiatric care, the latter is still characterized by large institutions. The reasons lie in the secular traditions of the capital, dominated by the liberal university, in contrast to the northern regions, where religious congregations predominate in psychiatric care. The early 1960s marked a pivotal moment in Brussels at which new approaches to mental health issues were developed outside the traditional institutional psychiatric framework and the biological conception of mental illness. Influenced by new paradigms of social psychiatry from abroad, new spaces outside traditional settings were created, new mental health practitioners emerged, and new treatments were introduced.[6]

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2 Despo Kritsotaki/Vicky Long/Matthew Smith (eds), *Deinstitutionalisation and After. Post-War Psychiatry in the Western World*, Cham 2016; Alexandre Klein/Hervé Guillemain/Marie-Claude Thifault (eds), *La fin de l'asile? Histoire de la déshospitalisation dans l'espace francophone au XXe siècle*, Rennes 2018; Wilfried Rudloff et al. (eds), *Ende der Anstalten? Großeinrichtungen, Debatten und Deinstitutionalisierung seit den 1970er Jahren*, Paderborn 2022.

3 Enric J. Novella, Mental Health Care in the Aftermath of Deinstitutionalization: A Retrospective and Prospective View, in: *Health Care Analysis* 18 (2010), pp. 222-238; Winnie S. Chow/Ali Ajaz/Stefan Priebe, What Drives Changes in Institutionalized Mental Health Care? A Qualitative Study of the Perspectives of Professional Experts, in: *Social Psychiatry and Psychiatric Epidemiology* 54 (2019), pp. 737-744.

4 Sophie Thunus, The System for Addressing Personal Problems. From Medicalisation to Socialisation: Shifts in Belgian Mental Health and Psychiatric Institutions, PhD thesis, Political and Social Sciences, University of Liège 2015.

5 Benoît Majerus, La désinstitutionnalisation psychiatrique. Un phénomène introuvable en Belgique dans les années 1960 et 1970?, in: Klein/Guillemain/Thifault, *La fin de l'asile?* (fn 2), pp. 143-155.

6 Benoît Majerus, *Parmi les fous. Une histoire sociale de la psychiatrie au XXe siècle*, Rennes 2013.

Rather than continuing well-known narratives of opposing approaches, the cross-referencing of archival sources allows us to follow individual patients through a web of different institutions and thereby explore how the different systems of care in psychiatry in Belgium played out in their lives. The research project ›Life Trajectories of Patients: Heterogeneity of Institutions‹ (led by Benoît Majerus) aims to capture the transformations in mental health care by utilizing new methodological approaches and analytical perspectives. It seeks to illuminate the complexities of the transition from closed psychiatric institutions to open, outpatient, and community mental health services. In this project, the chosen scale focuses on individuals admitted to the Institute of Psychiatry in 1963. However, it goes beyond the walls of the mental hospital by situating psychiatric patients within broader temporalities. By reconstructing long-term experiences and studying life trajectories, it seeks to understand how a person's psychiatric hospitalization fits into wider timelines in which mental illness and hospitalization constitute just one aspect.[7]

To achieve this, our project examines the life paths of individuals with varied sociological profiles and pathologies, all of whom were hospitalized at the Institute of Psychiatry at Brugmann Hospital in Brussels in 1963.[8] Analyzing these long-term life trajectories allows us to understand the diversity of experiences and the increasing heterogeneity of care spaces, actors, and treatments. Ultimately, it addresses the hypothesis that the phenomenon is not one of deinstitutionalization per se, but rather of trans-institutionalization, as this period is marked not by the end of institutional care, but by a diversification of institutional responses to individuals traditionally placed in asylums.[9]

1. Sources and Their Limits

Each hospitalization at the Institute involves three sets of records. The first type is the medical file from the Institute of Psychiatry. These primary sources are highly valuable as they reveal a polyphonic narrative, bringing to light the diverse voices involved in institutional care, including doctors, nurses, social workers, family members, and patients. Preserved in the archives of Brugmann Hospital, these files have been relatively well-maintained, although their organization methods remain complex and obscure.

The second type of record is the administrative file from the Public Assistance Commission (CAP) of Brussels. This municipal social organization oversees the Institute of Psychiatry and is responsible for the financial management of psychiatric stays.

