Beyond the asylum: Colonial psychiatry in French Indochina, 1880-1940

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ABSTRACT

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This dissertation looks beyond the asylum to consider the development of psychiatry in French Indochina as the product of everyday exchanges between lay people and experts. Drawing on archival research conducted over two years in Vietnam and France - including hundreds of patient case files - I trace the movements of patients in and out of asylums and between prisons, poor houses, youth reformatories, hospitals and family homes. Together, these individual patient itineraries challenge our notion of the colonial asylum as a closed setting where patients rarely left, run by experts who enjoyed broad and unquestioned authority. Instead, they reveal how ideas about what it meant to be abnormal, as well as normal enough to return to social life, were debated between psychiatrists, colonial authorities and the public throughout the early decades of twentieth century.

By examining the dynamics of patient movements in and out of psychiatric care, this study shifts our perspective from the asylum itself to its relationship with the world beyond its walls. Colonial scholars have focused on the way psychiatry provided a new scientific discourse of racial difference and how it figured within a wider biopolitics of colonial rule. However the social histories of the asylums themselves, and how they functioned within colonial political systems, remain little explored. I argue that by situating the history of psychiatry within the local dynamics of colonial rule, the asylum emerges as less of a blunt instrument for the control and medicalization of colonial society than as a valuable historical site for reframing narratives of colonial repression and resistance.

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For my parents

Chapter 1. Getting out of the asylum: writing the social history of psychiatry in French Indochina

In December of 1920, Tieu van Sau was admitted to the Bien Hoa asylum outside Saigon, a year after the asylum first opened its doors. Sau was thirty years old and worked as a security attendant at a large commercial house in the city center. Charged with multiple counts of assault, theft and vagrancy, Sau came to the attention of colonial authorities like many others who were eventually sent to the asylum: as a threat to public security. Once confined, Sau was diagnosed with delirium, characterized by violent episodes brought on by heavy drinking. Six months later, he had improved to the point that the presiding psychiatrist recommended his release but only under the condition that his family exercise strict surveillance.

Sau's family had long petitioned the colonial government for his release, as many other children, parents and spouses of asylum patients would do throughout the interwar years. Yet two years later, in June of 1923, Sau found himself once again at the asylum, this time after committing murder. A doctor charged with providing an expert opinion in the case found Sau to be irresponsible by reason of insanity and recommended his confinement. Yet he used Sau's case to warn of a broader pattern in which "the existence of these individuals is a vast cycle where prison and asylum alternate with phases of liberty when they commit minor offences, misdemeanors and crimes which lead to a new confinement."[1]

Sau's case file is one among hundreds I discovered over a two-year period in the colonial archives of Vietnam, Cambodia and France. What struck me most about these files were the extraordinary movements of patients, many of whom seemed to cycle endlessly in

[1] *Trung Tam Luu Tru Quoc Gia 2* (TTL2), Goucoch, IA.8/281(2), Le Procureur Général près la Cour d'Appel de Saigon à Monsieur le Gouverneur de la Cochinchine, June 29, 1925.

and out of asylums, hospitals, prisons, youth reformatories, poor houses and family homes. Taken together, these individual patient itineraries challenge our notion of the colonial asylum as a closed setting where patients rarely left, run by experts who enjoyed broad and unquestioned authority. Instead they reveal how ideas about what it meant to be abnormal, as well as normal enough to return to social life, were debated among psychiatrists, colonial authorities and the public throughout the early decades of the twentieth century.

This study is a social history of psychiatry and mental illness in French Indochina. I focus on the region that is now known as Vietnam during a period of major transformation under French colonial rule, from shortly before the official foundation of the Indochinese Union in 1887 through much of the interwar period. In the late nineteenth century, French observers, newly arrived to the colony, remarked on what they believed to be a striking absence of mental illness among the indigenous populations of Indochina. Those few believed to be mentally ill were thought to suffer from more chronic forms of dementia or senility and did not pose any serious public danger. Why then did the French decide to build an asylum that opened in 1919 and how did demands for confinement grow so quickly that psychiatrists were no longer able to keep up? Explaining this remarkable shift is one of the central tasks of this dissertation.

Specifically, I am interested in tracing the kinds of social arrangements that allowed for the identification and transformation of the problem of mental illness into a problem of colonial governance. This is a story of the institutionalization of mental illness, on the one hand, but even as psychiatrists enjoyed a widened scope for their expertise I demonstrate how they came to rely more than ever on the participation of the public. By studying the history of mental illness as at once a legal concept, medical diagnosis and social designation, I insist on the category's inherent dynamism and flexibility that was mobilized by a wide range of colonial

actors in pursuit of their own goals and agendas. How "abnormal" individuals came to circulate throughout the colony, I argue, reveals the emergence of new networks of institutions and people that place responses to mental illness on a kind of continuum marked by both repression and more subtle forms of negotiation.

This project is the first study of the history of psychiatry in Vietnam and it is part of a growing literature on colonial psychiatry that has expanded our understanding of both colonialism and the social history of medicine. In particular, historians have emphasized psychiatry's contribution to a colonial discourse about race and how it figured within a wider biopolitics of colonial rule. Meanwhile the social histories of the asylums themselves, and how they functioned within local colonial political systems, remain little explored in the historiography. This dissertation adopts a wider perspective that takes us past this narrow focus on experts and discourses. Instead it looks beyond the asylum to ask what the history of psychiatry can tell us about the local dynamics of colonial rule. I draw on previously unused sources - including medical reports, architectural blueprints and hundreds of patient case files - in order to reconstruct the social world of the asylum in Indochina. This was a world that included not only psychiatrists and their patients but also the police and prosecutors, parents and neighbors. My project's central claim is that looking at the interaction between the asylum and community offers a more complex picture of colonial psychiatry, and of colonialism more broadly. This is a story of not just simple imposition from above but also one of continual recasting from below.

II. Beyond Fanon

In the pages that follow I aim to revise our understanding of psychiatry in the colonies by first separating the history of psychiatry from the history of confinement.[2] That is, by examining the movements of asylum patients as the product of everyday interactions between lay people and experts, I critically re-examine our assumptions about the asylum as an instrument for the control and medicalization of colonial society. By "getting out of the asylum," I therefore mean to shift the focus of the historiography from the asylum itself to its relationship with the world beyond its walls. I want to challenge the trope of colonial repression and resistance that has come to dominate histories of colonial medicine, and colonialism more broadly.

The asylum was, in many ways, a unique kind of colonial institution - as both hospital and prison it brought together naturalist explanations of disease with social judgments about individual behavior. It therefore serves as the natural point of departure from which to examine, and critique, the close links between medicine and power in colonial settings. This research agenda is largely indebted to Frantz Fanon who in his 1959 work *A Dying Colonialism* described the clinic and medical knowledge as spaces of colonial violence, and called for resistance against imperialism and the sickness it generated. In his writings, Fanon (himself a psychiatrist trained in France) argued that psychiatry, by insisting on the over-determined inferiority of the colonized, worked to justify and facilitate the brutal use of state power. Rather than locate the origins of Algerian violence in the inherent features of the North African mind, Fanon insisted that the violence of colonialism actually engendered madness

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[2] Here I follow the work of David Wright who critically re-examines assumptions about the social role of asylums in nineteenth century Britain by calling for the separation of the history of psychiatry from the history of confinement. David Wright. "Getting out of the asylum: understanding the confinement of the insane in the nineteenth century." *Social History of Medicine* 1997 10(1): 137-155.

and savagery among the colonized. He therefore called for violent action as a necessary and reciprocal step in the development of revolutionary consciousness and the liberation of colonial society.[3]

Scholars in postcolonial studies have since taken up the Fanonian tradition to examine the psychology of the colonial experience marked by dislocation, dependence and ambivalence. These psychoanalytically framed accounts of the 'condition' of the colonizer and colonized, by largely ignoring the specifics of local circumstances, occlude the diversity of experiences on either side of the colonial divide. In this way, these authors tend to reify the very divisions they mean to critique.[4]

Other scholars have drawn on the rich literature in the history of colonial medicine and public health to chart out new directions for thinking about the implications of psychiatry for colonialism. If the body was the site on which the colonial construction of categories was carried out, then the history of medicine becomes an invaluable site for examining the tensions, ambiguities and contradictions of imperial rule predicated on racial difference. Indeed as David Arnold and other historians have shown, colonial rule built up an enormous battery of discursive practices, therapeutic interventions and policies that concerned themselves with the *physical* being of the colonized, from large state-run anti-plague campaigns to the regulation of prostitution to the control of the spread of venereal disease, to interventions in the realm of indigenous breast-feeding practices.[5] Yet, as scholars of colonial

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[3] Frantz Fanon. *The Wretched of the Earth*, trans. by Constane Farrington (New York, 1963). For a description of Fanon's significance to the history of colonial psychiatry, see also Richard Keller, *Colonial Madness: Psychiatry in French North Africa*. Chicago: University of Chicago Press, 2007, pp 164-165.

[4] See for example Ashis Nandy. *The Intimate Enemy: Loss and Recovery of Self under Colonialism.* Delhi, 1983.

[5] David Arnold. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. Berkeley: University of California Press, 1993.

psychiatry have reminded us, the mind also became a critical field for shaping ideas about race and difference. The diagnosis of mental illness cannot be accomplished by a serological exam and its prevention cannot achieved by a vaccine; rather the designation of the "normal" and "pathological" subject responds to a wide range of biological, social and behavioral considerations which provided colonial experts with fertile ground for specifying and solidifying distinctions based on race. Psychiatrists also spoke directly to questions about the mental capacity of indigenous populations to assimilate to modernity and French styles of civilization, and so played an important role in framing debates over the social and political rights of the colonized.[6]

In different ways and with different emphases, historians have worked to elaborate the ways in which psychiatric knowledge became enmeshed in wider colonial discourses about race.[7] Historians of Sub Saharan Africa like Megan Vaughan, for example, have examined how distinguishing true "madness" from merely unusual or abnormal behavior in an alien culture proved a challenge for colonial psychiatrists and officials alike. Instead, in *Curing their Ills*, Vaughan demonstrates how the "normal" African mind became pathologized, whose primitiveness was presented as the obverse of Western rationality. If all Africans were essentially abnormal in their normal state it follows that "the madman and madwoman emerge in the colonial historical record not as standing for the 'Other' but more often as being

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[6] Keller (2007), 9.

[7] For a comprehensive overview of the historical literature on colonial psychiatry see Richard Keller. Madness and Colonization: Psychiatry in the British and French Empires. 1800-1962. *Journal of Social History* 35,2 (Winter, 2001): 295-326.

insufficiently 'Other.'"[8] Mental illness stood as vivid evidence of the inability of colonial subjects to adapt to modern life and the loss of their customs.

The "insufficiently other" has since emerged as an important trope in histories of colonial psychiatry which remain largely dedicated to exploring the mechanisms by which people came to the attention of colonial authorities, whether for threatening social peace, disrupting labor regimes or, for one reason or another, simply being in the wrong place. Lynette Jackson describes this process as one of "surfacing up" in colonial Zimbabwe where confinement in psychiatric institutions (or the threat of confinement) satisfied the ideological needs of the colonial state to "domesticate" space and people.[9] In his study on the Yaba and Aro asylums in colonial Nigeria, Jonathan Sadowsky argues that the British appear to have confined patients not necessarily because their behavior was "anomalous or deviant" but instead "because they drew attention to structures of power in ways which denaturalized those structures." Sadowsky is especially interested in the *content* of madness in the colonial context, that is, the political implications of specific manifestations of mental illness in colonized patients. He cites indigenous voices to reveal how patients appropriated symbols of British dominance (military power and cars, for example) to offer an implicit critique of colonial rule. These symptoms, according to Sadowsky, should be read not as resistance per se but rather as "inchoate articulations of the stresses of colonial society."[10]

White Europeans living in the colonies could also be considered "insufficiently other" in the sense of "going native." Just as the poor and criminal were seen to compromise

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[8] Megan Vaughan. *Curing Their Ills: Colonial Power and African Illness*. Palo Alto: Stanford University Press, 1992, 18.

[9] Lynette Jackson, *Surfacing Up: Psychiatry and Social Order in Colonial Zimbabwe, 1908-1968*. Ithaca, NY: Cornell University Press, 2005.

[10] Jonathan Sadowsky. *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*. Berkeley: University of California Press, 1999.p. 76.

European hegemony, so too did psychopaths call into question the privileges of race in the colonial context. The diagnosis of mental disorders among Europeans occurred against the backdrop of more long-standing fears about mental and moral degeneration in tropical climates. Referred to as "tropical neurasthenia," this condition was thought to derive from physical exposure to intense heat and sunlight as well as the effects of dislocation, the impact of being removed from one's natural climate and social milieu. Concerns about tropical neurasthenia raised an important tension in colonial racial discourse that navigated between racial supremacy and vulnerability. For this reason, when it came to the treatment of mental illness, Waltraud Ernst argues how the British in India were primarily concerned with the health of their European settlers rather than indigenous communities[11] Historians have also increasingly examined how concerns of class and gender intersected with race to provide a more nuanced account of the ways in which psychiatrists and administrators sought to maintain white supremacy in South Asia and other colonial settings.[12]

That psychiatry brought a new degree of sophistication to colonial racism is only one (and perhaps the most obvious) feature of what has proven to be a much richer story. In the recent literature, historians have come to consider the field's development from wider perspectives: in the context of the growth of international scientific networks, as a forum for colonial debates over the obligations associated with the civilizing mission, and how

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[11] Waltraud Ernst 'Out of sight and out of mind. Insanity in early nineteenth-century British India', in J. Melling and B. Forsythe (eds), *Insanity, Institutions and Society* (London and New York: Routledge, 1999), pp. 245-67.

[12] See Waltraud Ernst. 'European madness and gender in nineteenth-century British India', *Social History of Medicine*, 9 (1996), 357-82.; Catharine Coleborne. Insanity, Gender and Empire: Women Living a 'Loose Kind of Life' on the Colonial Institutional Margins, 1870-1910. *Health and History* 14 (2012): 77-99.

knowledge of the "native mind" served as a guide for colonial policymakers.[13] From this growing body of research, spanning India and the Pacific, East Africa and the Maghreb, emerges a portrait of a profession whose science became less a tool for social control than an important means for underwriting the ideologies and structures of colonial power. In *Colonial Madness: Psychiatry in French North Africa*, for example, Richard Keller looks at how psychiatric ideas informed the colonial encounter in French North Africa. By placing Fanon's attack on colonial psychiatry in a wider history of psychiatric theories, institutions and practices, Keller calls attention to the "paradox of how a responsive, nuanced medical circle that positioned itself at the cutting edge of mental science could be at the same time a violent, uncomprehending, racist organism."[14]

This reorientation of the field has also come with a major expansion of its scope. In histories of psychiatry in the French, Dutch and British empires, scholars have demonstrated, for example, how colonies effectively served as spaces for experimentation and clinical practices and therefore acted as "laboratories of modernity" whose findings were exported back to the metropole. Others have situated the development of psychiatry in a more comparative or transnational frame to study how diagnostic categories become translated across vast cultural divides, the social function of asylums in different political contexts, and the portability of treatment regimes across the globe.

Studies from Southeast Asia, however, remain scarce with no work to date on Vietnam. In terms of the literature on the French empire, North Africa and Algeria in particular remain paradigmatic due to the influence of Fanon and by virtue of their proximity

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[13] See Hans Pols, 'The Nature of the Native Mind: Contested Views of Dutch Colonial Psychiatrists in the Former Dutch East Indies" and Jacqui Leckie, "Unsettled Minds: Colonialism, Gender and Settling Madness in Fiji" both in *Psychiatry and Empire*, eds. Sloan Mahone and Megan Vaughan. New York: Palgrave Macmillan 2007.

[14] Keller (2007), 8.

to the metropole. As Richard Keller underscores in *Colonial Madness*, Algeria's importance as a site of contestation over settlement and assimilation made the colony a logical site for the development of knowledge that insisted on the 'Algerian mind' as an ever-present threat to public safety. In particular, the psychiatric literature explaining the "over-determined difference" of the Algerian mind implied that the colonized were not ready yet for citizenship and justified the use of harsh techniques during the Algerian War.

French colonization of Indochina, by contrast, was slow and uneven. While the first conquest came in 1859, it was not until 1887 when those territories that comprise modern day Vietnam, Laos and Cambodia were formally integrated into the Indochinese Union. [See Annex for map] Due to its distance from France, Indochina only ever possessed a small white settler population and provided comparatively little migration to the metropole. As a result, it did not provoke the same kinds of questions about the possibilities of assimilation as France's North African colonies. The fact that different parts of the French empire had different relationships with the metropole undoubtedly shaped the discourse around psychiatric illness and the political stakes involved. The Vietnamese, at least at first, were thought to suffer from mental illness only rarely and common disorders were associated with more of a "psychiatric weakening" than those forms of agitation with which Muslim populations were most often diagnosed. Furthermore, while Algeria has received much more scholarly attention, it was Indochina that in the 1930s earned the praise of international onlookers for having made the most "serious efforts" of psychiatric assistance in all the empire. This study of the history of psychiatry in French Vietnam therefore fills an important gap in the historiography while also drawing out the depth of field of colonial practices and experiences.

III. Getting out of the asylum

In the history of colonial psychiatry, the asylum takes center stage, as both a symbol of colonial hegemony and as the site where the limits of this hegemony were tested, whether due to cultural misunderstanding, lack of resources or active forms of resistance within the asylum itself. Even as scholars have widened the scope for enquiry, the question of determining what is specifically *colonial* about colonial psychiatry continues to animate much of the literature. As a result, the asylum remains central to these histories in which the colonial experience is often presented as essentially a dialectical relationship between colonizer and colonized. The importance of wider social frameworks tends to be dwarfed in favor of explanations based on the dynamics of colonization: in terms of coercion and resistance, surveillance and evasion. As Waltraud Ernst warns, once "colonial medicine is abridged to its colonial provenance alone, as a tool for empire, it tends to deny political and social agency to people independent from colonial designs."[15] This makes for bad social history as it reifies ideas about what we mean by the "colonial" experience, here reduced to mechanisms of repression and forms of resistance, and the centrality of race, to the exclusion of other things. Instead she argues for a shift in emphasis, from a colonial history of medicine to a more richly textured social history of medicine in colonial settings.

One way scholars have sought a way out of this narrow focus on the "colonial" dimensions of colonial medicine has been to explore "indigenous medicine" both on its own

[15] Waltraud Ernst. Beyond East and West. Reflections on the social history of medicine(s) in South Asia. *Social History of Medicine* 20, 3 (2007): 505-527, 209.

terms and in relation to the medical systems introduced by European conquest.[16] Scholars have attempted to transcend the binaries of local and global, indigenous and European, to instead engage with the diverse forms of exchange that worked to transform medical systems. This trend is particularly pronounced in recent works on the history of medicine in Southeast Asia. Laurence Monnais, for instance, builds on her already extensive work on the history within the encounters between Western and non-Western medicines in colonial Vietnam.[17]

In her recent monograph *Mixed Medicines* Sokhieng Au approaches the study of medicine in French colonial Cambodia through a framework of "cultural insolubility" which Au defines as "differing epistemologies in French and Khmer cultures surrounding medicine and disease. These epistemologies underlie the social definition of disease, which in part determines its appropriate treatment."[18] According to Au, French and Khmer medicine can best be understood as distinct cultural systems that, despite undergoing powerful transformations during the colonial period, neither effectively hybridized nor displaced one another. Rather than frame her study in terms of simple exchanges or conflicts between two modes of medicine, one indigenous, the other western, Au uses a broadly interdisciplinary approach "to understand the process whereby vastly different cultures interacted and attempted to negotiate with and understand each other, the epistemological wrangling that resulted, and the wider social implications of the interface between Western medicine and

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[16] See David Wade Chambers and Richard Gillespie. Locality in the History of Science: Colonial Science, Technoscience, and Indigenous Knowledge. *Osiris* 2nd Series, Vol 15, Nature and Empire: Science and the Colonial Enterprise. (2000): 221-240.

[17] Laurence Monnais and Noémi Tousignant. The Colonial Life of Pharmaceuticals: Accessibility to Healthcare, Consumption of Medicines, and Medical Pluralism in French Vietnam, 1905-1945. *Journal of Vietnamese Studies* 2006 (1, 1-2): 131-166.

[18] Sokhieng Au. *Mixed Medicines: Health and Culture in French Colonial Cambodia*. Chicago and London: The University of Chicago Press, 2011, 157.

Cambodian society."[19] Here Au interprets Khmer reactions as derived from a set of particular experiences, resisting medical procedures not because they were imposed but because they made little cultural sense.[20] This is true for Cambodia as much as it is for France and helps to explain, for example, the paradox of Khmer rejection of French doctors while demanding access to (some) Western pharmaceuticals.

Au and Monnais, among a growing number of scholars, take seriously the study of culture to explain how people understood and made strategic use of different medical systems under colonial rule. Populating these histories are indigenous healers and their clients, colonial experts and bureaucrats, who are defined principally by their race and relationship to the medical field(s). Yet these histories seldom discuss the entanglements of medicine with other kinds of colonial institutions and how those under observation also occupied other social roles (as neighbors, children, notables, petitioners, etc.) that are relevant to our understanding of colonialism more generally.

Rather the focus of these new histories tends to emphasize the incomplete take-over of Western medicine in colonial settings. In the history of colonial psychiatry, for instance, asylums are typically described as "sites of a kind of creolization of pathology" in ways that are meant to signal the only partial grasp of experts over the production of psychiatric knowledge in the colonies.[21] While careful to emphasize the limits of psychiatric authority in colonial settings, scholars have largely stopped short of interrogating what the limits of expert authority can reveal about the social histories of the places under consideration and, in particular, the role of ordinary people in shaping these histories outside a strictly European

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[19] Au (2011), 7.

[20] Au (2011) 81.

[21] Sadowsky (1999), 74.

psychiatric sphere of control. As a result, these works often miss the ways in which hybrid forms of power and knowledge were produced in spaces where experts continued to exert their influence yet were also forced to engage with local understandings and practices around insanity. I argue that by considering the imposition of limits on colonial psychiatrists as a process of daily negotiation and exchange, we see less the shortcomings of a hegemonic European science than the emergence of a more diffuse, and localized, brand of psychiatric power forged between experts and non-experts.

By paying attention to the daily dynamics of institutional practice, as opposed to discourse, the asylum emerges less as a blunt instrument for the social control and medicalization of colonial society than as a valuable historical site for reframing narratives of colonial repression and resistance.[22] Psychiatrists did not come to Indochina finding a blank slate, devoid of any local expertise -- rather they encountered forms of care in the community that pre-dated French occupation and that would play an important role in the expansion of the formal asylum system throughout the interwar years. In this dissertation, I consider the development of psychiatry in French Indochina as a hybrid field of medical knowledge produced in exchanges between families and doctors, colonial bureaucrats and colonial subjects. I understand Vietnamese families as agents who, in the context of psychiatric care, pursued their own strategies of negotiation, collaboration and, at times, subversion. Armed with a different set of cultural beliefs and healing traditions, they nevertheless engaged with professional French psychiatrists to find common space for thinking about and discussing mental illness. Families, in their letters to asylum directors, worked to alternatively inform and challenge the coding of certain social behaviors as 'deviant' and notions about what counts as psychiatric knowledge as the basis for confining and releasing patients. Focusing on how the

[22] Here I draw inspiration from the work of Erica Peters. "Negotiating power through everyday practices in French Vietnam, 1880--1924." (PhD diss., University of Chicago, 2000.)

work of colonial experts came to rely on the families of patients, their neighbors and relatives, also highlights the creation of new kinds of spaces for surveillance that disrupt distinctions between the institutional and the familial and instead underscores how they worked to police each other.

This perspective draws on recent works in the history of Western psychiatry that have begun to look much more closely at the dynamic between informal patterns of family care in the community and formal medical treatment in institutions. The examination of linkages between the family and the asylum, and increasingly the crucial intermediary role of friends, neighbors and community members, has provided scholars with an invaluable opportunity to re-examine assumptions about the social role of asylums in the nineteenth century.[23] Following the contributions of Michel Foucault, historians of psychiatry worked to chart the prohibiting function of psychiatry that coded seemingly abnormal individuals as "pathological," as well as to explain the importance of asylums in the rise of a distinctly modern form of state power. More recently scholars have sought to situate the asylum within a wider social context to reveal the kinds of exchanges that shaped the construction of the category of the "insane person" and that worked to both constrain and enable the daily exercise of institutional regimes.[24]

For instance, many like David Wright now argue that the confinement of the insane, as well as their discharge and reintegration into the community, resulted from the participation of a diverse array of social actors; not, for example, as a "consequence of a professionalizing

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[23] See Andrew Scull. *Museums of Madness: The Social Organization of Insanity in 19th Century England*. Penguin Books, 1979; David Rothman. *The Discovery of the Asylum: Social Order and Disorder in the New Republic*. Boston: Little and Brown, 1971.

[24] See Joseph Melling. "Accommodating madness: new research in the social history of insanity and institutions" in Bill Forsythe and Joseph Melling, eds. *Insanity, Institutions and Society*. London: Routledge Studies in the Social History of Medicine, 1999, pp. 1-30.

psychiatric elite but rather as a strategic response of households to the stresses of social change or economic depression."[25] As Joseph Melling writes, this emphasis in current research on the detailed reconstruction of the social and cultural contexts of lunacy provision has enabled us to explore a "micro-politics of care" which shows bargaining among different actors with unequal power resources and capacities but who could nevertheless exert some degree of choice if not control over their environment.[26]

These works bring critical attention to the role of extra institutional care and, rather than a Great Confinement, insist on the historic permeability of the boundaries between asylum and community. However they remain largely restricted to nineteenth century histories of Western psychiatry and to Britain in particular.[27] In the colonial literature, references to local actors and indigenous understandings of mental illness are used primarily to frame discussions around the cultural relativity of diagnostic categories yet families rarely figure in the literature as key participants in the colonial psychiatric system or as actively shaping the system as it developed.[28]

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[25] Wright (1997), 139.

[26] Melling (1999), 6.

[27] John Walton, "Casting out and bringing back in Victorian England" in William Bynum, Roy Porter and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry*. London: Tavistock Books, 1985; Akihito Suzuki. *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820–1860*. Berkeley, University of California Press, 2006; Bill Forsythe and Joseph Melling, eds. *Insanity, Institutions and Society*. London: Routledge Studies in the Social History of Medicine, 1999; Peter Bartlett and David Wright, eds. *Outside the Walls of the Asylum: The History of Care in Community 1750-2000*. New Jersey: Athlone Press, 1999; Patricia Prestwich. "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876-1914," in Roy Porter and David Wright, eds. *The Confinement of the Insane, 1800-1965: International Perspectives.* Cambridge: Cambridge University Press, 2003.

[28] On cultural relativism in colonial psychiatric practice, see Jonathan Sadowsky, "The Social World and the Reality of Mental Illness: Lessons from Colonial Psychiatry." *Harvard Review of Psychiatry* 2003; 11:210-214. See also Sadowsky's brief discussion on the role of families in *Imperial Bedlam* (1999), pp. 54-58. Catherine Coleborne focuses on European families and colonial public hospitals, but does not address the interaction of colonial asylums with indigenous families or forms of knowledge. *Madness in*

Here I trace a kind of colonial "micropolitics" of psychiatric care to illuminate how families and communities interacted with colonial psychiatric institutions in ways that resulted not in the dissolution of psychiatric power but rather opportunities for its elaboration. I argue that everyday exchanges between French experts, colonial authorities and Vietnamese families signal not only small erosions in the authority of colonial psychiatrists, but also, and more significantly, the emergence of a new, more diffuse kind of psychiatric power. This power tied together the authority of European science backed by a repressive colonial state, to the social norms of local communities that prescribed the bounds of the conduct of individuals, as well as the obligations and duties of families charged with their care.

In this way, I am making a different kind of argument than Peter Zinoman who, in his work on the history of the colonial prison in French Indochina, challenges Foucauldian accounts that "locate in colonial environments a system of power relations marked by the pervasive circulation of disciplinary practices throughout the social body."[29] Instead he argues that colonial penal institutions, in their daily operation, represented a hybridity of modern and pre-modern forms of power that existed alongside each other, fostered instability, and produced critical fissures exploited by subaltern movements. In this study, I suggest that we think about "modern" forms of power typically associated with the reach of hegemonic institutions as also characterized by more hybrid forms of accommodation and dependency that extended out into the community. So here I seek to broaden our understanding of colonial power by uncovering a kind of middle ground whereby Vietnamese subjects succeeded in both expanding and limiting the basis for psychiatric practices in the colony.

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the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914. New York: Palgrave Macmillan, 2009.

[29] Zinoman, Peter. *The Colonial Bastille: A History of Imprisonment in Vietnam, 1862-1940*. Berkeley: University of California Press, 2001, 7.

It is important to underscore that these exchanges did not occur between equal partners but among colonial actors with differential access to power and resources, not least of which were the patients themselves. But in debating the suitability of individuals for social life, I argue that experts and lay people came to pursue their own strategies in ways that do not neatly adhere to more traditional narratives of colonial hegemony and resistance. Not all French colonial officials agreed on whether to confine certain patients and the desires of families to take care of the mentally ill at home often clashed with those of their neighbors. Indeed some families pleaded for the release of family members from the asylum while others challenged the refusal of colonial doctors to exercise the power of confinement. Remarkably these discussions largely occurred during the 1920s and 1930s, a period of high political drama in Indochina marked by prison revolts and the birth of the anti-colonial nationalist movement. In many ways this is a different kind of story about how ordinary people used colonial institutions for their own ends, and interacted with colonial experts in ways that helped specify the conditions under which the state could remove individuals from society, both for their own sake and the sake of others. So here I want to emphasize the extent to which the colonial order was negotiated even as the state sought to increasingly repress threats to its authority.

Finally, by expanding the history of psychiatry to include a wide range of social actors and institutions, this dissertation makes a series of empirical claims about what "getting out of the asylum" can tell us that's new about everyday life in Vietnam under French colonial rule. Scholars have tended to focus on the violence and economic oppression that characterized the expansion of French imperialism in the region, from the growth of the plantation economy in Southern Vietnam to the widespread political unrest of the 1930s. The tight-fisted nature of the colonial state, as well as its extreme distrust of political reforms, would set the stage for the birth of an anticolonial nationalist movement in the 1920s that would eventually wrest control

from the French in 1954. However there remains very little written on the social history of Vietnam during this period.[30] As the following chapters will show, social and economic change taxed those bonds of familial obligation on which the care of the mentally ill traditionally depended, while the movements of people from north to south, from country to city, posed unprecedented challenges to the efforts of colonial policing. This dissertation studies the history of psychiatry as a way to uncover some of the texture of daily life in French Vietnam - those emotional ties and everyday pressures that resulted in new strategies and forms of accommodation within and between families, communities and the colonial state throughout the early decades of the twentieth century.

IV. Chapter Outline

I opened this Introduction with the story of a patient named Sau who was among the first patients to ever enter the Bien Hoa asylum. Sau's movements in and out of the asylum demonstrate the wide range of social actors – including psychiatrists, prosecutors and family members - who all participated in deciding his fate. His case and others demonstrates the need for historians to get out of the asylum - and to situate the development of colonial psychiatry within both local exchanges between lay people and experts, as well as the transnational movements of people and knowledge. In this way, debates over whether patients were ready to reintegrate back into society, and the kind of care they would receive, reveals not only the limits of expert authority. Such a perspective also yields important new insights into the production of knowledge and power in colonial settings, as well as the social history of Vietnam under French rule.

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[30] See Haydon Cherry. "Down and Out in Saigon: A Social History of the Poor in a Colonial City, 1860-1940." (PhD diss. Yale University, 2012).

These themes are explored further in the following chapters. Chapter 2 lays the background for the history of confinement in Indochina. In particular, it traces the emergence of the "insane" person or, to use the French term, "*aliéné*," as an official category of person deserving of legal protections and entitled to state-provided services. In just a few decades, colonial officials moved from claiming there was very little legal basis or practical exigencies to build an asylum in Indochina to achieving one of the more comprehensive mental health care systems in the French empire. Here I draw on debates over extending France's 1838 asylum law to Indochina as a way of tracking shifting understandings about the pervasiveness of mental illness in the colony, among indigenous and European populations alike, and what should be done about it. I argue that it would take a combination of local developments and international pressures to transform perceptions about the problem of the mentally ill into a problem of colonial governance.

Chapter 3 moves from the policy and legislation regulating psychiatric care to the set up of the asylum itself: who these patients were, how they got there and what they saw when they arrived. The requirements of colonial asylums - from their physical set up, to expectations for the performance of emotional labor by the staff, to the mandate for "mixed" regimes across different classes of patients - set them apart from other kinds of colonial institutions. But in being asked to respond to a complex and unique set of imperatives, to discipline and confine, reform and heal, the realities of daily asylum management often significantly departed from the ideal. I argue, however, that these limits reflect more than just the racial prejudices of colonial society or the miserly leanings of the colonial state. They also expose the fluidity of categories and hierarchies that organized asylum life, ones that were intended to reproduce colonial order within the asylum's walls.

Chapter 4 shifts the focus to the process of determining an individual's medical diagnosis as the basis for internment and discharge. Specifically it examines the movements of asylum patients in and out of psychiatric care as the product of everyday interactions between psychiatrists, colonial authorities and the public, especially families. Throughout the interwar years, families and communities actively participated in psychiatric decision-making in ways that disrupt our notions of the colonial asylum as a closed setting where patients rarely left and run by experts who enjoyed broad and unquestioned authority. By debating the suitability of individuals for social life, Vietnamese families engaged with professional psychiatrists to find common space for thinking about and discussing mental illness, while also pursuing their own strategies in ways that significantly limited the power of experts. Debates revolved around the mental health of the patient but also the capacity of the families to assume their care upon release and the asylum itself as the most appropriate site for treatment and rehabilitation. By considering how lay people and experts came together to negotiate the confinement and release of asylum patients, this chapter offers a novel perspective on the development of psychiatric knowledge and power in colonial settings.

Chapter 5 explores the patient's journey from inside the walls of the asylum into the open fields and their eventual reintegration into normal social life. Asylums in Indochina were organized as large agricultural colonies, where patients would work the land on the path to healing and eventual liberation. These agricultural colonies offered a model of rehabilitation that connected strategies of social reform through labor across the imperial world. For colonial psychiatrists in Indochina, agricultural colonies seemed to offer a modern conception of psychiatric care that promised not only "cerebral hygiene" and discipline through physical labor but also, in simulating the appearance of freedom, a kind of moral re-education. These therapeutic and disciplinary goals came to merge with more pragmatic concerns - with nearly a

third of asylum patients participating in agricultural work, the program also off set major financial costs to the institution. Annual asylum reports reveal the ways in which colonial psychiatrists framed the therapeutic and economic imperatives for labor, and how they came to articulate a vision of "psychiatric re-education" that blurred the distinctions between patients and laborers, between institutional order and the organization of social life beyond the asylum. I argue that examining the release of patients draws new and much-needed attention to the moral and medical meanings of rehabilitation and the pressures on asylum directors to remove patients from their care.

The final chapter examines how psychiatric expertise in Indochina was produced locally in cooperation and competition with other actors, particularly members of the colonial penal administration. Until the 1930s, psychiatrists played only a limited role in the criminal justice system, charged with delivering judgments of insanity after a crime had already been committed. These "medical-legal" opinions became a flashpoint of controversy between the medical establishment, prison system and criminal courts, each of which sought to specify the nature of Vietnamese criminality and the appropriate service to be charged with providing oversight. Throughout the interwar years, psychiatrists turned to the social problem of juvenile delinquency as a way to redefine their role as experts and enhance their professional status within the colonial administration. I argue that situating the history of psychiatry within a wide institutional context yields critical insight into the complex alliances and fractures that characterized the everyday administration of empire.

V. Note on sources and methodology.

This dissertation is based on over sixteen months of research in the National Archives of Vietnam (Hanoi and Ho Chi Minh City), the National Archives of Cambodia (Phnom Penh), the *Archives Nationales d'Outre Mer* (Aix-en-Provence, France), the archives at the *Institut de médecine tropical* (PHARO) (Marseille, France), the *Bibliothèque Nationale de France* (Paris, France) and medical libraries in Paris and New York including the *Bibliothèque Inter-universitaire de Médecine* (Paris, France) and New York Academy of Medicine (New York, NY). It draws on a wide range of primary materials including patient case files, annual asylum reports, official correspondence, architectural blue prints and asylum photographs, medical treatises, newspaper articles and the proceedings from international conferences.[31]

In approaching colonial archives, Ann Stoler writes that "we must first be aware of 'what we think we already know. For students of colonialisms, such codes of recognition and systems of expectation are at the very heart of what we still need to learn about colonial policies.'"[32] This is especially true for histories of colonial psychiatry where the tropes of racism and oppression have often played a powerful (and stultifying) role in framing the kinds of questions that are asked of historical sources. In a review of the literature on the history of psychiatry in Sub-Saharan Africa, Sally Swartz offers this critique of what she calls the "reach me down" historical cliché of the colonial psychiatry-oppression link, "Through these accounts – different though they are on the surface – a discursive formation takes root, a

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[31] See James Moran, Leslie Topp and Jonathan Andrews, eds. *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*. New York: Routledge, 2007.

[32] Ann Laura Stoler. "Colonial archives and the arts of governance: On the content in the form" in *Refiguring the Archive*, C. Hamilton, V. Harris, J. Taylor, M. Pickover, G. Reid and R. Saleh, eds. Capetown, South Africa: David Philip, 2002, 92-100.

system of expectations, *despite* the archive, and in fact despite the often nuanced analyses in which they are embedded. Drawing its oxygen from words such as 'confined,' 'repressive', 'deranged', 'rebellion' it creates a dense intertexual web with an impressive genealogy," one which connects African experiences of confinement across the continent to the political concerns and disciplinary strategies of ruling elites. From this genealogy, Swartz argues, there emerges a particular "'law of what can be said" about colonial asylums that organizes the collection and interpretation of archival sources around the key themes of race and oppression.[33]

While Swartz's mission is to provide a more nuanced account about the functions of race for colonialism, my aim is different. I propose what at first might appear to be a counterintuitive approach to the study of asylum archives. Here I read patient case files for what they can tell us about life outside the asylum as much as the life inside its walls.

For historians of psychiatry, patient case files represent rich yet problematic sources. They tell an official history of madness through the eyes of the clinician while patient voices remain mostly muted if not absent. Although Foucault proposes the physician's "monologue" about madness as a critical element in the birth of modern psychiatry, many scholars have since employed innovative readings of asylum archives to instead draw attention to the "polyphony" of voices that shaped institutional narratives about mental illness. In the colonial context, case records can provide an invaluable glimpse into the experience of confinement as well as the encounter of different cultural beliefs about mental illness between doctor and patient. Yet reading colonial asylum archives also presents the formidable challenge of how to

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[33] Sally Swartz. Colonial lunatic asylum archives: challenges to historiography. *Kronos* 34,1 (2008): 285-302.

allow indigenous patients (and their families) to speak for themselves outside the trappings of a hegemonic Western discourse.[34]

In this study, I look beyond the doctor-patient interaction to study the letters written by family members on behalf of patients.[35] Why were these letters produced and what purpose did they serve? Using Natalie Davis's work on pardon tales in sixteenth century France as a model, I examine these letters as literary forms that adopted their own formalized narrative structure, thematic motifs and stylistic figures that are used by individuals to persuade those in power of their innocence, regret or sanity. Reading letters from the history of confinement can give voice to those typically ignored in the historical canon, yet they can also tell us much about the social life outside of institutions. Letters from the parents, spouses, children and other relatives of patients in asylums, for instance, can reveal a number of facets about Vietnamese life under French colonialism that have not yet received sustained scholarly attention: the practices and expectations for caregiving in the community; the emotional ties between family members; the forms of dependence and strategies for survival that guided the decision-making of households; and the ways in which indigenous understandings of mental illness helped shape diagnostic practices and informed the process of confinement and release.[36] Yet these letters also raise the thorny problem of language and the translation of

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[34] Gayatri Chakravorty Spivak. "Can the Subaltern Speak?" in *Marxism and the Interpretation of Culture*, C. Nelson and L. Grossberg, eds. Basingstoke: Macmillan Education, 1988, pp. 271-313. An excellent account of how to read patient case files can be found in Sadowsky (1999), 48-52.

[35] For letter writing in the context of asylums see Louise Wannell. Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910. *Social History of Medicine* 2007 20,2: 297-313; Catharine Coleborne. "His brain was wrong, his mind astray": Families and the language of insanity in New South Wales, Queensland, and New Zealand, 1880s-1910. *Journal of Family History* 2006 31,1: 45-65; Akihito Suzuki. "Framing psychiatric subjectivity: doctor, patient and record-keeping at Bethlem in the nineteenth century" in Bill Forsythe and Joseph Melling, eds. *Insanity, Institutions and Society*. London: Routledge Studies in the Social History of Medicine, 1999, pp. 1-30.

[36] Natalie Davis. *Fiction in the Archives: Pardon Tales and their Tellers in Sixteenth Century France*. Stanford University Press, 1988.

demands across deep cultural divides. Letters typically appear in the colonial archives in either French or in Vietnamese with a French translation attached to the original copy. Most were almost certainly written not by family members themselves but by someone whom they had hired, pointing to the additional layers of mediation that informed exchanges between doctors and patient families.

I nevertheless read these patient case files in order to uncover the experience of confinement and the pressures on those entrusted with their care, and equally to track the movements of patients in and out of the asylums and between different kinds of colonial institutions such as reformatories, hospitals, prisons and poor houses. Doing so brings together the perspectives of a wide range of social actors, both inside and outside the colonial administration, and reveals, for instance, how the priorities of medical experts did not always neatly align with those of colonial prosecutors or even other generalist doctors. While drawing primarily on official French sources, this dissertation nevertheless reveals the absence of a self-affirming narrative. Instead it highlights those episodes of crisis and points of contradiction that plagued psychiatrists in their attempt to expand their expertise beyond the asylum's walls.

Finally, studying patient files raises important ethical questions about how to make use of the stories of the suffering of individuals who were removed from their homes and often forced to travel long distances. Choosing which stories to tell also introduces a slippery tension between using "extraordinary" cases to arrive at a wider truth while also drawing on "typical cases" which necessarily become extraordinary for having been selected.[37] Here I try to resolve this tension by unpacking the anomalous and typical features of each case so as neither to flatten a patient's experience as merely representative of a larger whole nor to

[37] Swartz (2008), 1999.

emphasize the unique features of their experience as to diminish their common suffering. While I was fortunate to be granted full access to patient case files (which itself reveals the continued vulnerability of these individuals), I have elected to anonymize the names of patients to protect their identities as well as those of their families.

VI. Note on terminology.

Patient case files most often refer to patients as "*aliéné*," derived from the French term *"aliénation mentale"* or the state of being alienated or estranged from one's true rational self. Throughout the 1930s, patients were increasingly referred to by terms that denoted a more specific psychiatric diagnosis. My use of the word "insane" or "lunatic" (or any one of a number of broad diagnostic terms) in this dissertation represents a literal translation from French and does not purport to mean that these patients were actually mentally ill, only as how the French understood and expressed the need for confinement, and how families and communities made use of these terms to pursue their own strategies.

Chapter 2. The legal category of the 'insane' person in French Indochina: a background to confinement

Introduction

This chapter explores the evolution of the legal and institutional frameworks surrounding the treatment of mental illness in French Indochina. In particular, it traces the emergence of the "insane" person or, to use the French term, "*aliéné*," as an official category of personhood deserving of legal protections and entitled to state-provided services. This category first became encoded in the 1838 French asylum law which established the incapacity of the mentally ill to exercise their full political rights and imposed the mechanisms for their removal from society and confinement in an asylum.

In Indochina in the late nineteenth century, the popular belief among colonial administrators that Annamite populations did not suffer from violent forms of mental illness, therefore failing to meet the French legal definition of insanity that required state intervention, took hold. Instead the colonial government relied on local forms of care in the community that pre-dated French occupation but that would nevertheless play an important role in the eventual establishment of the formal asylum system. Whether a person legally qualified as "insane," their social and medical designation as someone who was mentally ill nevertheless taxed colonial resources in ways that could not be ignored. Mounting international pressures to expand psychiatric services in the colony throughout the early twentieth century also prompted debates about the necessity of an asylum in Indochina and the possibilities for adapting the 1838 law to the colony. These debates highlight new understandings about the pervasiveness of mental illness in Indochina, among indigenous and European populations alike, and differing opinions over what should be done about it. In particular, this chapter underscores the difficulty of translating the legal concept of insanity to a vastly different

cultural and institutional context, and the challenges associated with introducing the kinds of rights and responsibilities such a measure would entail.

French Asylum Law of 1838

The French asylum law of June 30 1838 represents a signal moment in the history of French psychiatry and modern psychiatry more generally. The product of many developments in France at the time, the law also formed the model by which other European countries developed their first legislation around mental illness. Philippe Pinel and Jean-Etienne Esquirol, the founders of modern French psychiatry, first introduced the idea that certain mental disorders were susceptible to improvement under the guidance of medical experts. They campaigned for a system of state-supported asylums based on the principle of isolation or the understanding that therapy for insanity required the removal of individuals from their habitual milieu. In their estimation, families formed an impediment to effective treatment.[1] But as historian Jan Goldstein argues, by insisting on a brand of institution-based therapy that required the oversight of a specialist, the principle of isolation also formed a "deliberate response to professional exigencies."[2] The strength of the therapeutic and scientific claims of psychiatry, together with the growing reliance on administrative sanctions to validate internment, profoundly influenced the provisions of the 1838 act. For the first time it

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[1] On the relationship between the disciplinary functions of the family and the asylum in nineteenth-century France, see Michel Foucault. *Psychiatric Power: Lectures at the Collège de France, 1973—1974*. New York: Picador, 2008 (reprint). On how ideas about the family and domestic sphere continued to shape the professional identities and practices of French psychiatry throughout the nineteenth century, see Jessica Rian Hewitt. Isolating Madness: Doctors, Families and the Gendering of Psychiatric Authority in Nineteenth-Century France. PhD thesis (University of California-Davis, 2012).

[2] Jan Goldstein. *Console and Classify: The French Psychiatric Profession in the Nineteenth Century*. Cambridge: Cambridge University Press, 1987, p. 288.

integrated the new medical specialty of psychiatry into the apparatus of the state. Its passage was considered an outstanding example of 'political medicine,' the result of a joint effort by doctors and political authorities.[3]

What were the main contributions of the law of 30 June 1838?[4] First, it provided the legal framework for two detention mechanisms, the *placement volontaire* and *placement d'office*, which were designed to safeguard the liberty and rights of the patient. *Placement volontaire* was a formal, signed request for the compulsory internment of the patient made on the patient's behalf. The order was considered "*volontaire*" not because it required the patient's consent but because it was initiated voluntarily by the patient's family or friends. The request nevertheless had to be supported by a medical certificate stating the nature of the patient's mental illness and confirming the need for treatment and confinement in a mental asylum. *Placement d'office* was an internment order made by the *préfets* in the departments or by the *préfet* of police in Paris. The order specifed the patient's mental illness and provided any evidence of dangerous behavior that compromised either the public order or the safety of individual persons.[5] In addition, the law of 1838 mandated the creation of a nation-wide network of asylums staffed by full-time medical doctors. The asylum was envisioned not merely as a hospital for patients but also as a facility for the training of future specialists. In this way, the 1838 law marked the first decisive step in the emergence of a psychiatric profession in France.

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[3] Goldstein 1987, 276.

[4] For a broad overview of the 1838 law and projects for its reform in France see Margaret Gwynne Lloyd and Michel Bénézech. "The French mental health legislation of 1838 and its reform. *Journal of Forensic Psychiatry* 3,2 (1992): 232-250. The psychiatric reassessment of the asylum was accelerated by developing distinctions between insanity and mental illness, especially as psychiatry and neurology began to merge at the end of the nineteenth century. See Ian Dowbiggin. *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth Century France*. Berkeley, CA: University of California Press, 1991, p. 164.

[5] These were also the two main mechanisms that were later adopted for use in Indochina. See Chapter 4 for a full discussion of procedures for confinement.

Almost immediately, within the first year of its promulgation, the law came under fire. Throughout the Second Empire (1752-1870), a series of virulent campaigns against the law described asylums as the "*Bastilles modernes*" and the *placement d'office* was likened to the former *royal lettre de cachet* when political dissidents or unwanted relatives were locked away without trial under the king's order.[6] During the Third Republic, the 1838 law continued to be an object of passionate debate. Between 1870 and 1940, there were some twenty attempts to persuade the National Assemblies to reform the 1838 law, including two major commissions of inquiry (one set up by Thiers in 1870 and another by Clemenceau in 1905). Even into the postwar period there were two major attempts to change the law (first in 1970 and again in 1982).

In the nineteenth century, criticisms of the law tended to center around three major concerns. The first addressed the possibility of arbitrary internment, arguing that the sanctions contained in the 1838 law inadequately protected patients from the abuse of being shut away in the asylum without just cause. This emerged from a number of scandals during the Second Empire regarding the suspicious detentions of political dissidents. Arousing the ire of the law's critics was also the absence of any role for the judiciary during the internment process. By allowing recourse to the judiciary only after the internment order has been made, the law of 1838 seemed to violate the fundamental principle of French legal tradition of the judiciary as the sole guarantor of individual liberty. Finally, by the late nineteenth century, progress in psychiatric care and methods of treatment seemed to render the 1838 law all but obsolete. With the broadening of the concept of insanity beyond the idea of the dangerous and incurable individual, and the concomitant movement towards open door care and preventive services associated with mental hygiene, critics increasingly questioned the fundamental

[6] See Arlette Farge and Michel Foucault, eds. *Le Désordre des familles. Lettres de cachet des archives de la Bastille au XVIIIe siècle*. Paris 1982.

concept of psychiatric care embodied in the 1838 act, namely that of treatment conducted by compulsory detention within the setting of an asylum.

Bringing the asylum law to Indochina

When the French first arrived in Indochina, they encountered a pre-existing legal framework around mental illness that seemed to reflect both local forms of social organization and Vietnamese understandings of mental illness. Traced to divine retribution for a prior sin, mental illness was interpreted as the work of those gods, genies and divine creatures that crowded Sino-Annamite mythology. Because of their other worldly origins, only a sorcerer was capable of ridding the body of those evil spirits (known as "*ma-qui*") intent on exacting revenge.[7] Mental illness implied not only a condemnation of the individual but also an indictment of the honor of the family as a whole who was charged with the duty of caregiving.[8] These responsibilities were formally recognized by Annamite law, which specified the judicial procedures by which families could gain legal guardianship of an individual judged to suffer from mental illness. The family was charged with exercising the appropriate oversight and would be held responsible for any crimes or disturbances resulting from poor surveillance.[9]

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[7] A more extensive discussion of Vietnamese understandings of mental illness can be found in Chapter 4.

[8] ANOM, BIB 12391, Dr. Gaide, "Les maladies mentales et assistance aux aliénés," 1931.

[9] For the full text of Article 261 of the Annamite Code detailing the legal guidelines and sanctions surrounding mental illness, see Henri Reboul and Emmanuel Régis. L'Assistance des aliénés aux colonies. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXIIe session. Tunis, 1-7 April 1912, pp. 121-123. The Annamite law limits its discussion to prescribing confinement by chains at home if the mentally ill individual had a family, and prison if they were without parents. In particular, it carefully details the responsibilities and penalties to be exacted against the family,

The first colonial regulations to address mental illness in southern Cochin China date to an October 1883 decree that created a system of provisional oversight for the care of the mentally ill in indigenous communities. A curious hybrid that recast Annamite law in French legal language, this decree reflected the uneven application of different legal traditions in the colony. The French Civil Code (also know as the Napoleonic Code) was first introduced in Cochin China in 1864 but applied only to the white population of the colony. The *indigènes*, meanwhile, continued to be governed by the Code Gia Long, the legal code introduced by the Chinese imperial court in 1810, which regulated "local" customs such as family affairs, marriage and property succession (in so far as they did not seem to conflict with the principles of French civilization). In general, French criminal law was far more prevalent than French civil law when it came to the administration of native populations. In 1881 the repressive *Code de l'Indigénat* (or Native Code) was introduced. Applied only to native populations and enforced by administrative procedures alone, the Code violated key French legal principles of universality and the separation of administrative from judicial powers.[10] The legal question of the *aliéné* sat at the intersection of civil and criminal law; by integrating concerns over threats to the public order, the management of private property and the care of the sick, it posed a unique challenge to the vagaries of colonial lawmaking.[11]

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neighbors, gardians and magristrates, if fault is determined on their part for the crimes and offenses committed by those entrusted to their care. This preoccupation with punishment formed a common point of critique among French officials when referring to the principles of this law and of Vietnamese law more generally. See for example F. Pech. "Note sur le régime légal de la Cochinchine. *Journal of the Siam Society* 4 (1907):1-18.

[10] See Emmanuelle Saada. *Empire's Children: Race, Filiation and Citizenship in the French Colonies*. Trans. Arthur Goldhammer. Chicago: University of Chicago Press, 2012; James David Barnhart also provides a comprehensive overview of the entire colonial legal system in Indochina. "Violence and the civilizing mission: Native justice in French colonial Vietnam, 1858-1914." (PhD diss., University of Chicago, 1999).

[11] Saada 2002, pp 96-97.

The 1883 decree followed Annamite law by providing the legal basis for parents or spouse to initiate a formal inquiry into the designation of an individual as "insane" and in need of legal oversight. (The decree expanded the scope for demands to include not only those initiated by family members but also those brought forward by the colonial Prosecutor's Office.) The indigenous tribunal would then take advice from the Family Council, in some instances to order an investigation into a specific case, and afterwards offer a judgment of what the French termed "interdiction" that could be subject to appeal. According to the Napoleonic Code, "interdiction" refers to a prohibition made against a person exercising civil rights him or herself, achieved by a judgment of a civil court. In the context of mental health, it denotes the legal certification of an individual as insane and incapable of managing his or her own affairs.[12] Interdiction represented the extreme end of a continuum in nineteenth century French legal culture that withheld the full exercise of rights from the insane, married women, children and criminals and, later, colonial subjects in the empire.[13] Lacking the capacity for rational judgment and autonomy, these "*incapables*" instead required tutelage (or removal from society all together) while others (primarily adult men) were free to enjoy the full exercise of their liberties. Of course, specifying the procedures by which to legitimately suppress the freedom of the mentally ill in the colony rubs up against the fact that as colonial subjects, the indigenous mentally ill never had full recourse to political rights in the first place. In this way, they can be considered as doubly relegated in the eyes of the colonial law.

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[12] Jeanne Louise Carriere. Reconstrucing the Grounds for Interdiction, 54 Louisiana Law Review (1994).

[13] Indeed the discourse on the supposed limits of the mental capacity of native populations was mobilized by colonial officials throughout the empire as an important justification for their continued subject status.

According to the 1883 decree, the mentally ill person would acquire the same functional legal status as that of a minor and entrusted to the care of a guardian referred to as a "Truong Toc" (who would exercise his functions under the authority of a village notable). The patient's family would cover all necessary costs and assume responsibility for their surveillance (which often meant placing the individual under lock and key). The "interdiction" would take effect on the same day that the judgment was rendered and the decision would be posted, within ten days, in the chambers of the tribunal and the town hall to broadcast the individual's changed status to the public.

In 1897, M.E. Assaud, the Prosecutor General and Chief of the Judiciary Service in Saigon, first raised the possibility of improving the system in place with the promulgation of the 1838 French asylum law in Cochin China.[14] There is little evidence of further discussion of this proposal until almost a decade later when in April 1908 the Governor General of Indochina wrote to the Administrative Chiefs, asking for their opinions on the extension of the 1838 asylum law (with the appropriate modifications to account for Annamite civil law). Collomb, in charge of the health service for Tonkin, replied in support of the project. He noted that despite some services available in hospitals, no comprehensive organization for the treatment of the European insane existed nor any health establishment dedicated to their care. Vietnamese patients, meanwhile, were interned at the Indigenous Hospital in Hanoi in a "cramped and insufficiently managed pavilion." He noted as well that the numbers of mentally ill in Tonkin had grown in recent years, among indigenous and European patients alike.[15] The

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[14] CAOM, Gouverneur Général de l'Indochine, 8317, M. E. Assaud, Procureur Général, Chef du Service judiciare de la Cochinchine et du Cambodge à Monsieur le Gouverneur Général de l'Indo-Chine à Saigon, September 30, 1897.

[15] TTL1, Résidence Supérieur au Tonkin, 73745, Le Médecin Principal de 1ère classe Collomb, Directeur local de la Santé du Tonkin à Monsieur le Résident Supérieur au Tonkin (3ème Bureau), April 28 1908.

Mayor of Haiphong, Monsieur Logerot, also endorsed the plan but expressed concerns over extending the provisions of the law to indigenous populations. In particular, Logerot worried over the question of whether they would be admitted to the same institutions as Europeans and what entity would be responsible for supporting the cost of their treatment.[16] The Chief of the Second Bureau also warned that villages, barring reforms to the creation of communal budgets, would not be in a position to contribute to the *Assistance Publique* and therefore help the state to cover the costs of confinement. [17] For the time being, there was the conundrum that even if the 1838 law happened to be promulgated, there would be no asylum to receive patients!

The Mayor of Hanoi similarly worried over the budget implications of the legislative project. Because the law would require the establishment of additional services, he proposed the construction of an asylum outside Hanoi where the administration could "centralize all those Annamite patients who until today have been taken care of by their family" and therefore rely on families and provincial budgets to redistribute costs. He proceeded to underscore other complications related to the antiquated nature of the 1838 law which in France had become the recent object of "many recriminations, so much that it was decided if not to suppress the law entirely, at least to completely modify."[18] He emphasized the complexity of the law and the difficulties associated with its execution. The Mayor drew on the example of a journalist in France who had reported how families would use the pretext of

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[16] TTL1, Résidence Supérieur au Tonkin, 73745, Monsieur Logerot, Administrateur Maire, à Monsieur le Résident Supérieur au Tonkin. Haiphong, May 5, 1908.

[17] TTL1, Résidence Supérieur au Tonkin, 73745, L'Administrateur Chef du 2ème Bureau, Note pour l'Administrateur Chef du 3e Bureau, Hanoi, May 7, 1908.

