# Drinkers, Drunkards, and Degenerates: The Alcoholic Population of a Parisian Asylum, 1867–1914

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*The medicalization of alcoholism by the psychiatric profession in the latter decades of the nineteenth century can be considered an important factor in the expanding power of the psychiatric profession in France. Yet the relationship between alcoholism and psychiatry has always been ambivalent. An extensive debate among French psychiatrists in the 1890s over the treatment of alcoholic mental patients reveals their desire to narrow the definition of alcoholism in order to restrict their clientele. These debates suggest that medicalization is a complex process that can involve the rejection as well as the appropriation of expertise.*

*La medicalisation de l'alcoolisme par la psychiatrie française au cours des dernières décennies du XIXe siècle peut être considérée comme un élément important du pouvoir croissant de cette profession en France. Pourtant, les relations entre l'alcoolisme et la psychiatrie ont toujours été ambiguës. Dans les années 1890, des débats importants au sujet du traitement des alcooliques internés comme malades mentaux révèlent que les psychiatres français ont tendance à limiter la définition de l'alcoolisme dans le but de restreindre leur clientèle. Ces débats indiquent que la médicalisation est un processus complexe pouvant comprendre le rejet comme l'appropriation de compétences spécialisées.*

ALCOHOLISM IN FRANCE, it is usually considered, had been medicalized by the psychiatric profession by the latter decades of the nineteenth century. French doctors had begun to study the condition even before the term alcoholism was coined in 1849 by the Swedish researcher Magnus Huss. With the publication of Valentin Magnan's classic text, *De l'alcoolisme*, in 1874, the clinical characteristics of alcoholism as a psychiatric disorder were firmly established.[1] By the mid-1880s, again thanks to the work of Magnan,

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1 The full title was *De l'alcoolisme, des divers formes du délire alcoolique et de leur traitement* (Paris: A. Delahaye, 1874). The book won a competition of the Academy of Medicine on the topic of alcoholic delirium and was translated into several languages. For the early research on alcoholism in France, see Claude Quétel and Jean-Yves Simon, "L'aliénation alcoolique en France : XIXe et Ière moitié du XXe siècle", *Histoire, économie et société*, no. 4 (1988), pp. 508–509.

alcoholism had been integrated into the psychiatric theory of hereditary degeneracy, an all-encompassing explanation of mental disorders and social ills.[2] As Magnan, the most eminent French psychiatrist of the period, warned, "not only does it [alcoholism] bastardize the race, but, as a powerful factor in poverty, crime and madness, it is the most important furnisher of asylums, hospitals, correctional institutions, and prisons."[3] By this time as well, asylum doctors controlled a statistically impressive population of mental patients who had been diagnosed as suffering from *folie alcoolique* (alcoholic madness) and who were, therefore, demonstrably in need of psychiatric expertise. Finally, alcoholism and its attendant asylum population had enabled psychiatrists to claim a public role as experts on health policy. In an era when madness and alcoholism were considered evidence of France's national degeneration, asylum doctors provided the pre-war anti-alcoholic movement with much of its leadership as well as its most effective iconography and its most alarming statistics.[4] The medicalization of alcoholism could, therefore, be seen as an important factor in the growth of a profession that, in the words of historian Jan Goldstein, was characterized by a "bid for power through psychiatric knowledge".[5]

Yet definitions of alcoholism have always proved controversial, and there has been a consistently ambivalent and often tense relationship between alcoholism and psychiatry.[6] If the concept of medicalization is to serve as a tool of analysis rather than as a tautology, it must be viewed as a complex, often contradictory, and not always linear process.[7] One example of such ambiguity can be found in the debate that erupted among French psychiatrists in the 1890s over the most effective means of treating the large number of alcoholics routinely admitted to public asylums. The debate was provoked by a deceptively simple request for advice from the General Council of the Seine. Alarmed by medical warnings about the dangers of alcoholism, the Council voted in 1894 to construct a special asylum for alcoholic mental patients; subsequently, it sought expert opinion on what types of alcoholics could be successfully treated in the new facilities. The result was a heated and confused debate in which psychiatrists quarrelled

2 For the development and popularity of hereditary degeneracy as a psychiatric theory, see Ian R. Dowbiggin, *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth Century France* (Berkeley: University of California Press, 1991).

3 France, Conseil supérieur de l'assistance publique, Fascicule 52, March 1895, p. 36.

4 For details, see Patricia E. Prestwich, *Drink and the Politics of Social Reform: Antialcoholism in France Since 1870* (Palo Alto, Calif.: Society for the Promotion of Science and Scholarship, 1988).

5 Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (Cambridge: Cambridge University Press, 1987), p. 379.

6 For some reflections on why psychiatrists have not always considered alcoholism a "noble" disease, see Jacques Postel and Claude Quétel, eds., "Alcoolisme et psychiatrie : rapport au Haut Comité d'étude et d'information sur l'alcoolisme", March 1983, p. 9.