7 For historical studies of life courses, see in particular: Nicolas Mariot/Claire Zalc, *Face à la persécution. 991 Juifs dans la guerre*, Paris 2010.

8 Benoît Majerus has taken this institution as the subject of his study on the history of psychiatry in Belgium, see: Majerus, *Parmi les fous* (fn 6).

9 The work of Canadian historians Marie-Claude Thifault and Marie LeBel has been a significant inspiration for this research, see: Marie-Claude Thifault/Marie LeBel, *Dérives. Une histoire sensible des parcours psychiatriques en Ontario français*, Ottawa 2021.

In these files, researchers can identify the various stakeholders involved in financing hospitalization and how patient trajectories are influenced by negotiations among them. Preserved in the archives of the Public Centre for Social Welfare of Brussels (CAP's successor institution), these files are essential for understanding the financial and administrative dimensions of psychiatric care.[10]

The third type of record is the compulsory admission file produced by the City of Brussels, which is responsible for most of the admissions to the Institute.[11] Including these files in the research framework allows for a better understanding of the role of public authorities in the psychiatric assessment process, particularly the involvement of the police in referring individuals to psychiatric hospitals. These well-inventoried files are preserved in the archives of the city of Brussels.

Each set of records documents the intervention of various medical, social, and administrative institutions, revealing multiple identities of the individual: mentally ill patient, socioeconomic agent, and citizen. These three types of records uncover a temporality that extends beyond the strict confines of the psychiatric stay. The Institute's records provide information on the individual's past through anamnesis and testimonies from relatives, as well as their future through psychosocial follow-ups after discharge. The CAP records often show how institutionalizations are financed before or after the stay at the Institute. Meanwhile, the records from the city of Brussels frequently continue to track the psychiatric patients after their stay at the Institute when they are transferred to another psychiatric institution.

The collection of data from these three sets of records allows for the identification of the types of institutions to which individuals are directed upon discharge and to assess how patient trajectories align with transformations in psychiatry and deinstitutionalization policies. This makes it possible to observe whether individuals are directed to new outpatient and community psychiatric structures, remain in closed psychiatric hospitals, or are redirected to new establishments targeting specific populations (such as the elderly and people with disabilities), shelters for the homeless, or prisons.[12] In addition to institution-specific records, there are general files such as the administrative documents from the municipality where the individual resides and the personal files produced by the immigration police (a significant number of patients at the Institute do not hold Belgian nationality).[13]

This involves an accumulation of data in which each new set of records complements the previous ones and allows for a more comprehensive reconstruction of long-term life paths. Indeed, each file reveals additional information about an individual's social,

10 The process of transferring, restoring, and inventorying the medical archives of the institute and the administrative archives of the CAP in Brussels is currently underway.

11 The city of Brussels was involved in 80 percent of the involuntary admissions to the institute during the year 1963.

12 Starting from the 1960s, new (psycho)geriatric establishments, centers for people with disabilities, and shelters for homeless individuals began to develop in Brussels.

13 The research demonstrated that, out of the total 880 women and men admitted to the open and closed services of the institute in 1963, 10 percent of them did not have Belgian nationality.

professional, familial, or medical situation, as well as about the institutions with which the client interacted. This enables researchers to measure the impact of mental illness and the assignment of mental patient status on long-term life trajectories, as well as how these morbid identities interfere with other aspects of the personal identity.

While these files offer numerous possibilities for historical research, they also present various limitations that need to be addressed. First, capturing the individual's subjective experiences requires access to personal sources, which institutional files do not inherently provide. Although ego documents – documents created by the individuals themselves, the psychiatric patients who are the focus of study – can sometimes be found within these institutional archives, they remain rare.[14] Second, the new guidelines imposed by the General Data Protection Regulation (GDPR) of the European Union make consulting these sources particularly difficult. In the name of the right to privacy and the right to be forgotten, access to archives containing personal data is highly challenging, even when strict precautions are taken to respect anonymization principles and the research is conducted within an academic framework for scientific purposes. This obstacle is even more significant for sensitive data such as health records, especially for individuals such as the patients of the Institute of Psychiatry from 1963, who may still be alive. Third, institutions often fear negative publicity that historical research on past psychiatric treatment practices and potential institutional violence might bring to their establishment. This concern can limit access to necessary records. Fourth, many records have been lost or destroyed, which creates gaps in the historical narrative. Finally, the records that do exist reveal only what the institutions chose to disclose. The data produced are not neutral; they are intended to serve specific purposes, resulting in an orientation that highlights certain facts while neglecting others.[15]