[18] ANOM, RSTNF, 73745, Le Maire de la Ville de Hanoi, à Monsieur le Résident Supérieur au Tonkin, Objet: A.s. de la promulgation de la loi du 30 Juin 1838 sur les établissements d'aliénés, May 7, 1908.

insanity to send one of the members of their family to an asylum or to prolong their detention, and that it was impossible for victims of the practice to denounce the charges against them.[19] As a result, the system depended on Prefects, Presidents, Prosecutors and Mayors to visit these establishments and provide important forms of oversight. He worried that if a similar system was instituted in Indochina, specifically for local populations, "we will see which dangers we would have exposed a population inclined to exercise vengeance and reprisals."

Given all these considerations, he continued, it therefore remained to be decided if the promulgation of the 1838 law was necessary at all. First, this question had to be answered: are there "*aliénés*" in Tonkin? To answer the question, he relies on the formal legal definition of "*aliéné*" (from a French legal dictionary, D.P. aliéné page 435), citing "We give the name '*aliéné*' to a person whose reason is perverted, totally or in part, but at the point at which the use of his liberty becomes an incessant danger, either for public security and order or for his own personal safety, or for his fortune, and for whom measures are taken, in the general interest of the police for public order and security and the protection of the interests of the *aliéné* during the period of confinement."

According to this definition, apparently no cases meriting the designation of "*aliéné*" existed among the Annamite populations of Tonkin. Here he adopts the widely accepted view of the time that the indigenous peoples of Indochina did not suffer from acute forms of mental illness, only those more chronic forms of dementia or imbecility. Simply lacking the full use of their mental faculties, they did not pose a serious threat to the safety of their community. As Louis Lorion, a French navy doctor, argued in his 1887 text on the distinctive

[19] For a similar account see Patricia Prestwich, "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876-1914," in Roy Porter and David Wright, eds. *The Confinement of the Insane, 1800-1965:International Perspectives.* Cambridge: Cambridge University Press, 2003

features of criminality in the region, for the Annamite, "His satisfactions, like his punishments are experienced on a purely material plane; his life is more vegetative than intellectual."[20] Dangerous forms of mental illness carrying the legal requirement of confinement therefore did not seem to apply to the Annamite population. As a result, legislation was needed to regulate proper forms of surveillance in the community rather than to oversee confinement.

Meanwhile, among the white settler population, the Mayor of Hanoi reported only a few cases of dementia (which he was careful to distinguish from true "madness") cared for at the local Hanoi and Quang Yen Hospitals. Depending on the circumstances, these patients would be sent back to France,which he deemed a "more comfortable and hygienic setting for recuperation than the colony." In any event, the small numbers of mentally ill Europeans meant that the establishment of asylums for their care would be of little practical use. As for the Annamite population, "it cares for and guards its own sick." Because of the apparent absence of any dangerous forms of mental illness in either the indigenous or European population, the Mayor voted against promulgating 1838 law especially as France had already condemned it and in the process of making significant modifications.

Morel, the Resident Superior of Tonkin, echoed the Mayor's claims that the local laws and customs sufficed for the protection of the "demented" in which the individual basically finds himself under the surveillance of the inhabitants of his village. When the "demented" becomes dangerous, "that is to say when he becomes an *aliéné* in the proper sense of the term," he is confined at the Indigenous Hospital in Hanoi where a space is reserved. However, as Morel noted, this space "truth be told is very narrow and poorly managed...its insufficiency bears witness to the difficulty of finding credits to cover the costs of a special establishment." He also worried over the costs associated with promulgating the 1838 law which would

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[20] Louis Lorion. *Criminalite et medecine judiciare en Cochinchine.* Lyon: A. Storck, ed., 1887.

require the participation of the commune for the expenses resulting from the transport and care of *aliéné*, especially before the official approval for measures that would require the contribution of funds to the *Assistance Publique*. Morel concludes his letter by stating that the promulgation of the law is "untimely," especially given its condemnation to the point of forcing its modification in France. He therefore suggests that it could be useful for the European population in Indochina but as for the *indigènes*, "for now it would run up against insurmountable financial difficulties."[21]

Others, such as Outrey, the Lieutenant Governor of Cochin China, voiced their support for the promulgation of the 1838 French asylum law to Indochina. For Outrey, "The promulgation of this law seems indispensable. Indeed it frequently happens that the Administration is obliged to confine those individuals seized by a 'furious madness,' whom it is not possible to allow to circulate freely without also compromising public security. But this practice, which is necessary, is nevertheless illegal, in the actual state of local regulations because it violates the principle of individual liberty and is not authorized in any text."

The existing 1883 decree may have organized the care of the mentally ill in the community, yet it said nothing about the legal provisions required to remove individuals from society as envisaged by the asylum law of 1838. Nor did it prescribe treatment for the mentally ill under the surveillance of certified experts. Indeed the Annamite legislation that formed the basis for the current system was described as "typical of those countries which remain insufficiently civilized. Preoccupied with enacting preventive measures against danger and the misdeeds of *aliénés* by the chaining, imprisonment, often indefinitely, of these unfortunates, or by punishments inflicted on those who are in charge of them, if they forsake their duties. It is

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[21] TTL1, Résidence Supérieur au Tonkin, 73745, Résident Supérieur Morel à Monsieur le Gouverneur Général, au sujet de la promulgation de la loi du 30 Juin 1838 sur les aliénés, June 18, 1908.

not until later, until the humane and medical conception of madness replaces the supernatural conception, that the legislation of assistance adds to the legislation of pure social protection, treatment by kindness, pity, and science instead of treatment by rituals, chains and strikes (hits)."[22] For Lieutenant General Outrey, the promulgation of the 1838 asylum law was therefore essential, both in the interest of the colonial administration, which was "insufficiently armed" against those suffering from mental illness, as well as in the interests of the patients themselves "who, in the future, can no longer be confined without the achievement of many formalities with the aim of wrapping their confinement in all the necessary guarantees for the safeguarding of their personal interest."[23] However, another decade would pass before Indochina's first asylum opened in 1919. Most mentally ill therefore remained at home with only the most extreme cases sent to hospitals where special pavillions were dedicated to their care.

For French colonial officials at the time, this custodial system appeared to be a more humane and less onerous alternative than insisting on the separation and confinement of the mentally ill, especially given the assumption that the vast majority would not trouble public safety or order. The state would only intervene when necessary and therefore divest itself of responsibility in terms of preventing of the onset of disease or providing care. This strategy of limited involvement marked the general approach adopted by the various territories that comprised the Indochinese Union (including modern day Vietnam, Cambodia and Laos) whose governance was nevertheless marked by distinctive political and administrative modes

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[22] H. Reboul and E. Régis. L'Assistance des aliénés aux colonies. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXIIe session. Tunis, 1-7 April 1912, 123.

[23] TTL2, Goucoch, IA.8/1724(2), Lieutenant Gouverneur à Gouverneur Général, au sujet de la loi du 30 Juin 1838 sur les aliénés, May 7, 1908.

of control.[24] For example, in the northern protectorate Tonkin, by the end of the nineteenth century, the only legislation that pertained to the state responsibility for insanity applied exclusively to urban areas. A December 31, 1891 law charged the mayors of various municipalities with taking the necessary steps against the insane who might compromise public morality, the security of people or the conservation of property.[25] When projects to extend the 1883 decree from Cochin China to Tonkin were discussed in 1908, the mayor of Hanoi voiced his support for the measure, remarking that doing so would obviate the need for an asylum. Rather in the event the "*dément*" or "demented" became dangerous, they would be confined at the *Hôpital Indigène* or another medical facility. Doing so would "save a lot of money," sparing municipal budgets while also sufficiently protecting patients.[26]

Not to overly burden local budgets in order to address a minor and easily managed problem remained the paramount concern for colonial officials. The status of institutionalized psychiatric care in Indochina therefore proved ad hoc at best, reserved for only those most acutely ill patients who threatened their own safety or that of others. In May of 1882, the Director of Chôquan Hospital in Saigon (dedcicated to the exclusive treatment of indigenous patients) reported the maximum capacity of the hospitals' five cabins reserved for the treatment of the mentally ill (ten patients in total) had been reached. It would therefore prove

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[24] Cochin China and most of Laos were governed directly as colonies whereas Tonkin, Cambodia and Luang Prabang were ruled as protectorates that relied to a greater extent on indigenous law. In reality, as Brocheux and Hémery make clear, these protectorates exerted "an unstable and unequal compromise between authoritarian policy of direct rule and recurrent attempts to renew the power of indigenous rulers." In the extreme case of Annam, the monarchy was retained and the precolonial juridical administration preserved almost in its entirety. See Pierre Brocheux and Daniel Hémery. *Indochina: an ambiguous colonization, 1858-1954*. Berkeley, CA: University of California Press, 2011.

[25] TTL1, Résidence Supérieur au Tonkin, 73751, La Maire de Haiphong, Gautret, à Monsieur le Résident Supérieur, September 3, 1903.

[26] TTL1, Résidence Supérieur au Tonkin, 73745. Le Maire de la Ville de Hanoi, à Monsieur le Résident Supérieur au Tonkin au sujet de la promulgation de la loi du 30 Juin 1838 sur les établissements d'aliénés, May 7, 1908.

impossible to receive any new patients. The *Secretariat Générale* of Cochin China demanded the provision of funds for the construction of four new cabins in the 1883 budget if the Administration had the intention of admitting more patients to Chôquan, stressing that it was "absolutely necessary that we construct solid cabins and that we augment the number of nurses." He drew on the example of one patient, apparently confined in Saigon's Central Prison, because "neither the cabins nor the nurses were capable of resisting this *furieux* although he had been weakened by a recent illness."[27]

While colonial doctors took the 1838 asylum law in France as their implicit model for professional practice, without the establishment and enforcement of formal legal regulations, confusion reigned. The question of whether hospital directors were required to accept all patients for whom admission was demanded, either by public authorities or by colonial subjects, proved the source of significant concern, especially given the lack of space or resources to manage the complications of mental illness. Furthermore, without sufficient numbers of European doctors to certify the presence of mental illness as an essential part of the normal confinement process, hospital directors were often forced to rely instead on the testimony of the patients' "families, neighbors, and village authorities."[28]

Repatriation and the European mentally ill

When it came to the local European population, French doctors worried most over the high rates of mental illness among the military personnel who comprised the majority of a

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[27] TTL2, Goucoch, IA.8/152(1), Note de Service pour M. le Directeur de Chôquan, 1882.

[28] TTL2, Goucoch, IA.8/162(9), M. L. Gudenet, Administrateur de Thudaumot, à Monsieur le Directeur de l'Interieur (3e Bureau), October 29, 1887. This reliance on families and communities for the purpose of establishing the basis for confinement forms the main topic of Chapter 4.

small but growing white presence in French Indochina. Doctors estimated 2.3 cases of mental illness for every 1000 troops. To explain these high rates, the director of Indochina's health service would later observe, "Among the military one often finds sunstroke as a result of exposure to intense heat and light, and alcohol intoxication...these influences, combined with the pressures of incessant surveillance associated with posts in the highlands and the exaggerated sense of responsibility among the chiefs, result in nervous tensions" not to mention the role of "acquired or inherited pathological defects."[29]

In 1880 the Governor General of Indochina, Charles Le Myre de Vilers, took the first steps to care for European patients when he agreed to build a pavilion dedicated to the mentally ill at the Military Hospital in Saigon.[30] Hospital beds would provide temporary relief for patients until they could be repatriated to France. Many factors contributed to the conclusion in favor of the repatriation of Europeans. First, doctors considered the European climate absolutely necessary for the improvement of the mental health of European patients.[31] This argument emerged out of widespread beliefs about the difficulties of whites to adapt to tropical climates, most clearly expressed in the condition known as tropical neurasthenia. As other scholars have observed, “neurasthenia” implied the effects of dislocation, the impact of being removed from one's natural climate. The diagnosis raised an important tension in

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[29] H. Reboul and E. Régis. L'Assistance des aliénés aux colonies. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXIIe session. Tunis, 1-7 April 1912, p. 132. Information in the text provided in the report by Dr. Rangé, Doctor-Inspector of Sanitary and Medical Services in Indochina, on February 24, 1911.

[30] TTL2, Goucoch, IA.8/085(3), arrêté du Gouverneur General a.s. Construction d'un pavillon pour les aliénés à l'hôpital militaire de Saigon, Novembre 22, 1880. European patients in Tonkin, meanwhile, received treatment at the *Hôpital de Hanoi*.

[31] TTL2, Goucoch, IA.8/104(1), Analyse de l'Affaire: Demande d'admission dans un asile d'alienes de Mlle. Henriette L., September 24, 1894; See also TTL2, Goucoch, IA.9/104(1), Le Dr Delrieu, médecin principal de 1ère classe, Directeur du Service de Santé en Indochine, au sujet de "Monsieur V" à Monsieur le Résident Superieur au Tonkin, Hanoi, October 22, 1903.

colonial racial discourse that navigated between racial supremacy and vulnerability. In an interesting move, variations on this argument would later be used to protest against exporting Vietnamese patients from northern Tonkin to the Bien Hoa asylum in the South on account of the difference in climate.[32] Second, concerns about the exposure of European patients to contagious disease in major hospitals also helped to consolidate colonial opinion in favor of repatriation.[33] Furthermore, the alternative of keeping European patients in Indochina raised difficult questions about the responsibility of the colonial state to care for mentally ill patients indefinitely especially without the necessary specialists and resources at hand.[34]

In November of 1902, the colonial administration signed a contract with the St. Pierre Asylum in Marseille formalizing an agreement to receive French patients from Indochina.[35] The agreement stated that patients would be admitted and cared for at a rate of two francs per day. Before they departed for France, patients were required to gather the necessary paper work including their background and legal status, as well as a medical certificate detailing the particularities of their case and verifying the lack of any symptoms of epidemic or contagious disease. They were also required to bring with them any clothing that would account for the climate difference between Indochina and France. The costs of treatment, transportation,

[32] See Laurence Monnais. Colonised and Neurasthenic: From the Appropriation of a Word to the Reality of a Mailaise de Civilisation in Urban French Vietnam. *Health and History* 14,1 (2012): 121-142.

[33] TTL2, Goucoch, IA.8/104(1), Le Docteur Henaff, Chef du Service de Santé de la Cochinchine du Cambodge et du Laos, à Monsieur le Lieutenant Gouverneur de la Cochinchine, Saigon, July 15 1903. These concerns over contagion also provide a sense of the poor sanitary conditions found in hospitals during this period.

[34] *Ibid*. See also TTL2, Goucoch, IA.8/104(2), Le Médecin principal de 1ère class Henaff, Sous-Directeur du Service de Santé en Cochinchine, au sujet de "Madame M," à Monsieur le Lieutenant-Gouverneur de la Cochinchine, October 23, 1908.

[35] TTL2, Goucoch, IA.8/097(8), Contrat au sujet de l'hospitalisation des maladies de Cochinchine atteints d'aliénation mentale, November 22, 1902; See also TTL1, Goucoch, IA.9/104(4), Projet de traité avec l'asile public d'aliénés à Marseille, extrait du Conseil Colonial, Séance du 4 Septembre 1902.

correspondance, etc., incurred by the Bouches-du-Rhone government would later be reimbursed by the administration of Cochin China. The case of Henriette L., however, illuminated gaps left unresolved by the new legislation, particularly over what to do about indigent European patients. The Colonial Council in Cochin China decided in 1894 that they would pay the costs of her repatriation, so long as the costs of hospitalization in France were covered by her department of origin or by public assistance in the metropole.[36]

Of all Europeans ever repatriated to France, the vast majority came from the military. In the ten years following the formalization of the agreement with the Asylum St. Pierre, 209 patients were sent back to France, including 177 military officers and 32 civilians. Whereas former military were first sent to the Military Hospital in Marseille and, after a time of observation, sent either to the Saint Pierre asylum or the nearby Pierre Feu asylum, civilians found themselves sent directly to Saint Pierre. Vietnamese members of the military were also eligible for repatriation. From 1900 to 1905, 94 cases among the European military were sent to France as well as 14 indigenous cases.[37]

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[36] TTL2, Goucoch, IA.8/104(1), Mesures à prendre lorsqu'un cas d'aliénation de français se produit en Cochinchine, 1903. The Colonial Council was a body tasked with assisting the Governor of Cochin China on issues related to colonial laws, land, domestic transportation and public works.

[37] As of 1912, the Saint-Pierre asylum had received from Cochin China: in 1903, 2 women (mania); in 1904, 3 patients (melancholy, mental debility, mania); in 1905, 3 patients, 2 men and one women (general paralysis, dementia, melancholy); and one case in 1910 (manic excitation). Of these 9 patients, 4 died, 4 were cured, and one had improved but not to the point of cure. Source: H. Reboul and E. Régis. L'Assistance des aliénés aux colonies. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXIIe session. Tunis, 1-7 April 1912, p. 139.

First proposals for an asylum

At first, discussions to formalize repatriation included the possibility of sending all mentally ill populations, indigenous and European alike, to France. However this proposal was soon abandoned. At the August session of the Colonial Council in 1902, when projects for the treaty with Marseille were first discussed, the commission charged with providing recommendations expressed their concern over the repatriation of indigenous patients who would be hospitalized with "1200 to 1300 other French patients and forced to endure a different climate and diet to which they were not habituated." Pech, a French lawyer and head of the Commission, suggested that this might even harm their health and asked if it would not be better to create in Cochin China a special asylum dedicated to their care. Besides the onerous costs of patient transport, Pech questioned the practicality of "sending a mad person 4,000 leagues in order to try to recover his sanity." The Council decided to table the question of sending indigenous patients to France and instead to explore the option of creating an asylum in Cochin China.[38]

A little less than a year later, on August 1, 1903, the Council voted for the creation of an asylum for both the indigenous population and "foreign nationals" of Asian descent in Cochin China with the view of servicing the entirety of Indochina. The idea was that it would be preferable to concentrate resources across the Indochinese Union than to create multiple institutions. The Council therefore proposed that Cochin China support half the costs of the establishment. The other territories of Indochina would share the remainder of the costs, pro-

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[38] TTL2, Goucoch, IA8/104(4), Rapport de la Commission, August 30, 1902. Among those Vietnamese who had been sent to France as infantrymen or laborers, it was feared that new cases of madness might appear. See TTL2, Goucoch, IA.8/294(1), Le Gouverneur General de l'Indochine à Monsieur le Gouverneur de la Cochinchine, Saigon, January 18, 1918.

rated by the number of their inhabitants. The costs of surveillance and food for patients would be reimbursed to the local budget of Cochin China depending on the number of days of hospitalization incurred by patients from each region of the Union. An official decree would set the daily rate of patient care.

Due to the project's expected high price tag, Rodier, the Lieutenant Governor of Cochin China, wrote to the Resident Superior of Tonkin in the North to ask if he would help share in the financing of the asylum. The Resident in turn asked those French provincial chiefs under his jurisdiction for their opinions about the need for the asylum in their particular districts. Their responses provide important insight into strategies for addressing mental illness prior to the birth of the asylum in Indochina and to what extent mental illness had emerged as a problem of colonial governance by the early twentieth century.

Responses to the inquiry varied considerably. Many provincial chiefs reported a very low incidence of mental illness. One noted that in the two years he had served as the chief of the province of Hai Duong, he recalled only one incident when he had encountered the problem of mental illness.[39] The chief of Yen Bay, meanwhile, reported no cases of mental illness in his province. One hypothesized that the rarity of more "tragic" or violent forms of madness could perhaps be attributed to the low rates of alcoholism in his region.[40] Those individuals designated as mentally ill were largely considered "inoffensive," marked by, to use more descriptive language, a "softening of the brain." As a result, they did little to threaten public security. As the chief of Thu Lang Nhuong province reported, "They rarely leave the village of their birth, live off the compassion of others...as a result there is very little urgency

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[39] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Haiduong à Monsieur le Résident Supérieur (3ème Bureau), October 19, 1903.

[40] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Sontay à Monsieur le Résident Supérieur, October 21, 1903.

to adopt the project of constructing a centralized asylum for the insane." He remarked that funds would be better spent in the establishment of a leper colony in Tonkin, maternity wards and schools in Hanoi for the training of mobile vaccination teams and, above all, the education of indigenous midwives.[41]

The provincial chief at Truyenduang thought differently and instead described the necessity of constructing an asylum from "a humanitarian point of view as much as the maintenance of order." He worried about sending patients from Tonkin to an asylum in Cochin China due to the change in climate, as well as concerns over the high costs of transport and the difficulties of negotiating with navigation companies who, he anticipated, would refuse passage to the insane.[42] He also objected to the project on the grounds of separating patients from their families, especially if they did not disturb public security or order. Indeed many provincial chiefs feared that removing patients from their families would not only appear inhumane but also politically unwise. The Chief of Haiduong, for instance, worried such a move would be poorly received by affected families who, while constituting only a small proportion of the population, had nevertheless "not yet given any worry to the administration."[43] The chief of Hung Hoa also insisted that the insane were in general well taken care of by their families who would not be willing to send them to an asylum. He remarked on the beliefs of the local population who "do not believe in the incurability of madness and whose hope for a cure more or less complete always subsists" and who, as a

[41] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Thu Lang Nhuong à Monsieur le Résident Supérieur, October 17, 1903.

[42] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Truyênduang à Monsieur le Résident Supérieur, October 19, 1903.

[43] TTL1, Résident Supérieur du Tonkin, 73750, L'Administrateur Résident de France à Haiduong à Monsieur le Résident Supérieur (3ème Bureau), October 19, 1903.

result, would only view the asylum as a "place of last resort."[44] According to the Resident at Bac-Dan, Vietnamese families assumed the spiritual causes of madness and performed special prayers and sacrifices on the behalf of the patient. For these reasons, "affected families will not consent to voluntarily confine the mentally ill in a special asylum - they refuse to believe that our doctors can cure them." As a result, the question of obligating families to deliver their family members to the asylum, “risk creating difficulties of a somewhat delicate nature, which is something to consider." It also undoubtedly meant that the colonial government could not count on families to support the cost of confinement.[45]

Others remarked on the negative effect of this separation on the possibilities of the patient's rehabilitation. For example, the provincial chief of Sontay argued against "pull[ing] the insane away from their natural milieu where there is still a chance for recovery, for there they can more easily reclaim their consciousness of themselves and the world around them than in an agglomeration where melancholy and desperation could not but aggravate their mental state."[46] Given these concerns over family reactions, reinforced by the costs and difficulties of transport, many provincial chiefs recommended the creation of several asylums rather than one centralized asylum far away. The notion that Tonkin should undertake a similar project of its own was a constant refrain.[47]

[44] TTL1, Résident Supérieur du Tonkin, 73750, L'Administrateur Résident de France à Hung Hoa à Monsieur le Résident Supérieur, November 5, 1903.

[45] TTL1, Résident Supérieur du Tonkin, 73750, L'Administrateur Résident de France à Bac Ran à Monsieur le Résident Supérieur, November 13, 1903.

[46] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Sontay à Monsieur le Résident Supérieur, October 21, 1903.

[47] Because it the anticipated costs of care for patients were relatively high, some suggested placing asylums in wealthy regions, with access to rice fields in order to decrease the costs of food. See for example TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Bac Ran à Monsieur le Résident Supérieur, November 13, 1903.

Of course those provincial chiefs who perceived a greater problem of mental illness within their own jurisdiction, especially in the provinces of Thuy-Ly and Ninh-Binh (which counted 11 "*aliénés*"), were more likely to vote in favor of the establishment of an asylum in Cochin China. The reasons for favoring the project proved equally diverse. While most chiefs agreed with their colleagues that insanity was quite rare in Tonkin, some nevertheless supported the project on practical grounds. It would relieve pressure on the administration from the demands of families who, in the province of Phu Lo for instance, would apparently at times request the Resident take responsibility for the troubled family member. The colonial administration, however, was presented with little option beyond sending patients to the Indigenous Hospital in Hanoi where the surveillance insufficiently protected patients against accidents.[48] The asylum would care for those "calm" patients in a more efficacious manner than families or villages while also protecting communities from violent individuals by removing them from society.

Many provincial chiefs invoked the language of humanity in opposition to the project by noting the difficulties of separating patients from their families. Others in favor of the asylum would also often speak in the language of humanity but in terms of protecting patients from wrongful and often brutal treatment. The chief of Ninh Binh province declared the construction of the asylum to be of the "highest humanitarian and moral order." He noted that, at best, patients would be tended to by their family members and at worst, especially if they were dangerous, would become the objects of repulsion and brutal violence including enclosure in cages.[49] Such a practice proved "disastrous for the moral education of the

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[48] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Phu-Lo à Monsieur le Résident Supérieur, October 19, 1903.

[49] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Van Bui à Monsieur le Résident Supérieur, October 27, 1903.

people."[50] Moral lessons waited not just in witnessing the poor treatment of the insane but also in observing "the sad spectacle of their demise," another benefit of removing patients to the asylum.[51] Others floated the possibility that cures among mentally ill at hospitals would over time dissipate "ignorance and popular loathing" of mental illness and the popular notion of the asylum as a place of last resort.[52]

At the conclusion of the inquiry, the Bureau Chief summarized these responses in a letter to the Resident Superior of Tonkin, noting a general consensus that the creation of an asylum would be very useful from both a humanitarian point of view and from the perspective of maintaining order. Yet "the advice generally expressed is that the establishment must be installed in Tonkin if we want to attain the desired goal. Although it would come with a high price, at least it would have the advantage of not offending the morals and beliefs of the *indigènes* by removing their family members to far-flung regions of the colony." In December of 1903, two months after the initial inquiry, the Resident Superior relayed the news to the Lieutenant Governor of Cochin China, writing that it would be "impossible" for the local budget of Tonkin to support the project of an insane asylum in Cochin China.[53] This decision would delay the project for years to come.

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[50] TTL1, Résidence Supérieur au Tonkin, 73750, L'administrateur-Résident de France Duvilliet, à Monsieur le Résident Supérieur au Tonkin, à Hanoi, Novembre, 4, 1903.

[51] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Quang Yen à Monsieur le Résident Supérieur, November 10, 1903.

[52] TTL1, Résidence Supérieur au Tonkin, 73750, L'Administrateur Résident de France à Bac Ran à Monsieur le Résident Supérieur, November 13, 1903.

[53] TTL1, Résidence Supérieur au Tonkin, 73750, Minute de la lettre no 248 du 14 Décembre 1903 en Résident Supérieur à M. le Lieutenant Gouverneur de Cochinchine.

Mounting pressures: local and international influences

The development of a legal and institutional infrastructure addressing mental illness in Indochina was, in this way, characterized by a series of fits and starts. At the turn of the twentieth century, one could say that colonial policy around mental illness represented more of a social action rather than a medical one with recourse to the hospital used to segregate and confine rather than to diagnose and treat. Nevertheless the lack of experts and more comprehensive regulations generated confusion and placed increased pressure on what resources did exist for the treatment of the mentally ill in the colony, especially for those doctors charged with their care. It would take a combination of local developments and international pressures to transform perceptions about the problem of the mentally ill as a problem of colonial governance and to re-commence the search for a more permanent solution.

While the initial inquiry into the creation of an asylum stalled, the early twentieth century nevertheless marked a broad expansion of Indochina's colonial administration, including its health service and hospital network.[54] In 1897, a general budget for Indochina was created including provisions for the creation of a health care director for each territory and the application of the French law of 1892 in Cochin China (which mandated any person practicing medicine to have a doctorate in medicine). A law passed the following year, in January 1898, established a preliminary plan regarding the classification of hospitals, the conditions of admittance and their general functioning. In 1902, the French public health law was put into effect throughout Indochina and the Hanoi School of Medicine was opened its

[54] For a comprehensive overview of medical policy in Indochina see Laurence Monnais. *Medecine et colonisatio*n: l'aventure indochinoise, 1860-1939. Paris: CNRS Editions, 1999.

doors for the purposes of training "auxiliary" doctors (a term used to designate local physicians who remained subordinate to their French counterparts).

In 1905, the Indigenous Medical Assistance Program (*Assistance Médicale Indigène* or AMI) was established. The first of its kind in a French territory (along with that of French West Africa), the AMI oversaw a vast health care program including both preventive and treatment programs and the creation of a basic hospital network. The service formed an integral part of France's broader civilizing mission by providing free health care in facilities funded by various local, provincial and municipal budgets. Animated more than just by a "duty to help," earning the approbation of the local populations formed one of the explicit goals of the expansion of the colonial medical service.

1906 witnessed the first wave of construction under the purview of the AMI. By 1908, Indochina was home to 153 medical institutions, both publicly and privately financed, including five major hospitals. Much of this expansion occurred in Saigon, Hanoi and other large urban centers, resulting in major disparities in access to medical care as compared to rural regions. This was especially true for Cambodia and Laos that had to make do with a loose network of makeshift and poorly supported hospitals.[55] These new hospitals, however, soon became overcrowded with colonial officials reading demands for services as evidence of increasingly favorable public opinion towards Western medical practices. In 1908, the Indigenous Hospital of Hanoi reportedly housed one hundred patients per room instead of ten (its theoretical capacity). As a result of the overcrowding, in the words of historian Laurence Monnais, it became clear that Indochina's facilities would have to "build, rebuild and specialize: to build to respond to a growing demand, to rebuild to combat the weather damage

[55] See Sokhieng Au. *Mixed Medicines: Health and Culture in French Colonial Cambodia*. Chicago and London: The University of Chicago Press, 2011.

that caused a tremendous strain on limited budgets, and to specialize to make the capital a recognized center of French medicine and a showcase for its scientific expansion."[56]

This push for the specialization of Indochina's health services occurred as strains on the meager resources dedicated to mental illness in the colony continued to grow. In October 1904, Lieutenant Governor Rodier wrote to the Provincial Chiefs in Cochin China about the growing numbers of patients at Chôquan Hospital in Saigon suffering from mental illness and other incurable diseases such as paralytic beri beri and chronic bronchitis. In order to "put an end to this state of affairs" which "detours the hospital from its true destination," Rodier commissioned a new study for the creation of an asylum. While waiting for its eventual approval and construction, he stressed that the mentally ill and other "incurables" could no longer remain hospitalized at Chôquan. Those currently under treatment were to be returned to their village of origin and placed under the guard and surveillance of the local notables. Rodier therefore asked the provincial chiefs to take the necessary steps to protect patients upon their return as well as to ward off any danger they might present to public security. Medical care would be provided by the provincial doctor or, in his absence, by the "nurse-vaccinators" trained at the *Ecole Pratique de Médecine* at Chôquan.[57]

In 1906, Chôquan Hospital reported fourteen cases with "mental troubles" diagnosed with a range of mental and neurological disorders including: epilepsy, partial or full paralysis,

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[56] These hospitals and clinics also served as important sites for medical research. Laurence Monnais. "In the Shadow of the Colonial Hospital: Developing Health Care in Indochina, 1860-1939" in *Viêt-Nam Exposé: French Scholarship on Twentieth-Century Vietnamese Society*, Gisele L. Bousquet and Pierre Brocheux, eds. Ann Arbor: University of Michigan Press, 2002, 174.

[57] Chôquan became a training hospital for the School of Practical Medicine of Chôquan in 1904, the first of its kind and the colony and a model that others would follow. See Monnais (2002), 150; TTL2, Goucoch, IA.8/1724(3), Circulaire: au sujet de l'hospitalisation des aliénés et des incurables sans ressources, Le Gouverneur de 1ère Classes des Colonies Rodier, Lieutenant-Gouverneur de la Cochinchine, a MM. les Administrateurs, Chefs de province de Cochinchine, October 8, 1904.

hysteria, monomania, "mental troubles" and idiocy. Two died of beriberi. The construction of an isolation pavilion was anticipated for 1907. Comprised of ten cabins, to be placed in the most distant wing of the hospital, the new pavilion would allow the hospital staff to keep the insane under observation without disturbing the other patients.[58] Over a nine-year period, between 1902 and 1910, Chôquan received a total of 209 mentally ill patients or an average of 23.2 per year.[59] Most patients were returned to their home villages after a period of isolation at Chôquan. In July 1908, the Municipal Hospital in Cholon, also in Saigon, reported receiving about twenty mentally ill patients per year.[60] Members of the Colonial Council, including both Vietnamese and French representatives, continued to recommend the establishment of an asylum, considering that "day by day cases of 'furious madness' become more numerous and constitute a public danger against which administrative and judicial authorities are presently disarmed."[61]

Meanwhile, in northern Tonkin, colonial administrators met with similar challenges over what to do with mentally ill patients who were too ill or violent to be taken care of at home. The Indigenous Hospital in Hanoi received some indigenous patients while Hanoi and Quang Yen Hospitals accepted European patients. Yet only the Hanoi Hospital possessed the facilities specifically dedicated to the care of the mentally ill, consisting of three distinct cells

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[58] By 1912, "*aliéné*" had become a category in the official record-keeping of Chôquan hospital. TTL2, Goucoch, IA.8/096(8), Situation journalière des malades traités à l'Hôpital de Chôquan.

[59] Reboul and Régis (1912), 135.

[60] TTL2, Goucoch, IA.8/1724(2), Monsieur F. Drouhet, Sécretaire Général des Colonies, Maire de la Ville de Cholon à Monsieur le Lieutenant Gouverneur (3ème Bureau), Saigon, July 31, 1908.

[61] TTL2, Goucoch, IA.8/1724(3). The documented is undated but found in a file that spans 1904 to 1908.

whose construction started in April 1908.[62] Between 1906 and 1910, the Indigenous Hospital in Haiphong (a major port city just south of Hanoi) received a total of twenty-two mental patients which they kept in common rooms or isolated in "disciplinary rooms" (or *"locaux disciplinaires*" typically reserved for sick criminals) when they became agitated. By 1916, the Hospital still lacked facilities dedicated specifically to the care of mentally ill patients, making it effectively impossible to isolate them from the rest of the patient population. As a result, Sivelle, the Commander of the Indigenous Guard in Haiphong, complained that the colonial government was reduced to placing patients under the surveillance of their families and villages, a surveillance that was necessarily "illusory" given the nature of "indigenous constructions that were not suitable for the isolation of individuals." He quoted the words of a local notable (commonly referred to as a "Ly-Truong") in the village of Luc-Hanh (in the suburban zone outside Haiphong) who, after hearing Sivelles' reproaches, observed, "not without reason, that to not keep individuals constantly bound hand and foot there is little possibility of preventing them from evading when the desire strikes them."[63]

The picture that emerges from these accounts is that of an improvised and incomplete system, premised on sending only the most acutely ill patients to generalized services in hospitals if available. Those who posed a more serious risk to public security were destined for prison cells or, whenever possible, immobilization in a cot at a hospital.[64] It was within the context of increasing numbers and pressure on the system that doctors pushed for a more complete account of mental illness in the colony, prompting French officials to continually

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[62] See TTL1, Résidence Supérieur au Tonkin, 73751, M. Gautret, Maire de Haiphong à Monsieur le Résident Supérieur, September 3, 1903.

[63] TTL1, Résidence Supérieur au Tonkin, 73757, L'Inspecteur 3ème classe Sivelle, Commandant la Brigade de Garde Indigène à Haiphong à Monsieur l'Administrateur-Maire de la Ville, April 26, 1916.

[64] TTL1, Résident Supérieur du Tonkin, 73751, Feuille 107, Fait à Bac-Ninh, April 12, 1916.

revisit the question of creating an asylum in Indochina in 1907 and again in May 1908.[65] In 1910, Governor General Klobukowsky opened the October 10 session of the *Conseil Supérieur de l'Indochine* by expressing his vote in favor of the foundation of an asylum in Cochin China. Two days later, the Vice President of the Colonial Council, Dr. Flandrin, submitted a report that highlighted the poor conditions of care for the mentally ill and echoed the urgent need for an asylum. He spoke of a recent visit to Chôquan Hospital where,

> like me, gentleman, you had before your eyes a poor devil, a veritable wreck of a human, a victim of a tenacious atavism or one of those diseases which throws a profound obscurity into the human brain. He was chained at the heart of a cell which today we no longer even give to the worst criminals: he does not receive any light of day - the only thing that could have him a bit of joy, to awaken those gentle sensations among the miserable - only that which comes through a thick door, pierced by a window and only opened from time to time, is all that he can think about. A life this miserable, in our time, can only continue if it is ignored. To know, that is to condemn. Does our colony not have the obligation to create, without delay, an establishment where the right to light, the right to a means of existence ("*la vie matérielle*") since these disinherited are refused those moral and intellectual pleasures by fate and by nature.[66]

Here we see one of the earliest articulations of the mentally ill person in Indochina as a person deserving of protections and the obligations of the colonial state to provide a minimum level of care and comfort.

With increasing numbers of patients testing the capacity of hospital administrators and the budgets at their disposal, colonial doctors and officials tried to determine more accurately the numbers of mentally ill in the colony who had not yet been captured by official hospital statistics. In general, mental illness among Annamite populations continued to be perceived as quite rare at least as compared to European populations in the metropole. The medical

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[65] A commission was created to discuss the possible establishiment of an insane asylum in Cochin China on November 14, 1907. On 3 May 1908, a decree was issued for the creation of the Bien Hoa asylum. TTL2, Goucoch, IA.8/1724(2), Outrey, Le Lieutenant Gouverneur de Cochinchine au Président du Conseil Colonial au sujet de la commission chargé d'examiner la question de la création en Cochinchined'un asile d'aliénés, April 16, 1908.

[66] *Le Courrier saigonnais,* Vendredi 14 October 1910. As quoted in Reboul and Régis (1912), 126-127.

inspector for Indochina, Dr. Rangé, offered this explanation in a 1912 report on the state of mental illness in the colony, presented at the 22nd meeting of the Congress of French and Francophone Alienists and Neurologists (*Congrès des médecins aliénistes et neurologists de France et des pays de langue française*) in Tunis, "The Asian populations of our Indochina colony still ignore almost all of occidental civilization, impassive, indifferent to questions about the future which impassion us, opposing a conservative quietude of mental equilibration to the incessant agitation of the European, still unscathed, at least for the time being, but for the defects and degeneration engendered by alcohol intoxication, these populations will supply rare subjects for the alienist."[67] This language typifies much of official characterizations of life in the colony as, for example, "colorless and monotone, deprived of any activity, ambition or worry among indigenous populations who were mostly farmers." Accordingly, for those found to be mentally ill, their disorders generally represented more of a "psychic weakening" than true agitation.

These descriptions stand in dramatic contrast to how French psychiatrists spoke of the Muslim populations in their North African colonies at the 1912 meeting. The colonial medical literature often presented the "Algerian mind" as an ever-present threat to public safety, characterized by an "over-determined difference" rooted in the "constitutions, temperaments and traditions invariably blazed a path toward criminally impulsive behavior." Historian Richard Keller offers this explanation of the racial implications of this discourse, "Algeria's importance as a site of contestation over settlement and assimilation made the colony a logical site for the development of this knowledge...An insistence on the biological nature of psychological constitution that had shaped approaches to difference in the colonies since the

[67] Reboul and Régis (1912), 124.

turn of the century lent itself easily to explicit political advocacy."[68] Indochina, by contrast, possessed a much smaller white settler population and furnished many fewer migrants to the metropole so it did not provoke the same kinds of questions about the possibilities of assimilation as Algeria. The stakes of the racial discourse around psychiatric illness were therefore different.

While some attributed the relative lack of mental illness in the colony to the unique aspects of the Annamite personality, others offered another kind of explanation: they stressed that the perceived rarity of mental illness in Indochina was "certainly much more *apparent* than *real*" especially given the lack of reliable statistics.[69] Indeed doctors and other colonial officials often complained about the imprecise basis for understanding mental illness in the colony. Even Rangé underscored in his own report,

> It is difficult to give here a statistic indicating the percentage of mental illness in the population. Even in urban centers, families only rarely bring themselves to a European doctor; the sorcerer only is consulted, and often the *dément* (the 'demented') is relegated to a corner, if he is inoffensive, and enclosed in a cage made of bamboo if he is dangerous. It is only by chance that we are informed of his existence. The figures...given by the chief doctors of the provinces are not comparable with each other. Some note only those cases that they themselves observed at the hospital, while others note all those cases which have been signaled by the notables without proceeding with a verification. Given these conditions, the most wise and prudent thing to do would be to not come to any sort of generalization and instead simply report the cases as signaled province by province.[70]

The diagnostic procedures upon which assessments were based also came riddled with errors, the reports from medical institutions filled with imprecise and vague mentions of "mental troubles," "mental alienation" and "idiocy" and confusion among different diagnostic categories.

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[68] Keller 2007, pp. 138-139.

[69] Reboul and Régis (1912), 134. [Italics original]

[70] *Ibid.*

In a 1913 article published in a Parisian medical journal, Henri Reboul, a physician and Director of Public Health in Indochina, also complained about the poor quality of available mental health statistics. Based on his own personal documentation, and information gathered from local authorities, Reboul determined that while the incidence of mental illness was low the absolute number of mentally ill, guarded in their villages, remained elevated. He estimated on average one hundred mentally ill for every six million inhabitants of Annam, all while admitting this was probably on the low end. According to Reboul, because Annamites worried over their reputations, they tended to hide their insane family members whom they considered like a blight or defect on the family's honor. As a result, most of the patients that his service received at the main hospital in the city of Hue arrived on the behest of police after displaying eccentric behavior in public spaces. Indeed the growth of urban populations in cities like Hue and Saigon throughout the early twentieth century supplied large numbers of migrant workers in search of new opportunities as well as vagabonds, some suffering from apparent mental disorders, who had been abandoned by their families or villages. New forms of transportation including roads, canals and trains, made it easier for people to circulate throughout the colony while also introducing new challenges for the colonial police force who aggressively pursued the punishment of vagrancy as a criminal offense. Some of these vagrants were sent directly to hospitals for psychiatric observation and subsequently on to the asylum.[71]

Reboul deplored the fact that the two cabins dedicated to the mentally ill at the hospital ran at full capacity and he often had to send patients to the room designated for hospitalized prisoners due to the lack of space. Yet Reboul was convinced that once a regular

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[71] On the rise of conviction rates among vagrants and beggars in early twentieth century Cochin China, see Haydon Cherry PhD dissertation (2011), p. 158. Contemporary observers also remarked on the growth in vagrancy in the colony. See Maurice Chautemps, Le Vagabondage en pays annamite (Paris: Librarie Nouvelle de Droit et de Jurisprudence, 1908).

hospital service functioned and families knew that they could entrust their patients with the Health Service, run in good conditions, "we will discover a whole other site of local pathology which until now has remained totally unrecognized."[72] In this way, the reason for the apparent rarity of mental illness among indigenous patients was attributed to the low visibility of mental illness in the colony, a product of both the prejudices of families as well as the lack of services that could capture patients in official statistics as the basis for policy making. Yet the fact that the appearance of patients had begun to exert pressure on the limited hospital-based services in major cities also suggests how the previously hidden problem of mental illness in villages was increasingly becoming also a public, urban issue for the first time.

Both Rangé and Reboul are speaking here to local as well as international audiences. These texts therefore demonstrate the networks of psychiatric expertise that were beginning to connect metropole with colony and specialists throughout the empire. The 1912 meeting in Tunis where Rangé presented his report, for example, marked an important turning point in discussions about the need to put into place comprehensive psychiatric services in all of France's colonial possessions, including Indochina. And it was Reboul alongside Emmanuel Régis, a professor of psychiatry in France, who authored the meeting's final report in which they underscored the colonial dominion "created not only rights, but also imperative duties," including the "duty of medical assistance to those in need.[73] Indeed this meeting centered on broad discussions about the content of the civilizing mission as well as the role and responsibility of French doctors to improve the health and living conditions of colonial subjects. For psychiatrists developing mental health services in the colonies represented an

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[72] H. Reboul, Médécin Principal des troupes coloniales. Hospitalisation des aliénés en Indochine. *Annales d'Hygiene Coloniale*. Oct-Nov-Dec 1913. Reboul's patients reportedly suffered most from epilepsy and hysteria, as well as "mental confusion" and "acute mania."

[73] Keller (2007), 29.

important opportunity to revive their profession whose reputation had fallen into serious disrepair at the turn of the century. In particular, the meeting signaled French concerns about falling behind other European powers that had made more progress in implementing psychiatric services in their empires.[74]

Regis and Reboul's report recommended the organization of a service of psychiatric assistance in different colonial outposts according to certain common principles of regulation but with room for adaptation to local conditions. They called for a two-tiered system that would consist of a service for patients suffering from acute or more short-term forms of mental illnesses and asylums for those with chronic or incurable conditions.[75] They also called for the organization of medical training in the colonies and the creation of a corps of specialists. Inspiration was sought in the works of other colonial powers, especially the Dutch, who had built one of the most comprehensive asylum systems in the colonial world in Java. French doctors working in Indochina, in particular, had long been interested in Dutch efforts given what was taken to be fundamental ethnological and geographical similarities between Java and Indochina. Throughout the early 1900s, French doctors took a series of study trips to the Dutch East Indies, commissioned by the colonial government with the goal of gathering texts related to legal regulations and asylum design including documentary photographs. In particular, as will be discussed at greater length in Chapter 4, the use of patient labor for

[74] Regis and Reboul (1912), 9.

[75] See H. Aubin. L'Assistance Psychiatrique Indigène aux Colonies. Rapport de congrès des médecins aliénistes et neurologistes de France et des pays de langue francaise, XLIIe session – Alger, 6-11 Avril 1938.

therapy in Dutch asylums would constitute an important inspiration for Indochina's own asylum system.[76]

Following this seminal meeting, Indochina's government authorized the construction of an asylum in 1912 and dedicated funds to its construction in 1914.[77] Importantly this coincided with the doubling of the AMI's budget between 1912 and 1914 (from 1,527,000 piasters to 3,120,000 piasters).[78] The credit necessary for the project was fixed at $90,000,000. Yet the newly formed *Assistance Aux Aliénés* in the end only received a small sum (just 100,000 piasters) for the construction of the asylum. The province of Bien Hoa's chief, M. Krautheimer, suggested his district as the site for the establishment of the asylum. The administration favored the site because it sat along a colonial route directly accessible to Saigon. However World War I delayed the realization of these programs. It would not be for another four and a half years before the Bien Hoa would welcome its first patients in January 1919.[79]

Revisiting the 1838 French asylum law: the interwar years

With the arrival of the colony's first asylum at the end of World War I, reformers once again sought to develop a legal infrastructure around mental illness in Indochina, one that would go beyond the simple grafting of French law onto pre-existing Annamite traditions.

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[76] TTL2, Goucoch, IA.8/274(4), Rivet, Gouverneur de l'Indochine à Monsieur le Consul de France, September 21, 1916.

[77] See TTL1, Résident Supérieur du Tonkin, 73747-01, Asile d'Aliénés de Bien Hoa, Rapport annuel pour 1928.

[78] The *piastre de commerce* was the silver-standard unit used by the French in Indochina between 1885 and 1952. In 1930, the *piastre* was pegged to the French franc at a rate of 1 piaster to 10 francs.

[79] TTL2, Goucoch, IA.8/281(1), Asile d'aliénés de Bienhoa, Rapport Annuel de 1923.

The French 1838 asylum law, while not officially promulgated in the colony, nevertheless continued to be routinely cited in case files as the touchstone guiding psychiatric practices in the colony.[80] Renewed debates over its extension to Indochina throughout the interwar years reveal the range of concerns about what kinds of local adaptations the Indochinese context would require. What's more, at this time in France, the 1838 asylum law faced intense scrutiny both from within and outside the psychiatric profession. Indeed the 1838 law was not finally modified in France until January 1968 when a law passed that strengthened the protection of civil rights of mental patients, particularly those rights related to the administration of their property. Colonial administrators therefore faced the double task of both improving the law and adapting it to local conditions.

Reformers in the colonies, however, enjoyed more freedom to experiment and innovate than their counterparts in the metropole. When the new asylum law was finally promulgated in Indochina in 1930 it adopted many innovations including the broadening of the category of "*aliéné*" to those individuals who suffered from "lighter" or non-violent forms of mental illness. But by introducing the "*aliéné*" as a new kind of legal category in a vastly different social and political context than that from which it first emerged, the 1930 law presented the colonial administration with new kinds of obligations that would prove to be a major challenge and face great opposition.

With the anticipation of the Bien Hoa asylum's grand opening in January of 1919, a November 6, 1918 law established the provisions for the asylum's functioning and oversight. It marked the first attempt to formally regulate institutionalized psychiatric care in the colony and to legally designate the "*aliéné*" as an official category of person in the colony. While the

[80] TTL2, Goucoch, IA.8/162(9), M. André, Directeur de l'Hôpital de Chôquan à Monsieur le Directeur de l'Intérieur à Saigon, February 8, 1887.

term was put in varying use alongside others (*déments, fous*, etc.) to describe what appeared as mental illness to French doctors and officials, this marked the first time the term was invested with legal meaning in terms of the protections accorded patients and the kind of care they would receive upon confinement. The decree contained certain general dispositions which reproduced, in part, prescriptions from the 1838 law and adapted them to the administrative vocabulary of the colony. All other articles of the law were deemed not conducive to local regulation due to the "irreducible differences that exist between the metropolitan and Indochinese social milieux."[81] The November 1918 law fixed the mechanisms for proper surveillance of the asylum, including different forms of administrative control, the modalities for the entrance and exit of patients and the internal functioning of the asylum including the type of work that would eventually be demanded of patients and their separation by sex. (A second law, promulgated on 23 November 1918 law, established the rules for the financing and bookkeeping of the institution.)[82] These measures were taken only on behalf of the indigenous populations with repatriation continuing to regulate locally the cases of the European mentally ill.[83] The law, however, remained mute on important points about the civil capacity of those admitted to Bien Hoa and the administration of their property once

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[81] ANOM, Gouverneur Général de l'Indochine, 65151, Le Gouverneur General de l'Indochine Commandeur de la Legion d'Honneur à Monsieur le Ministre des Colonies, Objet: Projet de décret sur l'assistance psychiatrique en Indochine, February 23, 1928.

[82] TTL2, Goucoch, IA.8/215(3), Arrêté du Gougal: création d'un asile d'aliénés à Bien Hoa (hospitalisation des personnes atteintes de maladies mentales de l'Indochine), May 3, 1918.

[83] Despite the official legal regulations, from its earliest days Bien Hoa did receive European patients. By 1928, the "constant increases" in the European population who remained in Indochina, as well as the increasing number of *métis* who retained French legal status, drew attention to the critical deficiencies of the 1918 decree. See TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

confined. Furthermore, the law failed to distinguish between the "special ethnic characteristics and dissimilar juridical norms" that prevailed among the various groups of patients.[84]

As the Governor General of Indochina would later point out, the law was intended to regulate the organization and functioning of the asylum and constituted only an initial step in the search for a definitive legal regime to be applied to *aliénés* in the colony.[85] The 1918 law therefore assumed an important role. As the only legal regulations around insanity in Indochina throughout the 1920s, it served as the de facto guideline for mental health care throughout the Union until a more comprehensive legal regime was instituted in 1930. In the meantime, as Poulin, the Résident Superior of Tonkin, stated in 1921, the principles of the 1918 decree should be applied generally as they have a "broad reach."[86]

In September of 1925, the Minister of the Colonies in Paris created a commission to advise on the development of mental hygiene programs in the colonies. This was part of a major interwar effort to organize colonial policy around the principles of social and economic development, otherwise known as "*mise en valeur*," a project for which health services were to play a central role. Given the "relatively little advanced knowledge on the subject of colonial psychiatry and the diversity of races in their overseas possession," the commission undertook a comprehensive study of each colony in order to identify the more specific and general problems of creating a psychiatric assistance program. To this end, the commission distributed a questionnaire to the member governments of Indochina, French West Africa (AOF) and

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[84] ANOM, Gouverneur Général de l'Indochine, 65151, Le Gouverneur General de l'Indochine Commandeur de la Legion d'Honneur à Monsieur le Ministre des Colonies, Objet: Projet de décret sur l'assistance psychiatrique en Indochine, February 23, 1928;

[85] *Ibid.*

[86] TTL1, Résidence Supérieur au Tonkin, 73745, Résident Supérieur du Tonkin, Poulin, à Directeur Local de Santé, November 2, 1921.

Madagascar. Once in possession of all the responses, the commission cooperated with the various colonial administrations to put into place psychiatric services for both European and indigenous populations as "an important aspect of our colonial medical assistance program."[87]

The questionnaire set out to determine the essential parts of the original metropolitan legislation and how much needed to be adapted to the needs of each particular colony. It was organized into two separate sections for "Natives" and "Europeans." In the "Natives" section, the questionnaire asked about the "local situation" including the "norms, prejudices, habits and customs about the succession and management of property in the population." As for the European insane, the commission recommended the repatriation of all European patients, both military and civilian, from all corners of the empire. If Europeans were to remain in the colony, however, the questionnaire asked if their treatment would occur in different institutions as colonial subjects or in the same institution while also "assuring the separation of these categories of patients, which would permit an economy of material and specialized personnel."

Drawing on the earlier recommendations of the 1912 Tunis meeting, the questionnaire similarly proposed a two tiered system: a first line of defense consisting of medical services annexed to medical establishments used to receive, isolate, observe and treat all the "*délirants*." The second component called for the creation of asylums in major colonial centers where they would be easily accessible (from a geographic, demographic and administrative point of view) and would receive only those indigenous patients with conditions that were "serious and long term." The questionnaire also asked a series of questions about whether asylums would be

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[87] TTL1, Résidence Supérieur au Tonkin 73745, Le Ministre des Colonies (Perrier) à Paris à Monsieur le Gouverneur Général de l'Indochine, March 3, 1926.

necessary, if so, how many and where they would be placed, and for indigenous patients whether it would be convenient to design the asylum as an agricultural colony.

Before replying to the questionnaire, the Governor General of Indochina created his own commission under the direction of the Inspector General of Sanitary and Medical Services who was charged with examining the conditions for applying the 1838 law in all territories of the Indochinese Union.[88] In January of 1928, Graffeuil, the Secretary General of the colonial government responded to a request for his opinion from Rougier, the Director of the Health Service in Tonkin. Graffeuil deemed the promulgation of the law premature given the state of the general medical service in the colony which he found "absolutely insufficient." The project would divert funds from other medical branches whose development pressed more urgently. Following World War I, the target of health care services in Indochina shifted to meet local needs including an increased awareness of general hygiene, both public and private (including the education of the local populations, provisions for clean drinking water and better sanitation in urban centers), as well as battle against infectious diseases in the form of targeted campaigns against epidemics and the creation of specialized services for lepers, those suffering from tuberculosis and pregnant women. According to historian Laurence Monnais, during this post-war period there was both a "physical expansion and a qualitative diversification, which rested on specialization, the development of small, rural facilities and the increase of services in urban institutions including the construction of isolation wards, maternity hospitals and paying consultations."[89] Mental health care therefore had to be

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[88] ANOM, Governeur Général de l'Indochine, 65151, Projet de decret sur l'assistance psychiatrique en Indochine, Le Gouverneur General de l'Indochine, Commandeur de la Legion d'Honneur à Monsieur le Ministre des Colonies, February 23, 1928.

[89] Monnais (2002), 144.

carefully weighed alongside other concerns demanding attention and the dedication of considerable resources.

Graffeuil also characterized the 1838 legislation as "too complex, rendering it inevitably inapplicable." To take one example, article 55 of the French asylum law determined the management of the confined person's property following the change in their personal legal status to one of diminished capacity. He worried that this measure could not be applied in many regions of Tonkin and would require intervention by the Prosecutor's Office in the confinement and liberation of those mentally ill individuals who fell outside his jurisdiction. According to Graffeuil, the property question must instead be regulated by a royal ordinance, taking into consideration the law, morals, family organization and special legislation of the indigenous population. He therefore found the moment "inopportune" given the complexities associated with adapting metropolitan laws in accordance with local needs and customs. Instead Graffeuil recommended reserving regulatory powers to the Governor General, leaving him in charge of "administering all the details of the law's application, according to the circumstances of time and place, of those propositions organized by the administrative and sanitary authorities in the colony."[90]

Rougier echoed many of Graffeuil's concerns in his message to the Resident Superieur of Tonkin, especially over how adapt the metropolitan legislation to local conditions. He too warned of the "practical difficulty of execution that is impossible to avoid, as one might believe, by a simple adaptation of vocabulary. The spirit of the law risks being misunderstood by the majority of the indigenous population and all the guarantees of administrative and judicial control, instituted in order to safeguard the liberty and protection of interests of the

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[90] TTL1, Résidence Supérieur au Tonkin, 73745, Graffeuil, Le Secretaire General du Gouvernement General de l'Indochine, à Directeur Local de la Santé au Tonkin à Hanoi, January 11, 1928.

aliénés, are at risk of appearing as irksome and vexing formalities." Furthermore, in order to assure the practical execution of the decree, "The royal ordinances and local laws that will be drawn on to regulate the application of the regime of *aliénés* in the diverse territories...will differ so notably that they will constitute texts that are superimposed and contradictory."[91] Rougier instead basically argued that the policy should come from the ground up: rather than imported from abroad, it should derive from local conditions and possibilities of action.[92]

This preoccupation with local interpretations and applications of the law reflected a central tension faced by the colonial administration over how to effectively govern different kinds of people across a wide territory. In France, the law provided one way of rationalizing French society, of bringing equivalence as a way to build social space. This project reached its limits in the colonial situation where as Emmanuelle Saada has argued the *métis* question introduced racial discrimination for the first time into French law.[93] For French administrators tasked with elaborating a legal framework around mental illness in the colony, the challenge to take traditional habits and morals and transform them into a generalizing and overarching framework was formidable. At stake was balancing uniformity with efficiency. Doing so would require not only squaring French law with local customs but also arriving at a shared understanding of the *aliéné* as a category of legal personhood deserving of state protection.

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[91] TTL1, Résidence Supérieur au Tonkin, 73745, Le Directeur Local de la Santé (Rougier) à Monsieur le Résident Supérieur au Tonkin, January 26, 1928.

[92] *Ibid.*

[93] Emmanuelle Saada. *Empire's Children: Race, Filiation and Citizenship in the French Colonies*. Trans. Arthur Goldhammer. Chicago: University of Chicago Press, 2012.