7 I am grateful to Dr. Ludmilla Jordanova of Essex University for her perceptions on the implicit tautology of the term, namely that the results are implicit in the definition.

over definitions of drinkers (*buveurs*), habitual drunkards (*ivrognes*), chronic alcoholics, and alcoholic degenerates and failed to agree on which of these types were, in the words of one doctor, "the clients of the psychiatrist".[8] With no clear guidance from the reputed experts, the Council decided that the new asylum (Maison Blanche) would be devoted to female mental patients, who were as numerous as alcoholics but less controversial. The episode did little for the professional reputation of psychiatrists. As Paul-Maurice Légrain, an advocate of treatment for alcoholics, noted acerbically, when architects for the new asylum turned to psychiatrists for advice, the reply was "This is all new to me; I have not thought it out; I have no statistics. Look abroad or consult my colleague," to which the architects replied, "Your colleague is as knowledgeable as you are."[9]

Ostensibly, this debate was about the treatment of "alcoholic lunatics", i.e. alcoholic patients in public asylums. In reality it was an attempt by asylum doctors to narrow their definition of alcoholism in order to restrict their clientele. This desire to demedicalize, in effect, certain types of alcoholism sprang not from any scientific interest in the problem or any deep concern for treatment, but from a professional and institutional crisis that confronted asylum doctors in the 1890s. The daily realities of their asylum experience in fact led doctors to re-evaluate clinical and legal definitions of alcoholism that no longer appeared to serve their professional interests. Parisian psychiatrists, who had some of the highest proportions of alcoholic patients in France and who were, not coincidentally, the leading experts on alcoholic madness, dominated the debate.[10] The Parisian asylum system also experienced most dramatically a dual crisis common to many such institutions in the late nineteenth century: overcrowding made treatment unlikely, and the high proportion of chronic patients resulted, psychiatrists charged, in an abysmally low rate of cure.[11]

Although psychiatrists in North America and Britain faced similar crises, the situation was arguably more critical for the French, whose careers were

8 *Procès verbaux de la Commission de surveillance des asiles publics d'aliénés de la Seine*, May 7, 1895, p. 137. One of the rare psychiatric experts on alcoholism, Paul-Maurice Légrain, sought to clarify the debate by explaining that "a drinker [*buveur*] may be neither an alcoholic nor a habitual drunkard [*ivrogne*], but may be both at the same time; the alcoholic is not inevitably a habitual drunkard but can be; and the habitual drunkard may not necessarily be an alcoholic or intoxicated." *Comité de surveillance*, May 7, 1895, p. 136.

9 Paul-Maurice Légrain, "Les asiles d'ivrognes", Paris, Victor Goupy, 1895, p. 6.

10 Valentin Magnan, the leading French expert on alcoholism and on degeneration, and his pupil Paul-Maurice Legrain dominated the debate. Charles Lasègue (died 1883), the psychiatrist of the Police Infirmary in Paris, and his successor Paul Garnier were also prominent French experts on alcoholism.

11 By the early 1890s Paris had four major asylums, Sainte-Anne, Vaucluse, Ville-Evrard, and Villejuif. The Admissions Office, headed by Magnan, certified all patients, who were then sent to the various asylums. The cure rate for French asylums at this time was estimated by doctors themselves at 20% to 22%. Congrès annuel de médecine mentale, *Compte-rendu*, 1891, p. 264.

more closely tied to public asylums than those of their counterparts in other countries.[12] Moreover, since the 1860s, French psychiatrists had faced a vociferous anti-psychiatric movement that condemned asylums as "modern Bastilles" and sought to limit the legal powers of asylum doctors.[13] By the 1890s Parisian psychiatrists were so frustrated with their working conditions that, in terms familiar to their critics, they increasingly denounced overcrowded asylums as "barracks", "depots", and "emporia".[14] Their solution was to create a medically more interesting and professionally more advantageous clientele by ridding the asylum of those patients whom they considered to be inappropriate. With some success, they argued that the senile, epileptic, and mentally handicapped could be cared for in less costly institutions, such as agricultural colonies. These patients, whom psychiatrists characterized as being on the "borderlines of madness", were not central to the development of psychiatric theory and therefore could easily be labelled as incurable and in need of custodial rather than therapeutic care.