Addressing these limitations requires a careful and critical approach to archival research, recognizing both the potential insights and the inherent biases within these sources. The difficulties in accessing archives, along with incomplete, fragmented, and biased sources, make the task of reconstructing long-term life trajectories challenging. There are always temporal gaps, life events that are poorly documented, and crucial elements of the individual's life that escape the researcher. These challenges should not hinder the investigative work but rather serve as a driving force for historical inquiry. It is essential to first value the preserved and accessible records and to compare different

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14 Regarding ego documents and their role in historical research, see among others: Sandro Guzzi-Heeb, Egodocuments, biographie et microhistoire en perspective. Une histoire d'amour?, in: *Études de Lettres* 1-2 (2016), pp. 269-304.

15 These issues have been the subject of various reflections by Belgian historians in recent years – notably in Flanders the project ›Zorgzaam (met) Erfgoed‹ by the Catholic University of Louvain and the Guislain Museum (<https://faro.be/project/zorgzaam-met-erfgoed>). In French-speaking Belgium, within the framework of the study day of the Belgian Association of Contemporary History in 2024, the author of the present contribution, along with historians Anne Roekens and Aurore François, addressed the theme: ›What will remain tomorrow to write the history of marginalities and subalternities? Personal files between the right to information and the protection of privacy‹.

life trajectories to fill in the gaps. The goal is that the silences in one existence may be partially explained by the details in another, allowing for hypotheses to be made and revealing the realm of possibilities through similar types of existences.

2. Two Case Studies

For demonstrating the potential of pooling sources by cross-referencing, I will now trace the life trajectories of two individuals admitted to the Institute of Psychiatry in 1963: Anton D. and Marie M., the two cases mentioned at the beginning.[16] These individuals represent the most common psychiatric disorders diagnosed at the Institute: alcoholism for Anton and psychosis for Marie. By examining their long-term trajectories, we can explore the multiple effects of deinstitutionalization policies and assess to what extent they were able to leave closed institutions, benefit from new treatments, access new care spaces, and interact with new mental health professionals. The addition of new sources helps to fill in the gaps left by others, as some records are incomplete or even missing. For instance, Anton's administrative file from the CAP of Brussels is absent, resulting in a lack of information on the financial aspect of his psychiatric hospitalization.[17] However, other archival sources make it possible to obtain information about Anton's socio-economic situation.

The first source consulted to trace Anton's biography is his medical file from the Institute of Psychiatry.[18] Indeed, the doctors and social workers traced the long-term trajectory of his life, particularly since the onset of his disorder. From his file, we learn that Anton was born in 1929 in the Belgian Congo and developed a problem with alcohol in 1948. After abandoning his medical studies in South Africa in 1949, he attempted to manage a coffee plantation in 1956, which he eventually gave up. In 1961, his father arranged his marriage. In 1962, he went to Europe, where he worked as a medical delegate – a career imposed upon him that ended in failure – and underwent treatment at a clinic in Flanders for alcoholism, including psychoanalysis and sleep therapy.

Between 1962 and 1965, Anton experienced numerous admissions to the Institute of Psychiatry due to issues with alcoholism, depression, and social maladaptation. Despite receiving various treatments, including the use of Antabuse,[19] he faced persistent relapses, battled suicidal tendencies, and endured significant personal

16 Their names have been anonymized as prescribed by the agreements that bind the author of the present contribution to the archivists.

17 There does not seem to be any institutional logic to these gaps; it is more likely that these shortcomings in the archives result from a lack of organization, which is itself related to a lack of financial and human resources.