In February of 1928, the Governor General of Indochina returned the completed questionnaire to the Commission's offices in Paris.[94] The first set of questions concerned the structure and application of the law, including the possibility of promulgating the law of 18 June 1838 in its entirety to the colony. The Governor General replied that in Indochina, it would not be desirable. He noted that since "the law had been written for a country characterized by strong centralization, and a homogenous mentality" it could not "be applied without adjustment to Indochina where its constituent territories are marked by different forms of administration (direct administration vs protectorate and tributaries)." For example, Cambodia and Laos were characterized by oral traditions and customary law while other regions such as Annam and Tonkin remain governed by imperial written law "which, in its spirit, cannot be superimposed on top of metropolitan legislation." In the event, these local laws remained inadequate to address the problem of mental illness, "frozen in an archaic formula; they only envision the severe restraint of the mentally ill and the repression of criminal acts for which they are held accountable." Yet despite these differences in legal regimes across the Union, he emphasized that it would nevertheless be possible to come up with some sort of flexible legal structure that could account for these internal variations. The law, however, would need tailoring according to the different legal categories that existed in the colony: Europeans or assimilated and naturalized *indigènes* (for whom the same text as the 1838 law would apply but Administration Chiefs would be given the power to manage the

[94] ANOM, Governeur Général de l'Indochine, 65151, Projet de decret sur l'assistance psychiatrique en Indochine, Le Gouverneur General de l'Indochine, Commandeur de la Legion d'Honneur à Monsieur le Ministre des Colonies, February 23, 1928.

affairs of the individual in the colony or in the event of his repatriation); native colonial subjects and natives with "protected" status or *indigènes protégés français*.[95]

The requirement of repatriation, meanwhile, represented a "singular burden" on the colonial administration. He acknowledged that European populations in Indochina found themselves in an "abnormal" climate and milieu from both a "physiological and sociological point of view," which rendered them vulnerable in such a way as to threaten the "prestige of French sovereignty." Yet even if the scientific reasoning in favor of repatrition was "solid," the legal authority to repatriate only extended as far as civil servants and military personnel; as the Governor General pointed out, under no legal basis could his administration force civilians to leave the colony. And of course, there still lingered questions about the cost and forms of oversight that such a journey required.

Instead he stressed the improving "livability" of the colony including the expansion of colonial projects dedicated to urban hygiene, domestic hygiene (including draining and drying of the ground, purifying of water, provision of electricity, etc.) as a result of the continuing development of sanitary and medical organizations, networks of roads, facility of communications, the growing wealth of the colony and improved well-being of its inhabitants. In particular, he signaled those commercial interests which had resulted in an increasing number of European settlers in the colony, especially those working outside the colonial administration. He also remarked on the concomitant increase in the number of *métis* (or children born to European fathers and Vietnamese mothers) who "constituted, from the point of view of colonization, an important dynamic." It was because of this growing European

[95] *Indigènes protégés français* refers to the natives of "protected" states including Annam, Tonkin, Cambodia and in Laos, Luang Prabang. Like colonial subjects, they were neither French citizens nor enjoyed the rights associated with French nationality.

presence that Indochina was obliged now more than ever to complete the local organization of a psychiatric assistance program for European patients.

Due to the difficulties of repatriation, and the small numbers of European mentally ill eligible for such a journey, the Governor General endorsed the creation of "mixed" asylums for both European and indigenous populations as a way to consolidate resources. He argued that the problem was little more than one of simple architecture - to divide European and indigenous elements in the limits of the same establishment under one director.[96] He envisioned the expansion of the asylum system from Bien Hoa which, in practice, only received patients from Cochin China, Cambodia and the South of Annam to include a second asylum, also organized as an agricultural colony, located near the administrative center of Hanoi and the port of Haiphong.

Indeed projects for an asylum in Tonkin to service the North of the colony had been discussed for over twenty years.[97] The first serious study was pursued in 1913, and in 1921, Huot, the Inspector General for Sanitary and Medical Services, re-opened the discussion about the creation of an asylum to service the north of Annam, Tonkin and adjacent parts of Laos. The 1922 General Budget of the colony dedicated 55,000 piasters to the project but forward movement stalled. In a 1927 asylum report, the director of Bien Hoa pointed to the

[96] Others, however, stressed the difficulties in administering mixed asylums in colonial settings that went well beyond questions of architecture. These included accounting for the "thousands of details of hospitalization as well as the prestige of the colonizer" and the "delicate" application of the principles of separation to those who defied neat categorization: creoles, *métis*, and natives with French citizenship status, as well the need in some contexts, to separate historically antagonistic ethnic groups. As we will see in the following chapter, the maintenance of boundaries within the institution proved a major challenge of everyday asylum administration. H. Aubin. L'Assistance Psychiatrique Indigène aux Colonies. Rapport de congrès des médecins aliénistes et neurologistes de France et des pays de langue francaise, XLIIe session – Alger 6-11 Avril 1938.

[97] It was even suggested that it was the Vietnamese population who actually demanded the creation of a second psychiatric institution in the colony. E.L. Peyre. "Les Maladies Mentales aux Colonies." *Journal de Psychiatrie Appliquée* 8 (1934): 185-212.

increase in number of hopitalisations of patients under his care in order to underscore the necessity of another asylum, noting, "The asylum of Bien Hoa is not indefinitely expandable and the distance of patients from their homes while they are interned at Bien Hoa makes this confinement particularly painful for patients and their families. No doubt as soon as Bien Hoa possesses an asylum it will be quickly appreciated and a good number of *mentaux* that the families previously hid would benefit from its organization. In our report last year we insisted on this point of the inconveniences of confinement from a long distance from country and family."[98]

Together these two asylums would serve as the basis of a new psychiatric assistance program tasked with the treatment of curable patients, hospitalization of the incurable, and the isolation and surveillance of those patients with "anti-social" tendencies or criminal pasts.[99] Working to extend the reach of these asylums would be a number of secondary services run out of civil, military or private hospitals that radiated into the interior of the colony. These services would aid asylums by way of the early observation of patients, putting them out of harm's way and treating curable cases in a short amount of time. A strict separation of indigenous and European patients would also guide their organization.

To the completed questionnaire the Governor General also attached a project for a law that would govern this new system. Developed locally in cooperation between the civil administration, judicial administration and the health service, the draft decree included dispositions from earlier laws but was assembled in such a way so that, taken together, as the Governor General emphasized, "this new regulation represents more than a simple adaptation

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[98] TTL2, Goucoch, IA.8/2912(3). Asile des aliénés de Bien Hoa: Rapport annuel de 1927.

[99] TTL1, Résidence Supérieur au Tonkin, 73750, Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, November 30, 1927.

of the law of 1838 to the colony." While other colonies had completely abstained from legislating the question of mental illness, adopted the law of 1838 wholesale or only certain essential prescriptions, Indochina drafted a new, stand-alone legislation adapted to the particular needs of the colony.

The law establishing a psychiatric assistance program in Indochina (referred to as the decree of 18 July 1930) was officially promulgated on September 6, 1930.[100] It regulated the procedures for the internment and release of patients, their care while confined and asylum oversight by an independent surveillance commission. The law took inspiration from the French asylum law of 30 June 1838 and also subsequent projects for its modification. For instance, the Loi Dubief, a 1907 project named after a doctor and former minister of commerce in France, attempted to improve the 1838 law most importantly by working to guard against arbitrary confinement and the transfer of mentally ill criminal offenders from prisons and into asylums.[101] The project came out of the movement in the metropole at the turn of the twentieth century for more humane forms of psychiatric assistance including different forms of "open" or family care, following accusations of negligence and corruption of the asylum system. In Indochina, reformers took up the spirit of the Dubief project by providing widened scope for the intervention of the judiciary during the process of confinement at the expense of those administrative powers that had been greatly expanded under the 1838 law. The result, as psychiatrist and former Voi asylum director Pierre Dorolle

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[100] For the full text of the law see TTL1, Résidence Supérieur au Tonkin, 74028, Décret du 18 Juillet 1930 sur le traitement et la garde des malades atteints d'aliénation mentale, 1930.

[101] Dr. Lucien-Graux. "La Loi Dubief: Le regime des alienes" *Gazette Medicale de Paris*. 15 February 1907.

pointed out, was to "augment those guarantees provided to the patient and to assure the most humane conditions for the protection of himself and his belongings."[102]

Other dispositions differed from the metropolitan legislation in ways that signified the innovative qualities of the Indochina legislation. In particular, the law abandoned "isolation" as the sole guiding principle of psychiatric treatment and broadened the legal definition of *aliéné* to include those who suffered from 'lighter' or non-violent forms of mental illness. Specifically these innovations of the Indochina law included: the regulation of care of patients at home, their treatment in ordinary hospitals and the civil capacity and administration of patient property; the provisional character of confinement until a decision by the tribunal; possibility of voluntary placement by the patient himself; the regularization of the confinement of epileptics and drug addicts; *sorties d'essais* or "test leaves" before an official designation of cure; and the regulation of the confinement of patients accused of crimes but found irresponsible by reason of insanity.[103]

According to the legislation, families retained the power to pursue the confinement of one of their family members and the administrative branch retained the authority to place in a special establishment any person whose mental state was found to compromise public decency, tranquility or security. But these placements (whether those demanded by family or ordered by administrative powers) could only take on a provisional character. At the end of a period of observation of six months, the placement of the insane person could only be prolonged by the decision of the justice, in the form of a judgement rendered by a civil

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[102] Pierre Dorolle. *La Législation Indochinoise sur les Aliénés: Exposé et commentaire des dispositions du décret du 18 juillet 1930*. Saigon: Imprimerie A. Portail, 1941.

[103] *Ibid*. See also Dr. R. Lefèvre, Médecin-Lieutenant-Colonel des Troupes Coloniales au Ministère des Colonies. L'assistance psychiatrique en Indochine, in *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, 1931, 293-297.

tribunal. Furthermore, the new legislation regulated the care of the insane at home, and instituted, as another innovation, voluntary placement (without any legal formalities) from the simple verbal demand of the patient himself. Part of the originality of the 1930 legislation was to provide release even before cure, in the form of "provisional exits" or "test leaves" which allowed the legislation to take on a more medical character. Under these "test leaves," patients were sent back to their families and communities where medical observation would continue (in the form of regular visits by the local doctor who would administer medicines and advise in favor or against a permanent reintegration into the community depending on the medical progress of the patient.) In the event that a patient's exit from the asylum provoked opposition by the doctor, the patients themselves, their parents or guardian, or the administrative authorities, the Prosecutor could demand a hearing at a tribunal to make a final determination.[104] The decision of the tribunal was subject to an appeal within five days.

In terms of the regulations for guarding patients at home, the patient would be released to a private home where he or she would be prevented from communicating with the outside world. The family member or guardian charged with his or her care was obligated to address a written declaration to the Prosecutor's Office accompanied by a medical report dated within the first fifteen days of the patient's release. The Prosecutor could also demand a new report on the patient's progress whenever he judged necessary. If home care was found insufficient, the tribunal could mandate that the patient be given to another guardian or placed within a private or public institution.

The law also regulated the creation of psychiatric services run out of major hospitals for those patients waiting to be confined in mental instutions, those under medical

[104] The process of going in and getting out of the asylum is discussed at much greater length in Chapter 4.

observation, and those seeking immediate treatment for either more acute forms of mental illness or those who suffered from less serious forms and did not require confinement. While open services had existed in France for a number of years, the Indochinese legislation marked the first time they were formally introduced into French law.[105] Last, the decree modified the rules relative to the civil capacity and administration of the property of confined insane (In any event, because most of the asylum patients were indigent, these provisions applied only rarely). Finally, a surveillance commission was put into place invested with the authority to make sure that the asylum administration adhered to the rules and regulations governing the care of patients.

Despite the innovative qualities of the law, challenges still remained with its implementation, especially in Tonkin where there was still no asylum to receive sick patients. As Dr. De Raymond, the Director of the Health Service in Tonkin, explained in October 1930, contrary to the Governor General's pronouncement, the law in Indochina was essentially a copy of the 1838 law in France in the sense that it "aggravated and complicated and was barely inspired, as far as the natives were concerned, by local necessities." He therefore worried over its application, especially before the opening of the second asylum in Tonkin, and recommended the law's postponement.[106] In the meantime, the services for the mentally ill in place at the Indigenous Hospital in Hanoi should be considered a place for observation, rather than treatment and confinement, so a simple certification of hospital

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105 TTL1, IGHSP, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934.

106 De Raymond was against the expansion of the system from the beginning, warning that it was "too premature." In December 1930 remarked on poor recruitment of surveillance staff, the poor choice of the placement for the Voi asylum in the North, and the overly burdensome nature of the regulations around mental health care. TTL1, Résidence Supérieur au Tonkin, 73745, Le Directeur Local de la Santé du Tonkin à Monsieur le Médecin Général Inspecteur, Inspecteur Général des Services Sanitaires et Médicaux de l'Indochine, December 3, 1930.

admission would suffice. Designating the Hospital as a place of observation, rather than confinement, would obviate the need for legal regulations because patients would be considered free until they were confined and deprived of their rights by court order.

The Administrator of the 1st Bureau, charged with the oversight of all colonial personnel, supported De Raymond's plea for a delay. He argued that putting the law's disposition into effect would be "materially impossible" given the fact that no public or private establishment for the mentally ill existed in Tonkin at the time and the secondary centers for assistance had still yet to be created and organized by decrees from the Governor General.[107] Rene Robin, the Resident Superior of Tonkin, allayed concerns by noting that only decrees signed by the *Chef de la Colonie* could determine the modalities of the application of the decree of 1930. So until the Voi asylum was put into service, and at the very least, all the necessary texts were signed into law by the Governor General, colonial officials must rely instead on decrees of 3 May and 6 November 1918.[108]

The problem of how to make the 1930 law coincide with indigenous legal customs also persisted. Indigenous law (also referred to as the Code Gia Long) addressed mental illness only in so far as removing individuals from society or punishing them for crimes but failed to provide patients with any guarantees of protection. In the words of the Advisory Committee of Annamite Jurisprudence (*Commission Consultatif de Jurisprudence Annamite*), "all latitude is left

[107] TTL1, Résidence Supérieur au Tonkin, 73745, Note du 1er Bureau, October 1930.

[108] TTL1, Résident Supérieur au Tonkin, 73745, Circulaire, Le Résident Supérieur au Tonkin (Rene Robin), Commandeur de la Légion d'Honneur, à Messieurs les Résidents Chef de province, Commandants de Territoire Militaire, Maires de Hanoi et Haiphong et Directeur local de la Santé, October 20 1930.

to the parents of the *aliéné* to act in favor of his personal interests. If the *aliéné* is a religious figure (*héritier cultuel)* he must be replaced in his functions."[109]

The 1930 law offered common prescriptions that could be adapted to the cadre of local laws and royal ordinances that prevailed in different regions of the Union. Yet, in practice, the colony's Second Bureau anticipated a very complicated process of applying the administrative aspects of the degree to the juridical conditions of those legally designated as "*aliénés*," especially the different categories of people charged with the administration of their property. In particular, they did not believe it possible to extend certain adaptations of terminology and protective measures of the French Civil Code to the indigenous population, as it would require writing a new part of the *Code Civil Indigène* (Native Civil Code). They recommended that if such a project was pursued the protection of the insane should modeled after provisions for the protection of minors.[110]

Conclusion

By the time of the promulgation of the 1930 law, earlier presumptions that the Vietnamese psyche remained "unscathed" by modernity had long began to shift. As one asylum director remarked in 1927, "It seems as though all development of civilization is accompanied by a growth in madness which follows in its wake."[111] Colonial officials

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[109] TTL1, Résident Supérieur du Tonkin, 73745, Note pour Monsieur l'Administrateur, Chef du 1er Bureau, February 20, 1931.

[110] TTL1, Résidence Supérieur au Tonkin, 73745, Note pour Monsieur l'Administrateur, Chef du 1er Bureau, February 20, 1931; see also TTL1, Résident Supérieur du Tonkin, 73745, Le Gouverneur des Colonies à Président du Comité Consultatif de Jurisprudence Annamite, March 9, 1931.

[111] TTL2, Goucoch, IA.8/2912(3), Asile d'Aliénés de Bien Hoa, Rapport Annuel de 1927.

attributed the increasing visibility of the mentally ill, counted among the thousands of vagrants who flooded into cities like Saigon, Haiphong and Hanoi, to the effects of dislocation and social upheaval under French rule.[112] The heightened visibility of mental illness indexed widespread social and economic change in the colony that formed the critical backdrop for the emergence of the "*aliéné*" as a responsibility of the colonial government. In just a few decades, colonial officials moved from claiming there was very little legal basis or practical exigencies for an asylum in Indochina to achieving one of the more comprehensive mental health care systems in the French empire.

This chapter has discussed this transformation in terms of shifts in the legal definition of insanity. Although at first only dangerous forms of mental illness were considered a requirement for legal intervention, this did not mean that in practice people coded as mentally ill by Vietnamese communities and colonial authorities alike did not become a burden to the colonial state. Once hospitals began to increase their capacity to care for these patients, however imperfectly, the availability of services began to generate new demand for their expansion, rendering a problem that was formerly hidden increasingly visible. The opening of the asylum in 1919 therefore gave mental illness a new concreteness that could be captured in official statistics. The concept's transformation into an official category of person, one which required legal protections and access to services, must thus also be understood within a growing health care infrastructure that responded to both local developments *and* international pressures for its expansion. Furthermore, the legal definition of insanity, encoded in the French asylum law of 1838, had not only to be made to reflect more modern understandings

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[112] Historians have also examined those economic pressures pushing migrants from the countryside to urban centers like Saigon. Saigon had only 12,000 residents in 1870. By the end of the nineteenth century, the city had 51,000 inhabitants. Over the next thirty years, the population more than doubled, reaching 120,000 in 1936. On the history of the urban poor in Saigon see Haydon Cherry. "Down and Out in Saigon: A Social History of the Poor in a Colonial City, 1860-1940." (PhD diss. Yale University, 2012).

of psychiatric knowledge and practices but also translated to a vastly different cultural and institutional context. In particular, Indochina's varied legal and administrative regimes, coupled with the lack of resources to make the inauguration of new services impracticable if not impossible, posed a major practical challenge to colonial reformers.

By the 1930s, Indochina's psychiatric assistance program was lauded as not only surpassing the efforts of other colonies but also those of the metropole. Yet despite these important innovations - as this chapter has foreshadowed and the following chapters will show - there emerged considerable difficulties in putting these policies into practice.

Chapter 3. Patients, staff and the everyday challenges of asylum administration.

I. Introduction

Throughout the 1920s, the number of patient admissions to the Bien Hoa asylum grew dramatically, generating new knowledge about psychiatry in the colony as well as new kinds of pressures on colonial resources. These pressures drove the colonial administration to call for the establishment of a second asylum, named Voi, to service the north of the colony. In designing this new asylum, colonial administrators drew lessons from the mistakes in the planning and management of Bien Hoa. In particular, they faced the challenge of recruiting and retaining a competent staff.

Asylums were seen as important elements in France's civilizing mission, as harbingers of modernity and progress, yet deficiencies in infrastructure and personnel coupled with a critical lack of funds meant the reality of daily practices departed significantly from the ideal. Surveillance commissions charged with their oversight often found asylums in states of serious disarray. Cramped quarters, the deterioration of physical surroundings, and the poor caliber of the asylum's staff were not, however, uniquely colonial features of Indochina's asylums but rather held important commonalities with other institutions in the metropole. What was uniquely colonial, according to historian Sally Swartz, was the "classification, segregation and differential treatment according to race and gender…the many texts which defined, justified and described such divisions [constituted] a distinctively colonial psychiatry." Swartz and other scholars working in colonial contexts have, in this way, tended to contrast the universalism of European science with forms of discrimination based on racial prejudice in the colonies. The disparities were particularly acute for "mixed" institutions like those in Indochina which were organized according to principles of segregation that warranted different regimes of care.

Different classes of patients (indigenous and European, men and women, indigent and paying clients) were to be given different diets, daily routines, and forms of treatment. These distinctions, however, were routinely blurred in daily practice.

Rather than explore the limits of this failed enlightenment vision, this chapter will specify what distinguished colonial asylums from other kinds of colonial institutions, particularly prisons. Penal regulations imported from France similarly called for the segregation of prisoners based on gender, age, sentence, juridical status and number of offenses. Yet the crude communal structure of provincial prisons in Indochina resulted in frequent overcrowding, episodes of epidemic disease and institutional disorder, a source of continual anxiety for colonial prison administrators.[1] Like colonial prisons, so too did colonial asylums faced gross inadequacies in funding. Unlike colonial prisons, however, I argue that modern forms of surveillance, institutional provisioning and health care *did* remain significant as a "code of action" that guided the efforts of colonial asylum directors.[2] In their physical design, their staffing, and their obligations to patients, asylums were asked to respond to a complex and unique set of imperatives: to discipline and confine, reform and heal. How to manage these competing impulses proved a major challenge to asylum administrators and reveals the disparities that emerged between policy and practice in the daily running of the colonial asylum. Rather than pointing to the weaknesses of the disciplinary impulse, I argue that the limits of colonial psychiatric practice underscore the dynamism of those categories and hierarchies that organized asylum life, ones that were intended to reproduce colonial order within the asylum's walls.

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[1] Peter Zinoman. *The Colonial Bastille: A History of Imprisonment in Vietnam, 1862-1940*. Berkeley, CA: University of California Press, 2001, 51.

[2] Zinoman (2001), 72. Here Zinoman makes the opposite point and instead signals the weakness of the disciplinary impulse in colonial penal institutions.

II. Diagnosing the problem

On January 15, 1919, the Bien Hoa asylum received its first patients. By the end of its inaugural year of operation, Bien Hoa treated 138 patients for a total of 5,629 days of hospitalization. Over the following ten years, asylum directors would witness a dramatic rise in patient numbers. In 1928, the asylum treated 473 patients for a total of 167,086 days of hospitalization for the year.[3] [See Figures 1 and 2]

In a 1928 report to the colonial administration, Dr. André Augagneur, the director of Bien Hoa, used the occasion of the institution's approaching tenth year anniversary to present a "rapid overview" of the etiology of mental disorders and other physical afflictions of the 1,009 patients who had ever entered the asylum's doors. He warned, however, that certain figures do not have a "rigorous accuracy" especially those for syphilis whose test had not been routinely administered to patients during the asylum's early years.[4] As of September 1925, all patients at the moment of their admission were systematically subjected to a serological examination on the basis of a blood sample and lumbar puncture.[5] The opening of a laboratory at the asylum in 1926 facilitated the expansion of testing. Whereas previously the asylum administration relied entirely on the Pasteur Institute in Saigon, the first ever to be established outside France in 1891, now the Pasteur Institute would act as a "valuable partner" in comparing and verifying the accuracy of test results.

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[3] TTL1, Inspection Generale de l'Hygiène et Santé Publique (IGHSP), 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine. Patient numbers continued to grow throughout the 1930s.

[4] *Ibid.*

[5] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

Augagneur's report found that the majority of patients ever interned were of Vietnamese origin, principally from Cochin China and neighboring Annam (827 out of 1,009 patients). This forms an important contrast with French Algeria where hospitals served far higher proportions of Europeans than North Africans.[6] Augagneur was quick to point out that these statistics did not mean that mental illness was necessarily more frequent in these regions, "It is certain that as soon as an asylum is running in Tonkin it will receive a numerous clientele, the same holds for Laos where the work of the *Assistance Médicale* is less extensive. Cambodia also has been sending more patients to Bien Hoa because of its proximity." A review of patient backgrounds revealed that most were also indigent with the highest rates of mental illness found among those without profession, farmers, coolies, day laborers, "that is to say those natives whose existence is the most difficult, a deficient diet in general, whose conditions of material existence are mediocre, joined by alcoholism." Augagneur further noted the maximum frequency of mental illness occurred between the ages of 26 and 30, followed by 31 to 35 year olds, then 21 to 25 year olds. In his formulation, because Asian races were "very precociously formed," the 26 to 30 age bracket could be considered the "normal period of activity of middle age."[7] Other factors included considerations of climate (most number of admissions were observed during the hot and dry season) and being unmarried which also seemed to predispose individuals to psychopathic illness.[8]

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[6] Richard Keller. *Colonial Madness: Psychiatry in French North Africa*. Chicago: University of Chicago Press, 2007, 89.

[7] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[8] *Ibid.* Julie Brown, in her study of mental institutions in imperial Russia, argues that the cyclical nature of asylum admittances and departures was linked to the harvesting season. See Julie V Brown. Peasant Survival Strategies in Late Imperial Russia: The Social Uses of the Mental Hospital. *Social Problems* 34,4 (1987): 311-329.

Drawing on the classic French nosology of psychiatric illness, Vietnamese and European patients were divided into broad diagnostic categories according to the symptomatology and evolution of the disease. In the early twentieth century, most psychiatrists assumed a biological origin of madness that could take the form of a cerebral lesion, a hereditary defect in the nervous system or a racially determined organization of the brain structure. (In France, this biological model held sway much longer than other parts of Europe, particularly Germany.) As Richard Keller has argued, by rooting madness in a primitive or defective biology, the classification of mental disorders grafted easily on to a "colonial order that constantly reiterated natives' biological inferiority, their simplemindedness and their incapacity to adapt to modern civilization."[9]

In the late 1920s, the most prevalent diagnostic category present at Bien Hoa was psychopathic disease or ‘psychosis’ including various forms of ‘mania’ (acute, melancholic and anxious as well as mental confusion), *démence précoce* and general paresis.[10] This was followed by patients suffering from a range of “impairment” disorders such as degeneration, idiocy and senile dementia. While degeneration as a diagnostic category had fallen out of use in the metropole by the interwar period, it continued to be frequently employed in Indochina. A set of nervous disorders including the most common diagnosis of epilepsy formed the last major group of patients. Among the 16 French patients ever admitted, "general paresis" was the most frequent cause of confinement followed by mental illness brought on by alcoholism. The *métis* or mixed race patients were also thought to form a "relatively important group." Of the

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[9] Keller (2007), 9.

[10] Dr. Roussy. Rapport sur le fonctionnement de l'asile d'aliénés de Bienhoa (Cochinchine). *Annales de médecine et de pharmacie coloniales* 24 (1926).

13 *métis* ever admitted, the doctor noted the extreme frequency of *démence précoce*.[11] As I emphasize in Chapter 4, these diagnostic determinations heavily relied on the information provided by lay people.

The main causes of psychiatric illness in the colony were attributed to the weight of heredity, intoxication and infection. Augagenur, like many other doctors and administrators at the time, particularly worried over the high rates of alcohol consumption thought to predispose and intensify the expression of psychiatric illness.[12] Nearly a third of patients at Bien Hoa (303 out of 1,009 patients) were classified as alcohol abusers. More so than opium, alcoholism concerned colonial doctors because of its easy accessibility to the lower classes. This was attributed to reduced prices as well as to the efforts of "bootleggers" and clandestine operations that proved impossible to regulate, especially the introduction of potentially toxic substances.[13] While Augagneur expressed sensitivity to the alcohol question by acknowledging its budgetary importance to the colonial administration, he nevertheless warned, "To emancipate the native [from his habit] is good but to not give him the means to self-intoxicate would be better." He therefore recommended limiting consumption of alcohol by raising taxes which would most likely act as a deterrant among the lower classes.[14]

Syphilis was also found to be extremely prevalent among the indigenous patient population (227 of the 1,009 patients who ever entered the asylum tested positive for the

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[11] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[12] *Ibid.*

[13] The 1926 Bien Hoa report includes a long discussion on the sale and regulation of alcohol in the colony. See TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926. On the alcohol monopoly in colonial Vietnam see Gerard Sasges. "Indigenous representation is hostile to all monopolies": Pham Quynh and the End of the Alcohol Monopoly in Colonial Vietnam. *Journal of Vietnamese Studies* 5,1 (January 2010): 1-36.

[14] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

disease). Left untreated, an infection of the brain or spinal cord would result in neurological damage and eventually mental illness. As a result the disease's high prevalence among the patient population formed an object of major concern and reinforced calls for better mechanisms of prevention in the community. Augagneur attributed its prevalence to "indifference of the native vis-à-vis venereal infections." He warned that the "native does not like to go to consultations at the hospital where he might be hospitalized [against his will]. The specialized consultation at the hospital never results in any success as we have tried to organize three consultations per week at the local hospital. Despite all the propaganda we have done on this subject it has been a complete failure." Instead he endorsed the use of mobile dispensary teams that would pass through villages on fixed dates and treat patients on the spot and without risk of detention.[15]

The rates of mental illness also followed gendered lines. Almost twice as many men as women entered Bien Hoa (289 versus 152).[16] The same proportion held true on a large scale. In 1928, throughout major hospitals the colony, among the indigenous population, 707 men were treated for mental illness, followed by 341 women and 68 children. For colonial psychiatrists, this male-dominated phenomenon echoed similar gender disparities in the metropole while also reflecting some of the special attributes of social life in the colony. Overall higher rates of mental illness among men were attributed to the fact that "by a general

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[15] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine. Patients suffering from syphilis were treated with sulfarsenol, novarsenobenzol and Treparsol. By 1934, most syphilis-related psychoses were treated by injections of "stovarsol sodique" using the Sézary and Barbe technique. Because of the "weakness of the constitutions" of their patients, pointing to the poor condition in which they often arrived at the asylum, doctors were forced to reduce the amount of stovarsal administered from 1 to 0,50 gram at the beginning of treatment. See Pharo, 182, Rapport Annuel d'Ensemble (1934), Fonctionnement de l'Asile de Bien Hoa.

[16] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

rule, men are subjected to more intensive work as well as intoxications (alcohol and opium assume an important place). The existence of the Native is in general rather disorganized. While his days are dedicated to some ordinary kind of work, he dreams only of resting for the coming night. To use a vulgar expression, one could say that in general the Indigene 'lives life in the fast lane.'"[17] This attention to young men reflects how concerns over psychiatric treatment bled into broader anxieties about the social organization of indigenous life and the development of a productive local labor force, for which young men formed a population of particular concern.[18]

Differences between men and women were found not just in rates of mental illness but also in diagnostic patterns. Women's reproductive organs were thought to introduce a tendency to mental instability as well as the experiences of childbearing and menopause.[19] For example, Augageneur reported among all women who ever entered Bien Hoa, 16 cases of psychosis brought on by post-child birth infections (resulting in mania but nevertheless leading to a "speedy recovery".)

In terms of treatment, patients received a variety of drugs including sedatives and calming agents such as opium, chloral and bromides.[20] Doctors also very successfully relied on "*somnifère*," a kind of sleeping agent administered by intravenous injections. Its use, according to Augagneur, resulted in the "absolute suppression" of mechanical forms of restraint such as the straight jacket that was used only as a last resort. The drug allowed asylum staff to equally

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[17] ANOM, BIB AOM, 12391, Etiologie des psychopathes par Dr. Augagneur, 1931.

[18] See Chapter 5 on the history of the agricultural colony.

[19] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[20] For a breakdown of all injections delivered at Bien Hoa in 1934, see PHARO, Carton 182, Rapport Annuel d'Ensemble (1934), Fonctionnement de l'Asile de Bien Hoa.

avoid the "onerous use" of padded rooms which could not be employed in Cochin China because of the "numerous parasites that would destroy even the best surfacing in a matter of hours."[21]

Psychiatrists also implemented treatment by shocks, a brand new therapy that was growing in popularity in the metropole at the time. The idea behind this kind of physical or somatic therapiy was to shock the brain - and the mind - to adjust itself out of an illness state using a physical stimulus. In Indochina, it was used primarily in cases of *démence précoce* and in any instance where it was necessary to create a state of pyrexia or fever favorable to the mental health of the patient. This followed from the theory that a rise of bodily temperature would produce increased metabolic changes some of which were deemed necessary for the formation of protective substances. Hence pyrexia was considered an essential part in the defense of the body against infection. In this way, injecting various substances to modify the action of the autonomic nervous system stood as a kind of throwback to thousands of years of humoral medicine.[22] At Bien Hoa, colonial psychiatrists injected patients with Dmelcos (also known as chancroid vaccine) and even milk![23]

Doctors in Indochina first experimented with malariotherapy in 1930. First tested in Paris in 1917 as a way to treat neurosyphilis, the introduction of the malarial vaccine was though to hold curative properties for both venereal disease and mental illness. However in

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[21] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[22] Edward Shorter and David Healy, eds. *Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness*. New Brunswick, NJ: Rutgers University Press, 2013. Electroshock therapy was also later practiced in Indochina. See Pierre Dorolle. "Traitement palliatif de l'épilepsie essentielle par la convulsivothérapie électrique."(électro-choc) (*Note préliminaire*). *Revue Médicale Francaise d'Extreme-Orient* 20 (1942).

[23] PHARO, Carton 182, Rapport Annuel d'Ensemble (1934), Fonctionnement de l'Asile de Bien Hoa.

Indochina it was only used with "extreme prudence." Despite or in some cases because of the higher prevalence of malaria in Southeast Asia, doctors feared that indigenous patients would be exposed to different kind of risks than those patient populations of France and Europe. In Japan, the technique had been abandoned altogether. It continued to be practiced in asylums in 1930s Indochina but only on a very limited basis.

Less intensive forms of therapy, such as hydrotherapy, were also practiced.[24] The term encompasses a broad range of therapeutic methods that take advantage of the physical properties of water, such as temperature and pressure, in order to stimulate blood circulation and treat the symptoms of certain diseases. But because of the insufficiencies of clear, running water at the asylum, hydrotherapy was used infrequently for therapeutic purposes. Throughout the 1920s, it mainly took the form of the construction of a large pool (20 meters by 50 meters, at a depth of 1 to 1.6 meters) with a sandy bottom where patients would clean themselves and play after they were finished working out of doors.[25] Meanwhile those agitated patients not employed in asylum labor schemes would be enveloped in a damp sheet as a kind of calming device, an easy method that required no additional installation and could be entrusted to the surveillance personnel who proved themselves "perfectly comfortable with performing this technique.[26]

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[24] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[25] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[26] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

III. Asylum organization and daily management

Throughout the 1920s, growth in the demand for asylum care increasingly strained institutional resources and quickly exposed the defects in the original planning and organization of the asylum. The serious problems associated with asylum overcrowding, in particular, gave new urgency to both expand Bien Hoa as well as to move forward with plans for a second asylum in the northern protectorate of Tonkin. In August of 1927, the Local Director of Health in the Tonkin recommended a visit from Augagneur, in his capacity as the director of the Bien Hoa asylum, to aid in the development of a similar institution in the North.[27] In many ways, Bien Hoa would serve as both model and foil for this next experiment in asylum care. Discussions over the creation of Voi asylum in Tonkin thus reveal the early challenges of asylum management in the colony.

Asylum placement

In September of 1927, Augagneur furnished a report to the government of Tonkin on the general organization and functioning of the Bien Hoa asylum, including a series of maps and blueprints of individual buildings. [See Figure 3] The first question facing the Tonkin administration concerned the physical placement of the institution. What were the necessary conditions for the site? First, according to Augagneur, the property had to be large enough to accommodate space for the individual buildings and fields for agricultural production. As discussed at greater length in the following chapter, asylums in Indochina were designed as

[27] TTL1, 73757, Le Directeur Local de la Santé à Monsieur le Resident Superieur au Tonkin, August 11, 1927. André Auganeur was a former clinical instructor at the Faculty of Medecine in Lyon, France. He had attained the title of "Commanding Doctor of the Colonial Troops" and served as the Director of the Bien Hoa asylum between 1925 and 1933.

large agricultural colonies where patients would work the land on the path to healing and eventual liberation. Augagneur accordingly recommended a larger property than the one currently occupied by Bien Hoa in order to allow for more space between individual pavilions. He proposed a distance of no less than 30 meters separating each building from the other.[28] At Bien Hoa, this issue had become the object of particular concern for the asylum director and his family who found themselves in close proximity to the buildings for female European patients (their pavilion was 30 meters away while their "promenade garden" was at a distance of only ten meters.) Apparently the cries from patients made it impossible to sleep on certain nights.[29] Within the individual pavilions themselves, the patients at Bien Hoa were found "jammed in." While this crowding did not seem to hold much importance to those patients who worked out of doors, "it is not the same for those who cannot leave."[30]

In addition to the cramped conditions, the enclosures immediately surrounding each pavilion also proved too narrow, making the surveillance of patients difficult.[31] This question of expanding space both inside and outside the various buildings was closely linked to security and hygiene concerns. The admission building at Bien Hoa, for example, was described as a "veritable heresy from a medical point of view," distinguished by "many tortuous corridors creating the ideal conditions by which patients could not be guarded and placed in

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[28] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[29] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[30] *Ibid.*

[31] TTL2, Goucoch, IA.9/2910, Le Directeur local de la Santé en Cochinchine à Monsieur le Gouverneur de la Cochinchine, September 24, 1927.

obscurity."[32] In his report, Augagneur also signaled the importance of anticipating the future extension of the asylum; instead of buying adjacent territory later, at a high price, it made more sense to purchase a larger property straight away. Doing so would also have the immediate advantage of creating a "zone of protection" immediately surrounding the asylum which would help prevent the delivery of alcohol to patients and asylum staff, as well as to minimize the distractions of noisy neighbors.

Following these recommendations, Graffeuil, the Resident Superior of Tonkin, suggested the site for the new asylum cover a surface area of at least 62 acres (although he noted 75 to 100 would be preferable). Roughly half the land would be dedicated to rice and other forms of agricultural exploitation which would have the "double advantage" of providing occupation to calm patients interned at the asylum. As for the site itself, Graffeuil signaled the importance of easy access to water for the daily running of the institution (much like the Bien Hoa asylum where a small river traversed its grounds). The site must be flat, especially where the pavilions for the patients would be located in order to facilitate surveillance and obviate the need for more guards. The site should also stand well protected from floods. Finally, the asylum should neither be situated too near or too far from an "agglomeration of sufficient importance." Bien Hoa, for example, was located thirty-four kilometers outside Saigon and four kilometers from the seat of the provincial administration on the border of Colonial Route 1.[33] The project for Voi similarly counted on easy accessibility to the colonial capital of Hanoi by transportation routes in order to facilitate communication and improve access to medical and food supplies. Voi would also benefit from the proximity

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[32] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[33] Rapport annuel d'Octobre 1931 sur le fonctionnement de la Direction Locale de la Santé de la Cochinchine.

of Hanoi's many hospitals, medical centers and laboratories, and serve as a training site for students pursuing studies in psychiatry at the Hanoi Medical University. Moreover, colonial administrators hoped the asylum's proximity to an urban center would ease recruitment of both European doctors and an indigenous medical and surveillance staff.[34]

In Tonkin, colonial administrators fielded several proposals for sites for the establishment of the asylum: the village of Co-Nhue-Vien in the province de Ha-Dong; the city of Ninh-Binh in Ninh-Binh province; as well as a proposal to transform the Hospital of Quang Yen into an asylum for the mentally ill, blind, elderly and incapacitated.[35] The Director of Health for Tonkin suggested placing the asylum in close proximity to the leper village in Qua-Cam in Bac Ninh province and in 1927 a Sanitary Commission was set up to examine Qua-Cam as a possible site.

After studying Augagneur's report on the general organization of Bien Hoa, the principal architect for Tonkin, the Chief of the Service for Civil Buildings, traveled to Bac Ninh to examine the site proposed by the Commission. He concluded that the site was indeed well suited to the project from the point of view of construction. He also noted the possibility of annexing land for rice paddies on the opposite side of the road in direct view of the diverse pavilions that would comprise the establishment. The neighboring leper village formed the only inconvenience; he suggested constructing a fence around its perimeter in order to avoid all contact between the lepers and the tranquil patients working in the neighboring fields.[36]

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[34] TTL1, Résidence Supérieur au Tonkin, 73757, Graffeuil, Le Résident Supérieur au Tonkin à Messieurs les Administrateurs Résidents de France à Hàdong, Sontay, Bacninh, Phuc-Yen, Vinh-Yen, Bacgiang, Quang-Yen, Haiduong. December 9, 1927.

[35] TTL1, Résidence Supérieur au Tonkin, 73757, L'Administrateur de 1ère classe Ernest Valette, Résident de France à Quang-Yen à Monsieur le Résident Supérieur au Tonkin, December 12, 1927.

In the end, the colonial administration made the serious miscalculation of placing the site not in Bac Ninh but in Bac Giang province near the city of Phu-Lang-Thuong. Construction started in 1928 with an anticipated finish date of 1930. However frequent delays pushed the opening of the asylum back to 1934.[37] The most serious cause for these postponements was the discovery that the site was infected with malaria. In 1930, Dr. De Raymond, the director of the health service in Tonkin, launched an immediate investigation of the three villages surrounding the asylum where he found a "severe infestation" of malaria-carrying mosquitoes. He deplored the fact that the administration had "lost sight of the lessons of the past and in particular forgotten the deaths from malaria suffered by the personnel who constructed the rail line of Langson." He asked: "What is there to do? Stop the work and repudiate those who have chosen and decided on this location?" He determined that this would be "impossible, the Resident Superior never giving his consent," so the work continued on the second wing of the asylum. The Pasteur Insitute conducted their own tests and also confirmed the earlier determinations by the health services. But it was all too late. A complete clean up would cost more than the asylum itself, rendering the problem "practically unsolvable."

They were left with no option but to move forward with individual prophylaxis which, in the words of De Raymond, constituted "only a last resort and an admission of weakness" that would shackle the future functioning of the establishment. The strategy of individual prophylaxis also raised its own set of challenges. First, how to protect those mentally ill who spend their days naked and for whom all prophylaxis by quinine is therefore impossible?

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[36] TTL1, Résidence Supérieur au Tonkin, 73757, L'architecte principal, Chef du Service des Bâtiments Civils à Monsieur le Résident Supérieur au Tonkin, December 22, 1927.

[37] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine. Once the plans were approved, 290,000 piasters were allocated to Voi's construction.

Agitated patients were denied the use of mosquito nets due to surveillance concerns, meanwhile barred windows would fail to protect them from infection. Fears of infection among the personnel joined with concerns over the recruitment and maintenance of a staff in "this unhealthy solitude," ten kilometers from the city of Phu-Lang-Thuong and nearly sixty from Hanoi.

For De Raymond, the malarial infestation of the site proved neither his first nor his only gripe with the project as a whole. The asylum's distance from any center or market made "provisioning difficult and onerous. Cars are therefore necessary. In addition, for twenty days a year there is no running water while the irrigation canals are being flushed out." In sum, he concluded,

> Voi constitutes an enormous error that translates into considerable costs and functions in fits and starts for which I do not take responsibility. It does not encumber me, I've done what was possible to stop it and I did not succeed. I have reserved funds for the creation of an admission pavilion for mentally ill patients at Bach-Mai Hospital which will become a psychiatric clinic, that's all I can do and even that was difficult. I fear that only upsetting surprises are in store for the future of Voi, whether sooner or later... I would like to be mistaken and will do what is possible to mitigate all inconveniences but I do not make any guarantees for the future. In all I cases I release myself of all responsibility of this ill-fated project to which I will remain on the outside.[38]

Patient pavilions

Despite Health Director De Raymond's words of caution, the plans for Voi pushed forward. Patient lodgings, also referred to "pavilions," were to be divided into different divisions for European and indigenous patients, men and women. This "mixed" model distinguished asylums in Indochina from those in India, for example, where separate asylums

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[38] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3683, Direction Locale de la Santé du Tonkin, Rapport Annuel de 1931, April 1, 1932.

were built for Europeans and native populations.[39] It also distinguishes asylums from other kinds of colonial institutions in Indochina like schools, prisons and hospitals that were racially segregated. Following the Bien Hoa model, each male and female division would consist of one pavilion for senile and epileptic patients, one for calm patients and another for "semi-calm" patients. Each pavilion would accommodate up to forty patients and consist of two common rooms, a refectory or eating area, bathrooms and a guard room. Another pavilion for agitated and dangerous patients would consist of twenty isolation chambers. In total, Augagneur recommended 6 pavilions each for male and female patients, with 220 places for each section, plus 30 places in the Infirmery, in addition to 10 for each section in the admission pavilion, bringing the total asylum capacity to 520 indigenous patients. Although these facilities would not need to be built all it once, he cautioned it would be important to build in such a way as to make allowances for future expansion.

In order to alleviate the overcrowding that resulted from rapidly rising numbers of patient admissions, Bien Hoa found itself in constant need of expansion.[40] This problem of how to "decongest" the buildings required additional credits from the colonial government which had been determined to cut corners from the very beginning.[41] Indeed asylum buildings were in a constant state of disrepair due to the initial lack of investment. In a 1926 report to the colonial government, the Bien Hoa administration signalled the burden of maintaining buildings that were constructed "too economically." The hearth of the kitchen, for example,

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[39] Waltraud Ernst. Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth Century British India. *Comparative Studies in Society and History* 39,1 (1997): 153-181.

[40] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[41] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

was fashioned out of ordinary brick instead of more heat resistant materials. While "at the time of construction savings were without a doubt very large" since then "it does not pass a single day that we are not obligated to reconstruct the unuseable collapsing foyers of the patient residences. We estimate that the foyers have been reconstructed at least twice. While the use of refrectory material is more onerous at the beginning, it will prove more economical over time and avoid disruptions of the service." Similar observations were made of the walls whose coating required new painting each year. Buildings covered with defective tiles became damaged during the rainy season. The panelling and structure of the buildings were also in need of "constant and onerous upkeep which could have been easily avoided during construction by using metals of a certainly more elevated price" but which would proved "much longer lasting and more solid." The upkeep of the septic system also mounted a "heavy charge and an unenviable task for the workers, which could have been avoided if the construction of the water tower had been done less economically and doubled in size. It results that the distribution of water is insufficient and requires the creation of new installations which cost double what they would have cost seven or eight years ago."[42] These mistakes served as cautionary warnings for the planners of the Voi asylum.

In terms of the design of the pavilions themselves, Augagneur recommended abandoning the Bien Hoa model altogether. Instead he proposed the adoption of the "U model" which he found "infinitely more practical and facilitates surveillance." Why abandon Bien Hoa's pavilion design? First, the absence of a refectory meant that patients were forced to eat in their rooms or outside during heat waves or the rainy season. There was also no interior courtyard that would have permitted the patients to remain out of doors during the warm season or the cool evening hours. The heat in the pavilions reportedly became quite

[42] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

intense from the sun heating the tiles that were placed in such a way so that no breeze could provide relief. Finally, there were numerous difficulties with surveillance due to the positioning of guards in a central lookout that joined together the two common rooms. The two windows that pierced the wall on other side of the lookout only let guards see the most immediate section of each common room. For those pavilions housing "calm" patients the use of mosquito nets meant the guard could not see past the first bed. As a result, asylum administrators complained that patient escapes would typically took place through the WC at the far end of the room. [See Figure 4]

The "U" model, however, presented several advantages: surveillance of the entire room (including the WC) made possible by multiple windows as well as a shallow and circular verandah where the guard on duty could view in an instant the entirety of the pavilion. There was also a refectory where during the rainy season and at times between meals could double as an atelier for different kinds of work including basket and mat making and embroidery. When the weather permitted those patients who could not be employed in exterior work could instead rest outdoors in the interior courtyard. Finally, the far end of the pavilion could largely stay open (albeit still furnished with bars) which permitted calm patients to stay outside during warm nights. [See Figure 5] For pavilions dedicated to the isolation of agitated or dangerous patients, a more rigorous surveillance was required. Augagneur recommended a kind of prototype conceived by De Clernambault, Doctor of the Special Infirmery of the Prefecture of Police in Paris.[43] [See Figure 6]

Augagneur emphasized that no matter the model eventually adopted the pavilions for every class of patients must possess the following: a tiled or cement floor; white-washed walls

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[43] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

with a base layer of paint to make for easy cleaning; barricaded windows and a large opening in the doors to facilitate surveillance; ventilation and heat (if necessary). Just like the "open asylums" in the metropole, the pavilions must be surrounded by iron wires crafted in the form of trellises two meters in height. This enclosure would effectively keep the patients from leaving but also prevent errant dogs from entering and finding scraps of food around the pavilions. Within this enclosure the patients would be permitted to grow flowers and cultivate vegetables that they could consume or bring to the administration to "be sold for their benefit."[44] A ceiling of reinforced concrete was also necessary. In recalling his experiences at Bien Hoa, Augagneur noted, "With the exception of agitated patients, pavilions for all other patients did not have ceilings, this is a gross lacuna as all the escapes have taken place in the following manner: the patient scales the length of the grating, reaches the rafters of the roof and has only to displace the tiles to be free. It is indispensable that all the pavilions are given a ceiling or better yet a metal covering that will not prevent the circulation of air. This improvement is urgent as we cannot demand from the guards a perfect surveillance in these horrible conditions."[45]

In addition, Augagneur stressed the importance of electric lamps protected by metal or unbreakable glass. This concern over adequate lighting stemmed from endemic problems with obtaining a steady current of electricity at Bien Hoa. A 1925 annual report underscores some of the difficulties faced by the asylum administration,

> On clear nights it would be pointless to illuminate the electricity in the alleyways...we are obliged to unnecessarily consume the current for about fifty lamps so the pavilions can stay illuminated when the night falls and so that surveillance can take place. Likewise

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[44] *Ibid.*

[45] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

> despite repeated rounds certain lodgings stay illuminated the entire night. The current from Cholon is often down during the rainy season resulting in a difficult surveillance because the asylum does not have a back up system. We must set up either an electric generator or storage batteries. This last solution seems too onerous to make it worth it but one must do something as the lack of light all night has already led to some very serious consequences.[46]

Annual asylum reports describe numerous outages and interruptions, some lasting minutes, others hours, especially during the rainy season. In 1928 for example, 172 interruptions were counted, resulting in 244 black out hours. While service marginally improved over the following few years, still by 1933, there were 95 outages a year (or 137 hours without service).[47] One of these outages reportedly led to a critical lapse in surveillance, resulting in a patient suicide.[48] Electricity was also expensive (it cost 6000 francs per month on average.) As a result, in order to conseve energy, the asylum staff increasingly sought to "modify the distribution so as to only allow those lamps strictly essential for the guards to stay illuminated." Doing so, they hoped, would reduce consumption of electricity by nearly a quarter. In 1926 asylum administrators already began to express the hope for the negotiation of a better contract in 1937 (once the current one expired) that would provide better rates and less frequent interruptions.

In turning his attention to lodgings for the European patients, Augagneur stipulated that they should remain entirely separate from the indigenous pavilions. These pavilions should consist of two sections, one male, one female, with each section including ten bedrooms (with a bath and water closet for every two rooms), its own dining room, a room for reading and games and between the two sections, a kitchen. A common room for physical

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[46] *Ibid.*

[47] TTL1, IGHSP, 50-03, Asile d'Aliénés de Bien Hoa, Rapport Annuel, 1933.

[48] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

education with hours reserved for men and women should also be provided as well as a large garden for walking.

This set up would represent a decided improvement over Bien Hoa where in 1925, for example, the quarter for European men consisted of three rooms (including two bedrooms and one isolation chamber, housing ten patients total), a bathroom and water closet. Converted from its original purpose as a pharmacy, the pavilion was too small, equipped with an insufficient garden without any shade or view. The wing for European women suffered from similarly cramped conditions. Given the numbers of French citizens, European or assimilated, as well as the *métis*, who lived in the colony, asylum administrators cited the "imperious need" for the construction a new European quarter.[49] These concerns were shared by members of the Colonial Council who also worried over the increasing numbers of Europeans born in the colony, including those with their families already established there, and for whom repatriation was not a practicable option.

The asylum administration believed the Colonial Council's request for a long-term solution in regards to the European mentally ill could be technically achieved, even if it ran against the opinion of the Colonial Commission on Mental Hygiene in Paris who favored repatriation in all cases (see Chapter 2). But they warned that conditions to assure the comfort of Europeans at Bien Hoa did not yet exist. Indeed as the asylum's director warned in 1925, "This can only be a resting place for those mentally ill awaiting their repatriation. It is impossible to aspire to guard these patients over a period of years without the comfort and space to which they have a right." To make patients more comfortable in the short term, asylum administrators proposed the purchase of additional furniture (to make the rooms

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[49] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

appear less spare) and the creation of a library. They also thanked the heads of various local newspapers for donating daily papers to the asylum each morning.[50] The cost of the new European quarters was projected at 60,000 piasters.[51] Yet due to the colonial budget deficit at the time the funds were denied.[52] Instead, years later, arrangements for European patients at Bien Hoa remained "insufficient, poorly arranged...The two pavilions that were available in 1927 requires two patients share the same bedroom." Meanwhile there was "no place to put loud or disruptive patients which means that one agitated patient prevents all the others from relaxing."[53] [Figure 7]

Those accused of crimes (but acquitted by reason of insanity and sent to the asylum instead of the prison) also required special attention. As of 1925, Bien Hoa still did not possess a pavilion specifically devoted to their care.[54] By 1934, only one building was destined for criminal patients whose number (79 men) had reached almost double the original intended capacity. Furthemore contrary to the regulations set forward by the 1930 law, the asylum's thirteen female criminal patients continued to be lodged in various pavilions with ordinary patients throughout the asylum. The asylum director urgently warned in 1934, "This situation has lasted for a long time and brings serious inconveniences from the point of view of security."[55]

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[50] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[51] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[52] *Ibid.*

[53] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[54] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

Personnel

Besides the construction and management of buildings, asylum administrators faced other kinds of challenges related to the recruitment and maintenance of staff charged with the day-to-day functioning of the asylum. Occupying the middle ground between asylum directors and patients, the duties of the asylum staff were complex and onerous: to ensure a well-regulated institution that provided protection and security for patients; to balance firmness with compassion, moral qualities with technical expertise; and to exert oversight of others while also subjected to disciplinary action by their superiors.

My attention to the asylum staff contributes to a growing literature in the history of medicine dedicated to the lower ranks of health workers. In the history of psychiatry, for instance, asylum officials take center stage while attendants generally only enter the picture as a way to illustrate or condemn the abuses of the asylum system. Increasingly historians have come to more closely examine the attendant's role as a remedial agent central to life at the asylum, especially as they played an increasingly therapeutic role with the advent of the moral treatment in the early nineteenth century. The discourse of ‘moral treatment' stressed the importance of the personal relationship between patient and staff member, especially the doctor, but also the attendant. Indeed, as Lee-Ann Monk observes, the initial neglect of attendants by historians is surprising given the contemporary emphasis on their importance to therapeutic regimes.[56]

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[55] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934; See also Chapter 6.

[56] Lee-Ann Monk. Working in the Asylum: Attendants to the Insane. *Health and History* 11,1 (2009): 83-101, 84.

The colonial literature has also moved away from a former over-reliance on the decisions of professional colonial authorities to instead look at the role played by intermediaries and interpreters.[57] This is particularly true in the colonial public health literature that has sought to reclaim the pivotal roles of subordinate workers including midwives, sweepers, native health workers, and others. In a colonial context, these intermediaries played a vital role in mediating Western and non-Western understandings of health and wellness. As Jonathan Saha argues in his work on the history of medicine in colonial Burma, medical subordinates made colonial medical authority possible yet because of their reliance on local subordinates, colonial medical officers never held complete control.[58] Others have noted the ambiguous position of the medical subordinates in terms of negotiating hierarchies of power and racial privilege within the institutions themselves. Here, in the context of the colonial asylum, I examine the expectations for medical subordinates who were tasked with providing care and oversight while also themselves being subject to surveillance and recriminations from above. In particular, I emphasize how the asylum staff was tasked with performing a special kind of emotional labor in contrast with the work of prison guards that has received attention elsewhere in the literature on colonial Vietnam.[59]

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[57] See Benjamin N. Lawrence, Emily Lynn Osbourne and Richard L. Roberts, eds. *Intermediarires, Interpreters and Clerks: African Employees in the Making of Colonial Africa*. Madison, WI: University of Wisconsin Press, 2006.

[58] Jonathan Saha. 'Uncivilized practioners': medical subordiantes, medico-legal evidence and misconduct in colonial Burma, 1875-1907. *Southeast Asia Research* 20,3 (2012): 423-443.

[59] For the role of the prison staff in the daily functioning of the colonial prison see Zinoman (2001), Chapter 3, "The Regime." There is also large social science literature on "emotional labor" defined as "what employees perform when they are required to feel, or at least project the appearance of, certain emotions as they engage in job-relevant interactions." See Arlie Hochschild. *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press, 1983.

In terms of the organization of the asylum staff: first, a European "*Medecin-Directeur*" was placed in charge of the asylum. Chosen from among the civilian or military doctors in service in the colony the Director had typically served as a former chief doctor at an asylums or psychiatric clinic in the metropole or those had interned or completed a "*stage*" or internship in psychiatry in a French asylum.[60] In Indochina, expertise denoted not just specialized training in psychiatry but also knowledge of the local language, considered "absolutely indispensable" when it came to the psychiatric treatment of the indigenous population.[61] The Director endorsed all administrative orders and assured the internal management of the asylum, everything from establishing daily budgets for meals, reimbursements to the colonial treasury, oversight of the infirmary and laboratory, electricity and heating and supervising the upkeep of asylum grounds. He was also tasked with submitting monthly and annual reports and budgets to the colonial administration in order to assure the good functioning of the asylum's service.[62] All patients that entered the asylum would fall under his observation, for whom he would approve documentation of their medical progress and provide recommendations for their care and treatment (including the assignment of tasks as part of labor therapy).[63] He also assured the personal care of European patients. Finally, the Director oversaw the recruitment, promotion and dismissal of all European and indigenous personnel under his authority.

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[60] TTL1, Résidence Supérieur au Tonkin, 73745. Etat des propositions présentées à l'Inspection Générale des Services Saniatires pour l'application au Tonkin du Décret du 18 Juillet 1930 sur l'assistance psychiatrique, 1391.

[61] *Ibid.* Chapter 6 discusses the history of psychiatric expertise in the colony at greater length.

[62] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[63] See Chapter 5 on the history of the agricultural colony.