The other group of patients blamed for overcrowded asylums was alcoholics, whom psychiatrists increasingly categorized as not "true" mental patients.[15] As early as 1874, Magnan had argued that the alcoholic "is a separate subject; he feels, he suffers and he reacts differently from other patients."[16] By the 1890s, alcoholics were often labelled as "not genuine", "pseudo", or "temporary" mental patients.[17] Frequently, the tone was overtly hostile: Édouard Toulouse, a young psychiatrist who sought to reform the asylum system, referred to "those elements that are foreign to mental illness: habitual drunkards, the depraved, the poor, and the elderly".[18] Alcoholics, however, posed a more difficult problem than the elderly or the mentally handicapped, which might account for the frequent hostility that psychiatrists expressed toward them. Because alcoholism was central to psychiatric theories of mental illness and played an important role in the public ambitions of the profession, it was not so easy to exclude alcoholics from the

12 French psychiatrists had fewer opportunities for a career in private practice than did their British or North American counterparts for, as Goldstein has clearly argued, their profession was based on a "statist model". The legislation of June 30, 1838, which created the system of public asylums, also created a "race of psychiatric functionaries". Goldstein, *Console and Classify*, p. 276. For the crisis that affected many such institutions in the late nineteenth century, see W. F. Bynum, Roy Porter, and Michael Shepherd, *The Anatomy of Madness*, vol. 3, *The Asylum and Its Psychiatry* (London: Tavistock Press, 1988), p. 4ff.

13 For the growth of the anti-psychiatry movement, see Dowbiggin, *Inheriting Madness*, chap. 5.

14 See, for example, Préfecture de la Seine, Direction des affaires départementales, *Rapport sur le service des aliénés de la Seine*, 1892, p. 211.

15 In talking of alcoholics, Valentin Magnan distinguished them from "véritables aliénés". *Commission de surveillance*, May 7, 1895, p. 122.

16 Magnan, *De l'alcoolisme*, p. 1.

17 See, for example, Congrès des médecins aliénistes et neurologistes de France, vol. 1, *Rapports*, p. 299.

18 *Rapport sur le service des aliénés*, 1894, pp. 76–77.

psychiatric realm by labelling them incurable. On the other hand, as a group, alcoholics displayed certain characteristics that set them apart from "normal lunatics" and made them unwelcome mental patients. Some of the ways in which these patients challenged both institutional and medical definitions can best be understood by comparing the alcoholic and non-alcoholic populations of one of the most important Parisian asylums, Sainte-Anne.[19]

The overcrowding of Parisian asylums could readily be blamed on alcoholics because they constituted the highest proportion of admissions, at least for men. When Sainte-Anne opened its gates on May 1, 1867, the first male patient was an alcoholic. In the early years (until the Franco-Prussian war of 1870, when patients were evacuated), alcoholics constituted 22 per cent of the male population. Over the next 40 years diagnoses of alcoholism made up 23.8 per cent of male admissions, and in another 7.3 per cent of cases alcoholism was listed as a contributing factor. This influx of alcoholics was a double burden. First, as Légrain charged, "they take the place of mental patients who, too often, because of the increasing demand on our institutions and because of the length of their illness, are evacuated to the provinces."[20] In fact, nearly half of Parisian mental patients were sent to distant and often inferior provincial asylums because of overcrowding. Secondly, because French psychiatrists were convinced that alcoholism was a major factor in the development of general paralysis (the tertiary and fatal stage of syphilis) and hereditary degeneracy, more alcoholic patients inevitably meant more chronic and incurable patients. Valentin Magnan, the chief admitting psychiatrist for the asylums of the Seine from 1867 until his retirement in 1912, continually warned that, if all the ramifications of alcoholism were considered, it could be blamed for at least 50 per cent of the mental patients in Paris.[21]

Alcoholics were also more visible because they came from lower occupational categories than other asylum patients and were more associated with police action. As Table 1 indicates, male alcoholic patients, with the exception of those in the wine and alcohol trades, were more likely to be vagabonds and unskilled or skilled workers and less likely to be drawn from the petty bourgeois categories of clerks and shopkeepers. They were also more

19 Sainte-Anne was the most prestigious of the Seine asylums and the only one within Paris itself. It also housed the teaching clinic for the Faculty of Medicine of the University of Paris. The majority of statistics in this paper are based on the admissions records for every second year from 1873 to 1913, a total of 7,100 cases. Of these, approximately 1,100 are male alcoholics. Since there were only 136 cases of female alcoholics, they have not been considered in this study.

20 Conseil général de la Seine, Deuxième sous-commission, "De l'assistance des alcooliques, Rapport", p. 5.

21 So influential were Magnan's views that visitors to Sainte-Anne were informed that up to 80% of its population had been interned as a result of alcoholism. *Revue philanthropique*, vol. 24, (1908–1909), p. 377.