18 Anton D., dossier médical de l'Institut de psychiatrie, 3109B.

19 Antabuse, originally Disulfiram, is a chemical compound that has been used in the rubber industry since the late 19th century. In the 1940s, its alcohol-aversion effects were discovered, as the ingestion of this molecule induces an uncomfortable reaction in individuals who have consumed alcohol.

hardships, such as a divorce and ongoing conflicts with his family. During this period, Anton also attended meetings of Alcoholics Anonymous and underwent an orientation examination at the Center for Traumatology and Rehabilitation at Brugmann Hospital to support his reintegration.[20] In 1964, following the advice of psychiatrists at the Institute, he began psychotherapy outside the hospital.

The second archival source is the institutional file from the *Club Antonin Artaud*.[21] Founded in 1961 in Brussels, it was one of the two early psychosocial rehabilitation centers in Belgium.[22] A membership list from 1963 confirmed Anton's involvement, marking the first time he was directed towards a structure outside of a hospital. Several hints in the archival material indicate that Anton participated in therapeutic activities there, but he did not stay and ended up returning to the Institute. A third source, the population census archives of the City of Brussels, where Anton resided, reveals that in September 1965, he was without income and lived in a shelter for the indigent, indicating his social and health conditions were very critical.[23]

Returning to his medical file, we learn that in the summer of 1965, Anton applied to join the *Foyer de l'Equipe* in Brussels, one of the other early psychosocial rehabilitation centers along with the *Club Antonin Artaud*.[24] His file from this extramural post-cure structure, which he joined in November 1965, reveals details about his care and its outcomes.[25] The *Foyer* gave him ›a semi-protected family atmosphere that allowed him to gradually reeducate himself to a normal social life and provided the necessary support for him to work outside‹.[26] During the seven months he stayed at the *Foyer*, he continued outpatient psychotherapy, received daily medication including neuroleptics and sedatives, and worked during the day as a temporary employee, a position found for him by the *Foyer*'s social service. He completed his stay in May 1966, apparently ›stabilized‹ at the point of his discharge, and had plans to marry a nurse from the Institute.

According to his medical records from the Institute of Psychiatry, Anton appears to have been in better health for four years, from 1966 to 1970. However, in the winter of 1970, he returned to the Institute. He was depressed and afraid of a relapse despite

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It has been marketed under the name Antabuse for the treatment of alcoholism since 1948, see: Helge Kragh, From Disulfiram to Antabuse: The Invention of a Drug, in: *Bulletin for the History of Chemistry* 33 (2008), pp. 82-88.

20 The Trauma and Rehabilitation Center (CTR) at Brugmann Hospital was founded in 1950 and is intended to care for people with disabilities. The founder of *L'Equipe*, Jean Vermeylen, worked there in the 1950s. Regarding Anton's assessment, the CTR promoted a professional retraining towards the librarian profession; however, it does not seem that Anton ever practiced this activity.

21 Club Antonin Artaud, Population 1963, Archives et Musée de la Littérature, ML8510/1/372.

22 Jacques Bradfer, Le Club Antonin Artaud, in: *Mosaïque. Revue nationale belge d'information psychiatrique* 2 (janvier 1966), pp. 41-44.

23 Anton D., fiche de population de la ville de Bruxelles, Service d'Archives de la Ville de Bruxelles.

24 See: Jean Vermeylen/Lucette Schouters-Decroly (eds), *Hors les murs! Naissance de la psychiatrie extrahospitalière*, Bruxelles 2001.

25 Anton D., dossier médical de l'Équipe, 4366926.

26 Anton D., Rapport du 7 octobre 1965 du docteur Vermeylen à la suite de l'examen d'Anton D. au centre de Traumatologie et de réadaptation, dossier médical de l'Équipe, 4366926.

having stopped drinking since his stay at the *Foyer de l'Equipe*. His wife informed the doctors about the psychological difficulties her husband was experiencing, attributing them to his being overworked. Since antidepressants had no effect, sleep therapy was administered. He was discharged ›stabilized‹ again, planning to change jobs and continue his outpatient psychotherapy.

A final document is found in his medical file at the Institute of Psychiatry. Anton presented himself at the emergency department of Brugmann Hospital in 1978, where he was diagnosed as an alcoholic and referred not to the Institute of Psychiatry but to another psychiatric hospital in the Brussels region. There are no clear indications of the causes of this relapse. However, his population record from the city of Brussels reveals crucial information: Anton divorced in 1975, which may have contributed to his relapse. The population record also provides a final piece of information: Anton passed away in May 1980.