The Director was assisted by the *Infirmier Chef* (also of European origin) who was charged with the general policing of the asylum, the management of the property and working conditions of the surveillance staff and patients. Because his role was less medical than supervisory, the designation of "*Surveillant Chef*" or "*Surveillant Européen*" was actually deemed the more appropriate term. As Augageneur wrote in his 1927 report to the Tonkin authorities, "The role of *Surveillant Européen* can only be conferred to an active and honest man who has knowledge of all that concerns construction and repairs. His role will be very important, especially at the moment of creation of the asylum which he would have the advantage of designing since the beginning the construction, for which he has a profound knowledge of buildings, distribution of water, etc."[64] As a result, he suggested that this post be given to someone not from the medical corps but to a retired agent from the Public Works service.[65]

A large (mostly) indigenous staff assisted the Director and *Surveillant Chef* in the daily running of the asylum. The staff fell into two main official categories of primarily medical or surveillance duties. In reality, however, their functions overlapped. The Medical Resident stood second to the Director in everything related to the functioning of the asylum's medical service. He was recruited from among the corps of indigenous medical doctors trained at the Hanoi Medical University and who constituted an essential part of Indochina's medical service. The Medical Resident assisted in the medical visits and follow-up examinations of patients, took notes on the course of therapy, and managed the clinical paperwork for each patient. He was also in charge of the Pharmacy and assured, with the assistance of a corps of

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[64] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[65] The officials in charge of the asylum were assisted by an administrative staff that included: a secretary for the director, someone in charge of the bursar's office and their secretary, as well as another administrator in charge of the delivery of mail.

nurses, the preparation and distribution of medications and the execution of any special treatments. He oversaw the health service for the personnel of the asylum which included the task of screening patients and staff alike for contagious diseases. Finally, he was instructed to notify the director immediately of any incidents in patient quarters, including brawls between patients, escapes, suicide attempts and deaths. He was also charged with maintaining the registry of autopsies.

Even as the patient population continued to grow apace, the number of Indochinese doctors remained more or less the same. In 1933, for example, the number of patients totaled 660 (up from 622 the year before) with only two doctors assisting the Medical Director. While their service was lauded for assuring in an "irreproachable fashion and with zeal and devotion worthy of praise" the job had nevertheless become "become more and more burdensome, working for four years without interruption."[66] By 1935, given the budgetary restrictions imposed by the economic circumstances in Cochin China, instead of insisting on higher salaries, the asylum administration instead worked to improve the material situation of the medical personnel of the establishment. This included the construction of new lodgings for Indochinese doctors that were considered too cramped and uncomfortable.[67]

Meanwhile the nursing staff *(infirmiers et infirmières)* that worked in the infirmary, admission service, the pharmacy and laboratory, was not above reproach. A 1931 report noted that, with rare exceptions, the nursing personnel proved generally to give the "minimum efforts for the maximum pretensions." Serving "with regret in a post they consider without interest, they are only ephemeral guests at the asylum; one might say they resemble those who

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[66] TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

[67] TTL2, Goucoch, 3730, Procès-verbal de la réunion du 23 Decembre 1935 de la Commission de Surveillance de l'Asile d'Aliénés de Bienhoa.

are making a holiday in a country that bores them." Apparently they considered their role as "one limited to providing a vague kind of oversight, making their work fall to those in the personnel of surveillance." Meanwhile their technical education and understanding of French (especially as compared to nurses with an older training) remained very limited and, in some cases, "it is to be demanded if during their internship ['*stage*'] they are given the least notion of order and asepsis."[68]

Problems with the nursing staff were blamed in part on deficiencies associated with their recruitment. In general, the mode of recruitment after a *stage* in a hospital or clinic and reception of a certificate after a professional exam was preferred, if not for their advanced knowledge at least for acquiring a more realistic set of expectations. Whereas a student who had completed a *stage* before entering the profession knew more or else what to expect, those admitted to school with a simple certificate arrived largely ignorant of the demands and inconveniences of the profession. As a 1931 report from Bien Hoa underscored, "Even if some are satisfied, a good portion will not continue their studies with great zeal, or do it only grudgingly, without knowing why. Assigned to a provincial health service after their exit from school, they arrive with exaggerated pretentions imbued with the superiority that they believe to have because of their diploma. They work like amateurs without enthusiasm, an important point that is too often invalidated by the professional handbook."[69] Confronted with an ill trained and poorly motivated nursing staff, at various points asylum directors tried to make improvements by proposing their replacement by a specialized staff of male and female guards or "*surveillants*" who would be promoted to the title of "*infirmier-surveillant*" based on seniority and performance. It was hoped that such measures would introduce a new level of economy

[68] TTL1, IGHSP, 48-05, Rapport Annuel de 1931 de Bien Hoa.

[69] *Ibid.*

and result in a more permanent staff that possessed the requisite knowledge for working in the special conditions of an asylum. In the end, asylum administrators successfully inaugurated a series of special night courses, for guards and doctors alike, which "allowed them to gain special knowledge necessary for their profession."[70]

A surveillance staf, meanwhile, worked under the general supervision of a principal warden and under the direct supervision of a small number of chief wardens responsible for the service provided in each of the patient pavilions. Chief wardens were tasked with the cleanliness and upkeep of the pavilion, the distribution of food and goods to patients, as well as to ensure that the guards under their watch did not mistreat the patients. Every morning they registered observations about the patients in a notebook that was then submitted to the Director. Those patients signaled by the guards as in need of medical attention were then brought to the infirmary. Inside the pavilions, the chief wardens helped to supervise the behavior of the patients, to make sure that the guards prevented evasions and brawls and strictly observed all regulations regarding the interior management of the pavilion. They also registered any complaints and demands from the patients and transmitted them to the Director.[71]

Ordinary wardens or guards were assigned to work in a specific pavilion where they were tasked with the general surveillance of patients. (Men oversaw male patients while women oversaw female patients.) Every morning, they were assigned a group of patients to oversee during the day labor, where they (along with the patients) were placed under the

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[70] The Medical Resident was put in charge of the courses but unpaid for his services. It was therefore found to be "just and infinitely desirable that he would be paid a renumeration much like the Ecole de Police." See TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

[71] This responsibility until this time was purely an honorific title but Augagneur in 1927 proposed an increase of salary to $2 per month to reflect their greater responsibilities.

orders of the asylum's chief of agricultural operations, and returned to the pavilions at the end of work. Other wardens stayed behind to oversee those who remained inside the pavilions or "*sédentaires*." With the help of patients, wardens would assure the general upkeep of the quarters and provision of meals. Without the aid of patients, they would shut the doors and windows during the regulated hours. Finally, they followed a schedule of "surveillance tours" established by the Director and *Infirmier Chef*.[72]

Recruitment of Surveillance Personnel

Problems with the recruitment and training of wardens appeared almost from the very beginning. As the asylum director of Bien Hoa wrote in his 1923 annual report to the colonial administration, "No legal statue ties them to the administration; they often engage themselves unwillingly and hasten to leave the asylum as soon as a more remunerative position is offered them." To remedy the situation, he urged the administration offer recruits an "advantageous situation that is above all stable; it is in this spirit that we annexed to our 1922 report a project of legal statutes concerning the asylum surveillance but no consideration has yet been given it; we are insisting again this year that it be applied. We will avoid the considerable turn over detrimental to the service; 20 specialized wardens are worth more to patient surveillance than 25 *ignorants* who do not accept the work to which they are obliged." This same critique was leveled against the indigenous auxiliary medical staff (the *infirmiers*) who, "given the distance of Bien Hoa, considers their position to be a disgrace and does everything in their efforts to transfer. Moreover, it is notably difficult to learn certain notions about psychiatry in less than a year; it is at the moment when the indigenous doctor could be of utility that he moves away."

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[72] The guards and patients were also assisted by a team of coolies, an electrician, mechanic, masons, carpenter, cook, a coach driver, a linen maid and concierge.

As a result, the report "sharply insist[ed] on the stabilization of personnel and the creation of an autonomous corps of asylum guards."[73]

In 1924 the colonial government finally caved to the demands made by asylum administrators.[74] An official decree established the creation of a special indigenous corps of asylum wardens. In order to be accepted into the special cadre one must: be a French subject or enjoy protected status; follow a good life and morals (with an accompanying certificate testifying to this fact as well as a police record); fulfill the minimum age requirements; and document their physical capacity to serve as a guard at the asylum (validated by a certificate complete with photographs and fingerprints).

Wardens were to be recruited from among those candidates who knew how to read and write French with preference given to former military personnel. Candidates were nominated to a temporary post, after which they were expected to finish a one-year *stage* and upon its completion, assume a post as a 3rd class guard in the local health services. Those who proved inept or badly behaved would be subjected to a range of penalties including: restriction to asylum grounds for a period of one to ten days; the noting of an official warning in their dossier, including a description of the violation with the possible delay of promotion by one year; a demotion or dismissal.[75] While on duty, their uniform consisted of khaki pants and a jacket with badges embroidered "AB" in yellow cotton (shorthand for "*Asile de Bien Hoa*"). The chief wardens wore stripes in silver in a reversed V pattern to indicate their seniority. The ordinary guards wore stripes in yellow cotton also in the form of a reversed V. The female

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[73] TTL2, Goucoch, IA.8/281(1). Asile d'Aliénés de Bien Hoa. Rapport Annuel de 1923.

[74] TTL2, Goucoch, IA.8/276(2), Asile d'Aliénés de Bien Hoa. Rapport Annuel de 1924.

[75] ANOM, BIB 50003, Journal Officiel de l'Indochine Française. August 13, 1924.

guards wore a blouse in white khaki with a single band of yellow linen across the chest for guards and two bands for female chief wardens.

This 1924 decree reflected the special demands of asylum work. Declared unlike any other branch of the colonial administration, the occupation of asylum guard was described as "particularly delicate...in effect this personnel is in the service of the patients but while also in the service of patients, he must make them obey." And for this reason it was important to recruit personnel of high moral quality, "To win the confidence of the patient in order to then direct him, to order him in such a way as to think that the direction and order are in his interest, is an often difficult task that requires much patience and devotion."[76] Given the influence they held over the patients, wardens played a critical role in the treatment and rehabilitation process. They were required to be conscientious, attentive and capable of discerning the particular needs of patients while also treating them with gentleness, patience, tact and firmness. It is thus "an arduous task, delicate and extremely tiring as the least weakness, the least negligence, might result in a serious accident. This is why the number of guard stuff must be increased and their situation improved."[77]

Indeed with the exception of a "few very good agents," the average warden was deemed mediocre at best and the kind of care they provided alternately described as "coarse" and "repulsive." Apparently "certain employees considered their occupation as closer to that of a guard in the penitentiary service." As the surveillance staff was deliberately recruited from among former prison guards this is hardly surprising. In order to remedy this unfortunate situation, the asylum administration began to strongly crack down on staff violations and to

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[76] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[77] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

pursue severe sentences for the brutalities exacted against patients. [78] While the indigenous personnel "must be submitted to a necessary purification" in order to obtain an effective surveillance, the problem could not be fixed by removing certain bad eggs alone. It was also undoubtedly a problem of education.[79] In a 1926 report, Augagneur cites the example of the famous American physician and medical reformer Oliver Wendell Homes who described the chronic patient like a "vampire sucking the blood of able-bodied people. While this opinion is a bit exaggerated it can, however, be applied in part to the mentally ill. To make a guard understand that the *aliéné* which he harasses, without leaving him a moment of respite is a patient, that is the most difficult thing above all, especially in this relatively primitive country where the spirit of devotion and solidarity only appears to be in its faint beginnings."[80] In response, asylum directors organized frequent conferences "to make the staff understand that the patient is not a convict and that he is a patient and it is therefore important to be patient, gentle and devoted."[81] With the elimination of "certain undesirables" and improved education, little by little the service began to improve. The administration had apparently succeeded in finally establishing between the surveillance staff and patients a "friendly collaboration" in the diverse works of the asylum.[82]

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[78] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[79] *Ibid.*

[80] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[81] TTL1, Résidence Supérieur au Tonkin, 73750, Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[82] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

Nevertheless there was much to do to improve the morals and discipline of the personnel. As one asylum director remarked, "one is obliged to stimulate them constantly."[83] In particular, the lack of attention to detail, born of a casualness and frivolity, was considered to be one of the principle defects of the asylum's indigenous personnel, "A child-like silliness, silliness as much for his person as for the service is a formidable obstacle which for a long time already has been the cause of many mistakes. Silliness and a lack of order are normal things and it is only by a constant surveillance that we can remedy it." [84] The asylum administration recommended the creation of the post of a "warrant officer" with a "fastidious temperament who could oversee the wardens without showing the least weariness and the least slackening in his role as inspector."[85] That said, "From the purely psychological point of view it is remarkable to witness how easy it is to influence and train the indigenous personnel. The spirit of a 'sheep herder' must not be lost from view." Indeed warnings hovered in particular around any large gathering of indigenous staff members "too easily vulnerable to those excitations which, while minor, might nevertheless result in disconcerting acts and take on a disproportionate importance to their cause of origin."[86] In this way, the oversight of the surveillance staff itself, rather than solely that of the patients, emerged as a crucial question of asylum management.

In particular, the asylum administration worried over their staff's affection for gambling. In 1926 they surrounded the lodgings of the wardens with wire fencing in order to separate each building, making "nocturnal walks" more difficult and, by extension,

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[83] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[84] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[85] *Ibid.*

[86] *Ibid.*

participation in "*la culte de la damée de pique*," a popular card game.[87] While the asylum administration may have eventually succeeded in suppressing gambling inside the asylum, they were largely unable to control agents from playing outside its walls. Solicited by the "unrepentant" and notorious managers of local bars and inns, the wardens who spent their nights gambling also tended to indulge in "profound napping" during the day and whose behavior resulted in the disconcerting monthly presence of debt collectors who waited at the door of the asylum on pay days.[88]

The discipline of the night guards also posed a formidable challenge. Between the hours of six at night and six in the morning the night guards would make the rounds of the asylum, following fixed itineraries, and would inform their superiors if anything seemed abnormal, indicating an escape attempt or disturbance (such as opened doors and windows, noise, light, etc). They were also asked to report any asylum employees they encountered after 9 pm in the alleyways or the pavilions.[89] Because of deficiencies in staff numbers, at the end of their overnight tour many night wardens would have to go oversee the work of the patients in the fields or guard those who remained in the pavilions. Deprived of sufficient rest, guards were permitted to bring to their overnight post material for sleeping such as mats, pillows and covers. Such a measure only "tempts the weak" and resulted in some "unfortunate errors over

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[87] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[88] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[89] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

the years."[90] As the 1927 report from Bien Hoa noted, "It has taken two years of efforts to arrive at the point where the night watch does not fall asleep."[91]

Improving recruitment

In 1927, Augagneur made some suggestions to improve the process for recruiting personnel as established by the 1924 decree. He noted, for instance, "those who know how to read and write French are in general pretentious and not very hard working." It is therefore "infinitely preferable to engage wardens who know how to read and write Quoc Ngu only and who also know a skill or occupation (mason, carpenter, basket maker, weaver, farmer, etc. The agents in charge of teams of workers must form an example by way of dedication for certain patients in order to rid them of their indifference."[92]

The following list details, in Augagneur's estimation, the necessary qualities for an ideal asylum guard:

> 1 - Absolute respect for the discipline of the establishment, a strict discipline being indispensable for the good functioning of the asylum;
>
> 2 - To be "well balanced" in order to be capable of occupying a special milieu made up of diverse kinds of patients, those who are unclean whom it is necessary to bathe incessantly, others who are violent, turbulent, vindictive, malcontent or insidious;
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> 3 – Able to exercise a constant surveillance during long periods of time, a surveillance that is often very thankless as a result of long periods of inaction;

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[90] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[91] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[92] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927. Quoc Ngu is the romanized script of the Vietnamese language, first introduced by Jesuit missionaries in the sixteenth century.

> 4 – Rigorous cleanliness on account of frequent contact with patients suffering from contagious disease, syphilis and tuberculosis;
>
> 5 - Absolute discretion as much towards the patients as those strangers to the service;
>
> 6 - To maintain authority, not to impose oneself brutally on the patients but to have an air of letting him follow by guiding;
>
> 7 - To be courageous, the situations which demand this quality are most often unexpected and also very frequent.[93]

These qualities reflected the principles of "moral treatment" which rejected mechanical restraint in favor of displays of kindness, gentleness and watchfulness from doctors and attendants alike. However, in those cases when the use physical force was necessary, the delicacies of guaranteeing surveillance in a "mixed asylum" in the colonies posed a special kind of challenge. In particular, the indigenous guards charged with the oversight of European patients were placed "in an awkward position because they did not have any authority over the European patient, even if he was mentally ill; on the other hand, the weak constitution of the indigenous guard does not allow him, most of the time, to take control of the agitated European who possesses a certain physical force. This inconvenience can be remedied, at least partially, by an '*infirmier chef europeen*' whose force and constitution, combined with the prestiges of his race, can naturally impose on this category of patients."[94]

Issues regarding the recruitment of a reliable staff naturally intertwined with concerns about the rise in the number of patients confined at the asylum. The number of guards rose steadily throughout the 1920s reaching a maximum number of 78 in 1930 (for 532 patients). By 1933, however, the number of guards had been reduced to 67 for an even greater number

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[93] TTL1, IGHSP, 48-05, Rapport Annuel de 1931 de Bien Hoa.

[94] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

of patients (658 in total). By 1934, the number of guards began to rise again. In 1931, Bien Hoa possessed three doctors for 580 patients, which was cited as an absolute minimum ratio. The asylum director drew on details of a British asylum in Rangoon to illustrate by contrast the paucity of caretakers in Indochina's asylums.[95] At issue was not just enhancing staff numbers to keep up with increasing patient load but also in preventing high turnover rates among the staff.

In order to ease difficulties associated with staff recruitment, asylum directors repeatedly called on the colonial administration to offer higher salaries.[96] Low pay and relative isolation were blamed for the successive and rapid passage of doctors, rendering the asylum, "a little favored post where one wants to spend as little time as possible." The asylum suffered when "at the precise moment he acquires a good practice of psychiatry, the doctor leaves his post."[97] Indeed, in terms of the smooth functioning of the service, "Knowing the patients and to be known by the patients singularly facilitates things."[98] Difficulties associated with purchasing supplies, the lack of distractions as the result of distance from an urban center, as well as the relatively low pay compared to other posts in Saigon and the interior all resulted in the abbreviated terms of the asylum's doctors.[99] This held equally true for the surveillance staff whose recruitment was characterized as "very mediocre, the good ones having been taken by plantations who offer much more interesting salaries that those we could offer."[100]

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[95] TTL1, IGHSP, 48-05, Asile d'Alienes de Bien Hoa, Rapport Annuel de 1931.

[96] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[97] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[98] TTL1, IGHSP, 48-05, Asile d'Alienes de Bien Hoa, Rapport Annuel de 1931.

[99] TTL1, IGHSP, 48-05, Asile d'Alienes de Bien Hoa, Rapport Annuel de 1931.

Asylum administrators therefore demanded an increase in salaries viewed as "totally insufficient," especially for female guards. Women received inferior salaries to men even though they "did the same work, took the same risks and faced the same worries," not to mention the fact that female patients were apparently, "often much more disagreeable than the stronger sex." The salary for female guards was accordingly raised from $9,92 per month to the equivalent rate of their male counterparts.[101] The measure resulted in a "much more demanding in the recruitment of women...one must recognize that the service of women guards is now much better assured than that of male guards."[102] Asylum administrators also proposed new bonuses for guards to serve as a kind of "necessary stimulation" and to "bring an end to the present equality to those who work well and those who are mediocre but continue to receive the same salary."[103]

That the salaries of asylum personnel reflect the relatively high cost of living at Bien Hoa formed an object of particular concern. Indeed it was much more expensive than Saigon because all products arrived via the city where intermediaries would raise prices.[104] As a 1927 asylum report signaled, over the previous two years the cost of living in the provinces outside Saigon had skyrocketed as a result of the expansion of the plantation economy and new kinds of industrial projects. These developments resulted in a huge influx of coolies from Tonkin, as well as an increase in the European population (including guards, secretaries and workers),

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[100] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[101] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[102] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[103] For an example of proposed indeminities as a means of advancement for personnel, see TTL1, Résidence Supérieur au Tonkin, 73745, Le Directeur Local de la Santé du Tonkin à Monsieur le Résident Supérieur au Tonkin, March 31, 1931.

[104] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

resulting in an automatic hike in prices in food and other commodities. An increase in salary must therefore reflect the elevated food prices and account for the fact that the asylum was four kilometers from the closest market. A significant amount of the staff's salary was apparently spent on transport alone (the fare by car, one way, cost at least $0,50).[105]

The asylum administration also sought to improve the quality of life at the asylum, for the staff and patients alike. The project was aimed explicitly at discouraging the personnel from "search[ing] outside for distraction. But in order to do this it is necessary to dispose of certain credits for the purchase of a film projector which will allow the showing of hygiene propaganda films and the organization of recreational séances. There is not much we can do by way of cheering up the patients but some attempts at concerts on certain holidays are much appreciated. We are in this respect very behind psychiatric hospitals in British India." In particular, a report authored by Lieutenant Colonel WHC Foster of the Indian Medical Service (the Director of Public Health in Punjab) stressed that when it came to medical assistance for the mentally ill, "recreation is not neglected either; football games are put on...different games...musical instruments are available for concerts on Sundays and holidays. Dancers are engaged periodically to sing and dance in front of the patients."[106]

At Bien Hoa, general instruction courses for staff in written and spoken French were organized, as well as a library and two tennis courts (constructed by the personnel themselves, funded by the collection of dues). A nursery and school were also established for the children of female guards so that they could be supervised for much of the day (about 30 children attended the school in 1928.)[107] In short, the goal of these measures was to encourage the staff

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[105] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[106] TTL1, IGHSP, 48-05, Asile d'Alienes de Bien Hoa, Rapport Annuel de 1931.

to stay put at the asylum and not leave in search of distractions elsewhere, "these less frequent leaves having a happy repercussion on the discipline and good functioning of the service."[108]

The recruitment of the asylum staff responded to the demands of technical expertise alongside the performance of emotional labor, to assert authority but to do so with compassion and kindness. Imagined as models of conduct for the patient population, the staff too became objects of discipline, recriminations and encouragement in ways that reveal the blurring of hierarchies within the space of the institution.

IV. Difference in regimes

By 1933, Bien Hoa housed 660 patients, well over twice the 300 patients for which it was originally attended. According to asylum regulations, as established by the 1918 and 1930 decrees, the organization of asylum life was to follow a "partitioning and absolute separation" between patients according to different racial, gender and diagnostic categories including the "calm, agitated, epileptic, senile and recovering, as well as those antisocial types under criminal investigation."[109] Despite official pronouncements, one 1933 report drafted by Bien Hoa's oversight body found the asylum's patients, "literally piled up and asleep on mats on the

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[107] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine. The asylum staff often moved to their new place of employment with their families. For instance, according to a 1925 report, there were 360 patients at Bien Hoa, plus 130 employees and their families (brining the number of related staff to 200 people) for a total of 560 at the asylum. TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[108] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926. See also Dolly MacKinnon. "'Amusements are Provided': Asylum Entertatinment and Recreation in Australia and New Zealand, c 1860-c.1945" in *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting,* Graham Mooney and Jonathan Reinarz, eds. (Clio Medica/The Wellcome Series in the History of Medicine), pp. 267-288.

[109] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

ground in an unhealthy promiscuity. The presence of too many patients in the common room makes their surveillance uneasy and sometimes creates bloody confrontations; in trying to separate these 'brother enemies,' the personnel, to whom falls the responsibility of re-establishing good order, are exposed to the danger of being struck and hurt."[110] In this last section, I examine how distinctions between patients (European and Vietnamese, indigent and paying) which were supposed to conform to different daily regimes, including the bedding and clothes provided, diet and leisure time, proved difficult to uphold in practice.

These different regimes corresponded to disparities in the daily costs of treatment. According to the 1918 and later 1930 asylum laws, a patient's hospitalization costs were to be sent from the asylum to the colonial Treasury and subsequently reimbursed either by the patient's family or, more often, by the budgets of their province of origin. (The costs for patients from the colonial civil service were reimbursed directly by the administration). Asylum administrators often faced the challenge of determining where exactly patients had came from in order to know which provinces to charge. In 1926, the asylum received $2001.50 from the families of paying patients while reimbursement from the provinces totaled $68,949.50. With the rise in the asylum population throughout the 1920s, demanding a physical expansion of the institution, in addition to constant hikes in food prices, clothing and medication, the asylum administrators proposed an increase in the daily tariffs of hospitalization.[111] In 1926, the tariffs were fixed at $2 piasters for European patients and $0,50 for indigneous patients. As of January 1928, the price for a day of treatment at the Bien Hoa asylum increased to $3,00 for Europeans and $0,60 for the *indigènes*.[112]

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[110] TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

[111] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

In 1933, asylum directors envisioned the expansion of the "paying service" into four class divisions for European patients and three for indigenous patients. These new classes of patients would not only encourage families to send patients in the belief that they would receive better treatment and care but also serve as an important source of revenue.[113] Doing so, however, would require an increase in personnel and lodgings due to the projected greater number of patients in treatment and the wider variety of regimes that would correspond to each category of *pensionnaires*. A 1934 decree decided that the two pavilions at Bien Hoa, named after the famous French psychiatrists "Emmanuel Regis" and "Gilbert Ballet" (previously occupied by Europeans who were moved to their new wing) would receive two new categories of patients ($1.50 and $1.00 per day) where members of the Annamite and Chinese bourgeoisie could find "all their desired comforts."[114]

These costs of treatment corresponded to varying levels of comfort across the different classes of patients. Indigent Vietnamese patients were given wooden beds and mats, and mosquito nets. The quarters for "agitated" patients were equipped with individual cells and bed made out of stone. Mosquito nets, however, were not distributed as a safety precaution. European patients, on the other hand, were given iron-framed beds with a

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[112] TTL1, IGHSP, 44-01, au sujet de la promulgation en Indochine du décret du 21 Novembre 1933 sur le frais d'hospitalisation à l'Asile de Bienhoa, October 22, 1927.

[113] Leonard Smith, in his study of asylum care in Victorian England, similarly points to the commercial imperative to adopt a "mixed economy" of care that integrated pauper lunatics and paying patients into the same instiution. Leonard D. Smith. "The county asylum in the mixedeconomy of care, 1808-1845" in Bill Forsythe and Joseph Melling, eds. *Insanity, Institutions and Society*. London: Routledge Studies in the Social History of Medicine, 1999.

[114] TTL1, IGHSP, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

wooden base, mattress sheet and comforter, mosquito net, tables and armchairs.[115] European patients were also provided with new clothes including pajamas, blouse and pants.[116]

Clothes provided to Vietnamese patients included a jacket and pant (whose form varied depending on the gender) as well as a traditional "Annamite hat." Calm female patients who knew how to sew were charged with any required mending. In 1923, the asylum administration looked into buying a sewing machine that would allow for more rapid and sturdy repairs.[117] In fact, the clothing provided to indigenous patients was often deplored as not only totally insufficient but also of poor quality and easily destroyed.[118] In 1926, the asylum administration requested an increase in credits for clothing, for, "Despite all the repairs and a very active surveillance a number of patients tear and do away with their clothing. It is therefore necessary to have access to a large enough reserve of clothing in order to avoid having to clothe patients in patched up garments that give them the allure of vagrants, which produces a very bad effect on families who come to pay them a visit. We therefore insist on the necessity of obtaining the funds for purchasing cloth that is thicker and stronger. An atelier for repairs works non-stop and despite all that we cannot change patients as often as is desirable."[119] In 1933, asylum administrators also petitioned for more credits to improve the living conditions for patients from a "strictly hygienic point of view." This extended beyond

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[115] TTL2, Goucoch, IA.8/281(1). Asile d'Aliénés de Bien Hoa. Rapport Annuel de 1923.

[116] *Ibid.*

[117] *Ibid.*

[118] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[119] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

clothes to include the provision of linens and covers especially for nights during the cold season.[120]

Patients also followed strict daily meal schedules. Indigenous patients were given iron bowls and chopsticks, distributed before each meal and returned to the kitchens immediately afterwards, where they would be washed and cleaned.[121] The allowances for indigenous patient diets were as follows: freshly husked white or red rice of second quality, fresh or dried fish, pork or beef (or two duck eggs or two Annamite sausages); fish sauce, green vegetables and tea. Beef was prepared Tuesday, Thursday and Saturday while fish was provided Sunday and Thursday. During the rainy season, dried fish was substituted for fresh fish or pork. Meals were prepared at the asylum (by a chef with the help of patient-laborers) and special meals were provided on the holidays.[122] There was also talk of varying the regimes to accommodate Muslim patients. It was observed that many patients became cured of their mental illness with the sole therapy of sleep and regular food.[123] While asylum reports state that the food provided patients was sufficient in terms of both quality and quantity, a 1925 report references a complaint from patients who believed that their quantity of daily rice had been reduced.[124]

Meanwhile European patients ate meals prepared in the French style. For breakfast, they were given black coffee or cafe au lait, and pastry with chocolate and butter. For lunch, they were served varied hors d'oeuvres, an entrée of fish or eggs or pasta, meat and vegetables,

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120 TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

121 TTL2, Goucoch, IA.8/281(1), Rapport Annuel de Bienhoa, 1923.

122 TTL2, Goucoch, IA.8/281(1). Asile d'Aliénés de Bien Hoa. Rapport Annuel de 1923. [See Figure 17]. There was also talk of varying menus to accommodate Muslim patients. See TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

123 ANOM, Résidence Supérieur au Tonkin, 3753, Proces-verbal de la commission de Surveillance de l'Asile d'Alienes de Voi (Séance du 15 Juin 1938).

124 TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

and a dessert. For dinner, they would enjoy a stew or soup, an entree, a meat course, a vegetable course, dessert and bread. European patients were also served "red wine of good quality: 30 centiliters per patient" and 250 grams of ice cream per meal.[125] A refrigerator was installed at the asylum in order to make ice cream and keep beverages cold. In a 1925 report, the asylum director indicated that the provisioning of wine was no longer desirable and should, if possible, be replaced by a light beer following the practice of most asylums in the metropole. He even proposed the manufacture of beer at the asylum itself using locally grown hops, estimating savings at 0.22 per liter. A year later, European patients regularly enjoyed beer as part of their meals. This is interesting given the concerns over alcoholism among the population of Vietnamese patients. There were concerns as well to vary diets in order to match the needs of different kinds of patients: for those Europeans who required subsistence on a mainly broth diet, a half regime or full regime, or those who were undernourished.[126]

The organization of leisure time also marked a fundamental difference in the experience of asylum life across the patient population. The colonial asylum was organized as an agricultural colony and premised on the principle of 'non-restraint' and open door care. As I examine at length in Chapter 5, for many indigenous patients this meant laboring in the fields as a form of therapy. They would take siestas in between laboring and would earn time off for recreational activities and holidays. For European patients, meanwhile, time out of doors took the form of various leisure activities. As these patients did not work as part of their rehabilitation, due to concerns over the intensity of the heat and sunlight, "it was important to

[125] TTL2, Goucoch, IA.8/281(1), Rapport Annuel de Bienhoa, 1923.

[126] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

give them space to walk, a common room and dining room where they can relax during the rains and play games."[127]

System under pressure

In 1934, the asylum administration warned that without the necessary improvements to Bien Hoa and expansion of the asylum system elsewhere in the colony, they would have no choice but to refuse patients whose confinement was demanded by their families, "The consequences of such an eventuality are incalculable."[128] As it was, they had trouble maintaining order and effecting a "rational treatment" of patients depending on their mental and physical state. This was a point also emphasized by the Surveillance Commission charged with Bien Hoa's oversight.[129]

In 1935, the Commission concluded that it was necessary to separate agitated European patients from other patients whose treatment demands an "absolute calm" and who complain about their "impulsive and loud" neighbors. They also recommended the construction of a second pavilion for agitated indigenous female patients whose number had increased by "considerable proportions" as well as a new lodging for agitated indigenous men who could be moved into the pavilion for criminal patients once a new, more secure, pavilion had been established for them.[130] Furthermore, concerns over significant overcrowding

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[127] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[128] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

[129] The Surveillance Commission was instituted by the 1930 law which required its members make physical visits to the asylum at regular intervals and furnish a report to the colonial administration.

included increased risks of contagion, especially for tuberculosis patients. The infirmary, for example, desperately required improvements including the addition of an isolation pavilion for contagious patients. Apparently many tuberculosis patients lounged about in the common rooms putting others at risk.

The opening of the Voi asylum did work to immediately relieve some pressure on Bien Hoa after two sets of patients (thirty in total) were sent to Voi in July 1934 and again in February 1935.[131] Even with the opening of Voi asylum administrations cautioned that it did not become any less necessary to create specialized psychiatric services in all parts of the Union.[132] Indeed the number of those still confined at Bien Hoa meant that the asylum remained overpopulated, especially among the population of "indigent natives" whose families did not contribute to their upkeep. Lodgings remained insufficient to accommodate those patients who were sent from all over the colony and whose numbers continued to rise. The administration of Bien Hoa therefore insisted on the necessity of constructing another asylum in Cambodia that would have the immediate effect of discharging a significant number of patients from Bien Hoa. (In 1934, the asylum housed 73 Cambodian patients, 63 men and 10 women.) Furthermore, "for Cambodian patients, to find themselves in a milieu that is more conformed to their moral and cultural traditions, where they will not feel exiled like at Bien Hoa, will right away act as a favorable influence on their morale and facilitate their psychiatric rehabilitation." In the meantime, Bien Hoa hired Cambodian guards as a way to provide a kind

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[130] TTL2, Goucoch, 3730, Procès-Verbal de la réunion du 23 Decembre 1935 de la Commission de Surveillance e l'Asile d'Aliénés de Bienhoa.

[131] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

[132] TTL1, IGHSPI, 50-03, Asile d'Aliénés de Bien Hoa, Rapport Annuel 1933.

of comfort to their Cambodian patients as well as to train them for future employment at the new asylum in Cambodia.[133]

Voi's day-to-day management was plagued by similar challenges as Bien Hoa. In 1937, the Resident Superior of Tonkin reported 424 patients at Voi, well over the institution's theoretical capacity of 300.[134] A report issued two years later by the surveillance commission charged with Voi's oversight subsequently discovered:

> The buildings that exist now and those that are in the process of being constructed will together turn out to be clearly insufficient after the completion of the works. The patients are piled up like prisoners in common rooms in contempt of any kind of psychiatric classification: the epileptics are neighbors with the senile, the impulsives with the depressed. This situation, due to the lack of space, is very detrimental to their well-being. Despite the construction of new pavilions, it remains impossible to classify the patients by their mental categories and it is for this reason that a large number of pavilions would still be necessary. On the other hand, if we would like to treat those 341 *aliénés* who live at the asylum normally (as you would expect), rooms will be needed where each patient will have his own bed, doctors to supplement the the present staff, able to take on the specialized services, a laboratory and annexed pharmacy.[135]

Distinctions over racial lines also blurred. *Métis* patients, already a conflicted legal category in French Indochina, proved especially difficult to manage when it came to organizing asylum life. To take the example of one *métis* patient, Hoang (alternatively referred

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[133] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934. In 1936, the colonial administration in Cambodia approved the construction of an asylum at Takhumau (in the province of Kandal) near Phnom Penh, provided with credit of one million francs supported by the special budget. See ANOM, Guernut 22 Bb, Note de la Résidence Supérieure sur Hygiène et Assistance au Cambodge, 1936.

[134] Pharo, 166, Le Résident Supérieur au Tonkin À Monsieur le Gouverneur Général de l'Indochine (Direction des Services Economiques et Inspection Générale de l'Hygiène et de la Santé Publiques), November 12, 1937.

[135] ANOM, Résidence Supérieur au Tonkin, 3753, Le Docteur de Raymond Directeur Local de la Santé à Monsieur le Résident Supérieur au Tonkin (1er Bureau), A.S. Voeux relatifs à l'Asile de Voi, September 21, 1939.

to in the case file by his French name, Jean G.) was the son of Colonel G., a lieutenant in the French army who lived in cocubinage with his mother Hoan Thi Thao from Yen Bay province. He was born in Hanoi on 5 September 1897 on the Rue de la Soie. His father left Indochina several years prior and was never heard from again. Jean G. was therefore classified as a "*métis non reconnu*" or "unrecognized" by his father. In 1921, Jean G. was found living in Hanoi, without a fixed home, in the grips of mental illness and identified as a well-known threat to public order.[136] Because he did not enjoy official French legal status, Jean G. could not be treated at Lanessan Hospital reserved for the exclusive use of European patients while the Indigenous Hospital was apparently unprepared to receive a patient of "his type." While his condition seemed to be improving, the colonial administration in Tonkin found it impossible to keep him in limbo so they decided to send him to Bien Hoa where he was interned on November 7, 1922. As a *métis non reconnu*, he was confined in the indigenous section of the asylum and, according to his doctor, "certainly suffered from this situation." It was determined that the "only way to make this situation better was to re-classify him in the category reserved for Europeans. The costs of his treatment will therefore be raised to $2 per day instead of 0$50." He was accordingly re-assigned to the European wing in November of 1927.[137]

There were other patients who simply broke the rules. For example, one French patient, a M. Collin, was sent from Tonkin to the Bien Hoa asylum in 1931. Without any room in the European quarter he was temporarily placed in the indigenous section. Collin apparently

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[136] TTL1, Résidence Supérieur au Tonkin, 73744, Monsieur Mourroux, Administrateur des Services civils, Résident Maire de la Ville de Hanoi à Monsieur le Résident Supérieur au Tonkin, November 14, 1921.

[137] TTL1, Résidence Supérieur au Tonkin, 81330, Le Gouverneur de la Cochinchine à Monsieur le Résident Supérieur au Tonkin, Objet: Au sujet de l'aliéné [...] dit Jean G., September 20, 1927.

refused to transfer to the European pavilion once there was space available and so was left to his own devices among the *indigènes*.[138]

V. Conclusion

In 1937, the Voi and Bien Hoa asylums were officially designated as "psychiatric hospitals."[139] This change in nomenclature could not mask the grave problems, from severe overcrowding to limited budgets, which continued to threaten the rational organization of these institutions. The requirements of colonial asylums - from their physical set up, to expectations for the performance of emotional labor by the staff, to the mandate for "mixed" regimes across different classes of patients - set them apart from other kinds of colonial institutions. Their limits, however, reflect more than just the racial prejudices of colonial society or the budgetary limits of the colonial state. Instead they expose the fluidity of categories and hierarchies meant to separate the 'calm' from 'manic,' European from Vietnamese, men from women, wealthy from indigent, staff from patients. In the next chapter we will see how these patients found their way to the asylum and the kinds of negotiations that shaped the possibilities for their confinement and eventual release.

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[138] Determined no longer a threat to himself or others, Collin was released from the asylum in January of 1934 only to be put under a "discrete administrative surveillance." TTL1, RST, 73741, Le Médecin Directeur de l'Asile (de Bienhoa, Cochinchine) à Monsieur le Directeur Local de la Santé (Saigon), March 11, 1932.

[139] See Nguyen van Hoai. De l'Organisation de l'Hopital Psychiatrique du Sud-Vietnam. Saigon: Imprimerie Francaise d'Outre Mer, 1954, p. 50.

Chapter 4. Going in and getting out of the colonial asylum: families and the politics of caregiving

I. Introduction

"There are no arbitrary confinements, there are only arbitrary releases."[1]

In 1931, Dr. Augagneur, the director of the Bien Hoa Asylum, located forty kilometers outside Saigon, quoted the words of Gaëtan Gatian de Clerambault in the introduction to the asylum's annual report. De Clerambault, a French psychiatrist who had worked in the 1920s as the head of the *Infirmerie du Dépôt* in Paris, was defending his profession against accusations of capriciousness and neglect that forced in some instances the early release of patients. Like the directors of Parisian asylums in the late nineteenth and early twentieth centuries, those of psychiatric institutions in French Indochina throughout the interwar years also faced problems of serious overcrowding and public pressures to both confine and release the insane. Suffering from insufficient space and resources, asylum care in Indochina came to be marked out of necessity by high rates of patient turnover. Even at the height of psychiatric activity in Indochina in the 1930s, annual asylum reports clearly reveal that the majority of the insane in Indochina spent their lives not confined in psychiatric institutions but circulating in and out of asylums, jails, hospitals, poor houses and family homes.[2]

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[1] *Trung Tam Luu Tru Quoc Gia I* (TTL1), Inspection Generale de l'Hygiène et Santé Publique (IGHSPI), 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.

[2] Annual asylum reports show high rates of patient turnover understood here in terms of length of stay in the asylum and the number of patients released relative to the number admitted. In 1934, out of a total 801 patients, 141 entered Bien Hoa while 101 were released. 35% were released after less than 10 months in the asylum and 92% after 2 years. By 1938, an even greater proportion of patients left the

This chapter argues that the ways in which people moved in and out of psychiatric care in Indochina were not arbitrary but were instead shaped by complex negotiations between psychiatrists, colonial authorities and the public, especially families. Confronted with the reality of few experts living in the colony, French bureaucrats and doctors developed mechanisms regulating the confinement and release of the mentally ill that provided for, and indeed depended on, the critical participation of families and communities for information, surveillance and care. Examining the processes of going in and getting out of the colonial asylum reveals the ways in which lay people participated in the negotiation and exchange of ideas around what it meant to be "abnormal" as well as disputes over what it meant to be "sufficiently improved," in the words of one French colonial psychiatrist, as to return to society. Debates revolved around the mental health of the patient but also the capacity of the families to assume their care upon release and the asylum itself as the most appropriate site for treatment and rehabilitation. I argue that situating the history of psychiatry in Indochina within exchanges that transcended the asylum's walls provides a critical vantage for exploring contests over the legitimate aims and forms of colonial psychiatric practice, the historical relationship between families and the colonial state, and evolving ideas about what it meant to be a normal productive member of society in French colonial Vietnam.

Recent works in the history of psychiatry have begun to look much more closely at the dynamic between informal patterns of family care in the community and formal medical treatment in institutions. The examination of linkages between the family and the asylum, and increasingly the crucial intermediary role of friends, neighbors and community members, has provided scholars with an invaluable opportunity to re-examine assumptions about the social

asylum relative to those who entered, with 511 released and 544 admitted, out of a total 689 patients. See *Institut de Médecine Tropicale du Service de Santé* (PHARO), Carton 166, Rapports Annuels de la Service de Santé, 1934 and 1939.

role of asylums in the nineteenth century. Many like David Wright now argue that the confinement of the insane, as well as their discharge and reintegration into the community, resulted from the participation of a diverse array of social actors; not, for example, as a "consequence of a professionalizing psychiatric elite but rather as a strategic response of households to the stresses of social change or economic depression."[3] As Joseph Melling writes, this emphasis in current research on the detailed reconstruction of the social and cultural contexts of lunacy provision has enabled us to explore a "micro-politics of care" which shows bargaining among different actors with unequal power resources and capacities but who could nevertheless exert some degree of choice if not control over their environment.[4]

These works bring critical attention to the role of extra institutional care and, rather than a Great Confinement, insist on the historic permeability of the boundaries between asylum and community. However they remain largely restricted to nineteenth century histories of Western psychiatry and to Britain in particular.[5] In the colonial literature, references to local actors and indigenous understandings of mental illness are used primarily to frame discussions around the cultural relativity of diagnostic categories yet families rarely figure in the literature

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[3] David Wright. "Getting out of the asylum: understanding the confinement of the insane in the nineteenth century" *Social History of Medicine* 1997 10(1): 137-155, 139.

[4] Melling (1999), 6.

[5] John Walton, "Casting out and bringing back in Victorian England" in William Bynum, Roy Porter and Michael Shepherd, eds., *The Anatomy of Madness: Essays in the History of Psychiatry.* London: Tavistock Books, 1985; Akihito Suzuki. *Madness at Home: The Psychiatrist, the Patient, and the Family in England, 1820–1860*. Berkeley, University of California Press, 2006; Bill Forsythe and Joseph Melling, eds. *Insanity, Institutions and Society*. London: Routledge Studies in the Social History of Medicine, 1999; Peter Bartlett and David Wright, eds. *Outside the Walls of the Asylum: The History of Care in Community 1750-2000*. New Jersey: Athlone Press, 1999; Patricia Prestwich. "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876-1914," in Roy Porter and David Wright, eds. *The Confinement of the Insane, 1800-1965: International Perspectives.* Cambridge: Cambridge University Press, 2003.

as key participants in the colonial psychiatric system or as actively shaping the system as it developed.[6]

This chapter traces the development of a kind of colonial 'micropolitics of care' using mainly patient case files, community surveys and asylum reports with a focus on those provinces that comprise modern day Vietnam. While colonial asylums in Indochina housed indigenous and European individuals of both genders, I focus here on Vietnamese patients, particularly men, who formed the overwhelming majority of the asylum population.[7] The first section, "Going in," discusses the role of families and communities in shaping the process of confinement and how their role changed with the shifting norms of institutionalization. The next section, "Getting out," examines letters written by family members requesting release of patients and how these requests were assessed based on determinations of both patient health and the care taking ability of the family. Embedded in these assessments, offered by doctors *and* families, were competing notions of what it meant to be normal enough to live in society and the nature and function of surveillance outside the walls of the institution.[8]

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[6] On cultural relativism in colonial psychiatric practice, see Jonathan Sadowsky, "The Social World and the Reality of Mental Illness: Lessons from Colonial Psychiatry." *Harvard Review of Psychiatry* 2003; 11:210-214. See also Sadowsky's brief discussion on the role of families in *Imperial Bedlam* (1999), pp. 54-58. Catherine Coleborne focuses on European families and colonial public hospitals, but does not address the interaction of colonial asylums with indigenous families or forms of knowledge. *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914*. New York: Palgrave Macmillan, 2009.

[7] European and *métis* patients formed only a small proportion of the total asylum population. In 1926, the Bien Hoa asylum housed 10 European and *métis* patients out of a total 379; at the end of 1932, while the total asylum population had grown to 660, only 15 were classified as European or *métis*. *Trung Tam Luu Tru Quoc Gia II* (TTL2), Goucoch, IA.8/2912(3), Asile de Bienhoa, Rapport Annuel 1927; *Trung Tam Luu Tru Quoc Gia I* (TTL1), IGHSPI, 50-03, Rapport annuel de 1933 sur le fonctionnement du Service de l'Assistance Médicale de Tan An, Bien Hoa, Rach Gia.

[8] A note on terminology: Patient case files most often refer to patients as "*aliéné*," derived from the French term *"aliénation mentale"* or the state of being alienated or estranged from one's true rational self. Throughout the 1930s, patients were increasingly referred to by terms that denoted a more specific psychiatric diagnosis. My use of the word "insane" or "lunatic" in this paper represents a literal translation from French and does not purport to mean that these patients were actually mentally ill,

III. Going in

In 1927, a fifty-seven year old farmer named "Cac" was found guilty and condemned to fifteen years hard labor for setting a fire that killed a nine-year old child. Following a psychiatric exam that found Cac irresponsible by reason of insanity, he was sent back home to live with his family. In response to a request from the colonial provincial head about the possibility of his internment at the Bien Hoa asylum as a "preventive measure," the local director of health called for a new administrative inquiry that would look into Cac's "attitude, his acts and his sociability" since he had reintegrated in his village, as well as a medical certificate describing signs of dementia that could justify his internment. The author of the inquiry, conducted in the village of Gia-Hoà in Sontay province where Cac resided, reported back saying, "the mandarin let me know that since his return to the village, Cac has lived a peaceful life, without experiencing any new crises, and not doing anything abnormal."[9] The doctor's mental exam also found no signs of psychiatric disturbances but warned that the crises could reappear in the future. Based on these eyewitness *and* expert reports, the local director of health expressed serious doubts about renewing Cac's confinement. Internment in an asylum, he argued, "could only be justified by actual mental troubles, or by default, by a

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only as how the French understood and expressed the need for confinement, and how families and communities made use of these terms to pursue their own strategies.

[9] TTL2, Résidence Supérieur au Tonkin, 73741, Nguyen Huy Tuong à Monsieur le Résident au sujet renseignements donnés sur le Né [....] CAC, déséquilibré domicilié à Gia-Hoà, huyên de Thach-Thât, April 30, 1928. The full names of all patients have been redacted in order to protect their privacy.

'fonds démentiel' that allows one to conclude the risk of a relapse that could endanger the security of persons or the public order."[10]

This episode highlights how lay accounts were as important as expert opinions in shaping the decision to confine the mentally ill in Indochina. In particular, the power to intern patients depended on the assistance of families and communities who could provide doctors with critical information about long term behavioral patterns and the specific circumstances surrounding a recent "crisis." In the 1930s, when French psychiatrists working in Indochina began to speak about the virtues of preventive care and the need to create a clientele for psychiatric services, the role of the family became reshaped. The idea of a "*fonds démentiel*" - literally a demented foundation or background - signaled not only a shift in the norms of institutionalization but a growing concern among doctors to identify early warning signs so as to avoid confinement entirely, a process in which the family was envisioned to play a major role. The concern here is therefore to situate the process of confinement within a social landscape marked by a diversity of actors that contributed to shifting colonial ideas about what it meant to be "abnormal," and to demonstrate the extent to which expert practices relied on the intervention of the public.

Mandated Placement

Before the first asylum was opened in Cochin China in 1919, the colonial state relied almost entirely on families and communities for information and surveillance of the mentally ill with only the most extreme cases sent to special pavilions in hospitals or repatriated to

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[10] TTL1, Résidence Supérieur au Tonkin, 73741, Rougier, le Directeur Local de la Santé à Monsieur le Résident Supérieur, May 18, 1928.

France.[11] In 1887, the administrator of Thu Dau Mot province wrote to the Director of the Interior Service, complaining of the lack of expertise and the continued absence in Cochin China of any decree prescribing the legal process of confinement, "Since the beginning of the year three lunatics have already been sent to Chôquan Hospital...It is impossible for me, given the absence of a doctor, to testify as to the mental state of the patients that I send to Chôquan; I am obligated to bring back the testimony of their families, their neighbors and the authorities of their village."[12] Investigations were often prompted by the concerns of community members, as in 1912, for whom "this individual is a continual source of anxiety, his neighbors are in effect obligated to exercise on him a continual surveillance in the fear that he will set fire to the village and would be very happy to see him locked away."[13] Given the scarcity of experts, the observations of notables, in addition to those provided by the police, attained their own kind of authority, prompting one Police Commissioner to declare, "it appears to be superfluous to submit [the patient] to a medico-legal exam."[14]

This practice of "*enquêtes*" or administrative inquiries continued throughout the asylum era as procedures for internment became increasingly formalized. In 1918, the Bien Hoa

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[11] In 1902, the colonial administration signed a contract with the Asile St. Pierre in Marseille which agreed to receive French patients from Indochina. While patients continued to be repatriated throughout the interwar years, especially those able to pay their own way, the practice was deemed expensive and impractical and formed a major impetus for the decision to build a "mixed" asylum for both European and indigenous patients that opened in 1919. TTL2, Goucoch, IA.8/104(1), Le Docteur Henaff, Chef du Service de Santé de la Cochinchine du Cambodge et du Laos, à Monsieur le Lieutenant Gouverneur de la Cochinchine, Saigon, July 15 1903.

[12] TTL3, Goucoch, IA.8/162(9), M. L. Gudenet, administrateur de Thudaumot à Monsieur le Directeur de l'Intérieur (3e Bureau), October 29, 1887.

[13] TTL1, Résidence Supérieur au Tonkin, 73751, Le Garde Principal commandant le poste de Dong-Chau à Monsieur l'Administrateur Résident Tuyen Quang, Dong-Chau, June 16, 1912.

[14] TTL1, Résidence Supérieur au Tonkin, 73751, M. P. Carlotti, Procureur de la république de Haiphong, à Monsieur le Procureur Général, Chef du Service Judiciaire en Indo-Chine, Hanoi, February 28, 1905.

asylum was established outside Saigon along with the colony's first legal regulations around psychiatric care. In 1930, the French law of 1838 regulating asylum care was officially extended and adapted to Indochina. The law included provisions for a psychiatric assistance system that would grow to include a network of psychiatric services in major hospitals and the establishment of a second asylum in Tonkin in 1934. Asylums received both European and Vietnamese patients who were segregated into pavilions according to race, gender and the severity of diagnosis. In charge of these services were French doctors who had either received specialized training in psychiatry in France or who had earned their degrees in tropical medicine and worked up the ranks of the colonial medical service. In 1934, the *Ecole de Médecine* in Hanoi added psychiatry to the curriculum as part of the advanced training of Vietnamese doctors who would come to staff the psychiatric assistance program and eventually assume control once the French left Vietnam in 1954.[15] A staff of nurses, guards and coolies assisted doctors with the daily care and surveillance of patients, the administering of medicines, and the translation of patient demands into French.

As in France, there were two principal ways people could find their way into the asylum. A "*placement ordonné*" or "mandated placement" was requested by the administrative authorities, while the other, a "*placement requis*," was initiated by the patient's family, relatives or friends. Each required a medical certificate confirming an insanity diagnosis and issued only on a temporary basis. At the end of six months, confinement could become permanent depending on the medical progress of the patient. Psychiatric expertise became routinized as part of the internment process, working to expand the legitimate terms of confinement. The

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[15] Recueil de notices redigées à l'occasion du Xe congrès de la "Far Eastern Association of Tropical Medicine." Hanoi (Tonkin), 24-30 Novembre 1938; Laurence Monnais-Rousselot. *Médécine et colonisation: L'aventure indochinoise, 1860-1939*. Paris: CNRS Editions, 1999; Nguyen van Hoai. De l'Organisation de l'Hopital Psychiatrique du Sud-Vietnam. Saigon: Imprimerie Francaise d'Outre Mer, 1954.

1930 law, for example, extended the grounds for confinement under a *placement ordonné* from disturbing public security, tranquility or decency to include more medically grounded justifications for those who risked their "own security or possibility of cure."[16]

Local investigations to determine what happened to provoke internment represented a key first step in initiating a "*placement ordonné*." Following an incident, the Police Commissioner would call for a "small inquiry in the quarter...if an inoffensive mad person, recommend stay with the family. If not sure, send to hospital for an exam."[17] In this way, non-experts continued to play a powerful role in framing diagnosis and the grounds for confinement. In some instances, anticipating possible objections by families and other colonial officials required doctors to adopt an essentially defensive posture when pursuing internment. As the Governor General urged in 1928, in order to avoid "any later complaints," it is "indispensable to establish for each patient whose internment is initiated by public authority an order of placement expounding the motivating circumstances which make it necessary."[18]

These "motivating circumstances" were established by community surveys which inquired after the mental state of the soon to be, or just recently, admitted patients. Distributed by asylum directors to local notables as a routine part of the confinement process, survey questions in the 1930s followed a newly standardized format:

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[16] People could also request their own internment under a "*placement volontaire*." Those convicted of crimes but found irresponsible by reason of insanity were issued an *ordonnance de non lieu* and transferred from the prison to the asylum. Pierre Dorolle, *La Législation Indochinoise sur les aliénés: Exposé et commentaire des dispositions du décret du 18 juillet 1930*. Saigon: Imprimerie A. Portail, 1941.

[17] TTL1, Mairie de Hanoi, 5782, H. Virgitti à Commissaire Central de Police à Hanoi au sujet […] Tho, June 11, 1935.

[18] TTL1, Résidence Supérieur au Tonkin, 73738-03, Note Postale Circulaire No. 130 au sujet de l'admission des aliénés à l'asile de Bien-Hoa.

1) Do you find (person) abnormal? If so, since when?

2) Has he or she committed any eccentricities? In the affirmative, what kinds?

3) Is he or she capable of working?

4) What is their conduct towards the other habitants in the village and the members of their family?[19]

The answers to these surveys provide a rare glimpse into how families and neighbors, in being asked to offer their own impressions of the mentally ill in their community, contributed to the development of colonial psychiatric knowledge. In a 1934 letter accompanying a survey of local inhabitants, one asylum director asked, "Have you heard people say in the quarter that Phuc is abnormal? Interrogate neighbors on this subject." And "Have you yourself ever noticed any eccentricities by this individual and if so, which kinds?" In response, Tin, the chief of Phuc's quarter in Hanoi, noted his neighbors insisted on his good conduct and claimed that he never violated the law. However, Tin shared his own impressions of an "*allure anormale*" that contradicted observations by Phuc's neighbors, suggesting they might have tried to protect him from the asylum: "[he] breaks into the houses of his neighbors without motive; left school; wanders all day in the streets; when there is a procession or a vaccination doctor in the quarter, he pretends to be very knowledgeable even though he has no idea. And finally, from time to time, he plays tricks on his parents as one

[19] These survey forms appear in dozens of patient case files. See for example: TTL1, Mairie de Hanoi, 5782, Le Médecin Directeur de l'Asile d'Aliénés à Monsieur le Chef de Rue Armand Rousseau à Hanoi, au sujet [....] Thanh, May 14, 1935.

does with small children."[20] This idea of an "*allure anormale*" underscores the kinds of eccentric but innocuous behaviors that the community had coded as deviant but clearly learned to accommodate.

For those lunatics who routinely antagonized their community, the results from the inquiries left no room for interpretation. Acts of violence, theft or arson represented the most common reasons for families and communities to seek confinement for the offending patient. A 1926 report from the Chief of Security in Bac Lieu province found that according to the local population Andre G. is considered "cracked," he is without profession, injures anyone who refuses him charity and will ride in a rickshaw for hours and for payment, hits the coolie. A *métis* abandoned by his French father, Andre had become such an object of terror in his community that one doctor insisted on his confinement in an asylum rather than imprisonment because "weakened or disabled in the head, Andre is resistant to sanctions as is shown by the numerous times he has been their object."[21] In some cases clear conflicts emerged between the patient and community, shedding light on the strategies each would pursue in their representations to colonial authorities. In response to the notables of one village whose report declared that "Hoc" had been "always crazy" for at least the past three years, the doctor noted the inconsistency with the patient's own statement who countered "that besides those periods which he had signaled, he stayed absolutely normal."[22]

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[20] TTL1, Mairie de Hanoi, 5782, Le Médecin Directeur de l'Asile d'Aliénés, à Monsieur le Chef de la Ruelle de Phat-Loc, Hanoi, August 23 1934; Tin, Chef de Rue des Changeurs à Monsieur le Commissaire Central de la Ville de Hanoi, August 1934.

[21] TTL2, Goucoch, IA.8/281(20), Le Médecin Directeur de l'Asile à Monsieur le Gouverneur de Cochinchine, August 10, 1926.

[22] TTL2, Goucoch, IA.8/275(1), Rapport Semestriel de l'Asile de Bienhoa, December 18 1919.