**Table 1 Male Occupations**

| | Alcoholic Patients | Non-Alcoholic Patients |
|---|---|---|
| Unskilled | 16.4% | 10.1% |
| Skilled | 48.0% | 40.5% |
| Petty bourgeois | 18.6% | 28.2% |
| Bourgeois | 3.0% | 7.2% |
| Alcohol trade | 7.1% | 1.8% |
| Vagabonds | 3.3% | 2.2% |
| No occupation | 2.5% | 8.7% |

*Note:* Total cases, 1873–1913: 1,029 alcoholic; 2,968 non-alcoholic.
*Source:* Admissions Registers, Sainte-Anne asylum, Paris

likely to have been committed by police procedures (*placement officiel*) than by their families.[22] Eighty per cent of male alcoholics were sent to the asylum by the police, compared with 65.6 per cent of all male patients. For alcoholics, then, asylum legislation functioned as a device for maintaining public order, and it is not surprising that the force of the law fell most heavily on the less privileged. Although asylum doctors wanted to treat the poor, by the 1890s they sought to distance themselves from any suggestion of forced confinement and therefore from police procedures, which were increasingly associated with the image of the asylum as a Bastille or prison.

Male alcoholic patients could also be distinguished by their violence. The clinical classification most often used by admitting psychiatrists to fulfil the legal requirements for committal was *délire alcoolique*, alcoholic delirium, with its panoply of violent and often terrifying hallucinations. In its most frequent or manic state, alcoholic delirium produced, in Magnan's words, "hallucinations of a painful, active and very mobile nature, extending to all the senses. ... Goaded by this excitement, patients shout, curse, quarrel, throw themselves about and become wild."[23] Many patients arrived at Sainte-Anne in a state of considerable excitement, and 53 per cent of all males admitted for alcoholism were suffering from hallucinations.

Male alcoholic patients were also associated with public and domestic violence or the threat of violence, although this generalization needs to be qualified. Judging from the admission certificates, most male patients at Sainte-Anne were not violent: actual violence was mentioned in only 8.5 per

22 Under the Law of June 30, 1838, there were two admission procedures. In Paris the most widely used was *placement officiel*, or internment by the police. This involved a patient being sent to the Police Infirmary, alongside the central detaining cells, and then, after an examination, being sent to the Admissions Office, located on the grounds at Sainte-Anne, for another psychiatric examination. Afterward, patients were distributed among the asylums of the Seine. A second type of internment, *placement volontaire*, allowed families to take patients directly to the Admissions Office and to bypass the police procedures. It was reinstituted in Paris in 1876 and became increasingly popular, both with families and with doctors.

23 *Rapport sur le service des aliénés*, 1898, p. 61.

cent of cases and threatened violence in 5.3 per cent. Within this context, however, alcoholics were more violent: in 35.8 per cent of cases of violence, the primary diagnosis on the certificate was alcoholism and in another 12.3 per cent of cases, excessive consumption of alcohol was a contributing factor. Similarly, 46 per cent of cases of threatened violence were associated with alcoholism and another 13.9 per cent with excessive consumption. Nevertheless, among male alcoholics, only 13 per cent had committed acts of violence and another 10.4 per cent had threatened violence. (The comparable statistics for non-alcoholic male patients are 6.4 and 3 per cent.) Therefore, in comparison with non-alcoholic patients, these men were more violent, but violence was not characteristic of the group as a whole.

One of the most prominent forms of violence was family or domestic violence, and in this category male alcoholics were again most visible. In 45.5 per cent of the cases of family violence by men, alcoholism was a factor, but only 7.7 per cent of male admissions for alcoholism involved family violence. This rate was still much higher than that among non-alcoholic male patients, where only 2.3 per cent of cases involved family violence. Self-inflicted violence was not, however, a noticeable characteristic of alcoholics. Male alcoholics did not have a significantly higher rate of suicide, despite their tendency to leap from windows or throw themselves into the Seine during their delirium. Suicide attempts were noted in only 11.8 per cent of alcoholic cases and in 9.3 per cent of other male admissions.

What most distinguished alcoholic patients and in the minds of many psychiatrists made them "pseudo" lunatics, however, was that they did not remain insane. Although alcoholic delirium impressed the clinical eye and satisfied the legal requirements for admission to the asylum, it did not last long. It was a "straw fire"[24] and, after a few days or a few weeks, the patient was again "lucid" and therefore had to be released, usually with the notation "cured" or "cured of this alcoholic incident". As statistics from Sainte-Anne indicate, all categories of male alcoholics had a significantly higher release rate than other male patients, and the duration of their stay was significantly shorter. In the years from 1873 to 1913, over 70 per cent of alcoholics were released, compared with 46 per cent of all male patients committed under police procedures. Similarly, the median length of stay for released alcoholic patients was much lower: 61 days versus 83 days for the average male patient.[25]

Such releases inflated the asylum's cure rate but also contributed to overcrowding. Doctors were convinced that many released patients had not

24 *Annales médico-psychologiques*, vol. 12 (1890), p. 260.

25 The same holds true if the most representative group, the interquartile ratio (between 25% and 75% of all patients), is considered. The IQR for alcoholic men was 116 days in comparison with 165 days for all men interned by police procedures.