The first information about Marie's life comes from her personal file produced by the *Police des étrangers*.[27] Marie was a Yugoslav refugee, born in a medium-size town in Serbia in the late 1920s. In 1956, she married a UN political refugee from Bulgaria. Both were florists before they arrived in Belgium in 1956. A few months later, their first child was born. Her husband became a laborer in the Brussels hinterland but fell ill and could work no longer; he then began receiving allowances from the Public Assistance Commission (CAP) of Jette (a municipality in the Brussels-Capital region) from 1957 onward. It appears that Marie began working in the same year. Their second child was born in 1958. This file also reveals their significant mobility during their early years in Belgium. Marie and her husband were travelers, moving around central Belgium in a caravan.

The second type of retrieved sources is Marie's medical file at the Institute of Psychiatry.[28] Through this archive, we learn that Marie's psychiatric journey began in 1959, after the birth of her third child, with a consultation for postpartum psychosis at the Institute; she was hospitalized at Lovenjoel asylum (Flanders) for behavioral issues from July to September. In October 1959, her husband reported on her paranoia, but language barriers prevented a clear diagnosis. In July 1961, Marie was detained by police for ›disorderly conduct‹ and admitted to the Institute as paranoid schizophrenic. Treated with various medications (several neuroleptics coupled with an anxiolytic), she expressed fear of her husband. After six weeks, she was discharged, but her children were temporarily placed in a foster home by the mayor's request.

Her medical file from the Institute allows us to reconstruct her life trajectory further: In early 1962, Marie was readmitted to the Institute and transferred to the psychiatric hospital in Duffel (Flanders) in February, where she was discharged in June of the same year,[29] but social services regarded her unfit to care for her children. In January 1963,

27 Marie M., dossier de la Police des étrangers, Archives générales du Royaume, 2691503.

28 Marie M., dossier médical de l'Institut de psychiatrie, 11412–18671.

29 The transfer of patients from the Institute of Psychiatry in Brussels to regional psychiatric institutions (such as Duffel or Lovenjoel) was a common practice. The Institute was not intended to accommodate patients for long stays, with a maximum duration normally set at 60 days. When a case was deemed too

she was admitted again for depression and suicidal tendencies, was transferred to Duffel in February, and was discharged from there in August 1963. Due to agitation and exhibitionism, she was admitted a fourth time to the Institute in September 1963, now diagnosed with paranoid delusions, though the Institute's staff struggled to communicate with her due to her poor French. A suspected pregnancy in November led to a therapeutic abortion and sterilization in December. She was transferred to Duffel in January 1964. It is at this point that her medical file at the Institute ends.

To find out what happened to Marie after 1964, we must turn to new records, her administrative file from the CAP of Brussels.[30] Through this source, we learn that Marie was still interned at Duffel in 1975, meaning that she was hospitalized for eleven years. During this period, she received no visitors and lamented her isolation. She also had no financial resources, as her husband claimed he could not provide financial support. An examination of their *Police des étrangers* files reveals the husband's significant precariousness, marked by professional instability and numerous legal issues. Her CAP Brussels file indicates that she applied for assistance from this social organization. Despite an agreement for allowance payments starting in 1970, she had still received nothing from this public body five years later. This is how her administrative file at the CAP of Brussels closes in December 1975.

Returning to the file from the *Police des étrangers* provides a final document on Marie: In January 1989, the police requested information from the municipality of Duffel regarding Marie as part of a program monitoring foreigners' movements. We learn that Marie was still interned at Duffel, marking twenty-five years of continuous hospitalization at this place. There, she resided in an open ward where ›most of the time, she is allowed to leave the establishment unaccompanied‹.[31] Thus, when we lose track of her in January 1989, it seems she enjoys relative freedom despite still living within the institution's walls.