Families were also in a position to offer specific information that psychiatrists used in making their diagnoses. Interrogating the family and neighbors of the patient both before and during a crisis was important because as one French psychiatrist pointed out, "it's the element that we are missing."[23] For example, the father of one patient described a turning point when his son began to suffer from strange episodes. He provided quite a detailed account of what French doctors later deemed epileptic fits that "began only three years ago, suddenly when Hang had a bizarre crisis, sat on the ground, swaying his body, his legs trembling and in the end declared himself a God." Neighbors and communal authorities later confirmed that Hang had indeed been "caught by madness." They reported that these crises appeared on a recurring basis, every month or two, during which Hang, possessed by spirits, would run wildly down the street and unfailingly attack the passersby.[24]

Doctors clearly took these lay observations about symptoms and behaviors seriously and incorporated them into their own diagnosis. While Hang's psychiatrist later noted that Hang displayed no symptoms during a twelve day period of observation, he nevertheless underscored the regularity of the fits reported by the communal authorities and diagnosed Hang as a 'para-epileptic' with a probable cerebral infection. Cases like Hang's also reveal the points of consensus that emerged between families and doctors over the presence of mental disability that required responsible oversight. Hang's father, for instance, reported that he would notice the onset of symptoms warning of an impending 'crisis' and would be entrusted by his neighbors with Hang's surveillance until the period of danger had passed. He also periodically cut his son's long unruly hair as a way to "refresh his head," revealing that while

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[23] TTL1, Résidence Supérieur au Tonkin, 73752-01, Rapport Médico-Légal de [....] Hang, December 30, 1919.

[24] *Ibid.*

beliefs in the causes and remedies of mental illness may have varied, the notion that illness was rooted in the brain and that 'abnormal' status derived from public displays of anti-social behavior provided common ground for making claims about 'insanity.'

Colonial psychiatrists clearly became frustrated, however, when they believed families willfully fed them ambiguous or misleading information,

> We've only been able to receive rather vague information on the acts and movements of our subject, watched over by the members of his family since the moment he was returned the last time until the day he was found guilty of the crimes that he is now accused of. How did he comport himself throughout this one year time lapse, exactly what did he do? It's difficult to know, as we estimate that it would be childish to absolutely believe the words of people who lie by nature and who, better yet, have a reason to hide more or less the truth. It might be better to believe entirely what the accused has to say himself.[25]

Despite doubts as to the quality of information they received, the clear frustration expressed here nevertheless underscores the extent to which psychiatrists depended on those who knew the patient best. It also reveals how some families and neighbors did all they could to obstruct the efforts of colonial authorities from sending patients back to the asylum. In one extreme case, on the evening of the 6th or 7th of February in 1909, a patient was kidnapped by his own family in order to prevent his confinement in a psychiatric ward at Chôquan hospital. By the 9th, despite leads from local notables, he had yet to be found.[26]

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[25] TTL2, Résidence Supérieur au Tonkin, 73743-7, Rapport d'examen médico-légal du nommé [....] Mân, détenu à la Maison Centrale de Hanoi, June 1928.

[26] TTL2, Goucoch, IA.8/1724(4), Monsieur C. de Laprade, administrateur de la province de Thudaumot, à Monsieur le Lieutenant-Gouverneur Saigon, February 9, 1909.

Requested placement

By the 1920s, the seeming reluctance of families to bring in their mentally ill for care became a major concern for French colonial psychiatrists who worried they only received patients once they were beyond hope. French experts attributed the hesitation of families to popular stigma against mental illness and imprecise notions that the "mad" were less gravely ill than they were in reality. Scores of colonial texts from the period remark on the superstitious and 'credulous' nature of the Vietnamese people who were said to trace the origins of mental illness to divine retribution for a prior sin.[27] As one Provincial Chief explained, "According to native beliefs, the cause of madness is entirely spiritual, such as the poorly chosen site for ancestral burial grounds, the unfortunate orientation of the family tombs, the breach of diverse rites or forms of worship, all causes that indispose the spirits and lead them to pursuit the guilty individual."[28]

According to these texts, in Sino-Annamite mythology, large numbers of gods, genies and spirits were anthropomorphized and endowed with human-like qualities including a weakness for pious attentions, flattery and vengeance. They would seek divine reprisals on earthly sinners in all sorts of ways but most often through sickness. Mental illness, which could assume a variety of forms, was therefore considered the work of "evils that emanated from the spiritual world whose invisible agents strike those human beings without distinction

[27] E. Langlet. *Le peuple annamite: ses moeurs, croyances et traditions*. Paris: Berger-Levrault 1913.

[28] TTL1, Résidence Supérieur au Tonkin, 73750, Note du Chef de Bac Ran, November 13 1903. Other misdeeds leading to 'madness' apparently included: violating a pagoda or sacred objects, wearing white in the middle of the day and passing under the shade of a large tree, bathing in a creek in the midday sun, the hour when the water divinities require calm and silence, and the poor selection of dates for marriage or the construction of a house. See H. Reboul and E. Régis. L'Assistance des aliénés aux colonies. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française*, XXIIe session. Tunis, 1-7 April 1912, 124.

of social class or rank, from the king to the commoner, the rich to the vagabond, the savant to the illiterate." But these gods, due to their "merciful and magnanimous" nature, would not seek the death of the sinner but merely demand they repent and express contrition for their mistakes.[29] In order to determine the origins of this mysterious evil (known as the "*ma qui*") and obtain the pardon of the outraged spirit, the family was compelled to seek out the help of a soothsayer or sorcerer to administer a cure.

Mental illness implied not only a condemnation of the individual but also an indictment of the honor of the family as a whole who was charged with the duty of caregiving.[30] While some French accounts describe the careful attention given to patients at home, others depict more brutal responses offered in powerful contrast to the rational and humanitarian character of modern French methods: that in order to exorcise the genies who had "ravished" the soul of the person as punishment for some misdeed or sacrilegious act, one French doctor reported that the Vietnamese engage in a range of brutal practices including flogging, violent dances and forced baths. Even after multiple failed attempts at cure, the "unfortunate" remained the family or village's responsibility.[31] According to the Annamite penal code that predated French occupation, the parents or family of the insane person were held criminally responsible for any acts of violence due to negligence and required to isolate

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[29] Andre Augagneur and Le Trung Luong. Croyances et Pratiques pour le traitement des maladies mentales en Indochine. *L'Hygiène Mentale*. Vol 23, 1928, pp 269-276. The fact that this piece was co-authored by a practicing French *and* Vietnamese doctor might indicate that it provides a more solid grounding in local understandings and traditions around mental illness than the work of armchair scholars.

[30] ANOM, BIB 12391, Dr. Gaide, "Les maladies mentales et assistance aux aliénés," 1931.

[31] ANOM, BIB 12391, Dr. Gaide, "Les maladies mentales et assistance aux aliénés," 1931.

the offending insane person under lock and key or send them to a prison.[32] For those families who could not afford the upkeep of patients, or for those patients who proved just too disruptive, the individual in question would reportedly be sent off, "abandoned to their sad destiny, chased from the village, they become errant, without shelter, a raggedy and dirty specter from which one would turn away and who live off begging and theft, given over to the malicious curiosity of crowds until his death comes or, by chance, stopped by the police, he is brought to the asylum. There he is, without civil status, inscribed under the designation of 'X' and this is how we have among our lodgers a dozen Xs."[33] Indeed many of those eventually sent to the asylum came to the attention of colonial officials as vagrants first and only later identified as mentally ill.

How local understandings of the etiology and cure for mental illness came to be grounded in the honor of the family helped to explain both the widespread social stigma associated with mental illness and the reluctance of families to give up the patient. "For these reasons," as one 1903 report underscored, "families probably will not voluntarily consent to entrusting the insane to the administration in order to place them in a special asylum. They refuse to believe that our doctors can cure them."[34] Reinforcing these views was the unfavorable image of asylums propagated in the local newspapers that likened the asylum to a prison and the personnel to prison guards who were "preoccupied only with guarding as many

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[32] Louis Lorion. *Criminalité et médecine judiciaire en Cochinchine*. Lyon 1887. See Chapter 2 for a more extensive discussion on Annamite law concerning mental illness.

[33] Augagneur and Le, 1928. As it became physically easier to travel throughout the colony with the advent of roads and trains, the colonial administration required greater numbers of policeman and security officers to improve surveillance of the streets and arrest vagrants. See Maurice Chautemps. *Le Vagaondage en pays annamite.* Paris: Librarie Nouvelle de Droit et de Jurisprudence, 1908).

[34] TTL1, Résidence Supérieur au Tonkin, 73750, Note du Chef de Bac Ran, November 13, 1903.

patients as possible."[35] According to one doctor, concerns over exposure to the other mentally ill in the asylum prompted many Vietnamese to declare, "to be enclosed here and not become completely mad!"[36] And, as another stated simply, "*prima facie* the thought of a long confinement scares families."[37] As a result, the asylum was only envisaged as a place of last resort, "All of these prejudices, these inaccurate critiques have created a frame of mind of which the principal result is that confinement is only envisioned as a final measure. A number of patients have waited until the last moment when it is too late and...often irreparable."[38]

Concerns that the majority of the mentally ill remained out of reach, especially those in isolated rural regions, continued to plague colonial psychiatrists throughout the 1930s. Yet some began to express hope that the local population had grown more accustomed to the necessity of psychiatric care.[39] For these optimists, the increasing relative numbers of *placement requis* signaled an apparently "profound modification in the indigenous mentality towards the insane."[40] In 1928, the director of the Bien Hoa asylum reported that following two tours of remote villages they had easily been able to convince families to allow their patients to be confined at the asylum.[41] Six years later, a 1934 report noted that in the province of Bac Giang, out of sixteen internments that year, fourteen originated with the families and only two were *ordonnés*. In all other provinces, the proportion was reversed. The proximity of the asylum

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[35] TTL1, IGHSPI, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.
[36] *Ibid.*

[37] TTL1, IGHSPI, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934.

[38] TTL1, IGHSPI, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.

[39] ANOM, BIB 12391, Dr. Gaide, "Les maladies mentales et assistance aux aliénés," 1931.

[40] TTL1, IGHSPI, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.

[41] Augagneur and Le (1928), 276.

and a firmer understanding of its purpose were thought to be significant factors in encouraging families to present their family members for care. One psychiatrist hoped that as knowledge and awareness increased more families would demand placement rather than conserve the insane in their villages under "lamentable conditions."[42]

Another was especially surprised that "the indigenous population has understood more rapidly than we would have believed the goal, the point, of the Asylum and they are more and more frequently receiving visits from family who come to demand the formalities necessary for internment, bringing patients in for an opinion and, after cure, maintaining relations with medical personnel in order to continue the required treatments. Also, patients who were given their liberty have solicited their own readmission."[43] For doctors, the contact with families was invaluable as a "source of precious information." Their participation revealed that,

> Annamite families, even of modest classes, are neither more nor less limited in their inability to understand than European families - I say even, much less. With a little patience, it's always possible to obtain useful information, and it's exceptional that families fail to surrender to our reasons when we explain the necessity of an internment or a prolongation of hospitalization. Little by little, they constitute a *veritable clientele of service:* those with intermittent crises are brought to us periodically by their families at the first sign of a relapse.[44]

With the creation of a clientele of psychiatric services, French psychiatrists in Indochina hoped to shift the focus of treatment from long term asylum care to early prevention and an 'open door' model. This turn came as part of a growing international

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[42] PHARO, 182, Rapport Annuel d'Ensemble de Service de la Santé, 1934.

[43] TTL1, IGHSPI, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.

[44] TTL1, IGHSPI, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934. Italics added.

movement for psychiatric reform that spread throughout France, England, Belgium and Germany, as well as to the United States, Canada, Argentina, Japan and Norway from the late nineteenth century.[45] With mounting concerns over asylum overcrowding and accusations of patient negligence, psychiatrists began to experiment with alternative forms of patient care that relied on the family and the incorporation of new uses of space and the environment in treatment regimes. In France, the League of Mental Hygiene, founded in 1920, campaigned for major reforms to the asylum system based on a more flexible conception of mental illness as an avoidable and curable disease. Under the direction of Edouard Toulouse, the League advocated for comprehensive services focused on prevention and rapid treatment as well as an expanded role for psychiatry in society.[46]

For psychiatrists in Indochina who closely followed the efforts of metropolitan reformers, and those of the Dutch in neighboring Java, the principles of mental hygiene inspired the development of the colony's own psychiatric assistance program. They worked to provide patients with care before the onset of acute psychiatric illness and stressed the rehabilitation of the chronically ill through labor and "life in the open air." Indeed asylums were organized as large agricultural colonies where patients could work the land on the path to healing and eventual liberation.[47] As an essential complement to the asylum system,

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[45] See Claude Quétel. *Histoire de la folie: De l'Antiquité à nos jours*. Paris: Tallendier, 2009; Waltraud Ernst and Thomas Mueller, eds. *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800-2000*. Cambridge: Cambridge University Press, 2010; Porter and Wright (2003).

[46] See Keller (2007), 53; Jean-Bernard Wojciechowski. *Hygiène mentale et hygiène sociale.* Paris: Harmattan, 1997; Jean-Christophe Coffin."'Misery' and 'Revolution': The Organisation of French Psychiatry, 1900-1980" in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century*, M. Gijswit-Hofstra et al, eds. Amsterdam University Press, 2005; Hans Pols, "Beyond the Clinical Frontiers: The American Mental Hygiene Movement, 1910-1945" in *International relations in psychiatry: Britain, Germany and the United States to World War II*. V. Roelcke, P. Weindling, and L. Westwood, eds. Rochester, NY: University of Rochester Press, 2010.

[47] Therapeutic labor was reserved for indigenous populations only while physical education for Europeans took the form of outdoor leisure activities. These distinctions in treatment regimes

Indochina's first outpatient clinic was established at Cho Quan hospital in Saigon in 1928, followed by the expansion of similar services in major hospitals throughout the 1930s, including those specifically geared towards the treatment of 'abnormal' children.

This more flexible and dynamic approach to mental illness also projected the cosmopolitan attitude of colonial psychiatrists who sought to participate in the growing international movement around mental hygiene and, in some instances, to position themselves as even more progressive than their metropolitan counterparts.[48] A 1926 report authored by the director of the Bien Hoa asylum, for example, boasted that Indochina's psychiatric services made patients in the colony the envy of those in metropole. He noted that with the exception of Madagascar, France's African colonies continued to lag far behind. Even in Tunisia, where Antoine Porot's clinic opened to much acclaim in 1911, innovations arose but in the context of the treatment of European patients. While considered a crucible for colonial mental health reform, Algeria did not adopt a more comprehensive system targeting indigenous communities for another two decades. Instead it was Indochina that in the 1930s earned the praise of international onlookers for having made the "most serious efforts" of psychiatric assistance in all the empire.[49]

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reflected not only assumptions about the racialized hierarchy of colonial life but also came to be inflected with class-based notions about the distribution of labor. Europeans did not labor but neither did the members of the Vietnamese bourgeoisie who came to occupy the old European wing when a "paying service" for indigenous populations was inaugurated at Bien Hoa in 1934. See Chapter 5.

[48] See “Introduction” in Keller (2007).

[49] H. Aubin. L'Assistance Psychiatrique Indigène aux Colonies. Rapport de congrès des médecins aliénistes et neurologistes de France et des pays de langue francaise, XLIIe session – Alger, 6-11 Avril 1938.

The 1928 creation of a neuropsychiatric clinic in Saigon thus borrowed much of its early design from open services attached to psychiatric hospitals in Paris.[50] What distinguished it from mental health services in France is that this was the first time that these open services were introduced into law. Indeed the service was formalized by the 1930 law creating the psychiatric assistance program in Indochina that included a specialist in charge of its service for the first time. While the 1930 law made it appear as if the service would be submitted to the same rigorous formalities as the asylum, the decree modifying the 1930 law's implementation (following the advice of the Director of the Administration of Justice) adopted a much more liberal interpretation, which stipulated that transfer to the hospital would not "constitute a confinement in a proper sense but simple provisional observation."

Whereas the asylum would receive chronic cases that took years to resolve, this open service would assure triage and treatment *en cure libre* for milder cases as well as those who demanded more immediate attention. Respect for the principle of individual liberty was of utmost important - that one could not maintain the patient against his will or against that of his family and that once a demand for release was formulated, he must be released if his mental state permits. If the resident doctors decides that the state of the patient is of the nature to compromise the public order or security *or* his own cure, he must immediately become the object of a regular procedure of confinement in an asylum. This "absence of all coercive character, the simplicity of admissions and exist have had a lot of success for the service...by encouraging families to entrust their patients before antisocial reactions which mandates their internment. The service would therefore play an important preventive role in

[50] TTL1, IGHSP, 51-01, Hopital de Chôquan. Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934.

the protection of public safety.[51] In this way, the open service encouraged families to bring in early, habituate them to idea of confinement if necessary. Not only would the service encourage the early detection of mental illness and prevent more serious forms from developing, it would also reduce costs associated with confinement and assure for those "*petits malades*" a more rapid "social recuperation."

The clinic grew out of what had previously been a collection of cells that received those stopped in the streets suspected of mental illness, awaiting their confinement. By 1934 the psychiatric service was described as "strewn" all over the hospital and consisted of a small room without amenities (neither showers nor toilets, nor garden) for calm patients; at the other end of the hospital a former pavilion for prostitutes and prisoners which had been converted into space for calm female patients. In the middle of the hospital were two groups of cells for agitated patients including one old building that resembled a prison where they confined only the extremely agitated and a modern building with a small barred in courtyard planted with grass and flowers, some shade where patients would spend their days. In neither of these buildings was it possible to separate men from women. Finally in the garden of the hospital was an isolated pavilion, removed from the three other groups, which served as the examination room and office for the service as well as two bedrooms for paying patients.

Between 1928 and 1934 the clinic doubled its patient load while decreasing the average length of treatment to just 50 days. The service also reduced by more than half the number of confinements in the asylum by hospitalizing those who could be cured more quickly. The numbers of patients leaving the service for reasons other than internment, such

[51] The service also participated in the observation of criminals suspected of mental illness. This is where medical-legal opinions would be formed as the basis for recommending confinement in prison or an asylum. See Chapter 6.

as cure, improvement or repatriation, also jumped from two in 1928 to 110 in 1934.[52] There was a fall in the number of deaths of patients despite the rapid growth in the number of admits (in 1928 for instance, there were 18 deaths for 110 admits while in 1934 there were 12 deaths for 256 admits. This was attributed to the specialization of the personnel which permitted more rational treatment of acute psychopaths. Out of the 287 patients treated in 1934, the majority (123) were diagnosed with manic-depressive psychosis with 86 particularly expressing the manic form. This reflects the fact that those who were sent to the asylum suffered from more acute illnesses that required immediate attention. [See Figure 9]

As clients of psychiatric services, families were asked to more actively participate in psychiatric care. For French psychiatrists, this required the Vietnamese share basic understandings about mental illness as something that could be prevented and cured under the proper surveillance of experts. Indeed the organization of an 'open service' was deliberately aimed at shifting the perspective of those families who continued to "hide their lunatics, drag them from pagoda to pagoda, from sorcerer to sorcerer, before bringing them to us in such a lamentable state that all our methods are ineffective and there's nothing more to do from a therapeutic point of view."[53] While some family members remained reluctant to present patients for care, others adopted a more insistent role, even challenging those experts who refused their requests for confinement.

For example, one man attempted to place his nephew, Phien, in psychiatric custody by bringing him to the Service for Municipal Hygiene in Hanoi in February 1942. After the examination, under the pretext of Phien not being a "raving lunatic," the doctor concluded

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[52] TTL1, IGHSP, 51-01, Hopital de Chôquan. Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934.

[53] TTL1, Résidence Supérieur au Tonkin, 78747-01, Asile de Bien Hoa, Rapport Annuel pour 1928.

that his hospitalization would be too expensive for the Administration ($18 per month) and consequently denied the uncle's request. Despite the legal regulations around confinement, in practice, psychiatrists continued to favor those who proved an imminent or dangerous threat. In protest, the uncle wrote to the Governor of Tonkin, complaining, "A quarter of an hour contact with one suffering from mental illness would not allow the determination of his true morbid state. Rather it's necessary, in my humble opinion, that a serious observation be made at the Service of Psychiatry so that they can provide with all knowledge an authorized report on the state of the patient, that would allow the Administration to subsequently decide to keep him in treatment or give him his liberty."[54]

What the French took as an evolving agreement over the existence of mental illness does not imply that the French and Vietnamese also held similar beliefs about the etiology of the disease or the appropriate cure, far from it. While Jonathan Sadowsky in his work on colonial Nigeria understands this "overlap" as demonstrative of the universal validity of psychiatric disorders, he also underscores the ways in which agreement nevertheless continued to be framed in Western terms and served as a powerful means to control socially deviant populations.[55] My focus here concerns more how this "overlap" created a common space for negotiation over care. While the categories of 'normal' and 'abnormal' continued to be framed in Western terms, I want to bring attention to the fact that the content of these categories critically relied on the kinds of information Vietnamese were willing or thought relevant to tell French doctors.

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[54] *Archives Nationales d'Outre Mer* (ANOM), Résidence Superérieur au Tonkin, 03749, Lettre à Monsieur le Résident Supérieur au Tonkin, au sujet de l'assistance psychiatrique en faveur de [...] Phien, February 23, 1942.

[55] Sadowsky (2007).

The rise in the numbers of patients treated at Cho Quan Hospital therefore raises important questions about the impetus driving the growth of psychiatric services in Indochina. Were families truly becoming more accustomed to psychiatry as the French suggested or were there other social forces at work, such as the financial crush of the depression of the early 1930s, which prompted families to confine the insane? Did the expanding availability of open services generate their own demand or did the growing demand reflect a more profound transformation in the perceptions of the local population? Throughout the interwar years, Vietnamese families increasingly resorted to institutional-based mental health care when traditional healers did not work, or in the event of the failure of asylum care, recommenced the search for alternative therapies. This dual uptake of Western biomedical and local healing practices reflects the complex and dynamic patterns of therapeutic pluralism in colonial Vietnamese society, as observed by historian Laurence Monnais in relation to pharmaceutical use.[56] In the context of mental health care, therapeutic preferences shifted with the availability of new forms of treatment in ways that served to broaden rather than replace pre-colonial strategies for the management of mental illness.

As psychiatric activities diversified and expanded from the treatment of acute mental illness to the identification of underlying abnormalities, a greater reliance than ever was placed on the participation of families and communities. Families continued, however, to pursue their own strategies in ways that both facilitated and constrained the ability of colonial psychiatrists to identify and care for the mentally ill.

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[56] Laurence Monnais and Noémi Tousignant. The Colonial Life of Pharmaceuticals: Accessibility to Healthcare, Consumption of Medicines, and Medical Pluralism in French Vietnam, 1905-1945. *Journal of Vietnamese Studies* 2006 (1, 1-2): 131-166.

IV. Getting out

Families also played an important role in determining patterns of discharge in Indochina. Confronted with the pressure to treat more acute cases, psychiatrists depended on family resources to support temporary or permanent releases for those patients deemed "sufficiently improved." Once the family agreed to assume responsibility for their care, the patient would be repatriated to their home village. Under the 1930 law, this practice became regulated as a "*sortie définitive*" when the patient was declared cured and released from the asylum or, more often, as a "*sortie provisoire*" when the patient was subject to a six month probation outside the asylum. The patient would be placed under a "sanitary" or "medical surveillance" of either weekly or monthly visits by the local doctor who administered medicine, kept track of the patient's progress and eventually recommended a *sortie definitive* or reintegration back into the asylum.[57] Pierre Dorolle, a French psychiatrist and tropical medicine specialist, emphasized in 1937 that this period should be viewed not as a break with the asylum but rather an extension of it, "The *congé d'essai* [test leave] therefore does not suspend completely the effects of internment from the point of view of restrictions on individual liberty."[58]

Dorolle praised the 1930 legislation for permitting premature exits from the asylum, "even before cure," which worked to protect the interests of those chronic patients who would not otherwise benefit from a long confinement. He lauded the innovative quality of the "*sortie provisoire*" for lending psychiatric assistance in Indochina "a more distinctly medical

[57] One the "*surveillance sanitaire*," see for example: TTL1, Résidence Supérieur au Tonkin, 73752-04, Internement à l'Asile de Voi (Bac Giang) des aliénés de 1936, Feuille 19, December 16, 1936.

[58] Dorolle (1941).

character." The legislation also allowed the patient, their spouse, friends, or family members to put in their own request for release and, if denied, to petition the decision to a tribunal for a second expert opinion. Examining the letters by family members requesting release, and the responses they received, reveals how the "*sortie provisoire*" became a flashpoint for extensive negotiations between families, communities, doctors and colonial authorities. These included competing definitions and assessments of the patient's ability to live in society, of which medical diagnosis formed only one of many considerations, as well as the ability of their families to take care of them. Whereas confinement allows us to look at how the abnormality of patients became established through a range of both lay and expert opinions and strategies, the process of discharge raises a different set of questions about what it meant to be normal enough to live in society and the nature and function of surveillance outside the walls of the institution.

Letter writing

French doctors often claimed in their reports that the Vietnamese were humiliated by the presence of mentally ill family members. The archive of patient case files, however, reveals large numbers of family members, men and women, who petitioned for the release of their loved ones to be returned home. As David Wright argues, letters by families in psychiatric archives, while little explored, nevertheless provide rich source material for uncovering those subtle negotiations inherent in the discharge process.[59]

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[59] These letters typically appear in Vietnamese with a French translation attached to the original copy. Most letters were almost certainly written not by the family members themselves but by someone they had hired, pointing to the additional forms of mediation that informed the negotiation process. For work on the history of discharge practices, see David Wright, "The Discharge of Pauper Lunatics from country asylums in mid-Victorian England, the case of Buckinghamshire, 1853-1872" in Forsythe and Melling (1999), 106. My attention to family letters also draws inspiration from Farge and Foucault's work on the *lettres de cachet* of the ancien régime as a window into the 'politics' of family life. See Arlette

Letters followed a particular format in which families pledged responsibility for the future actions of the patient, enumerated their caregiving qualifications and stressed their affective ties to the patient.[60] Family members reassured doctors about the kind of care the patients would receive at home, most importantly, by protecting them and others from danger. In 1887, a parent wrote "I engage to watch over my son very closely and to avoid any mishap if he once again falls mentally ill. I will engage moreover to keep him at my House at Phuoc Ly where I live and not let him come to Saigon."[61] Under one father's "personal surveillance" he assured doctors that he would not let his son near any firearms and to allow him to be cared for by the doctor at the medical assistance service in Ninh Binh, where he worked.[62]

In their pleas for release, letter writers would stress their qualifications as responsible caregivers including claims of their loyalty and devotion to the administration. Many would invoke the support of local notables with ties to the colonial administration to bolster their case, "I come here today to request to allow me to withdraw my son from this health establishment. The notables have certified that I am a good father and capable of properly

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Farge and Michel Foucault, eds. *Le Désordre des familles. Lettres de cachet des archives de la Bastille au XVIIIe siècle*. Paris 1982.

[60] Natalie Davis examines the formulaic qualities of prisoner narratives in writing to power. See *Fiction in the Archives: Pardon Tales and their Tellers in sixteenth Century France*. Stanford University Press, 1988. For letter writing in the context of asylums see Louise Wannell. Patients' Relatives and Psychiatric Doctors: Letter Writing in the York Retreat, 1875-1910. *Social History of Medicine* 2007 20,2: 297-313; Catharine Coleborne. "His brain was wrong, his mind astray": Families and the language of insanity in New South Wales, Queensland, and New Zealand, 1880s-1910. *Journal of Family History* 2006 31,1: 45-65.

[61] TTL2, Goucoch, IA.8/162(9), Au sujet de l'annamite [...] Nhut atteint d'aliénation mental, March 7, 1887.

[62] TTL2, Résidence Supérieur au Tonkin, 73742, Lettre de Tran-van-Ngoc, Greffier près le tribunal de Ninh-Binh à Monsieur l'Administrateur, Résident à Vinh, July 9, 1930.

feeding him."[63] Access to local elite networks represented an important boon, especially to indigent families, as they advanced with their petitions.[64] Others took more extreme measures. In Cholon in 1927, three brothers of a woman treated at Bien Hoa wrote in their request for her release, "We have reserved for her a small house in the form of an asylum on our property, well aerated, with a garden, in the country, and we give your our formal assurance that the public will not be worried or disturbed."[65] It was even argued that home possessed some important advantages over the asylum for "the country air and family joy will contribute largely to hastening the cure."[66] These attractions of home relied on declaring the strength of affective ties while also warning of the risk of emotional harm to both patient and family as the result of a prolonged separation. Personal pleas to colonial administrators reached the point where the petitioners above claimed, "[because of] our brotherly…love, we will fall into the same state as the person of interest, which is to say to suffer from the same mental troubles because of the separation" and the health of the patient will never improve.[67]

In the event of a refusal of request for release, families would continue to negotiate with asylum directors around certain aspects of patient care. Should her husband not be discharged from the asylum, one woman (after multiple requests for release over many years) asked that he be moved into the "paying wing" where he would be provided with better care.[68]

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[63] TTL2, Goucoch, IA.8/275(1), Lettre de Nguyen-van-Giat au sujet de [...] Phu, December 28, 1919.

[64] TTL2, Goucoch, IA.8/274(1), Le Delegue administratif a Monsieur l'Administrateur Chef de la Province de Tra Vinh, November 7, 1922.

[65] TTL2, Goucoch, IA.8/2912(2), Lettre à Monsieur le Gouverneur de la Cochinchine, au sujet de [....] Gia, October 26, 1927.

[66] TTL1, Résidence Supérieur au Tonkin, 73743, Lettre à Monsieur le Résident Supérieur au Tonkin, June 24, 1933.

[67] TTL2, Goucoch, IA.8/2912(2), Lettre à Monsieur le Gouverneur de la Cochinchine, au sujet de [...] Gia, October 26, 1927.

In another instance, before the Voi Asylum was opened to the public in 1934, a family, "panic stricken," asked the Governor of Tonkin to prevent the transfer of a patient to Bien Hoa in the South. They requested "the favor of leaving us, in Hanoi or in the province of Tonkin, our unhappy Man, where he will rest locked up until his death, we only demand the near presence of his family - so that we can have news and bring him whatever is necessary, and on his death, to arrange the necessary ceremonies that are demanded by our Buddhist religion." Although he was eventually sent to Bien Hoa, a visit by his wife to the asylum a year later secured the presiding doctor's permission to have Man transferred to a hospital closer to home.[69]

This sense of panic that suffused some letters meant also that psychiatrists would write to reassure families about the release of patients. In 1927, the director of Bien Hoa wrote to the Governor General in response to a request for a patient's release, "His family can remain calm, I'm trying to discharge as many patients as soon as their state does not present any danger for society or for themselves. 36 patients were released since the 1st of January 1927 versus only 30 all of last year."[70]

While at the moment of admission the inability to work secured the abnormal status of the patient, it was regaining the ability to work that emerged as an important prerequisite for release. In order to qualify for a *sortie provisoire*, the patient most often had to demonstrate that their symptoms of mental illness had gone away, which did not necessarily (and often did not)

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[68] TTL2, Goucouch, 73743-03, Lettre de [...] Phuc à Monsieur le Résident au Tonkin, July 11, 1963.

[69] TTL1, Résidence Supérieur au Tonkin, 73743-7, Lettre de Lê-thi-Duyên et Nguyên-thi-Keo à Monsieur le Résident Supérieur au Tonkin, July 27, 1928.

[70] TTL2, Goucoch, IA.8/276(2), Le Medecin Directeur de l'Asile à Monsieur le Gouverneur de Cochinchine, September 8, 1927.

mean that they had been officially "cured."[71] This was particularly true for those harmless or "calm" patients suffering from chronic diseases with no hope of a full recovery. Doctors writing in patient files would often associate the disappearance of symptoms with observations such as "he is calm, a good worker."[72] In Indochina, where asylum labor played a major role in patient therapy, the ability to work would constitute critical evidence of improvement in the patient's condition. Conversely, those who were unable to work were often found ineligible for release.[73]

The ability to labor fueled other practical concerns over the patient's capacity to "make a living by [their] own means" upon leaving the asylum.[74] This emphasis on self-support was not motivated solely out of concern for the patient's welfare. As the local director of health in My Tho province argued in 1920, "Many epileptics earn a living: this disease does not lead to hospitalization for life and perpetual care with costs to the Colony."[75] For those households who lost a principal breadwinner to the asylum, petitions for release were also linked to broader strategies concerned with the financial survival of the family.[76] In a 1921 letter requesting the discharge of her husband, Le Thi Mai wrote to the director of the asylum

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71 See TTL2, Goucoch, IA.8/281(2), Rapport médico-légal au sujet de l'état mental et de la responsabilité du nommé [...] Sau, June 1925.

72 TTL2, Goucoch, IA.8/276 (2), Le Médecin Directeur de l'Asile de Bienhoa à Monsieur le Gouverneur de la Cochinchine, February 17, 1925.

73 TTL2, Goucoch, IA.8/276(2), Le Médecin Directeur de l'Asile de Bienhoa à Monsieur le Gouverneur de Cochinchine, September 8, 1927.

74 TTL2, Goucoch, IA.8/274(3), Lettre de Gouverneur Général à Médecin-Directeur de l'Asile de Bienhoa au sujet de [....] Vinh, April 1, 1920.

75 TTL2, Goucoch, IA.8/274(3), Dr. Mul, Assistance Médicale Province de Mytho, à Monsieur l'Administrateur, Chef de la province de Mytho, March 18, 1920.

76 In her study of asylums in late Imperial Russia, Julie Brown makes a similar point about seasonal patterns of asylum utilization coinciding with peak harvest times. Julie V. Brown. Peasant Survival Strategies in Late Imperial Russia: The Social Uses of the Mental Hospital. *Social Problems* 34,4 (1987): 311-329.

asking for his "return home where he has left the heavy weight of eight children who have become very miserable since the absence of their father who is their sole support." She was successful, yet the asylum director underscored that her husband would never be able to provide for his family and must be kept preoccupied with household chores under the surveillance of his wife.[77]

In letters to asylum directors, family members offered their own opinions about the patient's condition and at times asserted that their loved ones had, in fact, improved enough to come home. Families would make claims based on either eyewitness accounts from asylum visits or written communications with the patient. The director of the Voi asylum observed in 1934 how families closely monitored confinement in the asylum: "It is certain that families are interested in their patients. Since the opening of the asylum, 325 visitors have come to Voi. What's more, a correspondence has been established between the asylum and families who frequently demand news. Even after they leave the asylum, families continue to write to let us know what has become of the patients and if they have readapted to normal life."[78] Exchanges of information, whether with the patients themselves or with the asylum staff, provided families with the opportunity to make their own determinations about the patient's condition. In 1921 a woman petitioned the release of her husband writing "my husband lost his reason suddenly after being sick for two months. The notables considered him to be insane and he was sent to the asylum in 1919. But as soon as he arrived […] his reason came back to him. The proof is that my sister went to see him two times..."[79] Others would rely on written

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[77] TTL2, Goucoch, IA.8/274(3), Le Thi Mai à Monsieur le Gouverneur de la Cochinchine, September 26, 1921.

[78] PHARO, Carton 182, Rapport Annuel d'Ensemble de la Service de Santé, 1934.

accounts received from the patient, "Judging from the tone of letters that my husband sends to us, he has a lucid spirit and consequently harmless for his entourage. I must add that I will engage to assume all responsibility of the acts of my husband."[80]

These family assessments did not always square with those of experts and, at times, would generate significant conflicts. Rather than ignore family protests, doctors would instead incorporate them when defending their diagnoses. In this example, the psychiatrist at Bien Hoa actually cites verbatim the claims of the family in crafting his response, "Although it actually appears that he is in a normal psychological state, I cannot share the opinion of VO-THI-NGU (mother of the patient) when she writes '…vi no thiet manh da lau roi….' or that of TRAN-TAI (husband of the patient) who writes:..'now she is cured."' He draws on language typically used in case files to accuse one of the petitioners, Tran-Tai, of himself being "incoherent" and of "presenting himself with an attitude that ripples with insolence demanding the immediate release of this patient."[81] In responding to challenges mounted by family members, doctors became exasperated and attempted to reassert their expert authority, "The petitioner writes in talking of her son, 'Nay no thiet manh roi…' he is now completely cured. That is an assertion without foundation. Ky has received since his admission to the Asylum […] only one visit, from his brother, and this happened nearly four years ago, that is, two months since his admission. I don't suppose that this visitor possesses the sufficient

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[79] TTL2, Goucoch, IA.8/274(3), Le Thi Mai à Monsieur le Gouverneur de la Cochinchine, September 26, 1921.

[80] TTL2, Goucouch, 73743-03, Lettre de [...] Phuc à Monsieur le Résident au Tonkin, July 11, 1963.

[81] TTL2, Goucoch, IA.8/294(2), Le Médecin Directeur de l'Asile d'Aliénés de Bienhoa à Monsieur l'Administrateur, Chef de la Province de Vinhlong, May 27, 1920 [Markings as appear in the original]

psychiatric knowledge for him to appreciate the cured or stabilized condition of our patients..."[82]

By quoting the original Vietnamese in their replies, doctors demonstrated the extent to which they took seriously attacks on their expertise even as they skewered the conceit of the petitioners. Yet in translating these demands into French, and emphasizing the distinction between the 'appearance' and reality of mental illness, their responses underscore how these debates continued to be framed in Western terms that limited the scope for negotiation. Families thus engaged in forms of protest that ranged from challenging the decision to confine to questioning the knowledge upon which such judgments were made. Ultimately, however, it was asylum directors who held the authority to determine the risk of the patient to the community, making recourse to police powers in order to enforce their professional opinion. The spaces of overlap that emerged between experts and non-experts therefore proved both shifting and profoundly unequal.

While psychiatrists faced opposition from families about their decision to prolong confinement, they also encountered resistance from colonial officials over the release of patients. As we will see in Chapter 6, for those with a dangerous history, even if their symptoms disappeared, it was feared by local authorities that the disease would manifest at a later point and the "lunatic" would again pose serious threats to the security of the community. In 1925, the prosecutor general in Saigon used the case of one patient to warn of a broader pattern in which "the existence of these individuals is a vast cycle where prison and asylum alternate with phases of liberty when they commit minor offences, misdemeanors and crimes which lead to a new confinement." The discharge of the patient in question would

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[82] TTL2, Goucoch, IA.8/275(1), Le Médecin Directeur de l'Asile des Aliénés à Monsieur le Gouverneur de la Cochinchine, September 7, 1920.

simply re-commence "the conflict between the Medical Administration and Judiciary Service in another form."[83] Family demands for release must thus be situated within a broader constellation of concerns that included not only those of psychiatric doctors but also those of colonial authorities who sought to protect public safety.

These concerns over public safety surely responded to the growing political unrest of interwar Vietnam, which included increasing strikes as the result of worsening economic conditions and the massive repression that followed such incidents as the Yen Bay prison uprising and Nghe-Tinh Soviets of 1930-1931. These events perhaps explain why the colonial police force may have felt more eager and emboldened to maintain order in the streets while institutional overcrowding and mounting financial pressure on asylum directors may have encouraged the release of patients before a full recovery. Communities, meanwhile, who had long developed their own mechanisms to preserve social order, became faced with a new set of social, economic and political pressures to consider when determining whether to petition for the discharge of the mentally ill from colonial institutions.

These pressures impinging on the capacity of Vietnamese families and communities to take care of their own increasingly came to the attention of colonial officials. In a 1930 letter to Governor General Pasquier, Rene Robin, the Resident Superior of Tonkin, reported that the custom of villages providing aid to the less fortunate had fallen into disuse in recent years. He observed that this communal custom, while not properly encoded in Annamite law, nevertheless formed an important part of oral tradition. The Code Gia-Long did, however, include some provisions including Article 78 which stipulated that "anytime a person over the age of 70 will be accorded someone to assist him or her and this person will be exempted

[83] TTL2, Goucouch, IA.8/281(2), Le Procureur Général près la Cour d'Appel de Saigon à Monsieur le Gouverneur de la Cochinchine, June 29, 1925.

from diverse personal taxes. Also article 85 noted that in case of a calamity, there was the obligation of villages of origin to recoup their nomads and strays who had wandered to other regions." But, as Robin underscored, "this imprecision of charges of assistance imposed on the communes does not allow a clear discrimination between the respective duties of the family, village and the administration." Instead, he observed that villages had developed the tendency of discharging all obligations towards their "miserables" by directing them to the provincial hospital and even to the offices of the colonial administration. He conjectured that the recent upswing in vagrancy, especially in cities, could be traced to the negligence of communal authorities and the inhabitants themselves and it would therefore "be convenient to remind them of their obligations towards the infirm and indigent, and to exactly spell out their responsibilities...Still I do not think its necessary to enact a new regulation. Simple respect for customs must suffice."[84]

Here we see evidence of how those social bonds of mutuality and obligation on which the care of the mentally ill traditionally depended begin to fray. How to allocate responsible for the sick and unwanted, especially those perceived as 'mad,' would require a complex re-adjustment in expectations that would tie families, communities and the colonial state together in unprecedented ways.

Assessing families as caregivers

Requests for patient release were not approved until it was also determined whether the family was in a position to take appropriate care of the patient. Family members were

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[84] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3893, Le Résident Supérieur au Tonkin à Monsieur le Gouverneur Général de l'Indochine, August 21, 1930.

expected to look after the patient until they were cured and pledge responsibility for any violent acts that might occur in the event of a lapse in surveillance.[85] Those patients considered potentially dangerous would often still be released provided family members took extra steps to ensure "a rigorous surveillance"[86] and to watch over them "day and night to avoid any sort of incident (fire, suicide)."[87] Some patients proved just difficult to manage, "I would like to signal that this is a cumbersome patient, difficult to feed and at times very loud. I doubt that his family can easily look after him."[88]

Given the burdens associated with guarding patients, psychiatrists investigated families, including their household income and personal habits, to determine if they were adequately equipped to provide care. Historians of Indochina have explored the ways in which the colonial state policed the intimate lives of families, especially in the realm of sexuality, but determining the capacity of families to meet the basic needs of their own sick responded to a different set of concerns about the social organization of Vietnamese family life.[89] As Hilary Marland argues, this practice of assessing the quality of family care allows us to see how the state entered the entire household of the lunatic.[90] In 1922 the President of the Municipal

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[85] TTL1, Résidence Supérieur au Tonkin, 73744-02, Le Tri-Huyen de Thanh-Oai à Monsieur le Résident de Hadong, July 26, 1923.

[86] TTL2, Goucoch, IA.8/281(2), Le Médecin Directeur de l'Asile à Monsieur le Gouverneur de Cochinchine, August 26, 1926.

[87] TTL2, Goucoch, IA.8/2912(2), Le Médecin Directeur de l'Asile à Monsieur le Gouverneur de Cochinchine, December 3, 1927.

[88] *Ibid.*

[89] Ann Laura Stoler. *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule*. Berkeley, CA: University of California Press, 2001.

[90] Hilary Marland. "At home with puerparal mania: the domestic treatment of the insanity of childbirth in the 19th century" in Bartlett and Wright (1999), pp. 45-65.

Commission in Cholon confirmed that Nho, the brother of a patient, lived in a hut bordering a rice mill where he earned 24 piasters per month. His salary was found sufficient to provide for the needs of his sister who was subsequently released into their parents' care.[91] The location of the family home itself could play an important role. In 1924 the release of a woman to her daughter was approved as her "home is found just next to the police station, which allows us one to believe she will be sufficiently guarded."[92] Scrutiny extended as well to the personal habits of family members. For example, in 1921, Etievant, the head of the Security Police in Saigon, described the brother of one patient as "35 years old, father of a family, a well-behaved and punctual worker at the Imprimerie Commerciale….When summoned to my office he renewed his assurance to watch over his parent and to urgently warn the authorities if he notices any sort of relapse."[93] This case, however, illustrates the fears should surveillance at home fail and underscores how colonial authorities and doctors could hold different opinions on the fitness of family members for care. While Etievant approved the family, the director of Bien Hoa asylum nevertheless worried about the quality of care Sau, the patient, would receive at home. He approved the release under the condition that the family take full responsibility because, "mentally disabled, he will, without surveillance, rapidly begin to lead a life of debauchery, of laziness, and of vagrancy which will bring him again to either the prison or the asylum." The chief prosecutor also worried that given medical reports that the patient was not yet cured and still at risk for "excesses of all kinds" it is "to be feared

[91] TTL2, Goucoch, IA.8/274(1), Monsieur de Tastes, Administrateur des Services Civils, Président de la Commission municipale de Cholon, à Monsieur le Gouverneur de la Cochinchine, October 6, 1922.

[92] TTL2, Goucoch, IA.8/281(1), L'Administrateur des Services Civils Chef de la Province de Vinhong à Monsieur le Gouverneur de la Cochinchine, January 16, 1924.

[93] TTL2, Goucoch, IA.8/281(1), Lettre de Commissaire Special Etievant, Monsieur l'Administrateur Chef de la Sureté au sujet de [...] Sau, December 15, 1921.

that his brother would not be able to effectively watch him because of his job and Sau would commit serious violent acts."[94] Sau was consequently kept at the asylum under observation for two more years.

Refusals based on poverty were most often motivated by similar concerns: if the family was unable to take adequate care of the patient, he or she would return to begging and vagrancy, risking relapse and a return to the hands of the colonial administration.[95] In a 1925 report to asylum officials, the administrator of Can Tho province described a set of petitioners as "very poor. They live...in a miserable hut of the value of 6$00. Nguyen Van May cultivates a hectare of rice belonging to Van-Dat-Lieng and only takes 60 units of paddy with which he feeds and take care of his mother. Another brother of the lunatic, Nguyen-van-Thau is currently in Saigon, in the Medical Auxiliary Service, and his monthly salary is 4 piasters. It is therefore impossible for the family of Duong to come take the patient from Bien Hoa and care for him."[96] Only if Duong was found "capable of working and assuring his own existence" could he be released. This example demonstrates that not only wealthy families requested release. Families from a range of income levels would appeal for the return of patients which, in certain cases, carried with it the assumption of a significant financial burden.

Doctors grounded their refusals not only in objections to the income level of the family but also in the type of care they thought the patient would receive at home. In one case, a psychiatrist determined that a patient, in the end, was "not a lunatic in the proper sense of the term." Yet the doctor worried that he was "a weak spirit, unfavorably influenced by

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[94] TTL2, Goucoch, IA.8/281(1), Le Procureur de la Republique près le Tribunal de 1ère instance de Saigon à Monsieur le Procureur General à Saigon, May 7, 1925.

[95] TTL2, Goucoch, IA.8/276(1), L'Administrateur de Can Tho à Monsieur le Gouverneur de la Cochinchine, September 3, 1923.

[96] TTL2, Goucoch, IA.8/276(2), L'Administrateur de Cantho à Monsieur le Gouvernement de la Cochinchine, February 18, 1925.

mystical ideas and by the religious life that he has adopted over the last nine years. Will probably give release on a trial basis but he must return to his family and not the pagoda."[97] Indeed French psychiatrists continued to compete with indigenous healers well into the 1930s, even as the colonial state worked to increasingly restrict the practice of traditional medicine and promote widespread and exclusive recourse to Western medical care.[98] In 1932, one psychiatrist worried over the "misdeeds of sorcerers in the psychopathic domains," noting that the "majority of the insane do not come to asylum until they have been dragged from pagoda to pagoda, sorcerer to sorcerer."[99]

In a 1928 article published in the French psychiatric journal *L'Hygiène Mentale*, André Augagneur, the director of Bien Hoa asylum, and Le Trung Luong, the asylum's Chief Resident, described the local practices surrounding the treatment of mental illness in Indochina. While contact with the Chinese over centuries may have held "incontestable advantages" for the Annamite, they also inherited those "tenacious prejudices, ineradicable traditions and a complete ignorance for all that concerns mental afflictions." In Augagneur and Le's formulation, Chinese and Annamite doctors were the most to blame. They describe, for instance, how these doctors would continually relegate those diseases for which they were unable to explain the etiology or pathogenesis to the "immaterial world," noting, "It is infinitely practical for a man of the art of medicine, finding himself embarrassed, to chalk up

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[97] TTL2, Goucoch, IA.8/294(3), Certificat Semestriel de [....] Nham, Asile d'Alienes de Bien Hoa, May 22, 1920.

[98] Monnais and Tousignant (2006), 132; On the relationship between psychiatry and mesmerism in colonial India see Waltraud Ernst. Colonial psychiatry, magic and religion. The case of mesmerism in British India. *History of Psychiatry* 2004 15,1: 57-71.

[99] TTL1, IGHSPI, 39-05, Rapport Annuel de 1931 sur le fonctionnement des Services Sanitaires et Médicaux à Bien Hoa.

his professional failures to occult powers. As doctors of the body, they can only master those physical sufferings which stem from the body but they are powerless to annihilate the evil effects of spirits who are the vindictive and earthly manifestations of the wrath of gods and genies." Once a family witnessed one of their own fall mentally ill, they most often called upon the services of a practicing doctor which invariably yielded no result. The authors describe a kind of "Asian politeness" whereby the family would insinuate that perhaps the disease was caused by spirits and therefore could not be cured by ordinary means. In this way the family and doctor would "mutually persuade each other" that malcontented spirits were to blame for the mysterious illness and that only one in possession of supernatural powers could counteract their evil effects.

It is here, as Augagneur and Le note, that the soothsayer "enters the scene." One apparently finds him "meandering in the streets, walking painfully with the aid of a cane, an indispensable accessory that serves as his guide, as this extra lucid clairvoyant is invariably blind. A very interesting detail which goes to show the naivety of people who address themselves to an infirm person who makes oracles appear out of cold hard cash." The sorcerer goes on to perform a series of rituals including the preparation of potions and "continues in this matter until the patient is cured (this must arrive, at least sometimes?), or until his state declines following a debauchery of deafening noise, cries and vociferations, or what happens most often yet, until the capacity of families to pay is reached and they cannot afford to continue to follow the sorcerer on such onerous grounds."[100]

These sorcerers or 'spirit mediums' were accused of not only promoting a spurious brand of medical treatment but for igniting underlying forms of dementia and even inducing states of mental illness that did not exist before. Another psychiatrist suggested that these

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[100] Augagneur and Le, 1928.

"superstitious instincts profoundly anchored in the spirit of the natives," especially tenacious in the countryside, would become "*surchauffé*" or "overheated" by sorcery practices. The unfortunate subject, suspended in a kind of excited delirium, would then slide all too frequently into a dangerous form of insanity.[101] At special risk were the sorcerers themselves who, in the course of their professional practice, would fall into a state of such "progressive excitation" and become "so strongly saturated that [they were] more or less under its influence." The craft of spirit possession was considered singularly ill-suited to "maintaining the equilibrium of one's mental faculties" and the reason why so many of its practitioners often fell "victims to the demands of their profession" (in 1928 alone, seven sorcerers were reported to be confined at Bien Hoa).[102]

At the time of "possession" French psychiatrists would routinely describe sorcerers and their clients as "momentarily deprived of reason." What for colonial experts was taken as evidence of an underlying psychosis, for the families of their patients it seemed rather to signal a state of being taken over by a supernatural force. There emerges here a shared notion of not existing as one's true self but with different explanations that demanded different responses. Psychiatrists would note in case histories that patients themselves would protest the terms of their confinement by explaining their irregular behavior as derived from genies or spirits and not from mental illness. In 1921, one patient claimed, "A genie (white tiger) had entered him and gave him the supernatural power to cure the sick and to supervise the notables."[103] The

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[101] TTL1, Résidence Supérieur au Tonkin, 73741, Rapport médico-légal [....] Cac, February 4, 1938; According to Annamite law, sorcerers were subject to harsh recriminations if their practices resulted in the death of the sick individual. See Edouard Jeanselme. "La Sorcellerie en Extreme Orient." *Journel de Médécine Légal Psychiatrique et Anthropologies Criminelle*. 1906.

[102] TTL1, IGHSPI, 004, Rapport annuel de 1928.

file of another patient noted that "Thai sees genies […] from time to time in the form of men (doctors and nurses), these genies talk to him and declare that he will be liberated soon..." Diagnosed as a megalomaniac, the file reported Thai's tales of great accomplishment, including curing a woman suffering from beri beri in just five days.[104]

The medical language used here is striking and suggests perhaps one reason French medical authorities felt threatened by sorcerers who continued to hold sway over local populations and why claims of medical expertise may have been taken as evidence of insanity in patients. Indeed it is clear that despite French pronouncements to the contrary, families and communities continued to view sorcerers as an important source of cures for a range of ailments, from mental illness to epidemic disease. In 1928, one asylum patient, a father of three and the guardian of a small but well-trafficked pagoda, was described as possessing no intellectual capacity and in the grips of senility. Nevertheless he was reported to have held a "certain influence" over other villagers among whom he had earned a reputation as a healer. During a violent outbreak of cholera one summer, parents delivered him their children in order to be cured. Despite condemning his supposed powers as pure superstition, the French doctor writing in his case file underscored the fact that this sorcerer trusted completely in his curative abilities and that he did his work with "conviction and fervor."[105] While colonial officials most commonly referred to sorcerers as charlatans who took advantage of a credulous and backwards population, it was those who truly believed in what they were doing that piqued the interest of colonial psychiatrists. In at least one instance, a French psychiatrist

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[103] TTL1, Résidence Supérieur au Tonkin, 73741, Rapport d'examen médical de la nommée [....Can], December 30, 1933; TTL2, 155(3), Certificat d'admission du Médecin-Auxiliaire Nguyen-van-Phan, Asile de Bienhoa, November 3, 1921; TTL2, 2751(1), Certificat Semestriel de [...] Luc, Asile de Bien Hoa, August 2, 1919.

[104] TTL1, 73737, Certificat Médical du nommé [...] Thai, June 11 1936.

[105] TTL2, Résidence Supérieur au Tonkin, 73741, Rapport Médical [....] Cac, February 4, 1928.

seemed almost seduced by the conviction of one of patient whom he described as possessing "the allure of a prophet, with long floating wavy hair, piercing eyes, an aspect of 'freedom' but absent...During the period of observation he presented no crisis or related symptom, spoke little but carried himself with an illuminated air, indifferent to what happened around him except for when we attracted his attention."[106]

The Absence of Families

While the relationship between doctors and families could prove problematic, the very absence of families generated a sense of crisis within Indochina's psychiatric assistance program. Families would refuse to take patients back but more often asylum directors and colonial administrators were simply unable to locate family members even after multiple attempts and, in more desperate instances, after testing broader family networks. In many cases, abandoned patients were simply hired on to work as coolies at the asylum.[107] In a 1937 letter the Governor of Tonkin, Yves Chatel, signaled the "serious inconveniences" posed by patients who occupied the place of those for whom more immediate internment was required. He cited the Voi asylum, built to accommodate 300 patients, which in 1937 housed 424. In June 1938, a Commission charged with Voi's oversight deplored the presence of "those abandoned, who uselessly encumber the rooms of the asylum and risk becoming human wreckage."

No legal text obligated families to take charge of patients ready for release. At the same time, it was unlawful to prevent patients from leaving the asylum after they had been

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[106] TTL1, Résidence Supérieur au Tonkin, 73752-01, Rapport Médico Légal [....] Hang, December 30, 1919.

[107] TTL2, Goucoch, 281(1), Le Médecin Directeur de l'Asile à Monsieur le Gouverneur de la Cochinchine, September 13, 1924.

certified as "cured."[108] This posed a distinct challenge to asylum directors. In 1925, a patient was approved for release but his wife was found ineligible to care for him. Legally, however, it was imperative he be released without any delay or, as the director of Bien Hoa warned, it would constitute "an arbitrary detention." Here we see the formal limits of the practice of assessing families' ability to care for their loved ones. The local director of public health also cautioned the family could not be used as an excuse, "I do not believe that it is possible to argue the precarious situation of the family for keeping him at asylum." He feared "an eventual accusation of sequestering, for which, if I were to say nothing, would make me appear to be an accomplice."[109] The case was ultimately referred to the Prosecutor General for review in order to absolve the medical service of any responsibility. As with confinement, fears of accusation over the refusal to release patients generated pressures that dictated changes in psychiatric practices. Psychiatrists became caught between the anticipation of push back from non-experts (whether from other colonial administrators or families themselves) and the very real problem of exactly what to do with the population of cured patients with no home to return to. Proposals for the creation of separate *asiles colonies* or villages of mostly cured patients placed into makeshift 'families,' while debated seriously in the late 1930s, never came to fruition.[110]

Examining the complexities of the discharge process reveals how the decisions to release patients were grounded in both judgments of the patient's condition and the care they

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[108] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, Le Residént Supérieur au Tonkin, Yves Chatel, à Gouveneur Général (Direction des Services Economiques et Inspection Générale de l'Hygiène et de la Santé Publique), November 12, 1937.

[109] TTL2, Goucoch, IA.8/276(2), Le Médecin Directeur de l'Asile à Monsieur le Directeur local de la Sante en Cochinchine, February 10, 1925.

[110] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, Rapport au sujet de la création d'un asile colonie sur le terrain de l'Asile de Voi par Dr. Grinsard, June 5, 1937.

would receive outside the asylum. But even as the households of patients became objects of expert oversight so too did families exert their own judgments of French psychiatrists, in some instances by turning to traditional healers instead. Earlier we saw how areas of overlap between French and Vietnamese understandings of mental illness formed a common space for establishing the abnormal status of patients as the basis for confinement. In the context of discharge, a different kind of overlap between the spaces of the family and those of the institution succeeded in generating new opportunities for surveillance outside the walls of the asylum. Exactly how to police those recovering from mental illness in the community - what that oversight should look like and with whom it should be entrusted - and whether patients were ready to reintegrate back into 'normal' social life continued to test the limits of expert authority.