**Table 2 Alcoholic Men: 1873–1913**

| | Approx. % of Male Alcoholic Cases | Age Distribution (%) | | | Release Rate (%) | Death Rate (%) | Length of Stay (Days) | |
|---|---|---|---|---|---|---|---|---|
| | | 20s | 30s | 40s | | | Median | IQR* |
| Acute/subacute alcoholism | 18.0 | 54.5 | 24.7 | 6.1 | 78.3 | 8.19 | 51 | 110 |
| Alcoholic delirium | 27.0 | 44.4 | 30.0 | 12.4 | 72.4 | 17.70 | 45 | 70 |
| Alcoholism | 15.0 | 38.6 | 32.2 | 13.2 | 71.0 | 12.50 | 68 | 187 |
| Chronic alcoholism with subacute incident | 12.6 | 30.2 | 42.4 | 20.9 | 69.1 | 12.20 | 58 | 75 |
| Chronic alcoholism | 18.0 | 23.5 | 37.5 | 29.0 | 67.0 | 17.50 | 109 | 169 |
| All male patients (police admissions) | | 13.2 | 32.4 | 28.3 | 45.1 | 32.10 | 83 | 165 |

*Interquartile ratio (between 25% and 75% of all patients).
*Source:* Admissions Registers, Sainte-Anne asylum, Paris

been cured of their addiction or, in the terminology of the period, their "penchant" for drink. Inevitably, they would have a relapse and be readmitted, thereby burdening already extended facilities. In fact, at Sainte-Anne, 28 per cent of alcoholic patients had already been committed at least once. Increasingly, psychiatrists assumed that the typical alcoholic resembled Coupeau in Emile Zola's *L'Assommoir* who, as neighbours joked, had his bed reserved at Sainte-Anne.[26]

For a profession whose power was based on the asylum structure and whose fundamental tenet was that treatment could only be achieved through prolonged isolation in specialized facilities, this non-conformist behaviour of alcoholic patients could only be considered disruptive. In fact, psychiatrists frequently referred to alcoholic patients as sources of disorder. Alcoholics, they charged, "destroy the good order of our asylums"; "[they are] ceaseless instigators of disorder and are harmful for the patients."[27] Marandon de Montyel, chief psychiatrist at the Ville-Evrard asylum, blamed habitual drunkards for a revolt by patients in 1890. Like epileptics and "moral lunatics", he argued, alcoholics were "very dangerous and always ready to revolt".[28] Because alcoholic patients could easily be connected with violence and police action, it is not surprising that they were often associated with criminals, for whom separate psychiatric facilities were also being sought.[29] One doctor expressed the opinion of many when he suggested that alcoholic patients did not need the comfort of a special asylum but rather the harsh treatment of a prison.[30]

The seeming unsuitability of alcoholics as mental patients led psychiatrists to re-evaluate the definition of alcoholism used for purposes of committal. Alcoholic delirium, critics charged, was so vague a concept that it filled asylums with those who were neither true alcoholics nor true lunatics. The harshest critic was Marandon de Montyel, who, with heavy irony, suggested that the drinkers of Paris should erect a statue to Charles Lasègue, who had originally classified alcoholic delirium as a psychiatric disorder. Lasègue, he continued, was the "Pinel of alcoholics", the man who had raised drinkers (*buveurs*) "to the dignity of patients".[31] Marandon argued that alcoholic delirium had no validity as a distinct psychiatric category and was, in

26 Emile Zola, *L'Assommoir* (Paris: Garnier-Flammarion, 1969), p. 394.

27 *Annales médico-psychologiques*, vol. 12 (1890), p. 251; *Rapport sur le service des aliénés*, 1897, p. 161.

28 *Annales médico-psychologiques*, vol. 12 (1890), p. 250.

29 The psychiatric campaign for separate and very secure facilities for the criminally insane was part of a larger public debate on crime and national degeneration. For a discussion of the wider concern over criminality, alcoholism, mental illness, and other social problems of the period, see Robert Nye, *Crime, Madness and Politics in Modern France: The Medical Concept of National Decline* (Princeton: Princeton University Press, 1984).

30 *Rapport sur le service des aliénés*, 1895, p. 208.

31 *Annales médico-psychologiques*, vol. 16 (1892), pp. 285–286.

reality, only *ivresse délirante* (delirious drunkenness). The only result of Lasègue's work was that wards were now filled with habitual drunkards (*ivrognes*) who treated the asylum as their holiday retreat, their Nice or Trouville, in periods of seasonal unemployment.[32] Marandon labelled these patients the "amateur alcoholics", who found in the asylums of the Seine "good beds and good food" and for whom readmission was not "a fear but a hope".[33] Légrain was equally caustic about alcoholics who exploited the internment process: these "swallows", as he called them, would simply go out and get drunk whenever they wanted a good place to stay.