These brief outlines reveal the concrete modalities of the effects of transformations in psychiatry on the lives of institutionalized individuals. While Marie remained interned, Anton left the hospital and benefited from new community care spaces. Certainly, these different trajectories can be attributed to their specific mental disorders, but not all psychotics were interned for thirty years (or even more) like Marie, and not all alcoholics like Anton were directed to post-care centers. Their psychopathology alone cannot explain their divergent paths.

The two cases share many traits that significantly reduced their chances of leaving behind institutional psychiatry. Both had low social capital; they were isolated, lacked stable employment, and had no financial resources. They were also both migrants (although Anton came from a Belgian family) and faced difficulties integrating into

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complex, the patient was sent to a regional institution. These psychiatric institutions, mostly located in Flanders and managed by religious congregations, admitted patients for much longer periods. They maintained more asylum-like practices and were, in some respects, considered spaces of relegation.

30 Marie M., dossier administratif de la Commission d'Assistance Publique de Bruxelles, 7555435.

31 Marie M., Rapport des autorités municipales en date du 24 janvier 1989, dossier de la Police des étrangers, Archives générales du Royaume, 2691503.

Belgian society. They were admitted to psychiatric institutions multiple times, and doctors described their conditions in terms of chronicity, implying incurability. Despite these similarities and shared burdens, however, Marie remained in custody, while Anton was given several opportunities to leave.

Explanations for their different treatment could be found in the outpatient psychotherapy Anton began in 1964, alongside other quite innovative therapeutic methods at the time, such as support groups (Alcoholics Anonymous, AA) and Antabuse treatment.[32] This outpatient psychotherapy was provided by a doctor who, thanks to complementary archives, was identified as a psychiatrist who was part of a circle of reformist doctors developing new community and outpatient care spaces in Brussels, such as the *Foyer de l'Equipe*. This encounter allowed Anton to leave the closed world of the psychiatric hospital and to experience other types of care. This trial was successful, enabling Anton to stabilize, reintegrate socially through his marriage, and find employment. But even for individuals transitioning from closed institutions to the community and to psychiatric outpatient services, the potential for returning to residential psychiatric care persists. Anton's trajectory illustrates that these paths often involve an oscillation between various types of care. The psychiatric hospital continues to play a crucial role within the system. Despite policies aimed at deinstitutionalization, widespread practices of internment remain in place.

Marie, on the other hand, was directly sent to a provincial asylum and did not have the opportunity to start outpatient care in Brussels. Numerous neuroleptics had little effect on her mental state, as Marie remained ›constantly prone to agitation attacks‹.[33] Because doctors claimed they were unable to communicate with her due to her poor command of French, they could not provide a clear diagnosis for Marie and consequently could not decide on an appropriate course of treatment. Worse still, her limited proficiency in French made her an unsuitable candidate for integration into an outpatient psychiatric structure, where psychotherapy and, more broadly, talk-based treatments were deemed essential for patients. Transferred to the province with a placement regarded as definitive,[34] she lost all contact with her relatives and became permanently institutionalized. More broadly speaking, her case reveals forms of intersectional discrimination. As a woman, foreigner, and impoverished individual, she faced various types of violence: sterilization, removal of parental authority, forced institutionalization, and deprivation of social benefits.

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32 The first AA meeting room was founded in 1952 in Belgium, in a working-class neighborhood of Brussels; three more were established in the following years in the Brussels metropolitan area. Regarding Antabuse (Esperal) implants, it appears likely that they began to be used experimentally in Belgium starting in 1964. For more information, see: Joris Casselman, *Van jeneverellende tot Tournée Minérale. 150 jaar aanpak van alcoholproblemen in Vlaanderen (1868–2018)*, Oud-Turnhout 2019.

33 Marie M., Note médicale du 26 décembre 1963, dossier médical de l'Institut de psychiatrie, 11412–18671.

34 Research in the medical records of the institute confirms the existence of permanent transfers of patients to psychiatric institutions. These lifelong placements remained one of the options in managing the institute's patients until at least the late 1960s.