VI. Conclusion

Families and communities played a critical role in shaping psychiatric practices in French Indochina throughout the interwar years. They provided information that assisted experts in forming their diagnoses, contributed to colonial ideas about what constituted valid grounds for patient confinement and release, and supplied crucial forms of surveillance and care in the community. Families were active participants in psychiatric care in ways that disrupt our notions of the colonial asylum as a closed setting where patients rarely left and run by experts who enjoyed broad and unquestioned authority. The hold of colonial psychiatric authority was therefore far less hegemonic than one might think. The power to confine or seek treatment for those perceived to be "abnormal" continued to grow throughout the interwar years with the expansion of psychiatric services in asylums and major hospitals,

including new forms of community surveillance. But rather than see this as a process that flowed inexorably from the colonial state, I examine how families and communities pursued their own strategies that profoundly shaped colonial ideas about the meaning of deviance and the therapeutic possibilities for addressing mental illness. In these ways, a focus on the movements of patients, and the role of families and communities in mediating these movements, help not only to blur distinctions between asylum and society, the institutional and the familial. For historians of Vietnam, such a perspective offers a new window onto the social relationships among and between families, communities and the French colonial state throughout the early decades of the twentieth century.

For historians of medicine, the relationship between the asylum and the community also offers an important site for examining the production of knowledge and power in colonial settings. As the symbol of colonial psychiatric authority, the asylum serves as the natural point of departure from which to examine what French doctors took to be their mission as well as the challenges they faced in realizing their ambitions in daily institutional practice. But such a perspective misses the emergence of those more fluid, dynamic spaces where doctors were forced to confront alternatives to the brand of care they offered. I argue that everyday exchanges between French experts and Vietnamese families signal not only small erosions in the authority of colonial psychiatrists, but also, and more significantly, the emergence of a new, more diffuse kind of psychiatric power. This power tied together the authority of European science backed by a repressive colonial state, to the social norms of local communities that prescribed the bounds of the conduct of individuals, as well as the obligations and duties of families charged with their care. Grasping the full extent of colonial psychiatric power, and the resistances it faced, only then becomes possible when we read

patient case files for what they can tell us about life outside the asylum as much as life inside its walls.

Chapter 5. Labor as therapy: agricultural colonies and the psychiatric re-education of the insane

> What are these pavilions on the side of the road,
> Questions the voyager, which bring all matter of joys
> From the mountains or the sea, to rejoice in the benefits
> of holidays which put worries to the side?
> That they appear elegant with their vaulted flowers,
> The green foliage mounting high towards the skies,
> Their grassy patios for the pleasure of eyes,
> And over there, in the distance, the mellow beauty of the setting sun.
> Do not judge them too much, friend, on appearance,
> All while conserving a full tolerance:
> Those "afflicted by god" serving at the house,
> Those who know the worst of Gehenna,
> Fighting without respite against their loss of reason,
> Knowledge, Kindness will not ease their pain.
>
> - Pélissier, Administrator of Civil Services, Extract from *Livre D'Or* (p. 39-40), dedicated to Dr. Baccialone, Director of the Psychiatric Hospital of Bien Hoa, and his "devoted collaborators"[1]
>
> Saigon, January 7, 1945

In 1905, Dr. Edouard Jeanselme, a professor of medicine in Paris and expert in tropical diseases, took a study trip to the Far East, traveling to Thailand, Java, Burma and Singapore. He sought inspiration for a model of psychiatric care that could be successfully introduced in French Indochina, which at the time possessed no mental health system of its own. Jeanselme joined a growing chorus of voices who criticized the rudimentary state of mental health care in the French empire as compared to other colonial powers whose own

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[1] Gehenna refers to a place outside ancient Jerusalem known in the Hebrew Bible as the Valley of the Son of Hinnom. Originally it was believed to be the location where children were sacrified to Moloch, hence it was deemed to be cursed. Poem cited in Nguyen van Hoai. *De l'Organisation de l'Hôpital Psychiatrique du Sud-Viêtnam*. Thèse de Doctorat d'Université en Médecine. Saigon: Imprimerie Française d'Outre-Mer, 1954.

programs were thought to be "growing more and more refined everyday."[2] During his trip, Jeanselme made special note of the asylum system in Java, at Buitenzorg, where in 1881 the Dutch had converted the entire asylum into a massive agricultural colony. Writing in the *Presse Médicale* on his return home, Jeanselme marveled that despite the absence of any restraint or coercion, there had been "no suicide, murder, or even escape, meanwhile the asylum is not enclosed by walls."[3] Buitenzorg represented the first systematic application of this kind of care, premised on the idea of labor as therapy, to a colonial setting. For French psychiatrists in Indochina who saw in neighboring Java fundamental ethnological and geographical similarities, it signified the prospect of incorporating many of the same elements within the colony's first asylum, Bien Hoa, which finally opened in 1919.

The Dutch experiment at Buitenzorg was part of an international flourishing of agricultural colonies and other forms of "open door" care that spread throughout France, England, Belgium and Germany, as well as to the United States, Canada, Argentina, Japan and Norway in the late nineteenth and early twentieth centuries.[4] The establishment of these *colonies agricoles*, or small farms attached to psychiatric hospitals, first emerged in Europe as a response to broader calls for psychiatric reform dating from the mid-nineteenth century. With mounting concerns over asylum overcrowding and accusations of patient negligence, psychiatrists began to experiment with alternative forms of patient care that relied on new

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[2] Edouard Jeanselme. "La Condition des Aliénés dans les Colonies Françaises, Anglaises et Néerlandaises d'Extrême-Orient." *La Presse Médicale*. August 9, 1905. In 1912, this article, along with several photographs taken by Jeanselme on his trip, was presented to the Conference of French and Francophone Alienists and Neurologists in Tunis.

[3] *Ibid*.

[4] See Claude Quétel, *Histoire de la folie: De l'Antiquité à nos jours*. (Paris: Tallendier, 2009); Waltraud Ernst and Thomas Mueller, eds., *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800-2000*. (Cambridge: Cambridge University Press, 2010); Roy Porter and David Wrights, eds., *The Confinement of the Insane: International Perspectives, 1800-1965*. Cambridge: Cambridge University Press, 2003.

uses of space and the environment; instead of chaining or isolation cells, psychiatric reformers argued that putting people to work in the fields, in the open air, would be more humane and therapeutically effective. Fresh air, sunlight and exercise gave labor a moral dimension, one that coincided well with the new emphasis on treating the psychological and emotional causes of mental illness, otherwise known as "moral treatment."

At the heart of discussions about the uses of labor as therapy was actually a much older idea rooted in anti-urban discourses and a vogue for experimental farms dating from the early 19th century. The first *colonies agricoles* were introduced in France as rural outlets for a revolutionary urban underclass and as penal colonies for orphans and juvenile delinquents, including the famous colony of Mettray. Early discussions about the *colonies* were marked by a condemnation of urban, industrial society and a countervailing valorization of the countryside as a site for the restoration of authority, order and social discipline. Reformers embraced these agrarian utopias but for reasons that went beyond an appreciation of their aesthetic or romantic qualities. As historian of France Ceri Crossley writes, "Rurality was not so much emblematic of an earlier, simpler world as constitutive of a passive citizenry. This was not the countryside as escapism: agricultural work – with religion in support – was understood as a process of socialization."[5] As a model of "socialization," the agricultural colony was premised on a set of distinctions between urban and rural life that guided psychiatric reformers in their efforts to rehabilitate "abnormal" populations. In contrast to the disorienting effects of city life, the agricultural colony would instead provide patients with a “life out of doors” and a

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[5] Ceri Crossley. "Using and Transforming the French Countryside: The *'Colonies Agricoles'* (1820–1850)," *French Studies* 45 (1991): 36–54. See also Laura Lee Downs. *Childhood in the Promised Land: Working-class movements and the colonies de vacances in France, 1880-1960*. (Durham, NC: Duke University Press, 2002). The Mettray agricultural colony for abandoned and delinquent children serves as the most famous example, popularized by Michel Foucault in *Discipline and Punish: The Birth of the Prison.* 2nd Edition. New York: Vintage Press, 1995.

daily routine structured around principles of regular exercise and discipline, a reorganization of the external social world would produce a reordering of the interior private one.

This chapter examines how French psychiatrists in Indochina reimagined the relationship between rural spaces, mental health and productive work in the everyday life of the colonial asylum. Drawing on a rich psychiatric discourse in the metropole about the virtues of patient employment, and lessons learned from their study trips to Java, experts in Indochina designed the colony's two asylums as large *colonies agricoles* where patients could work the land on the path to healing and eventual liberation. In spite of its early origins, the agricultural colony seemed to offer colonial psychiatrists a modern conception of psychiatric care that promised not only "cerebral hygiene" and discipline through physical labor but also, in simulating the appearance of freedom and normal life, a kind of moral re-education. Agricultural colonies could also yield significant financial and administrative benefits to the asylums themselves. Annual asylum reports reveal the ways in which colonial psychiatrists framed the therapeutic and economic imperatives for labor, and how they came to articulate a vision of psychiatric rehabilitation that blurred the distinctions between patients and laborers, between spaces of confinement and release. In simulating real life outside the walls of the asylum, the agricultural colony was designed to create a kind of continuity between the discipline of institutional order and social life in the community. In so doing, it provided patients with a path to rehabilitation and colonial psychiatrists with the challenge of articulating a vision of what the aims and forms of this kind of rehabilitation should look like.

In histories of the nineteenth century prison, scholars have examined the uses of labor to regulate people whose behavior violated social norms.[6] Rather than confinement itself, it

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[6] See Rebecca McLennan. *The Crisis of Imprisonment: Protest, Politics, and the Making of the American Penal State, 1776 – 1941*. The Cambridge History of American Law series, Cambridge University Press, March 2008; John A. Conely, "Prisons, Production and Profit: Reconsiderignt the Importance of

was the act of working that would transform those previously on the margins into industrious, disciplined and fully integrated members of society. For Foucault, the use of labor to morally condemn idleness united early institutional responses to the destitute, the criminal and the mentally ill. In describing the role of labor in the seventeenth-century Hôpital Général in *Madness and Cvilization*, he writes, "The prisoner who could and who would work would be released, not so much because the was again useful to society but because he had again subscribed to the great ethical pact of human existence.'"[7] The introduction of labor in asylums in early nineteenth century France also promised its own kind of moral transcendence, allowing the mentally ill to not only regain their sanity but also, in so doing, the ability to be free. In the opening to an 1873 study of agricultural colonies, the French psychiatrist Firmin Lagardelle writes, "Work is an invaluable blessing, and liberty, a need which cannot afford to be misunderstood... the word is holy and that which above all is the most desirable, but liberty in all its forms and all its degrees presupposes a state of reason."[8] This emancipatory rhetoric illustrates the ideological weight given to labor, even as it was promoted as an invaluable economic resource for sustaining these new institutions.

Experiments in agricultural labor offered new opportunities for social control that eventually came to connect strategies of confinement from metropole to colony and across the imperial world. Scholars have written extensively on the proliferation of the agricultural

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Prison Industries," *Journal of Social History* 14 (1980): 257-75; Michael Ignatieff, "State, Civil Society and Total Institutions: A Critique of Recent Social Histories of Punishment," *Crime and Justice* 3 (1981): 153-192; Larry Goldsmith, "To Profit by His Skill and to Traffic on His Crime: Prison Labor in Early Nineteenth Century Massachusetts," *Labor History* 4 (1999): 439-457.

[7] Michel Foucault. *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard. London: Tavistock, 1967, pp 59-60. See also Ted McCoy. The Unproductive Prisoner: Labor and Medicine in Canadian Penitentiaries, 1867-1900. *Labor: Studies in Working-Class History of the Americas* 2010 (6,4): 95-112.

[8] Firmin Lagardelle. *Etude sur les colonies agricoles d'aliénés*. Moulins: Imprimerie de C. Desrosiers, 1873. For work on agricultural colonies in the history of French psychiatry see Quétel (2009).

colony model throughout Southeast Asia as penal colonies for political prisoners, reformatories for juvenile delinquents, and as sites for the occupational training of poor white settlers.[9] Despite the discourse around the moral value of labor, agricultural colonies in Indochina and throughout the region instead came to be characterized by the more brutal and punitive aspects of their labor regimes. Unlike nineteenth century France where forced labor was seen as a way of reforming inmates and preparing them to enter the industrial workforce, in the colonies it was valued solely as an economic resource. In Indochina, as Peter Zinoman has shown, colonial attitudes towards prison labor were less informed by questions of behavioral modification and rehabilitation than shaped by chronic labor shortages, the reliance on outside contractors, racist prejudice, and a lack of technical expertise.[10]

I suggest that by taking a broader view of the history of confinement, we can see how agricultural colonies for the "psychiatric re-education" of the insane both intersected with, and departed from, these imperial visions for reform in important ways, most crucially by introducing an explicitly therapeutic element into the justifications for state organized labor. The use of labor as a kind of medical intervention, as a way not only to discipline the body but also to recalibrate the mind, remains little explored in the colonial historiography.[11] I argue

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[9] Ann Stoler. *Along the Archival Grain.* (Princeton, NJ: Princeton University Press, 2009); Jeroen Dekker, "Punir, sauver et éduquer: la colonie agricole "Nederlandsch Mettray" et la rééducation résidentielle aux Pays-Bas, en France, en Allemagne et en Angleterre entre 1814 et 1914. *Le Mouvement Social* 153 (Oct-Dec 1990): 63-90; Albert Schrauwers. "The 'Benevolent' Colonies of Johannes van den Bosch: Continuities in the Administration of Poverty in the Netherlands and Indonesia," *Comparative Studies in Society and History* 43, no. 2 (2001): 298-328; Stephen Toth. *Beyond Papillon: The French Overseas Penal Colonies, 1854-1952.* (University of Nebraska Press, 2006); Neil Roos. "Work colonies and South African historiography," *Journal of Social History* 36, no. 1 (2011): 54-76.

[10] Peter Zinoman. *The Colonial Bastille: A History of Imprisonment in Vietnam, 1862-1940*. Berkeley, CA: University of California Press, 2001, 16.

[11] When occupational labor is mentioned in the historiography on colonial psychiatry, it is typically used to illustrate the abuses of the colonial asylum system rather than in terms of a real tension of practice. See for example Jackson (2005), 160-161.

that what distinguishes agricultural colonies for the insane from other kinds of agricultural colonies was a patient's relationship to the labor regime strongly determined his or her experience (and length) of confinement.[12] The possibility of being diagnosed as 'cured' or at least improved enough to return to normal social life turned on the ability or willingness of the patient to work. In other words, labor invested definitions of mental illness with new meaning that in turn justified either a prolonged or shortened confinement and that, as a consequence, enhanced the coercive character of asylum life. In this chapter, I explore the ways in which the moral and medical meanings of rehabilitation became embedded in the logics and practices of colonial labor regimes.

In 1918, French officials constructed Indochina's first asylum, Bien Hoa, as an agricultural colony thirty-four kilometers outside Saigon. With the exception of Madagascar, Indochina was the only other French colony to adopt patient labor as the organizing principle of psychiatric care. This was in part due to racialized assumptions that the Vietnamese suffered less severe forms of mental illness as compared to other colonized peoples (especially the Muslim populations of North Africa) and therefore proved more amenable to this brand of intervention. The success of the experiment was owed as well to the particular energies of Dr. Vital Robert who pioneered the use of agricultural colonies in Madagascar and who eventually assumed the leadership of Bien Hoa in 1919.[13]

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[12] Here I follow Ted McCoy's argument in relation to the history of prison labor in Canada. See McCoy (2010), 112.

[13] It is important to underscore that the health service in Indochina also introduced agricultural colonies for the care of lepers during the post-World War I period. While calls to eventually replace conventional leprosaria by expanding the agricultural colony model were eventually abandoned, the idea of the agricultural colony nevertheless gained some traction by the end of the 1920s, seen in the context of leprosy not as an explicit form of therapy but rather as lending a certain humanization to the confinement of lepers. See Laurence Monnais. 'Could confinement be humanised'? A modern

Deliberately situated on a small river that traversed its grounds and provided irrigation to gardens and crops, the asylum occupied sixty-five acres of land: forty-three acres dedicated to agricultural exploitation surrounded a compound of thirty-four buildings including lodgings or "pavilions" for patients, the asylum director and staff, as well as a range of administrative buildings, kitchen, store, infirmary, pharmacy and morgue. [Figure 3] As we saw in Chapter 3, the asylum was conceived on an open plan, its organization marked by concerns there be enough space both inside the pavilions to accommodate patients and between the pavilions themselves, including the lodgings of the personnel (the Director's family was apparently disturbed by patients screaming at night). It was concluded that a distance of at least 30 meters should separate each pavilion. When drawing up plans for a new asylum to service the north of the colony, extra precautions were taken to create a "zone of protection" immediately surrounding the asylum grounds in order to avoid the sale of alcohol to patients and minimize disturbances due to noisy neighbors.

Patients entering the asylum were first sent to the "Admission" building where they were put under the observation of either the director of the asylum or chief medical resident to determine the specific nature of their psychosis. [Figure 11] Vietnamese patients were also required to give up any personal items, to be returned at the time of their exit, and in return provided with bed linens, a mosquito net and a new set of clothes including a white cotton jacket and pants and a traditional Vietnamese hat. Patients also underwent a number of hygienic measures. After their heads were shaved, the newly admitted were sent to baths and vaccinated against small pox and cholera. Psychiatrists often remarked that at the time of their admission a large proportion of the patients arrived in a state of such "physical decrepitude that they could be classified in the category of severe wasting. These unfortunates come to us

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history of leprosy in Vietnam in *Public Health in Asia and the Pacific: Historical and Comparative Perspectives*, eds. Milton J. Lewis and Kerrie L. MacPherson. New York: Routledge, 2008.

malnourished having suffered ill treatment at the hands of their entourage."[14] Diagnosed most frequently with skin diseases and pulmonary infections, it was observed that many patients became cured of their mental illness with the sole therapy of sleep and regular food.[15]

Once their psychiatric status was established, the asylum director would send patients to the appropriate pavilion. As discussed in Chapter 3, pavilions were segregated by race (between Vietnamese and European patients), by gender and by the severity of the diagnosis.[16] Each pavilion at Bien Hoa was named after a famous French psychiatrist, arranged on its own large plot, surrounded by plants, flower beds and some trees. Iron rails masked by live hedges separated the pavilions one from the other, with the entire group of asylum buildings also enclosed in the same way.[17] These covered rails were nevertheless two meters in height and deemed "perfectly sufficient" for reducing the risk of patient escapes.[18] For Vietnamese men and women, there existed one pavilion each for the "senile and epileptics," two for "tranquil" patients, and two for "semi-tranquil" patients. Each pavilion was designed to hold 40 people and consisted of two common rooms with a dining hall, bathrooms and their own watch guard. Legislation required they also come equipped with cement or tiled flooring,

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[14] Archives Nationales d'Outre Mer (ANOM), Résidence Supérieur au Tonkin, 3750, Compte rendu annuel sur le fonctionnement de l'Asile d'Alienes de Voi pendant l'annee 1941.

[15] ANOM, Résidence Supérieur au Tonkin, 3753, Proces-verbal de la commission de Surveillance de l'Asile d'Alienes de Voi (Séance du 15 Juin 1938).

[16] In India, by contrast, entire asylums were segregated by race. See Waltraud Ernst. *Mad Tales from the Raj: The European Insane in British India, 1800-1858*. New York: Routledge, 1991; James Mills. *Madness, Cannabis, and Colonialism: The" Native-Only" Lunatic Asylums of British India*, 1857-1900. London: Macmillan, 2000.

[17] Peyre 1934.

[18] TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927. The director of Bien Hoa proclaimed the floral decorations of patient living quarters a "success." See TTL1, Inspection Generale de l'Hygiène et Santé Publique, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

whitewashed walls for easy cleaning, a ceiling of reinforced concrete, barred windows including large windows for surveillance and electric lamps with protected metal plaques.

For those patients who had been convicted of criminal charges and required a special kind of surveillance, the "Quartier Morel," named after the famous French theorist of degeneration, Benedict Morel, was also later constructed (individual, isolation cells were reserved only for the most agitated patients).[19] New spaces for the more comfortable installation of European patients also joined in the expansion. Each pavilion for European men and women was comprised of 10 bedrooms, a dining room, reading and game room, a bathroom and shower for every two bedrooms. There was also a common physical education room with hours reserved for each gender and scheduled promenades in the large adjoining garden.

Psychiatrists organized asylum life around these open spaces so as to simulate the social world and provide patients with a kind of "semi-liberty" and "comfort in freedom previously unknown."[20] Not only did this reflect a more modern and more humanitarian conception of care than earlier methods of confinement - one that proved useful in improving the poor public image of the asylum – but the "appearance of freedom" itself was seen as curative.[21] Leslie Topp observes in her study of asylums in late nineteenth century Germany that the mental hospital's projection of the image of freedom and normality of the familiar

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[19] They consisted of twenty special isolation cells following the model of Dr. Clerambault, the Medical Chief of the Special Infirmary of the Prefecture of Police in Paris. [See Figure 6]

[20] *Trung Tam Luu Tru Quoc Gia 2* (TTL2), Ho Chi Minh City, Vietnam, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[21] Anne Digby. *Madness, Morality and Medicine: A study of the York Retreat, 1796-1914*. London and New York: Cambridge University Press, 1985; Danielle Terbenche. 'Curative' and 'Custodial': Benefits of Patient Treatment at the Asylum for the Insane, Kingston, 1878-1906. *Canadian Historical Review* 86 (2005): 29-52.

outside world was directed as much towards convincing patients as the public.[22] As the director of the Bien Hoa asylum explained in 1926, the colonial asylum "must form a special milieu, organized exclusively in view of the lunatic, where he will find the care and surveillance necessary without the sensation of being a prisoner, cut off from the world. This set up is almost realized at the asylum of Bien Hoa where patients enjoy liberty in their surroundings which would make them the objects of envy of many asylum patients in the metropole." He continued, "Labor loses from asylums the aspect of a prison where admission is regarded by families more like a punishment than treatment... Perhaps in seeing patients well treated, well fed and rejoicing in an expanded freedom more patients will demand hospitalization."[23] The model of the agricultural colony proved key in demonstrating to the public that the asylum was not a place of secrecy, cruelty and injustice but a psychologically sound environment geared towards cure. For visitors to Bien Hoa it was apparently a "surprise...to observe that the quarters in which one hears any kind of noise are those of the calm patients on the verge of leaving for the day. The entire organization of the asylum is designed to suppress any measure that is not absolutely essential to the order and discipline of the community."[24] [Figures 13 and 14]

Sending patients out to work also had the advantage of relieving severe overcrowding that had become a serious problem by the late 1920s. While the Bien Hoa asylum was originally designed to accommodate 300 patients, it easily surpassed its capacity within the first

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[22] Leslie Topp. "The modern mental hospital in late nineteenth-century Germany and Austria: Psychiatric space and images of freedom and control" in Leslie Topp, James Moran and Jonathan Andrews, eds. *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*. New York: Routledge, 2007.

[23] TTL2, Goucouch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[24] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

few years of opening. The local director for health in Cochinchina, for instance, complained about the lack of space which meant that patients are "literally crammed together and sleep on mats on the floor in an unhealthy promiscuity."[25] As we saw in a previous chapter, this "promiscuity" was characterized by the mixing of different kinds of patients in common space and the subsequent breakdown in psychiatric classification upon which doctors based the 'rational treatment' of mental illness.[26] Allowing patients to work outdoors helped ease the burden of care for those who were forced to remain indoors. Indeed the cramped quarters of many of the pavilions left patients unable to work "crammed into a tight space" while for those who worked outside these discomforts were deemed of "little importance."[27]

Yet patients laboring in the open air also exacerbated the practical challenges of maintaining order and discipline at the asylum. As Augagneur, the director of Bien Hoa, in stressed in his 1926 report to the colonial administration, "the sole important point is to watch over the patient and make sure that he is watched very closely at the beginning." A year later, he claimed that "We have not had a single accident because of the instruments available to the patients, naturally this necessitates a close surveillance and we must every night at the end of work watch over them and make sure the tools are put back and accounted for with care."[28] The chief of agriculture for the asylum was tasked not only with the supervision of all agricultural labor but with ensuring that the patients were kept well guarded at all times and that their tasks were not executed in dangerous conditions for themselves or for the personnel

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[25] TTL2, Goucoch, IA.8/2910, Le Directeur Local de la Santé en Cochinchine à Monsieur le Gouverneur de la Cochinchine, September 24 1927.

[26] TTL2, Goucoch, 3730, Procès-Verbal de la reunion du 23 Decembre 1935 de la Commission de Surveillance ee l'Asile d'Aliénés de Bienhoa, 1935.

[27] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[28] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

watching over them. He was also charged with preventing any escape attempts and with warning of any crisis or outbursts observed among the "patient-workers." The fact that there were only three escapes in 1926 - despite the greater freedoms permitted patients, who worked often at long distances from the asylum grounds and only under a limited surveillance - was interpreted as a testament to the acceptability and success of the method.[29]

The issue of visibility was also paramount. When in 1927 colonial officials began considering the site for a second asylum to service Tonkin in the north of Indochina, a major consideration concerned the availability of rice fields that could be easily annexed to the asylum. As the chief architect of the project noted, "The proposed location presents this appreciable advantage for the mental asylum: the possibility of adjoining, for the occupation of calm patients, rice fields and land for cultivation situated on the other site of the road and under the direct view of the diverse pavilions of the establishment."[30]

These concerns followed patients from the fields back to their sleeping quarters where the set up of the pavilions did not encourage an easy surveillance. The admission building, for instance, was distinguished by its "multiple winding corridors, a veritable heresy from a medical point of view, placing patients for the dark."[31] The pavilions themselves were not much better. With the exception of those for agitated patients, the pavilions did not have proper ceilings, in spite of asylum regulations, resulting in a number of successful escape attempts whereby the patient climbed to the rafters and easily displaced the tiles to be set free.

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[29] TTL1, Résidence Supérieur au Tonkin, 73750, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927; Goucoch IA.8/2912(1) Rapport Annuel de Bien Hoa 1926.

[30] TTL1, Résidence Supérieur au Tonkin, 73757, L'architecte principal, Chef du Service des Bâtiments Civils à Monsieur le Résident Supérieur au Tonkin Hanoi, December 22, 1927.

[31] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

In 1925 the director demanded an urgent remedy as it was otherwise impossible to exert "a perfect surveillance in such horrible conditions."[32]

Indeed, as we saw earlier, the design of the pavilions made it very difficult to observe what happened inside. Pavilions were constructed so that there were two dormitories separated in the center by a watch room. Bathrooms and showers were located on the far end of each side of the building, out of sight of those guards placed in the very middle of the room, and therefore the most common route for patient escapes. While during the daytime it was difficult for guards to keep track of those coming in and out of the dormitory, at night it was even more challenging. With only one window on either side of the central watch room looking onto the adjacent dormitories, and with the mosquito nets mounted above the beds blocking their view, the guards were not able to see past the first bed to the interior of the room.[33] These difficulties were further compounded by frequent power outages that occurred frequently during the rainy season. The administrative staff was often forced to use the asylum's power reserves to illuminate 50 lamps so that the pavilions could stay lit and the surveillance of patients could take place.

In the early 1930s, when asylum planners were busy devising the pavilions for the new Voi asylum outside Hanoi, they learned from the mistakes of Bien Hoa. They instead recommended a "U" shaped model which allowed for a more comprehensive surveillance, including the bathrooms, due to the installation of multiple windows and a narrow verandah that circled the perimeter allowing the watch guard to see in an instant the entirety of the pavilion. [Figure 5] During the rainy season, in the interval between meals, the dining hall would also serve as an atelier to keep patients occupied with different kinds of work such as

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[32] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[33] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

basket making and embroidery. During the dry season, those patients who were not employed in outside labor were able to rest comfortably in the interior courtyard where one wall had been replaced with mostly iron bars, allowing the patients to look out. It also had the appreciable advantage of allowing those calm patients to rest "outdoors" at nights during the summers.[34]

Theory of patient labor

As soon as they had "sufficiently improved," patients were sent to work. The fact that the majority of patients in Indochina were already farmers lent optimism to colonial psychiatrists who insisted on the special therapeutic value of agricultural labor.[35] It was seen as an important factor of "cerebral hygiene" on account of its physical, outdoor qualities and for the impact of repeated movements on the motor skills of the brain. The act of gardening, in particular, was thought to yield valuable results, demanding constant and meticulous attention. [Figure 16] Left idle, as one psychiatrist warned, patients' physical degradation would only accelerate their psychiatric degradation. Instead, labor would "channel" the unutilized energy of the insane for more productive ends.[36] One asylum report from 1931 thus framed patient

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[34] TTL1, Résidence Supérieur au Tonkin, 73750, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

[35] The belief that most patients were previously employed farmers was not based on vague impressions. Rather psychiatrists kept detailed records on every patient that entered the asylum that included their race, age, gender, home province and criminal background as well as their profession prior to entry. These records were compiled and analyzed in annual asylum reports. The occupation of "Farmer" was, by far, the most consistently cited. See, for example, TTL2, Goucoch, IA.8/2912(1), "Repartition par Profession," Rapport annuel de Bienhoa, 1926.

[36] TTL2, Goucoch, IA.8/2912(1), Rapport annuel de Bienhoa, 1926.

labor as "indispensable for the organism, a method of physical education which is to be valued above all others. The distraction it creates works against ideas that are obsessive, melancholic or depressive. It withdraws the patient from a delirious world and restores him to a sane reality."[37]

In their annual reports, colonial psychiatrists in Indochina drew extensively on international studies, conferences and publications that heralded labor practices as adhering to a universal standard of psychiatric treatment. Remarking that when it comes to patient labor there is a "unanimity that is rare among doctors especially concerning therapeutic methods," Augagneur and others quoted widely from the early nineteenth century works of the celebrated French alienists Pinel and Ferrus to the latest studies emerging out of Switzerland, Belgium, Germany, Italy, the United States and Canada. In tracing the genealogy of the international consensus around the *colonies agricoles*, psychiatrists in Indochina worked hard to present themselves as modernizers who not only inherited the expertise of their French forebearers but also stood at the vanguard of progressive psychiatric care. Citing a 1926 international conference in Geneva where patient labor received top billing, Augagneur concluded in his report, "Today it is recognized by all psychiatrists that work is the best therapeutic agent for psychosis, some even going so far to say that it is the only therapy that the director of an asylum should use."[38]

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[37] TTL1, IGHSP, 48-05, Rapport Annuel de Bien Hoa de 1931. Geoffrey Reaume and others have discussed how doctors provided a physiological basis to support their claims about patient work. See Reaume. "Patients at work: Insane asylum inmates' labour in Ontario, 1841-1900." in *Rethinking Normalcy: A Disability Studies Reader*. Toronto: Canadian Scholars' Press Inc., 2009.

[38] *Ibid.* In spite of this insistence on the consensus of the psychiatric community about the merits of the agricultural colony, the organization of patient labor continued to be vigorously disputed among French psychiatrists in the metropole. Throughout the nineteenth century, debates over therapeutic labor served as a forum for broader contests over ideas about the curability of mental illness, the need for different treatments of chronic and acutely ill patients, how best to balance economic imperatives and medical goals of institutional care, and how to achieve the most effective surveillance of patients.

In terms of who would provide the labor, it was up to the discretion of the asylum director to assign patients to any one of several labor activities based on their "professional and physical aptitudes, as well as their type of psychosis."[39] In making their assignments, asylum directors adhered to a typology of work choice, developed in the metropole, in which patients, depending on their diagnosis, were thought to derive a certain kind of benefit from certain kinds of work.[40] Labor in this way was transformed into a kind of therapeutic agent that asylum directors prescribed and whose effects they were able to observe and measure. Indeed the language used by one asylum director in 1933 displays a medicalization and rationalization of work choice that stands in sharp contrast to former methods of treatment, "From a medical point of view, work constitutes a powerful distraction and an excellent method of treatment that is easily implemented. Methodically organized, *bien dosé* ("well dosed"), and judiciously applied to able-bodied patients, it avoids the sad spectacle of those who are idle, crammed into rooms or wandering in the corridors."[41] In theory, this categorization of work choice represented a natural addition to asylum life organized around the principles of division and separation. For patients already classified into different pavilions based on their race, gender and form of psychosis, work assignments would easily follow.

At the turn of the twentieth century, some also began to favor new models of care that stressed the biological origins of mental illness and the use of pharmaceuticals, competing with those older conceptions of psychiatric disorders in which labor was seen as medically useful. Psychiatrists in Indochina did use a range of pharmaceuticals as part of their treatment regimes, and continued to administer medications to patients even after they had left the asylum. Asylum directors at Bien Hoa also experimented with hydrotherapy and electric shock therapy, as early as the mid-1920s. See Chapter 3.

[39] TTL2, Goucoch, IA.8/2912(3), Rapport annuel de Bienhoa, 1927.

[40] Ch. Ladame and Dr. Demay. La Thérapeutique des Maladies Mentales par le Travail. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue française.* Paris: Masson et Cie, eds, 1926.

[41] TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

While agricultural therapy was originally conceived in the metropole for patients suffering from chronic conditions, psychiatrists in Indochina came to advocate for its application to a broader asylum population. For them, the "modern asylum" should provide care "not only to dangerous and chronic patients with no hope of cure but it must also assure a therapy based on rational measures in the best conditions possible for those whose psychiatric troubles are both transitory and curable." As a result, one psychiatrist argued, "This therapy by work must be applied not only to tranquil patients (including the convalescent, degenerate, chronic types) but also the agitated, the perverse, the impulsives and the escapees."[42]

Labor was thought to transform passive and apathetic patients into active beings while also calming those who were more disruptive. It was even remarked that, contrary to what may have been assumed, those patients who were the most agitated also made the best workers.[43] For "excited maniacs" it was important to start work as early as possible in order to space out their periods of agitation. Manual work for the 'confused' meanwhile was seen to reduce the period of their isolation. For others, the effect was less immediately therapeutic than practical. Senile and epileptic patients, for instance, were tasked with the specific chores of cleaning, sweeping of alleys, gathering dried leaves, and transporting water. As one psychiatrist wrote,

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[42] *Ibid.*

[43] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

> This is clearly not a labor force of choice, with much activity, but this work presents an advantage in letting them leave the pavilions, where they otherwise rest unoccupied, because this inaction is always a source of arguments which easily degenerate into fights, especially in the women's quarters. In using them for work of no importance, we are able to guard them outside all day and only let them return to the pavilions for meals and at night. A day in liberty, in the great outdoors, is a serious supplement to any other therapy.[44]

While asylum directors drew on evidence from international conferences and studies to support patient labor, these findings only went so far as to support the uses of labor for the indigenous populations of Indochina on account of the perceived special vulnerabilities of Europeans to the local climate. The intensity of the heat and sunlight was thought to predispose European colonial settlers, especially men, to a condition known as "neurasthenia," a kind of mental disorder characteristic of the tropics, marked by physical degeneration and a weakening of the 'moral sense.'[45] Unable to labor on account of the climate, psychiatrists worried that the inactivity of European patients was exceedingly harmful to their recovery, "Witnessing how much idleness is detrimental to our European patients, rest of the body is not a very favorable condition for the rest of the spirit."[46] For some psychiatrists, such observations confirmed claims that neurasthenia could be considered not just a pathology of climate but an affectation of people who have simply nothing to do.[47]As a result, asylum directors complained about the European patients who, segregated in their own pavilions, "currently do nothing and pass the days smoking, resting sprawled out, it is necessary to create

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[44] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[45] On neurasthenia, see Laurence Monnais. Colonised and Neurasthenic: From the Appropriation of a Word to the Reality of a Mailaise de Civilisation in Urban French Vietnam. *Health and History* 14,1 (2012): 121-142.

[46] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[47] *Ibid.*

for them some sort of occupation."[48] Instead physical education took the form of outdoor leisure activities in the practice of sports like tennis, swimming and other games "in the open air."[49]

Patient employment was considered as much a form of "cerebral hygiene" as it was a kind of moral re-education, which, psychiatrists hoped, by approximating the habits of ordinary life, would better prepare patients for life outside the asylum. For asylum directors, outdoor work proved useful in preventing the patient from becoming "absorbed in false ideas" and experiencing mental degeneration but also in warding against those "habits of laziness which, in the case of cure, would be deplorable for him and for society."[50] This notion of "inactivity" formed a major preoccupation that bled concerns over psychiatric treatment into broader anxieties about the social organization of indigenous life and the development of a productive local labor force. A 1931 study on mental illness in Indochina, for example, reported that men between the ages of twenty-six and thirty, in the prime of their working years, experienced the highest rates of mental illness in the colony. The psychiatrist who authored the report, a former director of the Bien Hoa asylum, worried in particular over the high rates of opium, and especially alcohol, consumption among youth men, observing that "The existence of the Indigene is in general rather disorganized. While his days are dedicated to some ordinary kind of work, he dreams only of resting for the coming night. To use a vulgar expression, one could say that in general the Indigene 'lives life in the fast lane.'"[51] The report continues,

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[48] *Ibid.*

[49] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[50] TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

> It is the night when life is the most intense: Annamite or Chinese theater, gambling, interminable conversations, such is the existence of the inhabitant of cities. Peasants pay visits to friends who live more or less far away, play, or take advantage of cool weather for certain kinds of work or to hunt or fish. As a general rule, the Indigene sleeps little with the exception of the hot hours during the day and one is struck by the number of people that one meets at night going single file on paths, covering distances that are probably too long in order to visit friends or to see some sort of spectacle.[52]

The author of the report lauded the agricultural colony, which promoted the inculcation of rigid bodily discipline and values of hard work, as a powerful model for behavior by way of contrast. In sharp contradistinction to the decadence and intensity of this social world, the time and rhythm of asylum life in Indochina were strictly organized: Patients woke at 6 in the morning, they received their breakfast and would proceed with cleaning the pavilion, watering, folding mats and mosquito nets, then head to work until 10:30. They would then return to the pavilion where they would lunch and take a siesta until 2 in the afternoon. They would then work again until 4:45, when they would return to the pavilion for supper and sleep. It was stressed that patient labor, at a maximum, would last only six to seven hours a day. This rigid daily routine was described as producing a kind of metamorphosis in patients who were previously thought dangerous and incurable, "From a psychological point of view, the patient who, on entering does not recognize anyone, cannot eat alone, is incapable of walking, can now leave the pavilion, eat alone, learn again how to talk and even to read is a major improvement. We try to re-educate this kind of patient without much hope for the rest."[53]

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[51] *Archives Nationales d'Outre Mer* (ANOM), BIB AOM, 12391, Etiologie des psychopathes par Dr. Augagneur, 1931.

[52] *Ibid.*

[53] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

Even for those with no hope of cure, psychiatrists believed that approximating the habits of ordinary life would serve a kind of harmonizing function. Part of the ambiguity around the use of therapeutic labor derived from the fact that a cure was not the only or even necessarily the primary goal, indeed for some chronic patients a full recovery was considered impossible. Rather psychiatrists believed that the sense of accomplishment and confidence a patient derived from finishing a task, no matter how minor, represented a "precious moral benefit" which fought against the more harmful and destructive symptoms of mental illness. In 1936 one psychiatrist remarked, "the more they work, the better the morale of the inhabitants."[54]

Earlier beliefs about the uses of labor to occupy and distract thus became re-framed in the 1930s as no longer the most important outcomes of therapy. Instead asylum care increasingly concerned itself with the "attempt to readapt the patient. This re-education must interest the patient and awaken his initiative. For this goal we must do what we can to guide him, and reward him when he is finished."[55] Agricultural labor, as well as work in ateliers or workshops, therefore not only helped to promote a kind of psychiatric rebalance but also to arm patients with those professional skills that would allow them to secure work after their release.[56] Psychiatrists recognized that patients who left the asylum often needed special guidance during the first period of transition back to normal life. They therefore recommended the creation of a special form of social assistance specifically designed to help

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[54] ANOM, Résidence Supérieur au Tonkin, 3678, Inspection des services sanitaires et médicaux du Tonkin: Rapports, 1936.

[55] TTL1, IGHSP, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1931.

[56] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

patients once they left the asylum.[57] One proposal, discussed at greater length below, even suggested the creation of a kind of "village of transition" adjacent to the asylum where a number of patients could live in simulated families and learn how to live independently on the path to full emancipation.[58]

Embedded in the discourse on re-education was a colonial vision of what normal social life should look like. The internal organization of the asylum – from the segregation of pavilions along racial criteria to the strict schedule of daily labor, even the meals provided to different classes of patients – reflected a particular vision of colonial order aimed at patients on their journey from confinement to release.[59] This order reflected not only assumptions about the racial hierarchy of colonial life but also came to be inflected with class-based notions about the distribution of labor. Europeans did not labor but neither did the members of the Vietnamese bourgeoisie who came to occupy the old European wing when a "paying service" for indigenous populations was inaugurated at Bien Hoa in 1934.[60] The ways in which the agricultural colony obscured the distinction between life inside and outside the asylum held the key to the therapeutic promise, and rehabilitative potential, of this model of care. At

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[57] TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

[58] ANOM, Résidence Supérieur du Tonkin Nouveau Fonds, Rapport au sujet de la création d'un asile colonie sur le terrain de l'Asile de Voi par Dr. Grinsard, June 5, 1937.

[59] Historian Svein Skalevag describes how the pavilion system of asylum architecture, premised on the principle of segregation, reveals the ways in which "socialization was brought to the forefront of psychiatric healing." See Skalevag. Constructive curative instruments: psychiatric architecture in Norway, 1820-1920. *History of Psychiatry*. 2002 12: 51-68.

[60] TTL1, Inspection Generale de l'Hygiène et Santé Publique, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933. Waltraud Ernst has made similar observations of asylums in British India. Whereas in Brtain lower class patients would be put to work as both a therapeutic and cost-savings measure, in India, Europeans of all social classes, as well as people of mixed race and elite Indian patients, were exempt from asylum labor regimes. See Waltraud Ernst. Idioms of Madness and Colonial Boundaries: The Case of the European and 'Native' Mentally Ill in Early Nineteenth-Century British India. *Comparative Studies in Society and History* 39,1 (1997): 153-181.

the same time, its capacity to blur boundaries between spaces of freedom and spaces of surveillance, between patients and laborers, introduced fundamental ambiguities into the meaning of 'freedom' and treatment in the everyday practices of the colonial asylum.

Economics of patient labor

Economic productivity, meanwhile, was not an incidental but desired outcome of this kind of therapy and played a primary role in the constant promotion of therapeutic labor. Concerned over how best to finance the asylum's expansion as patient numbers grew at an alarming pace, colonial officials proposed the asylum generate its own revenue given the "abundant labor force put at its disposition."[61] For asylum directors, the mandate of self-sufficiency merged with concerns the asylum possess its own *caisse* or treasury. Frustrated over the lack of sufficient funding put at their disposal, asylum directors sought greater autonomy and authority to control the institution's finances. For example, in 1926, the asylum exceeded its budget even though Dr. Augagneur, the director of Bien Hoa, had asked the colonial administration for more funds the year before. The following year, concerned about the rapid surge in the patient population, as well as the rising costs of food staples, clothes, and medications, he requested the colonial government increase the daily rate of hospitalization (from 2 to 3 piasters for paying European patients, and 0.50 to 0.60 for the indigent).[62]

In order to offset the mounting costs of confinement, asylum directors decided to transform the scale of agricultural labor from simple self-sufficiency into a genuinely

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[61] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3678, L'Inspecteur Général de l'Hygiène et de la Santé Publiques à Monsieur le Gouverneur Général de l'Indochine (Direction des Affaires Economiques et Administratives), June 30, 1936.

[62] *Ibid.*

expansive revenue generating operation that targeted urban markets. Following asylum directors in France who had come to favor more intensive forms of cultivation, ensuring year-round harvests, colonial psychiatrists in the mid-1920s also called for the diversification and escalation of crop production, "Until now, we have cultivated rice, tobacco, cassava root and potatoes. These are crops that demand little time and little care because once seeds are planted there is nothing to do but wait. On the other hand, [gardening fresh vegetables for market] requires many cares, the preparation of the land, planting of seeds, watering twice a day, weeding out of harmful herbs, putting into place protective foils, garden stakes, etc. It is in this sense that we plan the extension of future works."[63]

Preliminary attempts to expand the annual harvest yielded promising results. Seeds imported from France – including varieties of lettuce, cabbage, carrots, celery and watercress, as well as green beans from Dalat – were tested in order to prove which would provide a "sure output." In addition, "thanks to the dam installed during the dry season on the Suoi river which traverses the asylum, we have at our disposal an abundance of very clear and pure water which allows us to grow vegetables without any danger to the consumer." Asylum directors proposed the sale of vegetables on a subscription basis to colonial settlers and bureaucrats, as well as to shopkeepers in Saigon, in order to establish an "easy flow of all quantities of vegetables."[64] The sale of fresh vegetables at the Saigon markets, estimated at 600 piasters per year, would join with the proceeds from the sale of rice and tobacco, rubber, pork, basket making and weaving, projected to total an additional 3100 piasters. Patients would not only receive more fresh vegetables above the normal ration but the expansion would also create a critical revenue stream for the asylum that could be used to purchase machines for the ateliers,

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[63] TTL2, Goucoch, IA.8/281(2), Asylum Report de Bienhoa, 1925.

[64] *Ibid.*

improve agricultural tools, increase the indemnity given to patients upon release and assure supplementary funds for special holidays. As one French psychiatrist remarked, "Happily the labor force of the asylum works well. Without it, the upkeep and repairs would represent an important loss."[65]

The organization of patient labor also proved remarkably efficient. For example, in order to remedy the persistent problem of patients sleeping on the floor, in 1932 it was decided that patient-laborers would construct a number of new beds out of wood. Teams were formed under the direction of the guards and a carpenter and the work was divided into specialized tasks with some sawing the boards to size and others charged with planing the wood for a smooth and even finish. The planks were then passed to assembly teams who would adjust the size of the feet and the frame. In a matter of days, they had managed to build two hundred beds. If purchased locally, the price of the beds (including transport costs) would have come to 5 piasters each. Using their own labor force, asylum directors were therefore happy to learn that they had procured more sturdy beds for half the cost.[66]

Yet at times, the therapeutic nature of labor itself was questioned, from the standpoint of both efficiency and the occupational health of patients. For a number of years, patients were employed with the banal task of removing rice husks. Not only was this chore incredibly labor intensive but it also forced patients to work in what was described as a "very dusty atmosphere." As compared to those patients exposed to the clean air of the open fields, a fundamental tenet of work therapy, psychiatrists found the situation of those husking rice "regrettable." As a result, in 1927, the director of Bien Hoa invested in the installation of a

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[65] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927. See also TTL2, Goucoch, IA.8/281(2), Rapport Annuel de Bienhoa, 1925.

[66] TTL1, IGHSP, 48-05, Rapport Annuel de Bien Hoa de 1931.

more useful Groundhand machine for preparing the rice that had been harvested on asylum grounds.[67]

By 1934, nearly a third of all patients at Bien Hoa were kept busy performing tasks associated with every aspect of the daily running of the asylum: from the harvesting of rice and vegetables for meals, to the construction and painting of new pavilions, laundry and the sewing of patient clothing, making baskets, husking rice, manufacturing bricks and the production of latex.[68] [Figures 16, 17, 18 and 19] To give a sense of the massive scale of the work, the annual rice harvest grew from 1,800 kilograms in 1924 to almost 7,000 a decade later. Crops were [also] diversified to include 12,000 tobacco plants, nearly 1000 rubber trees, 50 lemon trees, evergreens, and coffee plants, covering two acres of forest.

The particular fascination with the cultivation of rubber did not occur in a vacuum. Indeed, from the 1920s, rubber plantations expanded quickly throughout Cochin China, introducing a new engine for colonial development into the region but also the swift transformation of local economies and ecologies. The rapid growth of the plantation labor system led to massive labor migrations from the Red River delta in Tonkin to the south. That laborers abandoned the relative security of their home villages to find wage-paid employment on rubber plantations is often attributed to the socio-economic transformation of agrarian relations in the northern countryside, particularly the growing polarization of land ownership as the result of colonial economic policies.[69] The social effects of the plantation system can be

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[67] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[68] *Ibid.*

[69] Martin J. Murray. 'White gold' or 'white blood'?: The rubber plantations of colonial Indochina, 1910-1940. *The Journal of Peasant Studies* 19,3-4, (1992) 41-67; Pierre Brocheux. *The Mekong Delta: Ecology, Economy and Revoution, 1860-1890*. Madison: Monograph No. 12, Center for Southeast Asian Studies, University of Wisconsin-Madison, 1995.

traced here to the extra burden placed on the local health system around Bien Hoa. In 1928, for instance, local medical officials remarked on how the massive influx of migrant workers, attracted from all corners of Indochina by the growing demand for plantation labor, was straining resources and access to regional hospitals, including the Bien Hoa asylum.[70]

As of 1926, Bien Hoa possessed 350 rubber trees that generated a total of 500 piasters a year in revenue. Asylum administrators expressed their excitement by the prospect of planting an additional 700 trees the following year as well as the installation of new facilities for rubber processing. These opportunities would not only offer diverse occupations for patients but were also expected to yield in the future a "very interesting" fixed revenue stream.[71] By 1936, the asylum's patients had succeeded in planting an estimated 1000 to 1200 trees on the border of the institutions grounds, 800 of which were in a state of good development but remained untapped. Sensing a potential financial windfall, the oversight committee of the asylum decided to lease the trees to a local plantation owner. The gentleman was given a three year contract with annual rates increasing from $200 piasters in the first year to $350 by the third year.[72] Asylum labor, as we can see here, both drew its inspiration from, and interacted with, the local economy in important ways. By 1929, the administration of the asylum was described as "flourishing," and in 1931, while continuing to suffer from financial setbacks, produced in enough quantity in order to greatly lighten its budget.[73]

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[70] TTL1, IGHSP, 004, Rapport annuel de 1928 sur le fonctionnement de l'Inspection générale des services sanitaires et médicaux de l'Indochine.

[71] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[72] TTL2, Goucoch, 3730. Le Chef du Service Local de l'Agriculture à Monsieur le Gouverneur de la Cochinchine, April 25, 1936. It is unclear from the file if the asylum's patients continued to provide the labor on the estate.

Balancing act

Between 1919 and 1934, the Bien Hoa asylum treated a total of almost 1600 patients. Of those who had left the asylum, 80% were classified as cured, or roughly a third of the total asylum population.[74] In their annual reports to the colonial government, asylum directors attributed their therapeutic successes in overwhelming measure to the *colonies agricoles* and requested funds for continued land acquisition in order to provide expanded employment opportunities for patients.[75] The different goals of therapeutic labor often slid uneasily together in annual asylum reports. To take one example from 1933, "The work of lunatics is one of our dominant preoccupations. This form of treatment is not only a method of distraction but also a valuable resource for the establishment. It constitutes an important part of the functioning of the asylum. To provide an occupation to the largest number of patients in order to improve and perfect the conditions of work, that is our goal."[76]

While acknowledging the financial benefits of the practice, asylum directors also routinely insisted that the organization of patient labor was for medical purposes first and foremost and that in no circumstances were patients coerced into working. Much of the energy devoted to insisting on the voluntariness of patient labor, however, exposed an

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[73] E.L. Peyre, "Les Maladies Mentales Aux Colonies." *Publication de l'Hygiène Mentale Journal de Psychiatrie Appliquée.* No 8, Sept-Oct 1934. Paris: Gaston Doin et Cie, Editeurs, pp 185-212; Dr. R. Lefèvre, Médecin-Lieutenant-Colonel des Troupes Coloniales au Ministère des Colonies. L'assistance psychiatrique en Indochine. *Congrès des médecins aliénistes et neurologistes de France et des pays de langue francaise, 1931*, 293-297.

[74] Peyre 1934.

[75] TTL1, IGHSP, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu.

[76] TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

underlying sensitivity shared by asylum administrators to charges of mistreatment. In particular, therapeutic labor in France throughout the nineteenth and early twentieth centuries faced critiques by those who considered patient labor as inherently exploitative.[77] In Indochina, throughout the 1920s and 1930s, psychiatrists accordingly stressed that only those "able bodied and voluntary lunatics" who requested to participate were eligible for work outdoors. They even framed work as something that was actively pursued by the patients themselves who had come to appreciate its medical value. One psychiatrist, for example, noted that when therapeutic labor produced an improvement, no matter how slight, the patient would "demand to know the kind of work with which he was to be entrusted."[78]

This insistence by directors on the entirely voluntary nature of asylum labor, however, belied the actual use of a range of persuasive and coercive measures to encourage patients to work. In 1921 a decree mandated that those interned at the asylum would receive a *pécule* or two cents a day in compensation for their labor. One half would be given to the patients directly each Sunday to purchase cakes, sugar, cigarettes, and other goods that were subject to official approval. The other half would be noted in individual registers and returned to the patient following their release from the asylum. Three cents would also be reserved from weekly wages in order to cover the costs of food. [79] In 1934 at the Bien Hoa asylum, 230

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[77] There is also evidence of protest from the patients themselves. As late as 1910, reports of a bloody revolt at the agricultural colony of Chezal Benoit in central France described a group of patients who, misled by the appellation of a '*colonie*,' were apparently "disillusioned" to find themselves barricaded in and sent to the fields to labor rather than resting comfortably in the homes of the local peasantry. See "Une révolte à la colonie agrigole de Chezal Benoit" *Informateur des alienistes et des nuerologistes* 6,25 (June 1911): 140-142.

[78] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[79] TTL2, Goucoch, 3731, Indeminité allouée aux internés de l'Asile d'Aliénés de Bien Hoa, 1934.

patients performed 62,392 days of work and compensated an annual total of $1,247.84 piasters.[80]

The practice of the *pécule* derived from a metropolitan law in France formally regulating labor in asylums. The 1839 law, later revamped in 1857, developed in response to concerns about the protection of patients from exploitation especially around the introduction of "*la grande culture*."[81] The regulation specified work as a "method of treatment and distraction" and "limited, if necessary, the length of work and which can, in any circumstance, assure general working condition and related sanitary precautions." Patients could not be employed for labor that required the exclusive use of muscular force and the workday could never exceed eight hours in the winter and nine hours in the summer. The *pécule* was intended as a kind of "retribution for workers, not only for the execution of good work but also the recognition of the effort made by such and such a patient, even if the outcome is minimal." Patients were therefore not compensated for actual work output, like a normal worker, but for the additional energy that they put into the work as patients of the asylum.[82]

In Indochina, as a source of "precious encouragement," the *pécule* clearly succeeded: "As soon as they are able, improved patients are submitted to work therapy. No difficulty here; on the contrary, work is solicited because it is compensated."[83] Asylum directors would also encourage patients to work in teams by giving those with the best results supplementary

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[80] TTL1, IGHSP, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu.

[81] Ladame and Demay (1926).

[82] *Ibid.*

[83] TTL1, Inspection Generale de l'Hygiène et Santé Publique, 51-07, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1934.

rations of tobacco, fruits and cakes.[84] Asylum administrators did not shy away from using a range of techniques to encourage patients to work. In a 1926 report the director of Bien Hoa noted that, "Labor is, moreover optional, any patient who does not want to work is left at the pavilion. While they are laboring if the patient stops himself and does not work anymore the guards have been ordered to not force him to work. They should find out if he is tired, in which case he is brought back to the pavilion, if not they are to wait to see if he would like to take up his task again. Ordinarily this pause does not last for long, the patient being encouraged by the other companions of his team."[85]

How to balance the directives for labor, framed at once as an important benefit to the individual and to the institution, with the ostensibly voluntary nature of patient employment presented a challenge to colonial psychiatrists. In many ways, the art of convincing rather than forcing the patient to work emerged as the most suitable strategy. The asylum personnel were charged with this important yet "delicate" task of navigating the different impulses of patient care around both a firm discipline and compassion. As one asylum director explained, "To win the confidence of the patient in order to then direct him, to order him in such a way as to think that the direction and order are in his interest, is an often difficult task that requires much patience and devotion."[86] However the fact that the guards themselves often participated in the manual labor of the asylum alongside their charges and benefited from its revenues complicated their use of authority to encourage patients to work.[87] Asylums also

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[84] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[85] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

[86] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[87] *Ibid.* A part of the revenues from the staff's labor was reserved in the creation of a special fund for distributing bonuses on the occasion of the birth of children, for the creation of a small library, the

often hired back a number of patients as coolies who were deemed “cured” and ready for release but did not have families to return home to. Such an arrangement allowed these patients to continue to be an object of surveillance yet in their new role as “coolies” they were also entrusted with the supervision of labor and the exercise of the surveillance of other patients at night.[88] The fluidity of these hierarchies within the asylum's walls worked to disrupt ideas about what it meant to be a patient and what it meant to be an employee, as well as the notion of labor itself as a therapeutic strategy reserved for the sick.

While some patients required encouragement to work, psychiatrists wondered at those patients who "work with an activity and conscientiousness truly astonishing in a country where work at a slow pace is the norm" and often remarked on their "punctuality, tranquility and silence."[89] In one instance, the labor of ten patients was thought to have resulted in an output superior to that of the work of twenty coolies.[90] A 1925 report admitted, "It would seem paradoxical to claim that we find less difficulties with the patients than we would with another labor force" for "certain patients work with a real care and enjoyment." The ability to work also emerged as a major prerequisite for release and constituted critical evidence of improvement of the patient's condition. Those who were viewed as uncooperative were much less likely to be considered cured and ready for a return to normal social life. Indeed the inability or unwillingness to work was often cited as a reason to reject requests for release

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distribution of prizes for those who have most earned them on holidays especially Têt. Revenues were also flagged for organizing the showing of films for patients or productions by the local theater troop.

[88] TTL2, Goucoch, IA.8/281(1), Rapport Annuel de Bienhoa, 1923.

[89] TTL2, Goucoch, IA.8/2912(3), Rapport Annuel de Bienhoa, 1927.

[90] TTL2, Goucoch, IA.8/2912(1), Rapport Annuel de Bienhoa, 1926.

initiated by family members or by the patients themselves.[91] Here the more coercive aspects of an institutional logic guided by labor as therapy emerge the most clearly.

Asile Colonie

Subsequent efforts to establish semi-autonomous agricultural colonies outside the walls of the institution - as a kind of halfway measure - met with their own challenges. In June 1938, the Commission charged with examining the issue of asylum over-crowding found that for "those abandoned, who uselessly encumber the rooms of the asylum and risk becoming human wreckage," the best solution consisted of creating a village immediately bordering the asylum which would receive those whose families had refused to accept them upon release. There they could "once again find a normal active life and meet their own needs through cultivation and farming all while remaining under surveillance, from a distance, by the personnel of the establishment."[92] The village would represent "a social work of re-education allowing the recuperation of a social life by individuals currently confined. This creation, new in the Far East, has a humanitarian goal on which it is pointless to insist."[93] The proposed *asiles colonies* articulated a colonial vision for the reintegration of "ex-aliénés" back into their community.[94] They envision the continuity of the surveillance space of the asylum into the

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[91] For example, TTL2, Goucoch, IA.8/274(3), Lettre de Gouverneur Général à Médecin-Directeur de l'Asile de Bienhoa au sujet de [....] Vinh, April 1, 1920.