Other psychiatrists admitted the inadequacies of alcoholic delirium as a criterion for committal to an asylum, but tended to blame the lack of other facilities for the problem. Lasègue himself had recognized that not all those suffering from alcoholic delirium needed psychiatric care but that they often ended up in asylums because no specialized hospitals existed. Some doctors charged that, by the time alcoholics arrived on their wards, the mental problems that had caused their admission had disappeared. "They are the habitual drunkards [*ivrognes*] who are arrested every day and who are sent to us because no one knows where to put them," argued one exasperated psychiatrist.[34] Another doctor stated that he simply wanted to clear out his wards: "We need a lock-up, a guardroom, for those drunkards who are arrested and who are cured the next day."[35] Although the head of the Police Infirmary denied that habitual drunkards were sent to asylums, the belief persisted. As one frustrated doctor summed it up: "A drunk disturbs the peace and there he is, committed."[36]

An analysis of the patients at Sainte-Anne confirms that psychiatrists were confronted with a wide spectrum of drink-related conditions. This variety is reflected in the length of stay: 25 per cent of released alcoholic patients left the asylum within a month, 50 per cent within two months, and 75 per cent within five months; only 10 per cent remained after a year. The range is even more evident when the various classifications then used to distinguish degrees of alcoholic intoxication are examined. In contrast to their public discussions, in which doctors employed older, more popular terms such as drinker or drunkard, on certificates they used the terms alcoholic delirium, acute or subacute alcoholism, and chronic alcoholism. As Table 2 indicates, the least serious conditions were subacute alcoholism and alcoholic delirium, which represented 18 and 27 per cent respectively of all alcoholic diagnoses. These men were the youngest in age (predominantly in their 30s) and had the highest release rate and the shortest length of stay. However, as the

32 *Ibid.*, pp. 287–288.

33 *Rapport sur le service des aliénés*, 1895, pp. 281, 288.

34 Congrès annuel de médecine mentale, *Compte-rendu*, 1894, p. 221.

35 *Ibid.*, p. 233.

36 *Rapport sur le service des aliénés*, 1892, p. 210.

death rates indicate, alcoholic delirium could be fatal, and these patients had a death rate comparable to that of much older chronic alcoholics.[37]

At the other end of the spectrum were chronic alcoholics, with or without an incident of subacute alcoholism, who represented together about 31 per cent of alcoholic patients. Those labelled simply as chronic alcoholics were the oldest, had the lowest release rate, and stayed longer before being released. Not surprisingly, given their age profile, they also had a high death rate. Many of these were probably what doctors referred to as the "habitués" or "longtime pensioners of the asylum, these sad, poisoned derelicts".[38] Chronic patients who had been admitted as a result of an incident of subacute alcoholism were also older, but had a somewhat higher release rate and a very short length of stay. These were the patients whom doctors probably found most frustrating: they had been cured only of their passing overconsumption, not of their fundamental addiction, and therefore were likely to return. Those labelled simply as alcoholic appear to be an intermediate group in age, length of stay, and release rate. Although the label might simply be one of convenience (certificates were not always complete), it might also indicate that doctors considered the condition serious but were not yet ready to label it as chronic.

Notably absent from the asylum are those alcoholics whom psychiatrists deemed truly mad and therefore truly interesting, namely dipsomaniacs and *absinthiques*. French psychiatrists disagreed with Magnus Huss and others who saw dipsomania as simply an aggravated consequence of habitual drinking. Rather, for Valentin Magnan and his students, "the paroxysms of drinking" that characterized dipsomaniacs were an indication of a hereditary mental disorder. In a much-cited dictum, Magnan distinguished the dipsomaniac from the habitual drinker (*ivrogne*): "one is a lunatic before drinking, the other only becomes one because of drinking."[39] Yet as psychiatrists regretfully acknowledged, dipsomaniacs were rarely found in French asylums: at Sainte-Anne, in a sample of over 1,200 cases covering 40 years, there were only 22 cases, many of whom were women.

*Absinthisme*, a mental disorder supposedly induced by the consumption of the popular apéritif absinth, was equally scarce. In the words of Magnan, the acknowledged expert on this condition, "What distinguishes *absinthisme* is first, the manifestly epileptic attack, the vertigo, the early onset of delirium and, finally, the complete loss of memory."[40] Given Magnan's position as admitting psychiatrist for the asylums of the Seine, it would be logical to expect a number of such cases, particularly at Sainte-Anne, where the

37 Delirium tremens was rarely used as a diagnosis on certificates, but its effects are clear in the high death rate for this category.

38 *Rapport sur le service des aliénés*, 1897, p. 55

39 Valentin Magnan, *Leçons cliniques sur les maladies mentales (faites à l'asile clinique Sainte-Anne)* (Paris: Progrès médical, 1913), p. 106.