3. Conclusion

Analysis and comparative research allow us to put Marie M.'s and Anton D.'s trajectories into dialogue with other patients at the Institute. Cross-referencing the trajectories of several patients through their personal files serves two main functions. Firstly, it reveals unknown elements in Marie's and Anton's journeys, such as the reasons for their prolonged hospitalization, their (limited) capacities to act, and their needs and wishes. Comparing these trajectories with other cases transferred within the regional psychiatric system in Flanders allows us to evaluate the justifications given by doctors for prolonging their stay.[35] This comparative analysis can reveal how factors such as chronicity or a long psychiatric history, the absence of outside support or an increased risk of self-endangerment contributed to the doctors' decision to keep a patient institutionalized. Moreover, the ego documents in other files demonstrate how these patients tried to maintain agency and to resist the decisions imposed on them. For the historian, their voices echo those of people like Marie and Anton, who left no written testimony. Secondly, this comparative analysis allows us to assess the degree of similarity between trajectories and thus helps to avoid the pitfall of presenting an anecdotal story as a representative case. Only by means of the comparative approach can we observe that Anton's trajectory – oscillating between hospital and community psychiatry, and then returning to the hospital – appears relatively common among patients, while Marie's trajectory, characterized by thirty years of continuous hospitalization, appears as less typical.

This brief examination of the life trajectories of Anton and Marie demonstrates the possibilities offered by cross-referencing individual sources in historical research for reconstructing long-term life biographies. When pieced together, these different narratives provide a better understanding of what psychiatric deinstitutionalization entailed: Trends and anomalies can be identified by comparing multiple trajectories, thereby highlighting the unique or shared aspects of the respective lives. By embracing the variability of life trajectories, which are rarely linear and often take off in unforeseen directions, the narratives from below – which Roy Porter called for so famously[36] – allow for a more nuanced understanding of the grand narrative of deinstitutionalization. This is the name for a complex transformation which entailed a series of slow, localized, medical, legislative, and social moves and unfolded in many steps forward and backwards. Its influence varied greatly from one individual to the next, shaped by multiple determinants as well as the divergent institutional, medical, and social logics that either accelerated or hindered the deployment of its effects.

35 E.g. Robert V., dossier de collocation de la commune de Saint-Gilles, 1963, 63242; Émile S., dossier de collocation de la Ville de Bruxelles, 1965, n° 227.

36 Roy Porter, The Patient's View: Doing Medical History from Below, in: *Theory and Society* 14 (1985), pp. 175-198.

As rich as they may be, the findings drawn from this qualitative approach should ideally be placed in dialogue with a quantitative perspective, as these two approaches mutually enrich historical analysis.[37] The trends observed through the close reading of individual cases can be analyzed further and on a broader scale by employing quantitative tools that allow us to assess whether the dynamics observed align with wider transformations.

For instance, a close study of individual patient trajectories in a psychiatric asylum may reveal interruptions in treatment paths, family strategies, or institutional logics. However, to measure the extent of these phenomena, a broader statistical analysis can be mobilized: Did readmission rates change over several decades? Did average lengths of stay decrease with psychiatric reforms? Did the number of psychiatric hospital beds evolve at the same pace as the development of outpatient psychiatric structures? These questions, which cannot be fully grasped through a strictly qualitative approach, help to articulate a micro-historical reading with structural trends identified through quantitative data. The interplay of scales is therefore essential for understanding psychiatric deinstitutionalization.[38]

Finally, the reconstruction of life trajectories of (institutionalized) psychiatric patients does not only reflect ongoing reconfigurations of the mental health landscape but also opens a door to new historical inquiries. The biographical approach for examining psychiatric deinstitutionalization at the Institute of Psychiatry in Brussels sheds light on, for example, the history of migration in Belgium, the history of the welfare state, and the history of gender. In fact, studying an individual's life thus leads the historian to comprehensive forms of historical scholarship – reminiscent of what the American writer James Baldwin said, ›People are trapped in history and history is trapped in them.‹[39]

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37 Anne Digby, Quantitative and Qualitative Perspectives on the Asylum, in: Roy Porter/Andrew Wear (eds), *Problems and Methods in the History of Medicine*, London 1987, pp. 153-174.

38 See on this issue: Jacques Revel, *Jeux d'échelles. La micro-analyse à l'expérience*, Paris 1996.

39 James Baldwin, Stranger in the Village [1953], in: James Baldwin, *Collected Essays*, ed. by Toni Morrison, New York 1998, S. 119.