[92] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 03753, Réunion de la Commission de Surveillance de l'Asile d'Aliénés de Voi procès-verbal, August 7, 1939.

[93] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, Rapport au sujet de la création d'un asile colonie sur le terrain de l'asile de Voi par Dr. Grinsard, June 5, 1937.

space of the family, prescribe a domestic life for former patients organized around the principles of economic productivity and sexual discipline, and highlight the creation of a hierarchy of psychiatric wellness where people were afforded special privileges depending on their degree of cure. The *asiles colonies*, in proposing a domestic model of family care to promote cure and reintegration, represented the next logical step in patient recovery; rather than asylum directors, other family members who would be tasked with enforcing the principles of labor discipline and moral responsibility among former patients.

The Commission's recommendations were drawn from a 1937 report prepared by Dr. Grinsard, the Director of the Voi asylum in northern Tonkin, who argued for the creation of a rural *asile colonie* for those patients, especially the chronically ill and epileptics, who were "tranquil and inoffensive." Citing works undertaken by the Department of the Seine at Dun-Sur-Auron and Ainay-le Chateau in France and throughout Europe, Grinsard proposed the creation of colonies that simulated "family country life under an active and continuous medical surveillance."[95] Throughout the late nineteenth century, family care in Western Europe became the model against which formal institutional care of the mentally ill was contrasted, with the colony of Gheel in Belgium as the most famous example. Growing French interest in Gheel at the end of the nineteenth century responded to the concerns of asylum overcrowding and economic pressures that mandated the contraction, not expansion, of institutions. Psychiatrists and others at the time were also questioning the asylum as the most morally appropriate and medically acceptable solution to mental illness. Instead they

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[94] Use of the term "*ex-aliéné*" (or "formerly insane") became ubiquitious in patient case files starting in the late 1930s. See: ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 03749, Le Directeur Local de la Santé à Monsieur le Résident Supérieur au Tonkin au sujet ex-aliéné [...] Gioi, April 29, 1941.

[95] Grinsard 1937.

began warming to alternative forms of patient care that relied on new uses of space and the environment, including family placement and agricultural colonies, which a large number of professionals had rejected twenty five years earlier.[96]

The successful adaptation of the Gheel model to neighboring Java encouraged those French psychiatrists who sought to do the same in Indochina. In 1937, Pierre Dorolle, the former director of the Bien Hoa asylum, took a study trip to Java where in 1933 an *asile colonie* had been installed at Lengteng-Agoeng, halfway between Batavia and Buitenzorg, on 325 acres of land.[97] As in Indochina, the care for chronic patients who no longer required close surveillance or medical care but continued to use up precious space and resources tested the limits of the Dutch system. Under the direction of Dr. Palthe, a renowned psychiatrist and professor of clinical neurology at the Faculty of Medicine in Batavia, and financed by a private initiative "*Societé d'Assistance aux invalides mentaux*," the Dutch successfully organized the transfer of 200 calm, chronic patients to a large agricultural colony and, following, the Belgian model, later placed seventy at the homes of *nourriciers* throughout the countryside who housed and fed the patients under precise conditions and medical and administrative oversight. Not only did this hybrid model encourage the readaptation of patients back to the normal life of villages but it also helped to relieve a tremendous financial burden. Based on the Dutch experience, Dorolle argued that in Indochina, the removal of the chronically ill from asylums and the creation of these separate colonies would reduce by 10 to 15 times the cost of care. It

[96] See Thomas Mueller, "Community spaces and psychiatric family care in Belgium, France and Germany: A comparative study" in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, Leslie Topp, James Moran and Jonathan Andrews, eds. New York: Routledge, 2007.

[97] ANOM, Guernut 22, "Note sur la colonie agricole d'aliénés de Lengteng-Agoeng (Java) par le Dr. P.M.Dorolle," Octobre 1937; On the history of psychiatry in colonial Indonesia, see Hans Pols. The development of psychiatry in Indonesia: From colonial to modern times. *International Review of Psychiatry* 18,4 (2006): 363-370.

would also result in a six to eight fold reduction in the costs of the oversight of patients placed in the *colonies* as compared to those in asylums.

Dorolle became convinced that this model could work in Indochina for several reasons. He found fundamental similarities particularly with the countryside of Tonkin, citing the dispersed population, bare hills mixed with those covered with grass and the dedication of low lying lands to the cultivation of rice. Beyond topography, the striking ethnological similarities between the Tonkinois and local Indonesian populations, especially their diet, and their local economies (which shared comparable salaries for medical staff) all gave Dorolle hope. Some of the important challenges the Dutch faced in implementing this model, specifically how best to expropriate land from village ownership and irrigate land of often poor quality, served as important lessons for the French. For Dorolle, the Dutch experience underscored the importance of choosing land for the *colonie asile* with the collaboration and agreement of *both* agricultural experts and indigenous authorities. Dorolle also cautioned that the selected site should be in an area of low population density and in close enough proximity to the asylum to facilitate urgent care but not so far away that those "patients who had been transferred would have the impression that they had truly left the asylum for a new existence." [Figure 20]

Earning community trust was key. At first Dorolle observed the local Sundanese population, “afraid like any other people in a similar situation around the world," had begun to protest against the installation of this "colony of lunatics" without the protection of a wall or any other kind of fence. At the beginning, the villagers would barricade themselves in at night, waiting for some "horrible strike from their neighbors." As Dorolle recounts,

> Very rapidly however, in part due to the entanglement of the land belonging to the *colonie* and the land belong to the villagers, the peasants recognized that the *colons* were not dangerous and worked very peacefully in the fields. They started to converse and got to know each other, and in a matter of months, the villagers perfectly accepted the idea of welcoming one of these patients into their homes.

For Dorolle, the presence of nearby villages was indispensable in the pursuit of a "*placement familial*," viewed as the "second step" of the program after the initial transfer to the *colonie*. Dr. Grinsard in his own 1937 report, however, was more skeptical. Unlike Dorolle, Grinsard believed that in Indochina boarding out would not be advisable given the prejudices of the local population and difficulties of medical surveillance and control. Instead Grinsard proposed a different kind of model: a village of recovering patients, and its relationship to the asylum, would be modeled as a family. As Governor General Delsalle later wrote, in agreement, "there is room to conceive of the envisioned agricultural colony, not as an actual village that is more or less autonomous but as a special kind of agglomeration organized according to rural and familial ideas where the action of the family would be replaced by that of the doctor and the personnel of the asylum."[98]

The issue of surveillance was critical. While Grinsard originally suggested Tri Cu, the site of the province's youth reformatory, as the most desirable location, the Commission determined that its distance from Voi asylum (50 km) would not allow for adequate oversight and decided instead to purchase land adjacent to asylum grounds. This "typical country village" would therefore allow patients to come and go in the case of acute episodes and doctors could more easily monitor their medical progress. Two guardians for every fifty settlers would be required. In addition, those formerly confined patients "most neighboring normal" would serve as a kind of "reinforcement system for surveillance" and be held

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[98] ANOM, Résidence Supérieur au Tonkin, 3752, Gouvernor Général à Résident Superieur du Tonkin, June 13, 1938.

responsible for maintaining cleanliness and discipline in the village. They would receive honorary titles (ly-truong, notables, etc.) matching those in ordinary villages to signify their authority vis-à-vis the other inhabitants and live in small independent lodgings. Grinsard and others, however, repeatedly insisted that these "notables of the *colonie asile*" wielded no real authority and only employed staff were authorized to exercise administrative power.[99]

With the Director of the Asylum serving as a benevolent benefactor, villagers would live in homes attached to a parcel of land and be charged with the "*mettre en valeur*" of the fields. With seeds and tools furnished by the local provincial agricultural cooperative, they would work during the day under the eyes of an agricultural supervisor and sell their harvest to supplement their income and ease operational costs to the asylum. The *asile colonie* was thus conceived as a "center of re-education through work" where the therapeutic logic of labor would extend outside the asylum's walls and into the community. The *colonie* itself would be built by the patients, "helped and overseen by the employees of the asylum." Those still confined in the asylum working in the linen room would furnish the future villagers with one or two outfits. Villagers would also have the chance to exercise the skills they learned working at the asylum as not only farmers but also as carpenters, tailors and weavers.[100] Indeed this aspect of the design of the *asiles colonies* was lauded by the Governor General Delsalle who wrote in 1939, "The released patients abandoned by their families would be installed on vacated land next to the asylum where they will farm with the training they have been given and which will allow us to continue to watch over them as if they are still hospitalized."[101] It

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[99] Grinsard 1937.

[100] *Ibid.*

[101] ANOM, Résidence Supérieur au Tonkin, Lettre du Gouverneur Général de l'Indochine à Monsieur le Resident Superieur au Tonkin, June 7, 1939.

was also strongly stated that in no case would the land or buildings ever become the property of the villagers.

Yet this paternalist vision also had its critics who believed it sanctioned a fatal kind of dependence on the state. For example, in order to supplement their income, a monthly indemnity of $3 from the financial registers of the asylum was proposed with the "notables" receiving $1 or $2 more for their additional services. The amount of the indemnity was to be reduced over time yet critics of the plan argued, "it is to misread the existence of the compulsive love of gambling shared by the natives who will pass their nights playing, who will give refuge to gambling professionals who rob them (and to prostitutes with no means), and will not have any inclination to work the next day, especially when, having gotten rid of their monthly compensation, it is no longer possible for them to feed themselves sufficiently." It would not only be a waste of resources but it would "put into their heads" that the Administration had decided to pay them a salary until the end of their days and to "liberate" them from a future of performing any difficult work.[102]

There were other advantages for those who were "closest to approaching normal."[103] Depending on their degree of cure, certain villagers would be allowed to live with a partner and start a family. This would require prior medical authorization meaning that for everybody in the village there would be "no procreation...except under regulated exceptions."[104] Others would be placed into groupings of three or four patients simulating a Western European family structure. Yet visions of family life also had their limits. Regulating the sexual lives of

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102 ANOM, Résidence Supérieur au Tonkin, 3752, Heckenroth, l'Inspecteur Général de l'Hygiène et de la Santé Publiques à Monsieur le Gouverneur Général de l'Indochine, May 9, 1938.

103 Grinsard 1937.

104 ANOM, Résidence Supérieur au Tonkin, 3752, Heckenroth, l'Inspecteur Général de l'Hygiène et de la Santé Publiques à Monsieur le Gouverneur Général de l'Indochine, May 9, 1938.

the villagers represented the single biggest concern among proposals for the *asiles colonies*. De Raymond, the director of the health service in Tonkin, voiced a typical objection, "The constitution of an agricultural colony neighboring the asylums would leave these patients still in our care to a life in common between men and women and distressing procreations."[105] When Governor General Delsalle granted his approval for the creation of the villages in 1939 he nevertheless warned that their inhabitants must be prevented, "either through *'la vie en ménage'* or through accidental sexual relationships with the habitants of neighboring villages from breeding descendents who are more or less defected and crazy. The villages must thus be the object of a particularly severe surveillance by the personnel of the asylum."[106]

In 1938, Heckenroth, the Inspector General of Hygiene and Public Health, also warned that "an open door policy, with 'improved' men and women living freely....means, fatally, the *vie en menage* and the birth of children." He suggested two separate buildings be constructed for men and women, located immediately outside the asylum and kept locked at night.[107] But Grinsard objected to this proposal for generating its own set of problems, "The question of procreation is the most difficult to resolve. If we separate men and women, then cured male lunatics will found their own families elsewhere and the village of women risks being transformed into a brothel. It is materially impossible to prevent former patients from engaging in sexual relationships, either between themselves or with other individuals. Besides, the same question must be asked of those released from the asylum, entrusted to their

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105 ANOM, Résidence Supérieur au Tonkin, 3752, De Raymond, le Directeur local de la santé à Monsieur le Résident Supérieur au tonkin, September 17, 1937.

106 ANOM, Résidence Supérieur au Tonkin, 3752, Lettre du Gouverneur General de l'Indochine à Monsieur le Resident Superieur au Tonkin, June 7, 1939.

107 ANOM, Résidence Supérieur au Tonkin, 3752, Heckenroth, l'Inspecteur Général de l'Hygiène et de la Santé Publiques à Monsieur le Gouverneur Général de l'Indochine, May 9, 1938.

families, lunatics who share the same 'cured' status as the future habitants of this village." Grinsard nevertheless remained hopeful, "It's a difficulty that we must not exaggerate, for all the children of lunatics are not born lunatics, especially in a collectivity placed under 'psychological control.'"[108]

Some outright rejected the idea of the *asile colonie* as a complete waste of resources. De Raymond protested, "This village will grow slowly but surely on the costs of the Administration and will not realize any profit...It would be preferable that the families and village <u>must ultimately be obliged</u> to take them back as soon as possible."[109] In 1940, the Commission evidently had a change of heart and offered a different reason for deciding against the construction of the *asiles colonies*, arguing that it was "inappropriate, from a social point of view."[110] While the *colonies asiles* ultimately failed to take hold, these debates nevertheless illustrate the perceived difficulties of extending the principles of labor and sexual discipline into the life of the community. Concerns over surveillance, cultural prejudice, cost and sexual promiscuity thus marked the limits of colonial visions to reproduce asylum social relations, a model of family life and work relations that nevertheless continued to offer an idealized account of what normal life should look like.

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108 ANOM, Résidence Supérieur au Tonkin, 3752, Grinsard, le Medecin Directeur de l'Asile à Monsieur l'Administrateur Résident de France à Phu-Lang-Thuong, September 6, 1938.

109 ANOM, Résidence Supérieur au Tonkin, 3752, De Raymond, le Directeur local de la santé à Monsieur le Résident Supérieur au Tonkin, September 17, 1937. [The underlined portion is original to the text.]

110 ANOM, Résidence Supérieur au Tonkin, 3753, Réunion de la Commission de surveillance de l'Asile d'Alienes du Voi, December 5, 1940.

Conclusion

Located on the margins of asylum grounds, the agricultural colony signified the last step in patient recovery and re-entry into colonial society. By drawing our attention to those liminal spaces between confinement and release, the history of the agricultural colony reveals the fluidity of abnormality as an object of medical knowledge – a state that could be cured or at least improved through rational treatment – and highlights broader French debates over what kind of subjects the colonial state sought to mold. Recasting discussions around the development of a healthy and productive colonial work force, psychiatrists in Indochina claimed that the act of labor itself was an indispensable therapeutic mechanism for ridding individuals of mental illness. They argued that putting asylum patients to work would not only result in important health benefits but would also equip patients with the moral principles, self-discipline, and technical skills that would prove essential upon their liberation. Wanting to leave also emerged as an important indication of a patient's "cure." In the case of one orphan asked whether he would prefer to stay at the asylum or return to his sister, he elected to leave, revealing to his psychiatrist an "instinct for liberty" which demonstrated his readiness for discharge.[111] Those patients who failed to conform to institutional logics were also those most likely to be considered ill and therefore ineligible for release. Yet the discourse of patient freedom and work therapy clashed with the everyday imperatives of surveillance and economic profit that governed the administration of the colonial asylum. In some instances,

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111 TTL2, Goucoch, IA.8/275(1), Certificat Semestriel concernant le nommé [...] Huong, Asile de Bien Hoa, October 1, 1919.

asylum directors viewed these apparent contradictions as a practical challenge of asylum management, and in others, a real tension of practice that required more careful attention.

As a model of psychiatric care, the agricultural colony deliberately obscured the boundaries between life inside and outside the asylum's walls. By simulating the appearance of freedom and normal life, the agricultural colony projected a vision of an idealized colonial order, one premised on establishing a kind of continuity between the discipline of institutional order and life in the community. In so doing, it invites historians to consider how spaces of psychiatric surveillance and care in French Indochina did not, in fact, end with the formal limits of the institution. Rather strategies for the "psychiatric re-education" of the insane emerged as part of a broader network of colonial reform projects that sought to produce a new class of colonial subjects through the disciplinary effects of labor.

Chapter 6. Psychiatric expertise and Indochina's crime problem

I. Introduction

Throughout the late nineteenth century, French officials remarked on what they believed to be a striking absence of mental illness among the indigenous peoples of Indochina. For Louis Lorion, a French navy doctor, this impression formed the basis for sketching out the distinctive qualities of "yellow criminality" in the region. In an 1887 publication, Lorion insisted that without "knowledge of the violent emotions of European social life, its refined joys, nor its profound miseries," mental illness remained a rarity among the Vietnamese. Instead he characterized the Vietnamese personality as fickle, patient, easygoing and fatalist, declaring Annamite life "more vegetative than intellectual."[1] These observations helped to explain the idiosyncratic nature of crime in the colony distinguished by few violent episodes or crimes of passion. In Lorion's estimation, due to fundamental differences driving "yellow" and "white" forms of criminality, importing modern penal methods from France to Cochinchina would be of little use.[2]

Yet almost twenty years later, the "criminally insane" person would emerge in French Indochina as its own medical-legal category, one that required special forms of expertise and special forms of protection modeled after those in the metropole. This occurred against the backdrop of a major expansion of psychiatric services in Indochina including the

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[1] Louis Lorion.*Criminalite et medecine judiciare en Cochinchine*. Lyon: A. Storck, ed., 1887.

[2] See Peter Zinoman. *The Colonial Bastille: A History of Imprisonment in Vietnam, 1862-1940*. Berkeley, CA: University of California Press, 2001, 34-35.

establishment of the colony's first asylum, which opened outside Saigon in 1919. Here I explain this fundamental shift by examining the dynamic interplay between the emergence of a new disease category and the professionalization of psychiatry in Indochina.

Specifically this chapter examines how psychiatric expertise in Indochina was produced locally in cooperation and competition with other actors, particularly members of the colonial penal administration. Until the 1930s, psychiatrists played only a limited role in the criminal justice system, charged with delivering judgments of insanity after a crime had already been committed. These "medical-legal" opinions quickly became a flashpoint of bitter controversy between the colonial medical establishment, prison system and the criminal courts, each of which sought to specify the nature of Vietnamese criminality and the appropriate service to be charged with providing oversight. I argue that battles over the bounds of professional jurisdiction challenge assumptions about the neat alignment of psychiatric knowledge with the goals of a unified colonial state. Instead they expose the competing priorities of prosecutors tasked with the protection of public safety and those of psychiatrists who sought to safeguard their professional autonomy. These contests also generated new opportunities for the elaboration of psychiatric expertise itself.

Throughout the interwar years, psychiatrists came increasingly to focus on the problem of juvenile delinquency as a way to redefine their role as experts and enhance their professional status within the colonial administration. Rather than simply affirm or absolve the criminal responsibility of offenders, psychiatrists located the problem of adult criminality in the abnormal instincts of children that could be identified and managed under their expert care. In drawing attention to the failure of the state to protect children from those conditions that predisposed them to criminal careers, they worked to reposition themselves at the center of debates about child welfare reforms and the moral responsibilities of the colonial state

throughout the interwar years. I argue that situating the history of psychiatry within a wide institutional context - one that looks beyond the strictly medical - provides a more nuanced account of psychiatric expertise as not only a tool of colonial violence.[3] In turning their attention to juvenile delinquents, for example, psychiatrists sought to expand their expertise by also making the system more therapeutic.

This approach represents a departure from the work of other colonial scholars who emphasize how psychiatry offered a new scientific language for talking about race and the asylum itself as a symbol of colonial power. Meanwhile the social histories of the institutions themselves, and how they functioned in local colonial political systems, remain largely unexplored. In this chapter I draw from the literature on the sociology of the professions to consider how professional fields of knowledge and practice, and the boundaries that come to separate them, are defined in relation to each other. In particular, Andrew Abbott's concept of "jurisdiction" provides a way of thinking about the relationship between a profession and its work and the kinds of competing claims that drive this boundary making.[4] While Abbott focuses on who has control, and over what kind of task, the question of what arrangements must be in place for a task to be accomplished, and through what processes these arrangements are created, is largely left aside. Gil Eyal takes up this analysis of jurisdictional struggles by tracing how forms of expertise - analyzed as networks that link together objets, actors, techniques, devices and institutional and spatial arrangements - are gradually

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[3] In the context of French North Africa, Richard Keller similarly writes against dominant tropes in the historiography of colonial psychiatry by exposing the "paradox of how a responsive, nuanced medical circle that positioned itself at the cutting edge of mental science could be at the same time a violent, uncomprehending racist organism." Keller (2007), 8.

[4] See Andrew Abbott. *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press, 1988.

assembled.[5] Here I examine the jurisdictional claims of colonial psychiatrists and prosecutors within the broader context of the shifting priorities of the late colonial state.

This chapter also contributes to the history of criminality in Southeast Asia. Much of this literature has been animated by the work of John Furnivall who wrote in the 1930s on the history of British colonial rule in Burma. He drew attention to the ways in which the formation of the colonial state, what he referred to as "Leviathan," also created the conditions that led to the spread of criminality; by introducing a modern legal apparatus, the colonial state codified offenses for the first time as "crimes" that could be ajudicated, punished and counted. Following Furnivall, Southeast Asian scholars have since examined the conditions under which a distinctly modern notion of crime became "thinkable," whether due to the penetration of the capitalist economy and the forms of disruption and inequality that followed, or with the formation of the colonial, and later national, state. More recent work explores the centrality of the criminal to nationalist narratives and the formation of modernity in Southeast Asia, describing the criminal figure alternately as a vehicle for the reproduction of community identity, as an expression of anxieties about the foreign, and as a site for exploring fantasies of revenge. In this chapter, I examine the role of an emergent class of experts in promoting new ideas about criminals and their management, particularly in terms of identifying "abnormal" children as a reservoir of potential future offenders who required oversight from an early age.[6]

The history of psychiatric expertise in Indochina is presented here in two main sections: the first examines the practice of certifying lunacy for the criminally insane. I draw

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[5] Gil Eyal. For a Sociology of Expertise: The Social Origins of the Autism Epidemic. *American Journal of Sociology* (forthcoming).

[6] Vincente L. Rafael. "Introduction: Criminality and its others" in *Figures of Criminality in Indonesia, the Philippines and Colonial Vietnam,* Vincente Rafael, ed. Ithaca, NY: Cornell Southeast Asia Program, 1999.

principally on medical-legal reports found in patient case files in both Vietnamese and French archives. I use these reports to demonstrate how battles over jurisdiction were instrumental for the production of psychiatric expertise while also highlighting alternative forms of claims-making by prosecutors and generalist doctors who tested the limits of psychiatric authority. The second section examines how psychiatrists attempted to go beyond providing opinions that targeted the diagnosis and treatment of individuals. Instead, by joining a colonial reform movement dedicated to the protection of juvenile delinquents, psychiatrists increasingly pitched their expertise as helping to answer the social question of crime prevention. While psychiatric efforts to transform the colony's criminal justice system ultimately fell short, I argue that tracing the history of psychiatric expertise nevertheless reveals important shifts in ideas about the relationship between race, mental health and criminality, and yields critical insight into the complex alliances and fractures that characterized the everyday administration of empire in French Indochina.

II. Certifying insanity: the history of the medical-legal reports

A hallmark of modern psychiatry is the legal requirement of certification, or 'legitimation' of insanity by a medical practitioner, as a precondition for entry into asylums. The act of certifying not only divides the mentally ill from the sane but also introduces important financial and administrative obligations since all those who are certified as insane require immediate transfer into psychiatric care.[7] In this section, I focus on the practice of

[7] See David Wright. "The certification of insanity in nineteenth-century England and Wales." *History of Psychiatry* (1998): 267-290.

certifying lunacy for accused criminals to reveal a basic tension between the penal and medical establishments over the diagnosis of patients and the attribution of responsibility for their care. In Britain's East African colonies, historian Sloan Mahone has argued that the process of lunacy certification provides a snapshot of the medical and political tensions that existed between the medical establishment, prison system and the criminal courts.[8] Here I want to take Mahone's claim a step further by arguing that these tensions were actually constitutive of psychiatric expertise itself.

Following the 1918 decree regulating confinement and care at the Bien Hoa asylum outside Saigon, experts in Indochina were tasked with assessing the criminal responsibility of accused individuals and, following a period of observation, to recommend or advise against punishment. According to the decree's authors, the formal establishment of the "medico-legal opinion" was designed to protect the public's safety as well as the rights of patients against abuse and wrongful confinement. This constituted a vital improvement over prior measures where expert opinions were either provided ad hoc or rendered meaningless given the lack of services at the administration's disposal.[9] For psychiatrists, providing medical-legal opinions also represented an important opportunity to publicly elaborate their knowledge base and expand the legal basis for their authority into the criminal courts. Here I follow the work of David Wright who argues that in Britain the process of certification assumed a central role during the period of the professionalization of medicine. For Wright, certification serves as an indispensable "case study in the way in which the 'normalizing gaze' actually constituted the

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[8] Sloan Mahone. Psychiatry in the East African colonies: A background to confinement. *International Review of Psychiatry* 18,4 (2006): 327-332.

[9] It is possible to find examples of indigenous tribunals adjudicating criminal responsibility on the basis of medical opinions according to the Annamite legal code, prior to the 1918 regulations, resulting in the sequestering of the accused at home under lock and key. See *Trung Tam Luu Tru Quoc Gia I* (TTL1), Résident Supérieur du Tonkin, 73751, Au sujet de [...] Ngôn, April 12 1916.

superimposition of power and knowledge relations by an emerging medical profession."[10] In other words, the power granted psychiatrists to certify insanity created new opportunities for the production of specialist knowledge that in turn reinforced the professional authority to confine.

However, I want to emphasize that certification of insanity in Indochina did not result in the straightforward, progressive medicalization of the confinement process. Rather medical-legal reports are marked by the use of increasingly sophisticated and technical language alongside more generalized impressions of patient appearance or demeanor, including lay observations of behavior gathered from family members and neighbors. Furthermore, expert opinions regarding the responsibility of criminal offenders were subject to frequent challenges by other members of the colonial administration. For those officials increasingly concerned with preserving social order, the ability to send disruptive people to asylums emerged as a useful public security strategy, as well as serving to divert traffic from prisons to asylums.[11] Prosecutors would therefore often contest the conclusions of psychiatrists on the grounds of public safety, especially when they recommended the release of patients back to society or their return to the prison system. Psychiatrists, meanwhile, deplored the wrongful confinement of patients as they were also forced to grapple with the errors committed by generalist doctors. Here I draw on examples from individual cases to explore how these conflicting priorities played out in debates over the diagnosis of patient mental illness.

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[10] Wright (1998), 269.

[11] The total prison population in Indochina grew from 18,340 in 1913 to 29,871 in 1941. See Zinoman (2001), 48.

In 1918, Indochina's first asylum was established outside Saigon along with the colony's first regulations around psychiatric institutionalization, including the introduction of the medical-legal opinion. To briefly recount from Chapter 3, as in France, there were two principal ways people could find their way into the asylum. A "*placement ordonné*" or "mandated placement" was requested by the administrative authorities, while the other, a "*placement requis*," was initiated by the patient's family, relatives or friends. Each required a medical certificate confirming an insanity diagnosis and issued only on a temporary basis. At the end of six months, confinement could become permanent depending on the medical progress of the patient. Psychiatric expertise also became routinized as part of the internment process, working to expand the legitimate terms of confinement. The 1930 law, for example, extended the grounds for confinement under a *placement ordonné* from disturbing public security, tranquility or decency (as explicated in the 1918 regulations) to include more medically grounded justifications for those who risked their "own security or possibility of cure."[12]

Criminals suspected of mental illness were subject to a special set of procedures. They were to be transferred from their holding cell to special sections of hospitals (or prisons) where they would be put under psychiatric observation. In urban centers, these exams would be performed by specialists in major hospitals, which, by the 1930s also housed mental health clinics, and in rural areas, by doctors with basic psychiatric training at best.[13] The limited

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[12] People could also request their own internment under a "*placement volontaire*." See Pierre Dorolle, *La Législation Indochinoise sur les aliénés: Exposé et commentaire des dispositions du décret du 18 juillet 1930*. Saigon: Imprimerie A. Portail, 1941.

[13] For French psychiatrists in Indochina, expertise denoted not just basic specialist training but also knowledge of the local language which was considered "absolutely indispensable." TTL1, Résidence Supérieur du Tonkin, 73745, Etat des propositions présentées à l'Inspection Générale des Services Saniatires pour l'application au Tonkin du Décret du 18 Juillet 1930 sur l'assistance psychiatrique; TTL1, Inspection General de l'Hygiene et Santé Publique (IGHSP), 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934.

number of experts in the colony, however, emerged as a major problem and would continue to plague the colonial administration throughout the interwar years.

In the course of the criminal trial, experts were required to produce "medico-legal reports" that addressed the following two questions: is the individual dangerous to himself or to others? If so, should he be held accountable for their actions and punished or should he be acquitted and confined in an asylum for treatment and care?[14] Doctors based their medico-legal reports on a period of direct patient observation as well as interviews with the patient's family and neighbors. Reports included crucial information such as age, profession, and place of birth. They also detailed the patient’s family medical history, usually indicating the presence or absence of alcoholism and other disorders associated with “degeneracy,” as well as the motivating circumstances that led to their arrest. Reports tended to merge this background information with remarks on the patient's physical symptoms and demeanor, as well as impressions of the patient's degree of socialization, observing for instance how they would respond to questions and how they related to other people or objects in the room.[15]

An important aspect of diagnosis and determination of criminal responsibility also included assessments of whether the patient was aware they had committed a crime and risked imprisonment and, if so, whether they felt at all guilty or repentant.[16] Diagnoses also relied on moral determinations derived from the nature of the crime itself, "This criminal act which we have just related seems to be the act of an individual momentarily deprived of all reason

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[14] TTL1, Mairie de Hanoi, 5781, Internement des indigènes et européens à l’Asile d’aliénés de Bien Hoa, 1925.

[15] See for example TTL1, Résidence Supérieur au Tonkin, 73752-01, Rapport Médico-Légal a.s. du nommé [...] Hang, 30 December 1919.

[16] TTL1, Résidence Supérieur au Tonkin, 73741, Rapport médico-légal, d’examen du [...] Cac, 57 ans, cultivateur, détenu, February 4, 1928.

because if not it would have to be considered the crime of a sadist. This latter position is too difficult to grasp if we consider this elderly person, partially disabled and infirm, timid and mostly sweet during his normal state, such is the accused."[17] The language of these reports varies between highly technical, scientific terminology, affirming the special status of psychiatric knowledge, with more colloquial expressions, perhaps as a way to more directly address a lay audience, "In one word, this is a peasant who will always be primitive and whose minimal intelligence is in the process of deteriorating as much as possible under the influence of senility."[18]

Following a mental illness diagnosis, the medical expert would then issue an "*ordonnance de non-lieu*" and recommend to the courts the patient's removal to the asylum for treatment. While the 1930 law called for asylum pavilions designated for the criminally insane, to be named after the famous French theorist of degeneration, Benedict Morel, plans for their construction were plagued by delays. In the meantime, criminals found themselves temporarily in the wing for 'agitated' patients regardless of their diagnosis. To give a sense of the numbers of criminals sent to asylums and the kinds of crimes for which they were accused: In 1926, out of 600 patients residing at the Bien Hoa asylum, 56 were criminals (or approximately 9.3% of the total asylum population). They were described as "alcoholics and degenerates...which comprise the majority of simple delinquents."[19] In 1931 alone, 19 criminals entered Bien Hoa out of a total 165 patients, or 11% of all those newly admitted. This included 15 who were charged with theft or violence against others, up from four admitted in this crime category the

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[17] *Ibid.*

[18] *Ibid.*

[19] Dr. Roussy. Rapport sur le fonctionnement de l'Asile d'Aliénés de Bienhoa (Cochinchine). *Annales de médecine et de pharmacie coloniales* 24, 1926.

previous year. In his annual report to the administration, the asylum director attributed this increase to the consequences of the "troubling economic situation" which had resulted in a rise in crime, as well as the dangers of alcoholism which he warned had "made serious progress in the colony over the last five years."[20]

In 1928, the Chôquan Hospital in Saigon opened a psychiatric service alongside a special section of the hospital reserved for those accused or convicted of crimes. Together they allowed for the surveillance and clinical supervision of criminals and delinquents suspected of mental illness. This coordinated service was described as a significant improvement over the metropole that had yet to implement similar measures. The service not only offered a place to conduct psychiatric observation, and therefore provide an important legal role in terms of diagnosis, but it was also hoped with the future expansion of service it would be able to prevent serious crimes before they were committed. In 1934, the service received a "countless number" of "mentally disturbed delinquent minors" picked up for "theft, scandal, rebellion and minor injuries" as well as 11 criminals accused mainly of murder or attempted murder and arson. They were diagnosed with a range of mental disorders including idiocy, mental confusion, epilepsy, melancholy, dementia, mania and "mystical delirium." Following a study of the records of these criminal patients, the director of the service determined that 10 out of the 11 cases had previously shown signs of mental problems but for diverse reasons (ignorance, inability to cover the costs of hospitalization, etc.) families or villages had conserved the sick at home rather than present them for care.[21]

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[20] TTL1, IGHSPI, 48-05, Rapport Annuel de l'Asile d'Aliénés de Bien Hoa, 1931.

[21] TTL1, IGHSPI, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hôpital de Chôquan en 1934. See also Chapter 3 for a more detailed discussion of the open psychiatric service at Chôquan Hospital.

When experts issued judgments that appeared consistent with the wishes of the police and judiciary, an easy working relationship followed. But this was not always the case. Rather the medical-legal opinion became an important source of conflict among the different branches of the colonial administration throughout the interwar years. In 1928, for example, a patient named "Dung" was accused of killing his wife. Suspected of mental illness, he was put under the observation of the director of Lang Son Hospital who determined that Dung was insane and therefore should not be held responsible for his crime. The Prosecutor General in Hanoi subsequently registered his opposition to this "*ordonnance of non-lieu*" with the President of the Provincial Tribunal of Langson, claiming that the medical-legal exam "did not appear to him to be sufficiently in depth and the conclusions only hypothetical."[22] In a letter challenging the expert opinion, the Prosecutor drew on additional information he had obtained from Dung's neighbors and village notables with whom Dung apparently enjoyed friendly relationships. Evidently "nobody suspected that he was [...] mad." Indeed Dung's psychotic periods, as described by those who knew him best, seemed largely unremarkable; he did not dance or sing, destroyed no objects and hurt no one. These periods reportedly only occurred once or twice a day and would not last for long, immediately after which he would return to his normal behaviors and routine. The Prosecutor concluded with a request for a second opinion by a Doctor Naudin, specifically citing his "specialization in these types of questions," and requested the removal of Dung to the Indigenous Hospital of Hanoi (for which Naudin served as the director) for further observation.[23]

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[22] TTL1, Résidence Supérieur au Tonkin, 73748-02, Le Procureur Général, près la Cour d'Appel de Hanoi, à Monsieur le President du Tribunal Provincial, Lang-Son, July 4, 1928.

[23] *Ibid.*

This episode provides two critical insights: first, the reliance on indigenous knowledge and experience (privileged even above the expertise of the French doctor) which here is mobilized by the Prosecutor General to build his own narrative in the pursuit of the prosecution of Dung. Second, it demonstrates the distinction increasingly drawn between specialists and non-specialists. It was those opinions, however, where psychiatrists found the accused to be "sane" that drew the most fire. This included opposition over decisions to send patients back to the judiciary for sentencing or those individuals, previously charged with crimes and sent to the asylum, who had since recovered from their mental illness and deemed fit for social life. According to the law, special procedures were to apply to the release of criminal patients. If a patient was cured before the length of their prison term had elapsed, they were to be delivered back to the penitentiary where they would serve out the remainder of their sentence. If a cure did not arrive until after the term had expired, they would remain at the asylum until they were deemed healthy enough to return to society. In practice, most criminals had long since been transferred to pavilions with calm patients and treated like the others. This meant that once declared cured these patients were eligible for immediate discharge.[24]

Security and police forces most often articulated their challenges to expert opinions in the name of public safety, typically by underscoring the possibility that an individual's mental illness could come back. Long stretches between bouts of mental illness, in the words of one Prosecutor, "proves that the mistaken appearance of current calmness" has actually little to do with the underlying foundation of mental illness. He continued, cautioning, "Recent examples taken from the judicial records in France demonstrate the inconveniences that have resulted

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[24] In some cases, once declared cured, former patients would be reintegrated back into prisons, otherwise they would be sent home to families who would assume responsibility for their care. TTL2, Goucoch, IA.8/276(2), Rapport Annuel de Bien Hoa, 1924.

from giving freedom to criminals due to short periods of mental disorder."[25] These scenarios warning of the potential return of mental illness raised the difficult question over how to balance individual liberty as guaranteed by asylum laws against risks to public security. As signaled by the Police Commissioner of Hanoi in 1939, "It is to be wished that [the released criminal] does not make poor use of his recovered freedom and that he does not prove to be a future danger to the public." [26] There was also the question of what to do with those who were perceived as threats to the public's safety on account of mental illness but whose condition was not serious enough to merit asylum care.[27]

Debates between doctors and the police were framed not only by the competing imperatives of individual freedom and public safety but also pitched at the level of efficacy. Were accused individuals more likely to respond to the sanction of punishment or care in an asylum? For psychiatrists, answering this question required distinguishing simply 'abnormal' or deviant behavior from true mental illness. Making these distinctions proved to be the bread and butter of psychiatrists' efforts to expand their expertise in the criminal courts. In May 1925, Andre G., a twenty-two year old *métis* guard of the Public Works in Kampot, after found wandering the streets, demanding aid and making violent threats to kill others, was confined at the Bien Hoa asylum. Dr. Levot, the medical expert with the Assistance Médicale in the city of Cantho, charged with his initial examination, concluded in his report that Andre is "antisocial"

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[25] TTL2, Goucoch, IA.8/155(2), Le Procureur de la Republique près le Tribunal de 1ère instance de Mytho, à Monsieur le Procureur Général, Chef du Service judiciare de la Cochinchine et du Cambodge à Saigon, June 1, 1898.

[26] TTL1, Résidence Supérieur au Tonkin, 7376-02, Note de F. Faugère, Commissaire de Police (Hanoi) pour Monsieur le Contrôleur Général de la Sûreté, Chef des Services de Police au Tonkin. August 10, 1939.

[27] Colonial doctors also worried over individuals who they accused of faking their mental illness so as to avoid prison. See TTL2, Goucoch IA.8/281(1), Le Médecin Directeur de l'Asile de Bien Hoa à Monsieur le Gouverneur de la Cochinchine, au sujet de [...] Vo, June 15, 1924.

and could, given the occasion, commit a serious offense. He therefore argued, "In my opinion prison is illogical because this is someone who is of weak or rather infirm mind and any sanctions will therefore be ineffective as can be proven by his resistance to the numerous previous sanctions for which he has been the object."[28]

Two weeks later, after his transfer to Bien Hoa, Dr. Roussy, the asylum's director, concluded that the nature of Andre's mental illness was no longer "sufficient" to require his continued stay in the asylum. While admitting that he would likely continue to commit crimes after his release, Roussy argued, "imprisonment should be required rather than confinement," determining that his "responsibility seems only slightly diminished."[29] He was finally released from Bien Hoa in February of 1926, after months of protestations, from both Andre himself and the asylum management. A couple months later, however, Andre once again returned. When Dr. Augagneur, the new director of Bien Hoa, pressed for the details of the circumstances motivating Andre's re-commitment, he was presented with a laundry list of various "eccentricities": living by himself in a grass hut near the theater, shouting calamitous warnings in the street, forcing coolies to pull him around in rickshaws for hours, and demanding money from passersby, including forty piasters from the Governor of Cochin China, a request personally made in the Governor's own office. Augagneur contested the grounds for confinement in a letter to the Governor General arguing that, "From these reports one can only affirm the conclusions of both my predecessor and myself that Andre G. is mildly mentally retarded, amoral, lazy, perverted, violent at times and perfectly capable of injuring those who refuse his demands. But he does not remain less than perfectly responsible

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[28] TTL2, Goucoch, IA.8/281(2), Rapport Médico-Légal par Dr. Levot, fait à Cantho, May 7, 1925.

[29] Roussy, as quoted by Augagneur in TTL2, IA.8/281(2), Goucoch, Médecin Directeur de l'Asile de Bienhoa à Monsieur le Gouverneur de Cochinchine, August 10, 1926.

for his acts, this is not a mentally ill person, his place is not in an asylum. If Andre G. finds himself accused of any crimes, he must respond to the Tribunal."[30]

The difficulty in resolving the disagreement between psychiatrists and the police had their practical effects in the itineraries of patients who seemed to endlessly cycle in and out of asylums, prisons and family homes. The story of one patient named "Sau" provides a striking example. As noted in his 1921 case file, when Sau first entered the asylum, "His exit can be envisioned, but under the condition that the family can take care of him because, mentally impaired and without surveillance, he will start again to pursue a life of debauchery, laziness and vagrancy which will lead him all over again to the prison or asylum."[31] The observation proved prescient. Two years later, in June 1923, Sau found himself back at the asylum after being accused of murdering a Chinese man. Dr. de Baudre, of the *Hôpital Principal* in Saigon, charged with providing an expert opinion in the case, found Sau to be insane and recommended his confinement. Yet he used Sau's case to warn of a broader pattern in which "the existence of these individuals is a vast cycle where prison and asylum alternate with phases of liberty when they commit minor offences, misdemeanors and crimes which lead to a new confinement."[32]

Yet almost six months later, Sau had yet to present any symptoms of mental illness. His continued presence at the asylum, however, was justified on the grounds of a prolonged observation. Eventually Dr. Roussy, the director of Bien Hoa, recommended his release,

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[30] TTL2, IA.8/281(2), Goucoch, Le Médecin Directeur de l'Asile de Bien Hoa à Monsieur le Gouverneur de Cochinchine, August 10, 1926.

[31] TTL2, Goucoch, IA.8/281(2), Certificat Semestriel de [...] Sau, fait par Robert à Bien Hoa le 18 Juin 1921.

[32] TTL2, Goucoch, IA.8/281(2), Le Procureur Général près la Cour d'Appel de Saigon à Monsieur le Gouverneur de la Cochinchine, June 29, 1925.

stressing above all his qualities as an inveterate alcoholic, lazy and libertine. Roussy argued that Sau was "much better suited to Prison than to the Asylum; in my opinion he should only be brought to justice at the prison; intoxication and alcoholism should never be considered attenuating but rather aggravating circumstances."[33] He opposed the conclusions of Dr. de Baudre, even going so far as to accuse de Baudre of allowing his knowledge of Sau's first stay at the asylum to bias his expert opinion in favor of confinement.

While Roussy expressed concern over the legality of retaining a patient once cured, the Prosecutor General mounted a vociferous objection to Sau's release warning of his danger to society. He too cited the earlier medico-legal report provided by Dr. de Baudre but argued that a consideration of early violent episodes was an act of common sense, not bias, noting "in the future, one should not lose sight of earlier precedent." In any event, he warned that even if the advice of the asylum director is followed, and Sau is tried at court, the defense would not fail to establish the insanity of the accused, and he would be sent again to the asylum from which he would again be released. The discharge of Sau would therefore simply recommence "the conflict between the Medical Administration and Judiciary Service in another form."[34] As a result, in this particular case, the Prosecutor wrote, "these considerations exposed, I can only give advice to the Director of the Health Service while clearing, for the future, the responsibility of my service."[35]

Indeed for both doctors and prosecutors, the concern to establish clear jurisdiction over these cases also required determining the limits of responsibility, as a way to protect

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[33] TTL2, Goucoch, 276(2), Le Médecin Directeur de l'Asile de Bien Hoa à Monsieur le Gouverneur de la Cochinchine, April 22, 1925.

[34] TTL2, Goucouch, IA.8/281(2), Le Procureur Général près la Cour d'Appel de Saigon à Monsieur le Gouverneur de la Cochinchine, June 29, 1925.

[35] *Ibid.*

themselves and their service from potential accusations of negligence. Take for example the case of "Cuu" who murdered and proceeded to cannibalize his young victim.[36] A couple weeks before the incident, the Prosecutor of Cantho had released Cuu to his family without pressing criminal charges, in spite of a medico-legal report that confirmed his mental illness and need for confinement. In this case, the Prosecutor's office did not mount a challenge to the expert diagnosis but had instead completely disregarded it and as a result, failed to prevent the murder. The burden of negligence therefore fell on the Prosecutor's department as well as that of the Provincial Chief. The case also proved to be a local sensation in the newspapers, generating considerable public pressure on the colonial administration to take accountability.[37]

Colonial psychiatric services also came under fire from the Prosector's Office itself. In the summer of 1933, a patient named "Nguyen" died while receiving treatment as a patient in the psychiatric ward at the *Hôpital Indigène du Protectorat.* In the words of a nurse who was present the day of the incident: "Similar events as this are perfectly possible in a space where fifty individuals of more or less 'turblent' nature are installed and quarrel at every instant with different motives. Whatever kind of surveillance is exercised, however vigilant, one cannot prevent these quarrels. It is therefore very likely that Nguyen, finding himself at the edge of the bed, had an altercation with his neighbor and that he was pushed by this person, causing him to fall on the ground. The fall, even from not a great height, may have caused the rupture of an already fragile spleen." Dr. Naudin, the presiding doctor of the psychiatric ward, also blamed the incident squarely on conditions marked by a "precarious installation," noting, "It would be difficult to make it more efficacious given the actual conditions. As a result, one

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[36] TTL2, Goucoch, 1363, Négligence commise par le Parquet de Cantho sur un individu atteint d'aliénation mentale, 1926.

[37] ANOM, "Cantho - Anthropophage" in *L'opinion*, April 20, 1926.

cannot attribute the cause of death to the negligence of the surveillance. It must be thought of as an act of fortune that could not be avoided." Indeed even by 1933 Naudin was still waiting for the Voi asylum to open its doors and relieve some pressure on his service to care for all the mentally ill in the region.[38] Yet despite Naudin's best efforts, the Prosecutor General tasked the Police Commissioner in Hanoi with an investigation in order to ascertain the possibility of a "certain negligence in the surveillance of the mad which may motivate in this instance an intervention and administrative sanctions."[39]

Colonial psychiatrists thereby grew increasingly frustrated, complaining that their expertise was under-appreciated or simply bypassed. These frustrations were born of the challenge of working within a justice system concerned with punishing criminals rather than appreciating crime as a social and medical problem whose management required a special set of skills and expertise. Generalist doctors also complicated the efforts of experts to consolidate the authority of psychiatric knowledge by offering conflicting opinions that were often then mobilized by a dissenting judiciary. Medical-legal opinions provided by generalists also signaled the more fundamental problem of the lack of expertise in the colony. As one psychiatrist noted with clear frustration, "The magistrate is left with the responsibility of calling on experts, who (in the provinces) does not always possess the psychological rudiments necessary for his profession. It is thus how we have examined several criminals who have already been convicted and how, in a province in the Delta, the judge received an order to not use mental expertise or autopsies because the provincial budget would not support the cost?"[40]

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[38] TTL1, 73742, Rapport du Dr Naudin, médecin traitant au service de psychiatrie, August 5, 1933.

[39] TTL1, 73742, Le Procureur de la République près le Tribunal de 1ère instance de Hanoi, à Monsieur l'Inspecteur Général de l'Hygiène et de la Santé Publiques, HANOI, July 24, 1933.

Even prior to their first conviction, "The author of a crime is often known as a violent or dangerous person or presents anomalies of behavior. Sometimes, he is the object of simple police investigations, other times, he is admonished by the authorities, but always the most rational measure, the psychiatric exam, is not practiced."[41]

III. Turning to juvenile delinquents: the move towards prevention

In the second half of this chapter, I turn to how colonial psychiatrists, frustrated by their lack of influence, began to carve out an expanded role for themselves that went beyond individual determinations of insanity and instead focused on the social question of juvenile crime. By locating the problem of youth criminality in abnormal instincts that could be identified and managed by experts, psychiatrists worked to reframe the problem of juvenile delinquency in Indochina around the twin imperatives of prophylaxis and rehabilitation. Throughout the 1930s, colonial psychiatrists increasingly turned their attention to identifying and treating 'abnormal' children before they became fully pathological, emphasizing early screening and treatment that would re-route the movements of juvenile delinquents through their expert care. By offering new explanations for the patterns of youth criminality that tied social circumstances to individual pathology, psychiatrists worked to align themselves with a broad reform movement that included prosecutors, doctors, lawyers, educators and social workers.

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[40] Roger Grinsard. L'enfance coupable au Tonkin. *Revue Médicale Française D'Extrême-Orient*, 16, January 1938.

[41] *Ibid.*

Juvenile delinquents typically only appear in the historiography as a way to illustrate the shortcomings and pre-modern character of the colonial prison system.[42] Yet as I argue below the fact that children continued to be found in adult prisons throughout the 1930s implies more than just a general failure of Indochina's penal system. The notion that children were different from adults, and therefore required a distinct set of laws and forms of punishment, signified not only their special status encoded in French legal tradition but also an increasingly sophisticated field of expert knowledge and practice. Throughout the 1920s and 30s, the gap between metropolitan discourses and colonial practices around juvenile delinquency appeared all the more striking to colonial administrators and experts concerned with the rise of youth criminality and the limits of reformatories that looked more like penal colonies than "houses of re-education." Debates over how to reform the system drew on the work of metropolitan reformers to elucidate new ideas about childhood and the origins of deviant behavior. Rather than locate the history of juvenile delinquency within a history of the colonial prison, here I situate its development in the context of an emerging child health movement in Indochina and the proliferation of state institutions dedicated to the protection of children. While scholars have largely insisted on the absence of a rehabilitative impulse in the colonial penal literature, I suggest that this absence may be ascribed to an increasing division of labor among a new class of experts during the interwar period.

The impetus behind reforms in Indochina must also be understood as part of metropolitan changes during the first half of the twentieth century when reformers in

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[42] See Zinoman (2001). Histories of colonial children and childhood in Indochina meanwhile remain almost exclusively concerned with the problems posed by *métis* children. Emmanuelle Saada. *Les enfants de la colonie: les métis de l'Empire français entre sujétion et citoyenneté.* Paris: La Découverte, 2007; Christina E. Firpo. Lost Boys: "Abandoned" Eurasian Children and the Management of the Racial Topography in Colonial Indochina, 1938–1945. *French Colonial History* 8 (2007): 203-221; Ann Laura Stoler. "Sexual Affronts and Racial Frontiers: European Identities and the Cultural Politics of Exclusion in Colonial Southeast Asia" *Comparative Studies in Society and History* 34,3 (1992): 514-551.

psychiatry, social work and law transformed France's punitive juvenile justice system into a profoundly therapeutic one.[43] In France, the notion that incarcerated minors should be separated from adult prisoners and receive education in specialized institutions was established in 1810 by the Napoleonic Code. The Code also first introduced the concept of discretion - or determining a child's criminal responsibility based on whether he or she understood the difference between right and wrong - as a way to reconcile notions of punishment with protection for minors. But how to distinguish the guilty from the innocent, and increasingly to question if that distinction was relevant at all, animated debates over juvenile justice reforms between France and its empire throughout the early decades of the twentieth century.

As historian Sarah Fishman has underscored, psychiatric expertise played an important part in metropolitan discussions over juvenile justice reform; by introducing new medicalized understandings of childhood and deviance, psychiatrists worked to shift the focus of juvenile justice from the criminal act to the characteristics of the child himself.[44] Georges Heuyer, a founding figure in child neuropsychiatry, assumed a major role. He argued that recidivists (who, he wrote, incidentally comprise the majority of the prison population) most often demonstrate evidence of antisocial tendencies from their childhood or adolescence. In pronouncing "the problem of guilty children is that of adult criminality," Heuyer called for a broad collaboration between judges *and* medical experts in reorienting the juvenile justice system around the principle of prevention.[45] The transformation of the metropole's juvenile delinquency establishment from a punitive system to a profoundly therapeutic one occurred as

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[43] See Sarah Fishman. *The Battle for Children: World War II, Youth Crime and Juvenile Justice in Twentieth-Century France*. Cambridge, MA: Harvard University Press, 2002.

[44] *Ibid*.

[45] As quoted in Roger Grinsard. L'enfance coupable au Tonkin. *Revue Médicale Française D'Extrême-Orient*, 16, January 1938.

part of what Marc Renneville describes as a progressive, if uneven, "psychiatrization of the carceral system" in France during the early decades of the twentieth century.[46] That psychiatrists were most successful in the realm of juvenile delinquency was a point that they themselves often remarked on and took for an important lesson as they sought to expand their influence into other domains of the criminal justice system.[47] For psychiatrists in Indochina, the work of Heuyer and others would serve as an explicit model for practice in guiding their own reform efforts.

State of juvenile justice in Indochina

In Indochina, calls for reform emerged against the backdrop of a juvenile justice system in serious disrepair. Following the model of Mettray in France, the main strategy for addressing the problem of juvenile delinquency in Indochina had been sought in the creation of youth reformatories. In 1904, the colonial state established Indochina's first house of correction for delinquent youths adjacent to the Ong Yem agricultural station in southern Cochin China. A second reformatory, named Tri Cu, was later constructed in the northern protectorate of Tonkin in 1925. For an overburdened judicial system, reformatories represented a clear improvement over the transfer of children to adult prisons or simply back to their parents. Instead, the reformatory took the form of a large agricultural colony where

[46] Marc Renneville. "La psychiatrie légale dans le projet de réforme du code pénal français (1930-1938)" in in J. Arveiller (dir.), Psychiatries dans l'histoire. Actes du 6ème congrès de l'Association européenne pour l'histoire de la psychiatrie. Presses universitaires de Caen, 2008, pp. 385-405.

[47] See Paul Schiff. La prophylaxie criminelle et la collaboration médico-judiciare. *Revue de science criminelle et de droit pénal comparé* (1936): 479-492.

young Vietnamese male delinquents would learn labor skills and principles of moral discipline that would rehabilitate them into "honest workers."[48]

Within the institution's walls, the attempt to formally segregate the guilty from the innocent, and young children from older, more seasoned delinquents, reflected the ambiguities of the mission of the reformatory as both penitentiary for child criminals *and* as refuge for the indigent and abandoned. Indeed the majority of children ever sent to Tri Cu reformatory ended up there by an administrative decision alone. In practice, however, the enforcement of different regimes of children failed to hold. Colonial reformers grew alarmed at the possibilities of corruption, with one warning that the reformatory, "far from giving the hoped for results…is a center of contamination of the first order because of the presence of incorrigible wrong-doers of an older age."[49] Others insisted that even if physical separation could be achieved, the threat of an "inevitably promiscuity" remained ever present. Keeping children separate formed only one of many everyday challenges that seemed to overwhelm the system: dormitories and lodging of the staff "falling into ruins," lack of potable water, the malnourishment of children compelled to labor and the ineptitude of those tasked with their re-education.[50]

Institutional deficiencies were compounded by the worrisome rise of youth criminality in the colony. Throughout the 1920s, children from the countryside began arriving in Hanoi with such frequency that one police commissioner complained they were "infesting" the city.

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[48] TTL1, Résidence Supérieur au Tonkin, 72060, Note de M. Habert, Directeur du Service de la Justice en Indochine, sur le régime pénal applicable aux mineurs en Indochine, March 28, 1927.

[49] Lê-van-Kim, Docteur en Droit, "La Protection légale de l'enfance." *Congrès de l'enfance à Saigon*, 1934.

[50] ANOM, Gouverneur Général de l'Indochine, 65925, Projet de Créations ou de réformes de colonies de relevèment moral (filles ou garçons), Monsieur le Directeur des Bureaux du Gouvernement de la Cochinchine, Correspondance Privée, Saigon, March 1931.

Aged mostly between 11 and 17 years old, with no family or home, these young vagabonds "proliferated" in the streets and committed petty crimes for which they were either acquitted because of their young age or condemned to prisons and the corrupting influence of adult offenders. As the Police Commissioner of Hanoi protested in 1927, "Very frequently, I will send these young hoodlums back to their own country, without escort, which cannot but cost the Administration. It is, in any event, pointless because we see these undesirables reappear some time later."[51]

Yet children's stories, gleaned from official testimonies gathered during interviews, also served as sobering reminders of the crushing poverty of children in the colony. In 1929, in a letter to the mayor of Hanoi, the Commissioner of Police offered an explanation for the rising tide of daily arrests of children, noting that "almost all have fled their villages, chased by the flooding and finding refuge in Hanoi where, without shelter, without resources, they roam the streets surviving only by begging and theft."[52] For colonial officials, how to rid the city of young delinquents while also acknowledging the social circumstances which led them there - how to navigate between the different impulses of punishment and protection - presented a distinct challenge that distinguished the legal regime of children from that of adults. These stories also highlight the ambiguities of a legal order where being guilty of nothing more than finding oneself alone and poor in a new city, at a young age, meant falling within the purview of the colonial carceral system.

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[51] TTL1, Mairie de Hanoi, 3970, Le Commissaire Central de Police à Monsieur l'Administrateur Maire de la Ville de Hanoi, October 6, 1926.

[52] TTL1, Résidence Supérieur au Tonkin, 56151, Le Commissaire Central de Police à Monsieur le Résident Maire de la Ville, au sujet de l'internement de [...] Thuon à la colonie agricole de Tri Cu (Bac Giang), January 14, 1929.