40 *Rapport sur le service des aliénés*, 1889, p. 143.

Admissions Office was located. Yet in the 40-year sample, there were only 32 cases that involved the excessive consumption of absinth. Moreover, despite the supposed gravity of the disorder, patients diagnosed as suffering from *absinthisme* had release rates comparable to those of other alcoholics. Nor did alcoholism provide what Magnan and his students considered to be the clinically most interesting cases, namely degenerates. Although alcoholism was considered to be both a symptom and a cause of hereditary degeneracy, in only 43 cases out of over 1,200 in this study were alcoholic patients labelled as degenerate, and the highest incidence was associated with dipsomaniacs (four cases out of 22) or *absinthiques* (three out of 32).

The pattern of diagnoses at Sainte-Anne confirms the complaints of asylum doctors about the inadequacies of alcoholic delirium as a criterion for alcoholic insanity. Its application had resulted in an unwieldy, diverse, and medically uninteresting group of patients. The decision by the Council of the Seine to erect a special asylum for alcoholics offered psychiatrists a new and potentially advantageous classification, namely curability. In their debates about the suitable patients for this facility, psychiatrists eagerly used the concept of curability to redefine their proper clientele. Not surprisingly, some doctors simply rejected the concept of medical treatment for alcoholics. They argued that the scarce finances of the departmental administration would be better spent on more "deserving" patients, such as women or the elderly. For those who considered alcoholics to be worthy of treatment, the key issue was the point at which addiction made the habitual drinker not simply the client but specifically the treatable client of the psychiatrist. Although the debate was confused, with little agreement on what distinguished the drunkard from the alcoholic or the lunatic alcoholic, asylum doctors managed to eliminate from their care patients at both ends of the drinking spectrum.

Given that this issue had arisen because of institutional problems, it is not surprising that the definition of curability that emerged from these discussions was also an institutional one, namely the number of admissions to an asylum. At one end of the spectrum were the "simple" or "pure" alcoholics, who did not display the signs of addiction. These patients were the *intoxiqués* "whom we see only once in our asylums and when their delirium has passed ... they do not return. They are often the victims of their profession, of a momentary poverty, of temporary conditions or bad hygiene and prejudices. ... Their stay is a lesson enough."[41] These "pure" alcoholics who, it was calculated, represented about one-third of admissions for alcoholism were, in Légrain's words, "the client of the general practitioner".[42] If they were readmitted, however, and classed in the terminology of the period as recidivists, then they were no longer "simple" alcoholics, but men

41 Conseil général de la Seine, "De l'assistance des alcooliques", p. 3.

42 *Ibid.*, p. 2.

with a "fatal penchant for drink". As Alexis Joffroy, professor of mental medicine at the University of Paris, explained, those who came back were *alcoolpaths* and degenerates.[43]

These patients, whose reappearance in the asylum was evidence of profound mental disorders, were not necessarily the clients of the psychiatrist. As the debates made clear, treatment would only be extended to the lucid, non-delirious, and curable.[44] The difficult problem of determining at what point addiction became chronic and therefore incurable was solved by using the measure of repeated admissions. For Paul Garnier, head of the Police Infirmary, alcoholics became "incorrigible" after the third relapse. Paul-Maurice Légrain also argued that, in terms of treatment, the third relapse was "fatal" and he refused to treat such patients. Marandon de Montyel was the most intransigent: for him, one relapse was enough.[45] Magnan was the most generous: he argued that only after eight entries did alcoholics exhibit "this state of physical, intellectual and moral degradation that makes them the most wretched of society's outcasts".[46]

In equating readmission with a chronic condition, French psychiatrists — who had no experience in the specialized treatment of alcoholics — were merely relying on the opinion of British, American, and German experts. They did not, however, take into consideration that French drinking patterns and cultural influences were different. Their willingness to accept what might appear to be harsh judgements on which patients would respond to treatment, in a country with the highest rate of alcohol consumption in the world, was made easier by their experience with overcrowded asylums and with certain alcoholics who reappeared 15 or 20 times. Their frustration is evident in the language they used to discuss chronic alcoholics, which ceased to be medical and became both moralizing and vituperative. These patients were described as "lazy", "parasites", "depraved", "degenerate", and "perpetually condemned to alcoholism".[47] As usual, Toulouse was the most hostile: he suggested that incurable alcoholics be sent to penal colonies outside France.[48] (The most notorious of these colonies was, of course, Devil's Island.)

By eliminating from their professional concern alcoholic patients at both ends of the drinking continuum, doctors were left with the ideal patient, one who was in the early stages of addiction. Such patients were also few in number. After a two-year experiment in treating alcoholics in separate wards of his service, Marandon de Monyel estimated that 300 beds would be more

43 *Rapport sur le service des aliénés*, 1898, p. 71.