The system in crisis, the call for reforms to Indochina's juvenile justice system coincided with a broad reorientation of colonial health policy towards child and maternal health in Vietnam during the interwar years.[53] Throughout the 1920s and 30s, a growing interest in child welfare joined with fears over rising youth criminality to prompt discussions about the need to revamp the colony's juvenile justice system. In the late 1920s, the collaboration between religious, private, and public institutions in Indochina grew stronger as those concerned with child protection saw their mission as too important to not overcome any differences of opinion or principle.[54] This collaboration was overseen and coordinated by the Service of Social Assistance from 1929 onwards; youth reformatories were placed put under the purview of the service in that same year.[55]

In 1934, a meeting of the Conference of Childhood in Saigon brought together educators, doctors, lawyers and administrators dedicated to the promotion of child welfare. In particular, the meeting signaled a growing concern with the health of the Vietnamese child and its juridical rights, especially the failure to reform Indochina's juvenile justice system that continued to operate under the 1810 French penal code. France had since instituted a major set of reforms to the juvenile justice system in 1912. Psychiatrists played a major role in the metropolitan reforms; by introducing new medicalized understandings of childhood and deviance, they had worked to shift the focus of juvenile justice from the criminal act to the characteristics of the child himself. Among other innovations, the 1912 law recognized

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53 Laurence Monnais. Preventive Medicine and 'Mission Civilisatrice': Uses of the BCG Vaccine in French Colonial Vietnam between the Two World Wars. *International Journal of Asia Pacific Studies* 2,1 (2006): 41-68.

54 *Ibid.*

55 ANOM, Gouverneur Général de l'Indochine, 65925, Projet de Créations ou de réformes de colonies de relevèment moral (filles ou garçons), Monsieur le Directeur des Bureaux du Gouvernement de la Cochinchine, Correspondance Privée, Saigon, March 1931.

adolescence as a distinct stage of child development, stipulating that all minors between 13 and 18 years old were to be given an obligatory medico-psychological exam. This exam would serve as the basis for determining which outcome would be best for the child (to return them to their parents, place under psychiatric observation or send to a reformatory). [56]

The question over whether to extend the 1912 reforms to the colony included discussions about the similarities of delinquent populations of France and Indochina and to what extent the law's provisions needed to be adapted to local conditions. At the 1934 meeting, colonial reformers debated the creation of special tribunals for children, raising the age of legal majority, and the reinvention of the penitentiary as a "house of supervised education" where children would be transformed from troublesome wards of the state into productive laborers. For a system that had fallen into profound disorder, where those children who had been abandoned by their parents were sent to reformatories alongside others convicted of crimes, the push to rationalize the legal regime for children raised a critical question: to what extent were these populations actually distinct or the same? Are they criminals that need to be punished or vulnerable children in need of social assistance? Who is the juvenile delinquent? Answering these questions required a deeper understanding of the social causes of delinquency, its physical and psychological manifestations, as a way to not only assess the penal responsibility of children but also the responsibility of the colonial state for their rehabilitation.

The modernization of Indochina's juvenile delinquency establishment would require new kinds of data that quantified the pressure on the reformatories to expand and specified the origins of children sent to the reformatory and what happened to them after they left. A commission specifically charged with advising the colonial administration on the re-

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[56] Fishman (2002).

organization of youth reformatories found that the growing numbers of children at the Tri Cu reformatory could be attributed not only to an overall rise in juvenile crime but also to the fact that judges, knowing a special institution for minors now existed in Tonkin, "did not hesitate to pronounce convictions."[57] Whereas judges previously met with little option beyond sending delinquents back to their parents or village, the establishment of youth reformatories generated a reality of juvenile delinquency in the colony that did not exist before. These institutions allowed judges to hand down convictions and recommendations for confinement that could now be captured in crime statistics, and the institutions themselves served as spaces for the study of delinquency through the systematic collection of information on child backgrounds.

Following their metropolitan counterparts, colonial experts discarded the notion of 'discretion' or penal responsibility in order to address the more important question: what caused the minor to misbehave? Reformers, including psychiatrists, worked towards building a taxonomy of social conditions that predisposed children to delinquency as a way to stress the universality of childhood between France and colony. Comparative statistics were marshaled to demonstrate that delinquency, contrary to what might be expected, was not a more pervasive problem in the colony than it was in France. In a 1938 study, the Tri Cu reformatory's chief doctor merged anecdotal evidence with physical and psychiatric exams of children collected over a ten year period to conclude that "we have observed young children whose first offense was nothing but the consequence of the profound misery which confronts the Tonkinese people. Their history is common with all juvenile delinquents: a deficient

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[57] ANOM, Gouverneur Général de l'Indochine, 65925, Le Résident Supérieur au Tonkin à Monsieur le Directeur de l'Administration Judiciare en Indochine au sujet création colonie agricole de Tri-Cu, August 29, 1925; ANOM, Gouverneur Général de l'Indochine, 65925, Etat des mineurs justiciables du Tribunal de 1ère Instance de Hanoi pendant les années 1926, 1927, 1928, 1929 et 1930.

heredity, abandoned by family and society, promiscuity."[58] Vietnamese children, by virtue of their poverty, were also thought to suffer developmental delays rendering them less precocious than those in France.[59] In this way, rather than suggest important differences between colony and metropole, colonial experts tended to stress similarities in the psychology of children and child development as the basis for extending provisions of French laws around juvenile justice to Indochina. By comparing European and Vietnamese children, colonial reformers also tested notions of the universality of childhood itself. Here the specificity of colonial context is offered up not as a way to cast a fundamental difference between European and Vietnamese children but rather to highlight the need for similar if not greater protections for children in Indochina relative to the metropole.

The 1938 study of the children at the Tri Cu youth reformatory described the Vietnamese juvenile delinquent population as "made up of a majority of children on which weighs a heavy heredity of backwardness and perversions...they are undoubtedly abnormal beings."[60] The study, conducted by Dr. Grinsard, the director of the neighboring Voi Asylum, found that most suffered from a state of degeneration ("*dégénéré simple*") which barring early intervention threatened a gradual devolution towards either criminality or madness. Grinsard proceeded to chart the typical development of perverted children, from "anomalies of conduct and character (persistence in the accomplishment of forbidden acts, lying, lack of affection and emotion, excessive development of ego)" through to puberty when they began to engage in illegal activities of vagrancy, gambling, and theft. Grinsard drew on his experience

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[58] Grinsard (1938).

[59] Kim (1934).

[60] Grinsard (1938).

as an asylum director to warn of the potential consequences of high rates of degeneracy among Annamite children, remarking on the example of one child who "presented problems of character with perverse instincts who was interned three times at the Voi Asylum and who escaped each time."[61] Warning of the dangers of those children who had been left to themselves, Grinsard tended to emphasize the exacerbating conditions of social life rather than the inevitability of biological inheritance. As another psychiatrist wrote, in referencing one adult patient at the asylum, "But I believe that his perverted instincts originate not only from possible hereditary predispositions, but also the abandonment to which this young man was left at a certain age. We have often witnessed that these perversions can be created by certain social conditions, these abnormal children are recruited among abandoned children left to their own devices in milieu favorable for the development of base instincts."[62]

Grinsard reported that 55% (or 68 out of 151) of all young *colons* at Tri Cu given a psychiatric exam displayed evidence of "social inadaptation" and displayed symptoms of a "more or less primitive" degeneracy. While he noted that certain delinquents, upon leaving the reformatory, could return to a more or less normal life, Grinsard warned that the majority of those suffering from degeneration possessed the form most commonly found among recidivists. That said, mental disability among children was typically mild; more extreme cases, Grinsard noted, would be destined for the asylum as opposed for the prison. 14 children suffered from intellectual disability and formed the unfortunate "punch bags" of their "more healthy comrades who use them to satisfy the slightest whim." Four children were diagnosed

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[61] Some children were also sent to asylums. In 1938, for example, the Surveillance Commission for the Voi asylum recommended the creation of a pavillion dedicated specifically for children (8 children were interned at Voi at the time. TTL1, Résidence Supérieur au Tonkin, 3753, Procès-verbal de la commission de Surveillance de l'Asile d'Aliénés de Voi, Séance du 15 Juin 1938.

[62] TTL2, Goucoch, IA.8/281(2), Rapport Médico-Légal de André G., fait à Can Tho, le 7 Mai 1925 par le Dr. Levot.

with epilepsy, some of whom would require confinement at the Voi asylum depending on their mental faculties. Heredo-syphilis, on the other hand, was “excessively frequent," proven to afflict at least 43 children who showed the classic symptoms: malformation of the pupils, the absence or slowing of reflexes, etc.

While more than half of all abnormal children shared the diagnosis of “degeneration,” different physical and intellectual symptoms would be more or less pronounced. Alongside the psychiatric exam, a physical exam was also performed, revealing a variety of anomalies of development, including the form, dimensions and volume of a certain number of organs (head, ears, teeth, limbs, genitals, skin, etc). Each organ corresponded to a different point of psychiatric interest. Grinsard betrayed a particular fascination with the phenomenon of tattooing at the reformatory. Apparently 35% (or 60 out of 142) children were tattooed although the custom was apparently thought to be quite rare in the rural areas of the Delta from which most of the *colons* came. [It was observed that all tattoos had been executed either first at the prison, or at the agricultural colony where an older colon used a needle and a mixture of ashes and water for coloration.] Tattoos were considered a “manifestation of individual vanity,” and the form they assumed on children's bodies was thought to reveal a lack of imagination, particularly striking for those especially "desirous to externalize," especially as they only "prove that they are short on ideas." 80% of tattoos were of Chinese characters, followed by roman numerals, quoc-ngu characters, and rarely pictures. According to Grinsard, “The two tattoos worthy of interest represent a tiger and a hunter, the other a pile of manuscripts and an ink well. The Chinese characters, very well done, translate sentences whose moral value could surprise in such a place: “the provinces are tranquil” – “my life will be long and happy” – “I drink tea in the morning and alcohol at night” – etc…Are we far from reading such formulas on the bodies of French juvenile delinquents?”

Children's sexual organs and behavior were also described at length. Grinsard notes that sodomy is "not a unique sign of disability but most often the fruit of promiscuity of prisons." It was no different at the agricultural colony where "almost all colons engage in anal sex."

At the conclusion of his study, Grinsard remarked, "The State must substitute for the father of the family: he must, at the prison, materially and morally educate the young delinquent; and upon his release from prison, he must allow him to honestly make a living. We no longer live in an outdated time when the young delinquent is considered a pariah, but in a time when we see in him nothing but a 'sick person' that society must, if not cure, at least improve, with a goal that is as much altruistic as egoistic."[63] Rather than blaming children for the "multitude of defects, deficiencies, social and moral errors" which drew them into a world of crime, delinquency could be viewed as equally rooted in "their abnormal constitution and the abnormal circumstances of their life."[64] Indeed even Jules Brevie, the Governor General of Indochina, in 1938 began to suggest that there were no significant differences between "young delinquents, abandoned children and little beggars."[65] All required a "regular surveillance of their mental state."[66] While growing attention to the psychiatric designation of children as 'abnormal' seemed to provide a more humane basis for reform, this new scientific language

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63 Grinsard (1938).

64 *Ibid.*

65 ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3907, Le Gouverneur Général de l'Indochine à Monsieur le Ministre des Colonies (Inspection Générale du Service de Santé des Colonies 2ème Section), July 1, 1938.

66 ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3907, Le Gouverneur Général de l'Indochine Jules Brévié à Monsieur le Ministre des Colonies (Inspection Générale du Service de Santé des Colonies 2ème Section), July 1, 1938.

also worked to root delinquency even deeper into child natures and reinforce the perception that a tiny minority among them remained 'incurable perverts.'[67]

If delinquents were more sick than criminal, it followed that the state should adopt a more protective attitude vis-à-vis delinquent children. In debates over reforms, moral imperatives joined with more practical concerns that addressed whether reformatories could effectively rehabilitate children and prevent the emergence of a future class of criminal adults. For many colonial administrators, the reformatory was at its most valuable in its capacity not as a site of rehabilitation but rather as a kind of warning sign, a threat to potential delinquents that they would suffer the consequences of their criminal actions. Yet with growing attention to the social and psychiatric causes of delinquency, colonial reformers increasingly dismissed repression as a viable deterrent and instead insisted on more expansive reforms that included new kinds of pre and post-penitentiary prophylaxis to be rolled out under expert supervision.[68] This language found its way from conferences and the pages of medical journals into the reports of the colonial administration, signaling a broader shift in thinking around the aims and forms of juvenile reforms. A 1927 report on Indochina's justice service emphasized that internment (for minors) would no longer be considered punishment but re-framed as an "administrative order" one that was more "preventive than repressive... modern society should less enforce the punishment of crimes than amend the ready instincts that lead astray."[69]

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[67] Kim 1934.

[68] Trân-van-Ty address at the 1931 meeting of the *Congrès national de droit pénal colonial*, as quoted in Kim 1934.

[69] Rapport au Conseil Supérieur (Gouvernement générale de l'Indochine). Hanoi: Imprimerie d'Extrême Orient, 1927, p. 260.

A series of reforms were proposed. Following the metropole, these proposals envisioned a "close collaboration of the psychiatrist and judge"[70] and fell within two broad camps: the first called for the medicalization of delinquency by routing those children who had already fallen within the purview of the criminal justice system through the care of psychiatric experts. Dr. Pierre Dorolle, a psychiatric expert and diretor of the Chôquan Hospital, recommended the creation of a neuro-psychiatric service charged with examining these "abnormal and delinquent" children before their transfer to the reformatory (of which he estimated there were between 4 and 5,000 in all of Indochina). This new service would respond to the deplorable lack of screening and treatment for children, especially "in a service through which practically all psychiatric expertise passes in Cochin China, not a single juvenile delinquent has been examined in two years."[71] Delinquents destined for Ong Yem would first be removed from the central prison in Saigon to Chôquan hospital for a period of psychiatric observation.[72] The doctor would be charged with providing the director of the reformatory with "all the useful instructions that touched on the physical and intellectual possibilities of the children."[73] After their transfer, children were to continue to be given mental exams every three months by the reformatory's doctor, who also happened to be the asylum director of

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70 ANOM, Résidence Supérieur au Tonkin, 03749, Le Directeur Local de la Santé à Monsieur l'Inspecteur Général de l'Hygiène et de la Santé Publiques en Indochine, August 24, 1938.

71 Pierre Dorolle as quoted in Edouard Marquis. La protection de l'enfance en Cochinchine. *Revue médico-sociale et de protection de l'enfance* 1937: 369-381, 379. In 1935, a psychiatrist was also added as a member of the oversight council at the Ong Yem youth reformatory.

72 Chôquan possessed a center for psychiatry whose open service began in 1928 as an essential complement to the asylum-based system. It also functioned as a specialized service where prisoners were put under psychiatric surveillance and hailed as an important achievement over metropolitan practices. See TTL1, IGHSPI, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'hopital de Choquan en 1934. For more on the open service, see Chapter 4.

73 ANOM, Résident Supérieur du Tonkin, 3907, Jules Brévié, le Gouverneur Général de l'Indochina à Monsieur le Résident Supériur au Tonkin. January 10, 1939.

Bien Hoa. In 1938, observation centers for "abnormal delinquent children" were opened in the hospitals of Cho-Quan (Cochinchina) and Rene Robin (Hanoi).

The second category of reforms called for greater preventive measures, both pre and post-penitentiary. For the juvenile delinquent, who was nothing but a "future recidivist," prophylaxis at an early age, before any crime was committed, was imperative.[74] In 1939, Jules Brévié, Indochina's Governor General, authorized the establishment of a service for "abnormal *non-delinquent* children" where "special consultations would be organized for families who wished to receive advice on treatments for abnormal children who were to be conserved under the family roof."[75] Internment in an asylum should be a last resort.[76] Instead the open service would play a preventative role by performing triage and treatment *"en cure libre."* These proposals reflect wider efforts of the 1930s, detailed in Chapter 4, to reorient the psychiatric assistance program around the principles of mental hygiene and voluntary care. In the context of juvenile delinquency, psychiatrists also called for a more broad-based assault on "social diseases," specifically those with "hereditary repercussions" including: syphilis, tuberculosis, alcoholism and opiomania, the fight against slums and unemployment, the education of mothers, the moral protection of childhood and the prohibition of gambling.[77]

The extension of psychiatric expertise into the juvenile delinquency establishment was imagined as part of a sweeping vision of social reform: "If the rescue of criminal children

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[74] Grinsard (1938).

[75] ANOM, Résidence Supérieur au Tonkin Nouveau Fonds, 3907, Jules Brévié, le Gouverneur Général de l'Indochina à Monsieur le Résident Supérieur au Tonkin. January 10, 1939; See also ANOM, AGEFOM, 238, "En faveur de l'enfance malheureuse et déficiente" in *Bulletin quotidien*, October 4, 1939.

[76] This was considered particularly true for members of the upper classes of Annamite society. Dorolle as quoted in Marquis 1937.

[77] Grinsard (1938).

begins in the courtroom, it ends in the clinics, the patronages and the penitentiary colonies."[78] However the realization of this vision would require not only the creation of new institutions but also the availability of specialists to staff them. At the Lanessan Hospital and Rene Robin Hospitals in Hanoi, for example, psychiatric services were run without the oversight of a fully trained psychiatrist, the only one available stationed at the Voi asylum some 60 kilometers away. In 1939, the local director of the health service in Hanoi, Dr. De Raymond, described his attempts to recruit a specialist for Voi but failed because no candidates applied. De Raymond estimated that a full-fledged psychiatric service would run the Tonkin budget $150,000 piasters. This included the funds to support a position for a permanent specialist with benefits similar to those in France, especially as he would be responsible for treating the clientele of the region *and* providing medical expertise for tribunals.[79]

Lacking the cash, infrastructure and expertise to implement a more comprehensive overhaul of the system, the colonial state instead largely focused its efforts on improving the system already in place, including renaming the reformatory a "house of supervised education."[80] The modesty of these proposals reinforced the more general pessimism that colonial reformatories could ever offer a truly modern form of rehabilitation. Pettelat, the Provincial Chief of Bac Giang province where the Tri Cu reformatory was located, warned those administrators who naively thought that it could "ever be a house of re-education in the

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[78] Kim (1934).

[79] ANOM, Résident Supérieur au Tonkin, 3753, Le Docteur de Raymond Directeur Local de la Santé à Monsieur le Résident Supérieur au Tonkin (1er Bureau), Hanoi, September 21, 1939.

[80] ANOM, Gouverneur Général de l'Indochine, 65925, Projet de Créations ou de réformes de colonies de relevèment moral (filles ou garçons), Monsieur le Directeur des Bureaux du Gouvernement de la Cochinchine, Correspondance Privée, Saigon, March 1931; ANOM, Résidence Supérieur du Tonkin, 2493, L'Administrateur de 2eme classe Pettelat Résident de France à Bac-Giang à Monsieur le Résident Supérieur au Tonkin (Cabinet), August 17, 1937.

ideal sense of the word. Whatever title it may carry, it is nothing but a house of correction for minors...which can never recreate around the lost child a home-like atmosphere. This ambiance can only be found in a family or charitable institution."[81] Deemed more punishing than protective, the growing consensus on the reformatory's limits only went so far as to signal the need to seek alternatives for abandoned children. At the same moment that France was abandoning the penitentiary as a site of juvenile rehabilitation, Indochina thus reaffirmed its own commitment to the reformatory.

While children continued to be sent to penal institutions, projects for the regeneration of abandoned and delinquent youth did achieve some traction, including the creation of agricultural schools and *colonies de vacances*, discussed elsewhere in the literature on French policies towards the *métis*.[82] Jules Brévié, the Governor General, in 1938 for example, envisioned the eventual proliferation of "separate and smaller groups" for delinquents noting, "the multiplication of small agricultural colonies would be ideal."[83] Efforts to expand the state-run system also included the establishment of institutions dedicated specifically to delinquent girls and a home for abandoned children in Thu Dau Mot province where "little liars and petty thieves" were fed and received primary education and professional instruction including carpentry and the tapping of rubber trees.

Colonial officials also reached out to religious and charitable organizations as partners for collaboration, appealing to humanitarian principles in their requests for children to be

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81 ANOM, Résident Supérieur au Tonkin, 3907, L'Administrateur de 2ème classe Pettelat, Résident de France a Bacgiang à Monsieur le Résident Superieur au Tonkin, March 30, 1938.

82 See various newspaper clippings related to the "*colonies de vacances*" for children in ANOM, AGEFOM, 238; See also Christina Firpo. Crises of Whiteness and Empire in Colonial Indochina: The Removal of Abandoned Eurasian Children from the Vietnamese Milieu, 1890-1956. *Journal of Social History* Spring 2010: 587-613.

83 See Marquis 1937.

granted refuge. Yet even modest attempts to rationalize the system by removing those acquitted and abandoned children from reformatories posed its own set of challenges for the colonial administration. The President of the Society of Annamite Children, for example, informed the Resident Superior of Tonkin that it would "not be desirable to receive... those errant children from the streets of Hanoi who are brought to the institution by the police, having escaped the first time [who] will not be able to adapt themselves to the discipline and regular life of the establishment."[84] He considered them bad examples for the other '*petits campagnards*.' In this way, those juvenile delinquents previously conferred to the carceral system instead became increasingly integrated into Indochina's growing social welfare network. However, adopting a more protective role by removing the abandoned children from youth penitentiaries in the end, one might argue, resulted in an even more repressive system for those who continued to be sent there.

IV. Conclusion

Situating the development of psychiatric expertise within a broad institutional context, one that takes us out of the asylum and into the local dynamics of colonial rule, offers a revealing portrait of the everyday challenges of colonial administration. How to address Indochina's crime problem would require new forms of expertise but the content of that expertise, and how it would be weighed alongside other concerns of colonial governance and finance, proved the source of struggles both within the psychiatric profession and across the different branches of the colonial government. As this chapter has argued, the history of the

[84] ANOM, Résidence Supérieur au Tonkin, 3907, Lettre de Yves Chatel à Inspecteur Général du Travail en Indochine, 10 March 1938.

"medical legal" opinion reveals the production of new forms of psychiatric knowledge while also underscoring the particular challenges doctors faced in extending their expertise into the criminal courts. By forming alliances with the judicial branch and social reform movement, I show how psychiatrists sought new markets for their expertise that went beyond individual determinations of mental illness to instead address the social question of crime prevention.

While psychiatrists ultimately fell short of achieving their bold vision for reform, I argue that they nevertheless succeeded in changing the terms of colonial conversations around delinquency to privilege protection over punishment. Here we see how psychiatric expertise can be considered as not just a tool for colonial violence and instead occupied a more ambiguous position. In the case of juvenile delinquents, for example, psychiatrists sought to emphasize similarities with children in Europe as the basis for adapting laws from France to colony. But in attempting to render Indochina's criminal justice system more therapeutic, psychiatrists called for a widened scope for their expertise, including new mechanisms of increased oversight and control that would in some ways lend the system an even more repressive character.

Conclusion

Michael MacDonald opens his magisterial work on the history of psychiatry in seventeenth-century England, entitled *Mystical Bedlam*, with the observation, "Madness is the most solitary of afflictions to the people who experience it; but it is the most social of maladies to those who observe its effects."[1] Mental disorders, more so than any other kind of illness, are profoundly anchored in the social conditions and mores of any particular culture. As Michel Foucault has famously argued, it is by violating the rules of social life that individuals are pathologized and opened up to new forms of expert scrutiny and disciplinary techniques. But this process of social exclusion cannot be grasped from the perspective of the confining institution alone, and historians have since increasingly sought to situate the development of psychiatry within a wider social context. By adopting perspectives that look beyond the asylum, scholars have demonstrated how values attached to "normal" and "abnormal" behavior are assigned and shift on the basis of extensive negotiations rather than the straightforward application of expert knowledge, how material conditions make certain technical arrangements possible and not others, and how patients and their families alike experience confinement. These works are almost entirely restricted to North America and Western Europe while historians of colonial psychiatry remain largely preoccupied with answering a different set of questions. The study of colonial psychiatry tends only to lead in one direction if "colonial" is defined narrowly in terms of racial prejudice or the dynamics of repression and resistance.

In this study, I have instead pursued a social history of psychiatry and mental illness in French Indochina as a way of opening up new avenues for exploring the local dynamics of colonial rule. By examining the relationship between the asylum and the community, I argue that

[1] Michael Macdonald. *Mystical Bedlam. Madness, anxiety and healing in seventeenth-century England.* Cambridge: Cambridge University Press, 1981.

Vietnamese families, French experts and the colonial state became tied together in unprecedented ways. Psychiatry in the colony developed in response to the many competing and overlapping agendas of different actors that shifted with the massive social and economic changes in the region during the early decades of the twentieth century. These new social arrangements created the conditions of possibility for thinking about, quantifying, identifying and treating mental illness as a problem of colonial governance for the first time. I use the legal category of the "*aliéné*" as a way of tracing shifts in perceptions of mental illness as a problem of little interest to colonial administrators to the basis for one of the most robust psychiatric assistance programs in all the empire. This shift occurred as the result of both international pressures to expand mental health services in the colony, as well as the increasing visibility of "madness," especially in urban centers, and the mounting pressures on families who found it more and more difficult to care for their own.

This dissertation has demonstrated how considerations about the mentally ill brought together a wide range of colonial institutions and policies, from concerns over the policing of vagrants and juvenile delinquents to the creation of new forms of social assistance to the complex and varied legal regimes that ruled the colony. The networks that emerged to prescribe and police the movements of the "abnormal" throughout Indochina must therefore be situated within a more fully drawn portrait of the social, political and economic pressures facing the colonial state and its subjects. What it meant to find oneself on the inside or outside of colonial society often shifted with the changing fortunes of individual households, the prerogatives of colonial administrators and the professional ambitions of psychiatric experts.

The social history of Vietnam under French rule is paper-thin and so this study is intended as a contribution to our knowledge of the daily lives of ordinary people. The next iteration of this project will therefore demand a more serious engagement with Vietnamese

language sources in order to better understand how the Vietnamese interpreted mental illness in their own communities. Did they also perceive an increase in the numbers of those afflicted by mental disorders? If so, to what did they attribute the rise? Were different kinds of opinions offered? I have relied on evidence of how French psychiatrists thought they were perceived by the Vietnamese public. Were these French assumptions correct, and for the reasons that were given?

Reading Vietnamese source material alongside official French documentation will also offer a more finely tuned account of how determinations of mental illness were made on the basis of both lay observations and expert opinions. While the categories of "normal" and "abnormal" continued to be framed in Western terms, here I draw attention to the fact that the content of these categories critically relied on the kinds of information Vietnamese were willing or thought relevant to tell French doctors. Even with the introduction of a formal asylum system, psychiatrists continued to depend on families and communities for information, care and surveillance in ways that both expanded and constrained their power as experts. I outlined the confinement and release of patients as a process of negotiation, with debates revolving not only around the mental health of the patient but also the capacity of families to assume their care upon release and the asylum itself as the most appropriate site for treatment and rehabilitation.

In this dissertation I make the claim that Vietnamese families used colonial institutions for their own ends, but we must also recognize that the menu of options available to families was increasingly limited by the stark realities created by the colonial situation. How to talk about Vietnamese families as "agents" therefore requires a more precise articulation of the meaning of indigenous agency in a context where using colonial institutions also meant engaging with the system, a point over which indigenous peoples typically had no choice. This leads to a second important point, which is what makes this story specific to a colonial context and, for that matter,

specific to Indochina? I do not want to answer this question by falling back on familiar tropes that put racial prejudice or brute repression as the most important driving forces behind this story. The answer might be, at least in part, that psychiatric practices in the colony and metropole were not all that distinct. Asylum directors in both France and Indochina found themselves at the mercy of the political will of bureaucrats and the wishes of families, forced to sacrifice the mandates of their professional training to the exigencies of local circumstances. However, the stakes of their professional practice were very different. For example, the legal capacity of the "insane" in France touched on questions of autonomy and freedom that never really applied in the colonies. And whereas in Algeria, psychiatry responded to questions about the possibility of Muslim populations to assimilate to French civilization, in Indochina these concerns were always much less pressing.

I have also proposed a broader understanding of what we mean by the "colonial" by placing responses to mental illness along a continuum of practices that ranged from coercion to more subtle forms of negotiation and accommodation. Most colonial historians, following Foucault, associate "modern" power with the hegemonic reach of state institutions. They have explored the limits of this project in the colonial context, and have determined how the existence of modern alongside more pre-modern forms of colonial power led to either its intensification or unraveling. I contend that this kind of modern versus pre-modern formulation is limiting because it fails to acknowledge those spaces outside of institutions where, for instance, families and neighbors interacted with colonial experts and exercised their own forms of surveillance. In the context of psychiatry, I argue that designating someone as "abnormal" did not solely represent the pervasive power of the state but rather something more uneven, ambiguous and generative of something new and unintended.

To take one example, I illustrate how asylum overcrowding made daily patient management extremely difficult and put added pressure on asylum directors to release patients from their care. In order to avoid the burdens associated with long-term confinement, in the 1930s colonial psychiatrists increasingly promoted early prevention through the creation of open services in major hospitals. These services would require Vietnamese share basic understandings about mental illness as something that could be prevented and cured under the proper surveillance of experts. Families, however, continued to pursue their own strategies in ways that both facilitated and constrained the ability of colonial psychiatrists to care for the mentally ill (including seeking the help of sorcerers). In this way, as psychiatric activities in Indochina diversified and expanded from the treatment of acute mental illness to the identification of underlying abnormalities, I argue that psychiatrists enjoyed a widened scope for their expertise even as they came to rely more than ever on the intervention of the public.

The history of psychiatric expertise provides yet another perspective from which to examine the relationship between the asylum and the world beyond its walls. Attention to juvenile delinquency, for instance, allowed colonial psychiatrists to expand their influence outside the medical field and into the criminal courts. Studying how psychiatric experts re-framed Indochina's crime problem around the question of "abnormal children" provides an important opportunity to investigate the continuum of different strategies for confinement, a kind of "carceral archipelago" of empire, one that linked together the penal and medical services with a growing social assistance program.[2] I argue that situating the history of psychiatry within a

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[2] On the "carceral archipelago" of empire see Ann Laura Stoler. *Along the Archival Grain*. Princeton, NJ: Princeton University Press, 2009.

broader social and institutional context yields critical insight into the complex alliances and fractures that characterized the everyday administration of empire.

At a few points throughout the dissertation, I make implicit reference to Ian Hacking's concept of "human kinds" whereby institutions create the conditions under which individuals are labeled and counted, creating a demand for new services, and in turn generating a reality of mental illness that did not exist before.[3] What remains to be determined is the importance of the statistics that were collected in terms of actually shaping expert practices and policies. Using data from annual asylum reports spanning a twenty-five year period I plan to match aggregate data (organized with respect to race, gender, age, etc.) with descriptions of symptoms in patient case files in order to see how the content of diagnostic categories changed over time. Did the data confirm or challenge what psychiatrists thought they already knew? How did they make sense of discrepancies or did they ignore them all together? The answers to these questions will help to deepen this project's engagement with issues related to expertise and the creation of new kinds of people at the intersection of social norms and medical practices.

Specifying what makes someone "abnormal" also helps frame expectations for normal social life. In this dissertation I have drawn particular attention to the moral and medical meanings of rehabilitation in the colonial context. By simulating the appearance of freedom and normal life, the asylum as agricultural colony projected a vision of an idealized colonial order, one premised on establishing a kind of continuity between the discipline of institutional order and life in the community. This was reflected in the design of the institution itself but also the regime of self-discipline and industry that were taught as an essential aspect of labor therapy. In particular, I argue that strategies for the "psychiatric re-education" of the insane emerged as part of a broader

[3] Ian Hacking. "The Looping Effects of Human Kinds" in *Causal cognition: A multidisciplinary debate*, ed. by D. Sperber, D. Premack and A. J. Premack, Symposia of the Fyssen Foundation. New York, NY: Oxford University Press, 1995, pp. 351–394.

network of colonial reform projects that sought to produce a new class of colonial subjects through the disciplinary effects of labor.

This project therefore raises questions about the legacies that French psychiatry has held for the postcolonial period and in particular the continued embrace of labor as a model of rehabilitation for those relegated to the margins of Vietnamese society. (The Bien Hoa asylum is still the site of a functioning psychiatric hospital in Vietnam today.) Vietnam has recently come under intense fire from international human rights and public health organizations for using labor to rehabilitate drug addicts in a growing network of drug detention centers. While this model of rehabilitation is most commonly traced to "re-education camps" for prostitutes and drug users initiated under the Communist regime in 1975, my research reveals that these practices actually have a much longer tenure in Vietnam, and that what is often taken as a "local" approach is in fact part of a much more global story.

ANNEX

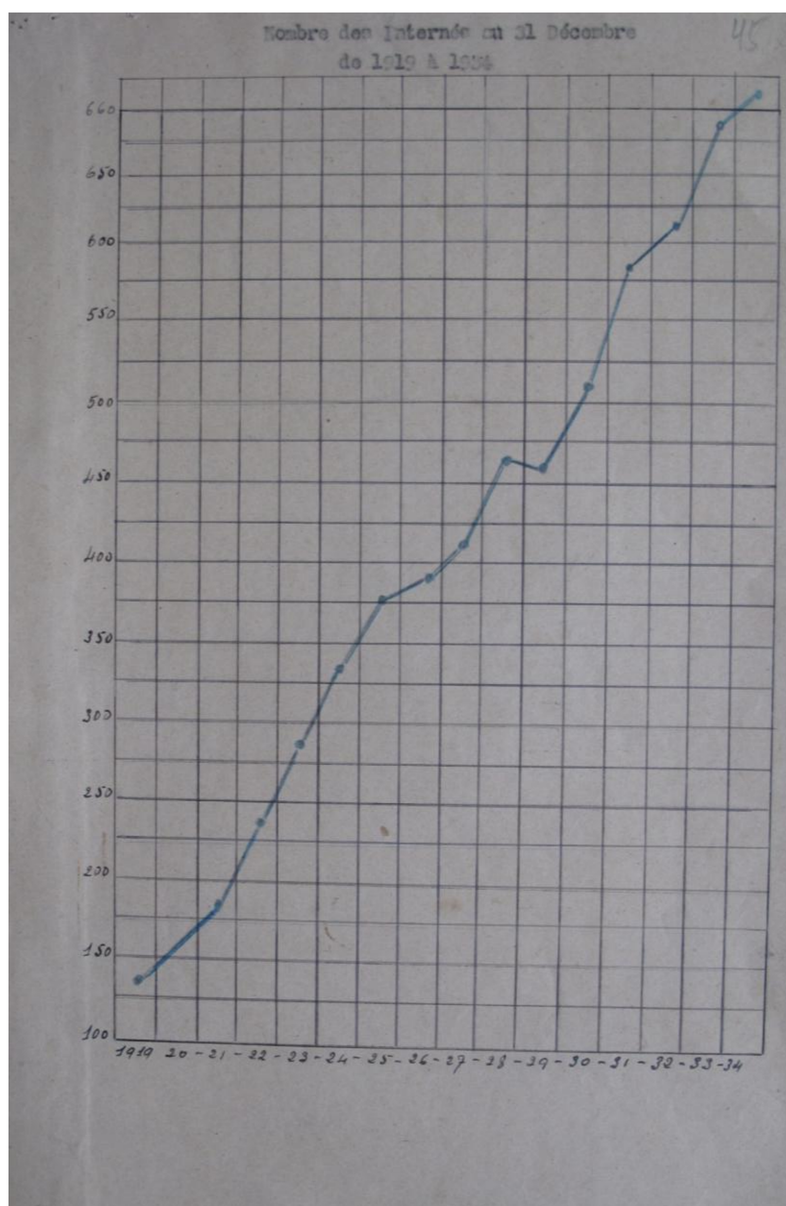
Map of French Indochina (1887-1954)

Figure 1: Table of Patient Numbers and Days of Hospitalization at the Bien Hoa Asylum (1919-1934)

Années	Nombre des hospitalisés	Nombre des journées d'hospitalisation.
1919	138	5.629
1920	159	10.040
1921	190	62.871
1922	241	79.242
1923	264	88.538
1924	326	107.909
1925	360	126.157
1926	379	131.282
1927	428	144.284
1928	473	167.086
1929	468	173.484
1930	532	177.690
1931	590	202.775
1932	622	216.851
1933	660	234.029
1934	636	235.538

Source: TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07, Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, 1934.

Figure 2: Chart of annual patient admittances at the Bien Hoa asylum (1919-1934)

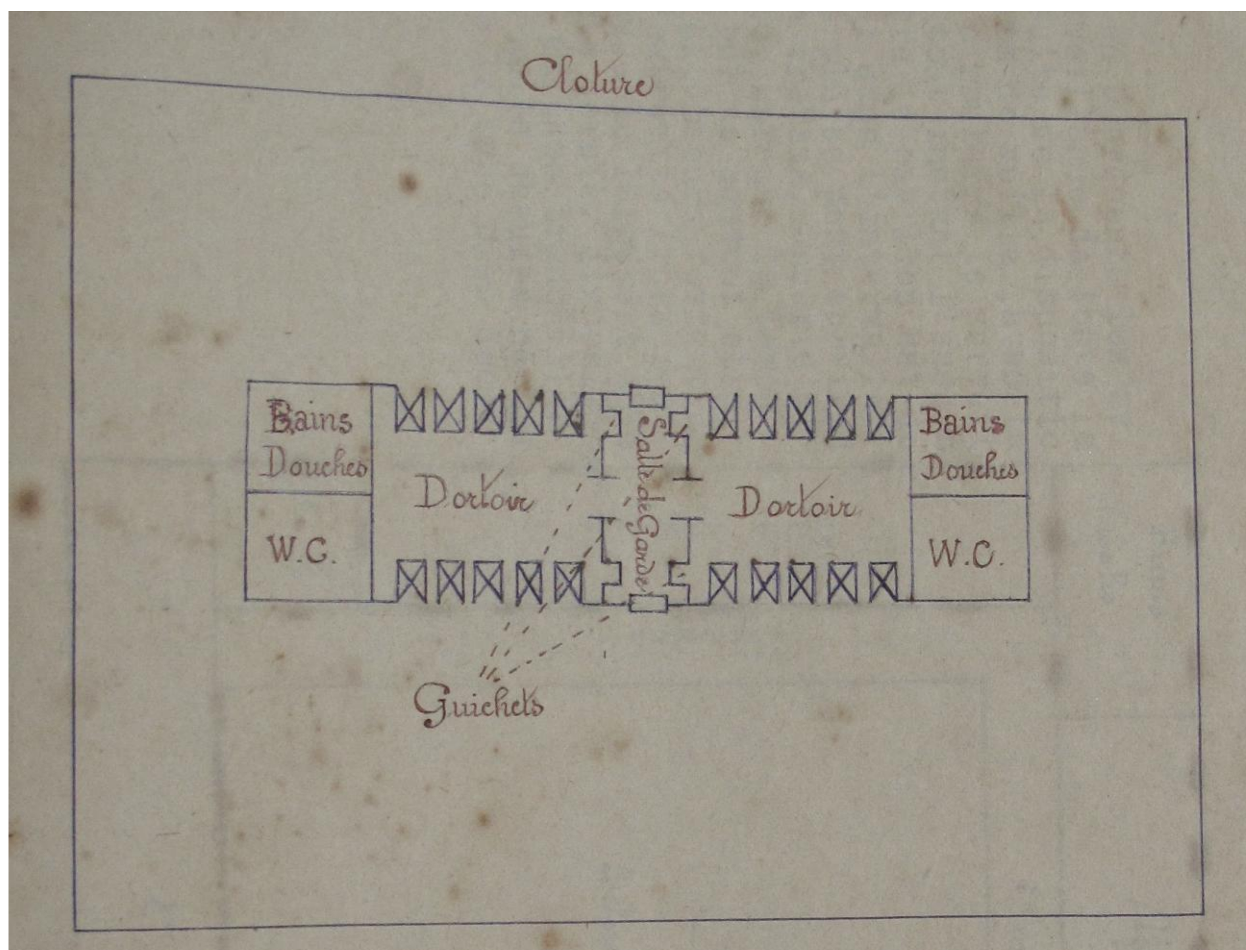


Source: TTL1, Inspection Général de l'Hygiène et de la Santé Publique, 51-07,
Rapport annuel de 1934 sur le fonctionnement du Service de l'Assistance Médicale de Bien Hoa,
Sai Gon, Bac Lieu, 1934.

Figure 3: Map of the Bien Hoa Asylum, Cochinchina, 1927

Source: TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

Figure 4: Drawing of Pavilion for "Calm Patients," Bien Hoa Asylum, 1927

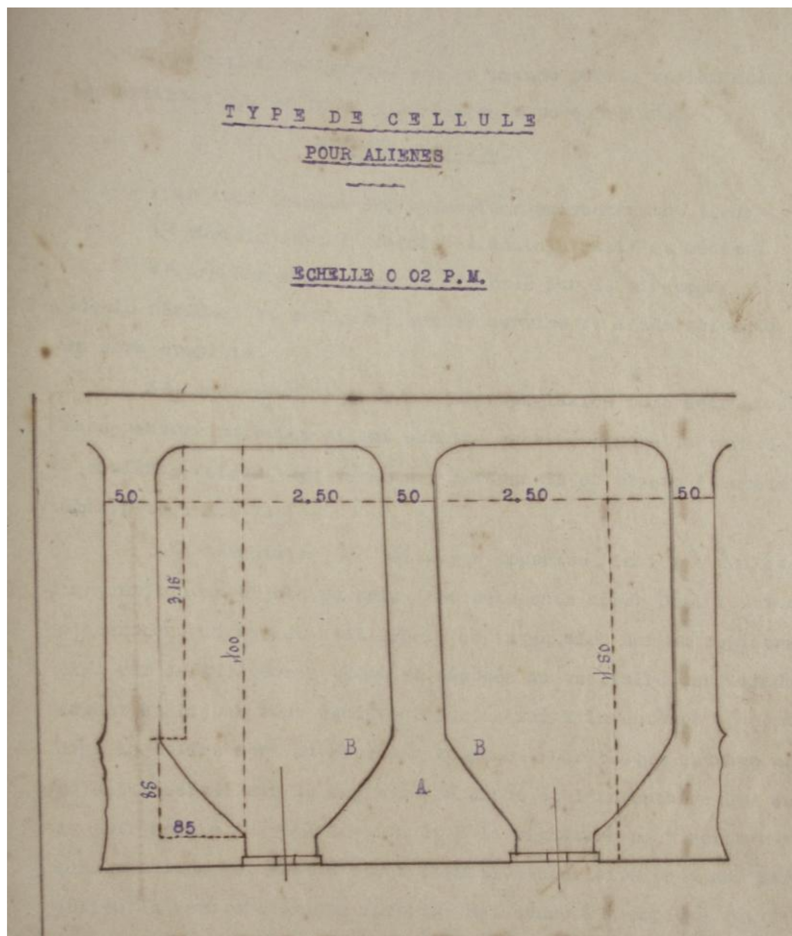


Source: TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

Figure 5: Plans for a "U" shape Pavilion, to be installed at the Voi Asylum in Tonkin, 1927

Source: TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

Figure 6: Model of the typical cell for patients in the "agitated wing" at Bien Hoa, 1927

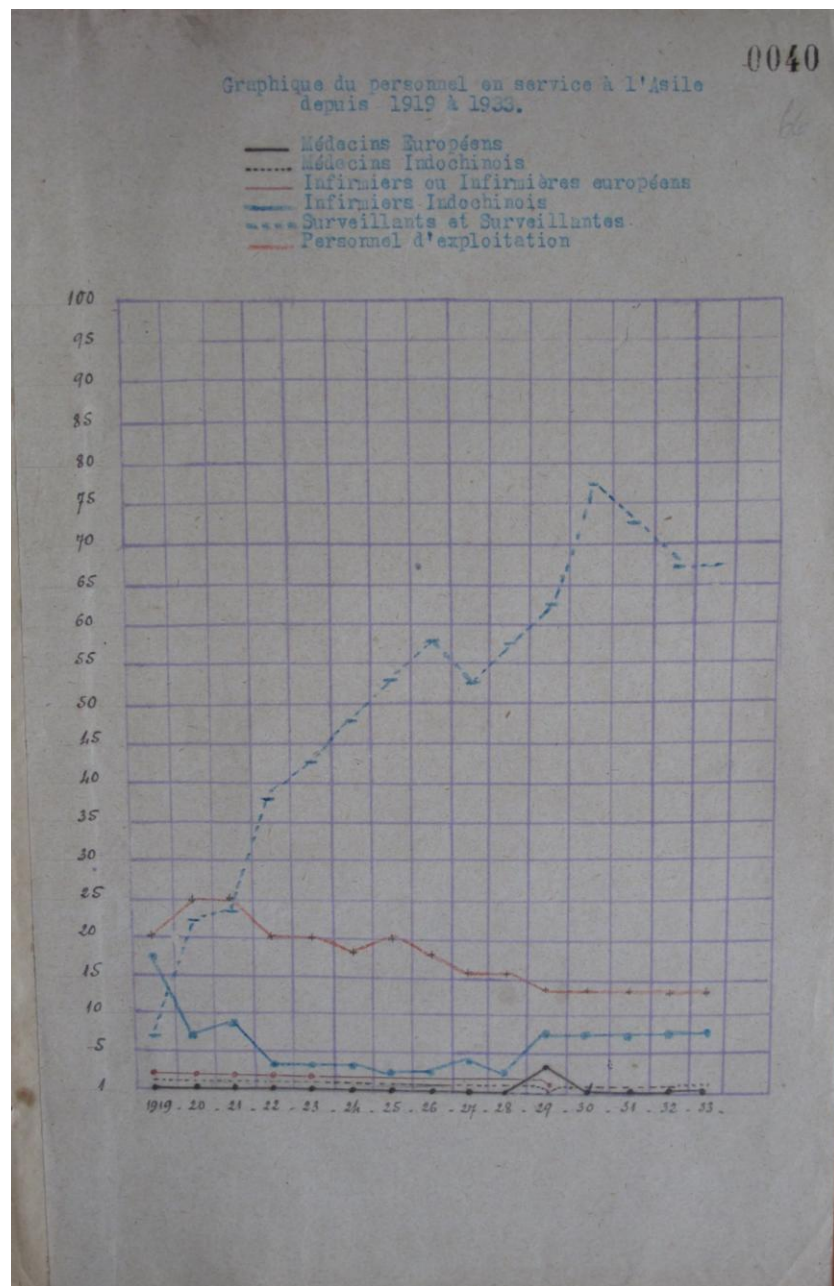


From: TTL1, 73750, Résidence Supérieur au Tonkin, Organisation et fonctionnement d'un Asile d'Aliénés à Bien-Hoa (Cochinchine), Note sur l'organisation générale d'un Asile d'Aliénés par le Dr. Augagneur, Médecin Directeur de l'Asile de Bien Hoa, 1927.

Figure 7: European Pavilion, Bien Hoa, 1931

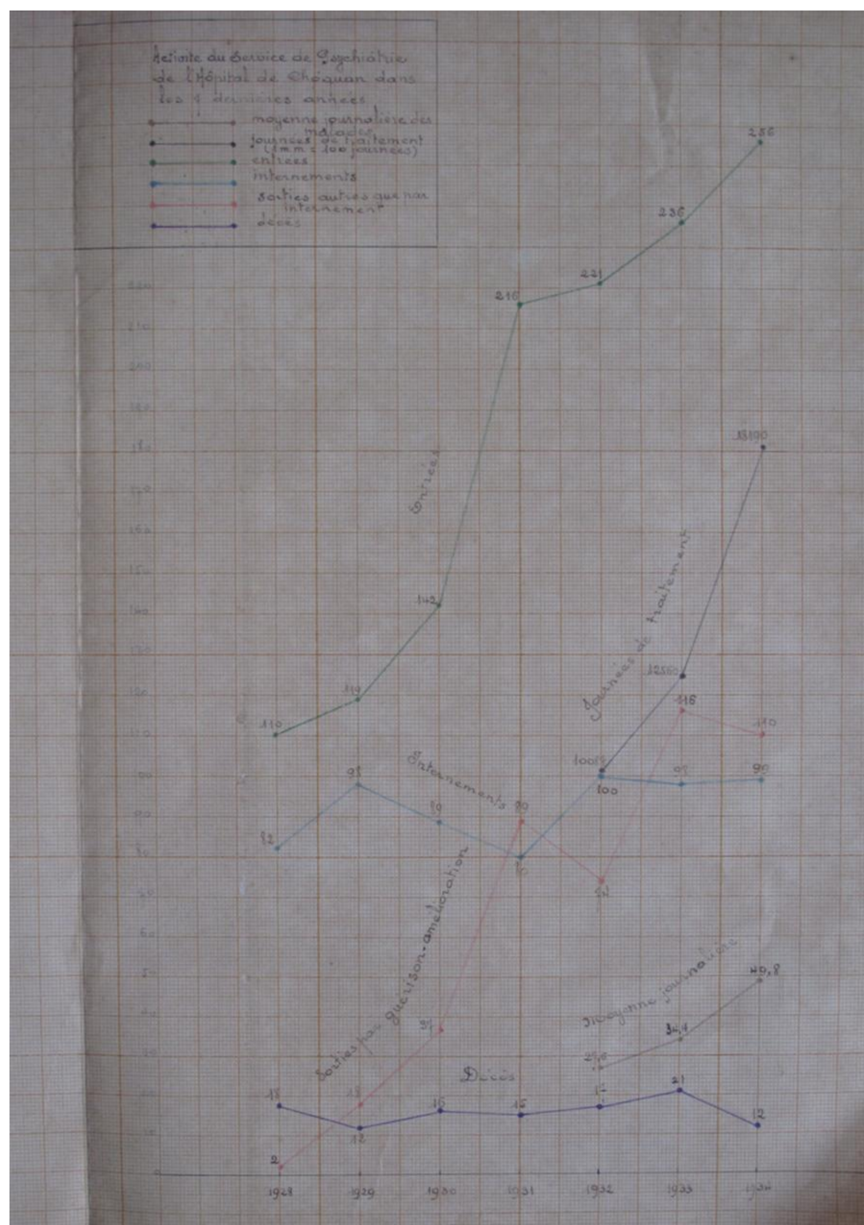
Image Credit: Archives Nationales d'Outre Mer (Base Ulysse).

Figure 8: Graph of Staff Mutations at the Bien Hoa asylum, from 1919 to 1933



Source: TTL1, IGHSP, 50-03, Rapport Annuel de l'Asile d'Aliénés de Bienhoa, 1933.

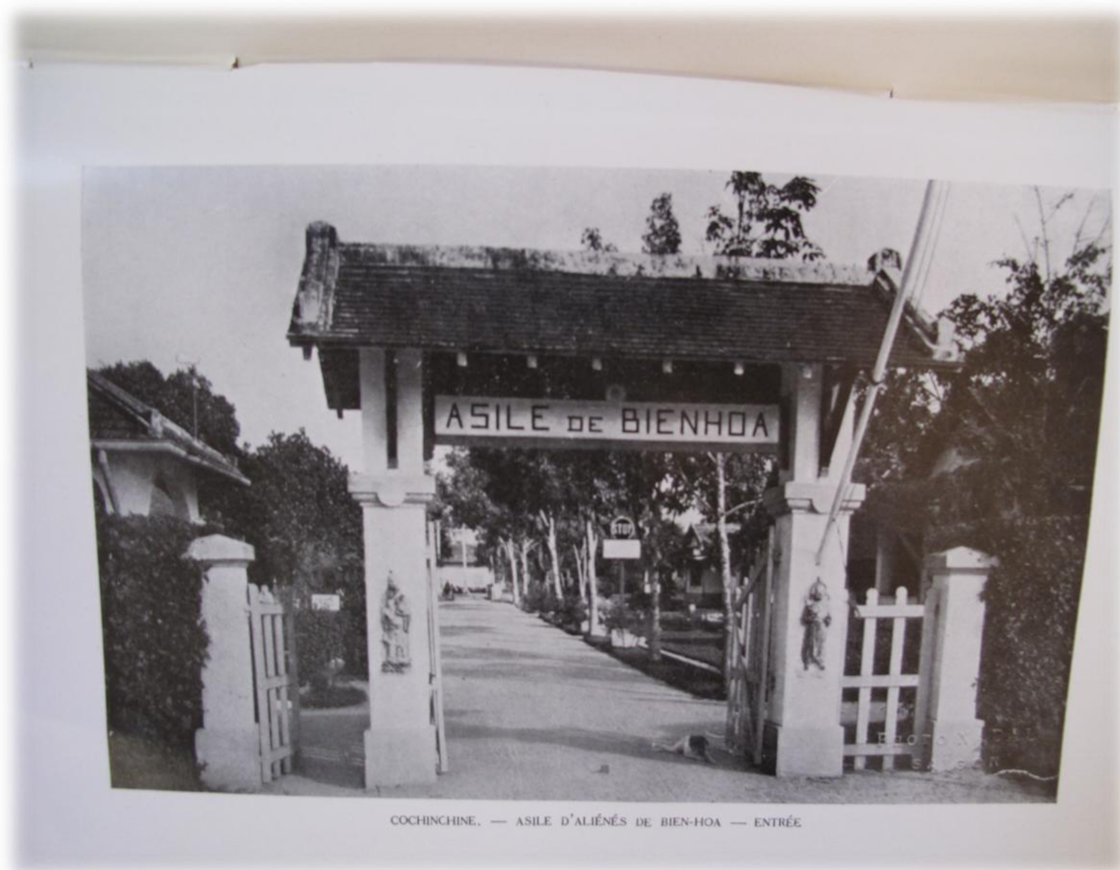
Figure 9: Graphic of Patient Movements at the Neuropsychiatric Service, Chôquan Hospital, 1934



Brown - average number of days at the service
Black - average days of treatment (out of 100)
Green - admittances
Blue - transfer to the asylum
Red - exits from service for reasons other than confinement at asylum (sent home, for example)
Purple - deaths

Source: TTL1, IGHSPI, 51-01, Rapport sur le fonctionnement du service de psychiatrie de l'Hopital de Chôquan en 1934.

Figure 10: Entrance to Bien Hoa, 1934



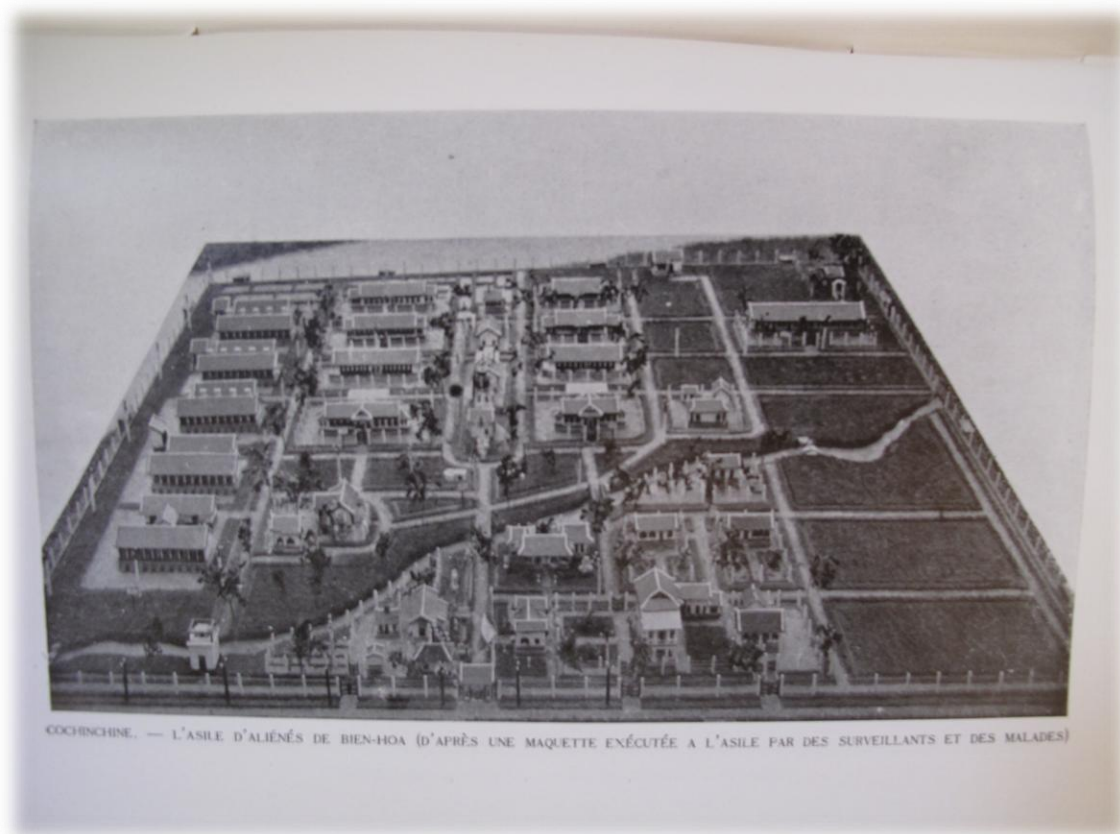
COCHINCHINE. — ASILE D'ALIÉNÉS DE BIEN-HOA — ENTRÉE

Image Credit: Archives Nationales d'Outre Mer (Base Ulysse).

Figure 11: Photo of Admission Building at the Voi Asylum, Tonkin

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 12: Photo of a model of Bien Hoa that was handmade by patients and asylum guards that was included as part of a colonial exhibition in France in the 1930s



COCHINCHINE. — L'ASILE D'ALIÉNÉS DE BIEN-HOA (D'APRÈS UNE MAQUETTE EXÉCUTÉE A L'ASILE PAR DES SURVEILLANTS ET DES MALADES)

Source: ANOM, AGEFOM, 554, Assistance Medicale - maguettes d'Asile de Bien Hoa, Exposition Coloniale (Indochine) Paris, 1931-32.

Figure 13: Photo of the inside courtyard of the Voi Asylum, Tonkin

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 14: Photo from the "Park" at the Bien Hoa Asylum, Cochinchna, 1931

Image Credit: Archives Nationales d'Outre Mer (Base Ulysse).

Figure 15: Photo of the inside of one of pavilions for "calm" Vietnamese patients, Voi asylum.

Notice here that the rooms are open, instead of individual, isolation cells which were reserved only for the most agitated patients. What you cannot see in this picture is that pavilions were constructed in such a way as to facilitate an easy surveillance.

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 16: Photo of patients tending to a vegetable garden at the Voi Asylum

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 17: Patients help with the preparation of meals at the Voi asylum

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 18: Photo of animal stables, Voi Asylum

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 19: Photo of patients at Voi preparing the fields for rice cultivation

Source: ANOM, "Assistance psychiatrique, Bac Giang (Asile de Voi)," ICO, 8 Fi-498.

Figure 20: Newly arrived patients at the *asile colonie* of Lengteng-Agoeng in 1934

Source: ANOM, Guernut 22, "Note sur la colonie agricole d'aliénés de Lengteng-Agoeng (Java) par le Dr. P.M.Dorolle," Octobre 1937

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