44 *Rapport sur le service des aliénés*, 1894, pp. 72–73.

45 Congrès de médecins aliénistes, 1896, vol. 2, *Rapports*, p. 100; *Rapport sur le service des aliénés*, 1894, p. 163.

46 Rapport sur le service des aliénés, 1895, p. 171.

47 See, for example, *Rapport sur le service des aliénés*, 1897, p. 161, and 1913, p. 157.

48 *Rapport sur le service des aliénés*, 1894, p. 75.

than sufficient to treat all the alcoholic asylum patients in Paris.[49] When a special section for alcoholics was opened at the Ville-Evrard asylum in 1896, Légrain, the psychiatrist in charge, began systematically to weed out unsuitable alcoholics: "the old incurable drunks, the recidivists, the amoral who drink, the weak and the senile".[50] By 1911 he was convinced that 300 "calm and curable" alcoholics could not be found in Paris and that 125 beds would be enough to treat the "simple drinkers [*buveurs*] who are lucid, non-delirious and more or less predisposed to be cured".[51]

Classifications, as Édouard Toulouse once reminded his colleagues, are "the expression of general doctrines that vary with each period, with each school, with each practitioner ... when psychiatrists no longer know what to do, they make up a new classification."[52] As the debates over alcoholic madness in the 1890s indicate, however, classifications need not always be clinical. The concept of curability, which was a therapeutic or in this case an institutional criterion, offered psychiatrists an escape from the perceived inadequacies of delirium as a definition of alcoholic madness. Determining who was to be treated in specialized facilities inevitably meant determining who was not to be treated, and it was the latter task that attracted the most enthusiasm. For many doctors, alcoholics had not yet found their Pinel. Even those psychiatrists who argued that alcoholics were genuinely sick and therefore "worthy" of treatment were not willing to treat all alcoholics in their wards. Their attempt to exclude certain types of alcoholic behaviour from their professional responsibility was ultimately fruitless, and wards continued to be filled with unwelcome patients. Yet their debates suggest that medicalization, even when viewed solely from the point of view of the medical profession, is an ongoing and often contradictory process that can involve the rejection as well as the appropriation of a certain expertise.

The debate also underlines that if, as Claude Quétel has argued, psychiatrists remain ambivalent about alcoholism, their uneasiness can be intensified by the experience of treating alcoholics. Just as alcoholic delirium fit awkwardly into nineteenth-century definitions of madness, so alcoholic patients were not suited to the nineteenth century asylum. The experience of coping with large numbers of alcoholics in daily practice did not induce a sympathetic response in physicians. Marandon de Montyel typified the attitude of many psychiatrists when he pleaded, "Lord preserve us from alcoholics!"[53] When he had been persuaded by Magnan to treat alcoholics in specialized facilities at Ville-Evrard, however, he began to see them not as troublemakers or parasites, but as human beings. As he admitted, "they

49 *Rapport sur le service des aliénés*, 1895, p. 275.

50 *Rapport sur le service des aliénés*, 1911, p. 224.

51 *Ibid.*, p. 224.

52 *Rapport sur le service des aliénés*, 1895, p. 174.

53 *Annales médico-psychologiques*, vol. 12 (1890), p. 253. He used the term *ivrognes*.

were as gentle and patient as lambs."[54] Marandon's experience suggests that the structures of treatment play an important role in the process of medicalization, and that in France it was only after the Second World War, with the development of treatment facilities separate from the asylum, that new opportunities for the psychiatric treatment of alcoholics appeared.

Finally, if the medicalization of any condition is to be justified, it must be in terms of enabling effective treatment. What can be said about the thousands of alcoholics who passed through the asylums of the Seine from the mid-nineteenth century to the First World War? Many, whose alcoholic delirium would pass in a few days, probably did not need any psychiatric treatment. They would have been better served by hospital facilities, but hospitals used the existence of the asylum to rid themselves of patients who, in the terminology of medical certificates, "disturbed the tranquillity of other patients". For some alcoholics, committal to an asylum may have served as a warning, as certain doctors and families hoped; for others, it provided a good hotel, as many doctors feared. For a number of patients, the asylum served as a detoxification centre, although this function should not be overestimated. As Légrain noted sardonically, "an absence of alcohol is not precisely the virtue of our asylums."[55] (Patients who worked in asylums were given bonuses of wine, and alcoholics were reputed to be the most reliable workers.) Probably the best that can be said is that most alcoholic patients emerged from the asylum better fed and in better physical condition than when they entered. Any benefit, however, came at the cost of a loss of liberty and the public stigma of being labelled a lunatic.

54 *Annales médico-psychologiques*, vol. 20 (1894), p. 432.
55 *Rapport sur le service des aliénés*, 1898, p. 177.