UNIVERSITY OF SOUTHAMPTON

FACULTY OF HUMANITIES

History

THE IMPACT OF WAR AND OCCUPATION IN PSYCHIATRIC HOSPITALS IN FRANCE 1939 TO 1944

by

Patricia Sinclair Legg

Thesis for the degree of Doctor of Philosophy

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ABSTRACT

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Patricia Sinclair Legg

Before the German occupation, mortality in French psychiatric hospitals was comparatively stable, the national annual average ranging from 3 to 10%. During the German occupation mortality rose precipitously to over 30% in some cases and total patient-deaths numbered more than 45,000. How and why this happened and who died is examined through a case study of four psychiatric hospitals: three 'closed' institutions in which patients were committed and interned as mentally ill and a C*olonie familiale,* similar to current community care, in which patients lodged in foster homes. Examination of the history of these hospitals offers an insight into institutions within the *Assistance psychiatrique* (French welfare system which included mental hospitals) managed by the state and by the Religious Order of the Brothers of Saint-Jean.

Normalcy of daily life for inpatients and personnel was disrupted when France joined the Second World War and the mobilisation of able-bodied Frenchmen by France's subsequent defeat and occupation. Psychiatric hospitals relied essentially on male labour for nursing, discipline and security, general maintenance and building works, internal hospital services, and crucially for food provisioning from their vast farmlands and agricultural production.

Disruption of daily life and the intensity of harsh restriction of foodstuffs and raw resources were brought about by the Vichy regime's rationing system imposed by the German occupiers. Severe malnutrition and ill-health affected the nation. For patients in psychiatric hospitals, already 'at risk' of increased mortality due to their mental condition, the consequences of the Occupation were fatal. Psychiatrists administering the target hospitals were unable to act autonomously and although many responded positively to the crisis of limited and ever-dwindling rations and consequent malnutrition suffered by their patients. The Occupation exposed grave and entrenched deficiencies in institutional management and professional practice for mentally ill inpatients.

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Research Thesis: Declaration of Authorship

Print name:	PATRICIA SINCLAIR LEGG

Title of thesis:	THE IMPACT OF WAR AND OCCUPATION IN PSYCHIATRIC HOSPITALS IN FRANCE 1939-1944

I declare that this thesis and the work presented in it is my own and has been generated by me as the result of my own original research.

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3. Where I have consulted the published work of others, this is always clearly attributed;
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information. At a local level, there are over 137 psychiatric hospitals listed as functioning during the occupation years and I am most grateful to all those involved in directing me towards my eventual target hospitals.
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If I have missed anyone out, my apologies but I want you all to share in my happiness at finishing my 'obsession'. Above all, I would like to thank my husband for his personal support and great patience at all times whether financing my research projects or university fees or having to read another chapter or the same one 'yet again?'

Abbreviations and Definitions

Abbreviations

AD	Archives départementales
ADA	Archives départementales d'Allier
ADCA	Archives départementales des Côtes-d'Amor
ADCDN	Archives départementales Côtes-de-Nord
ADHG	Archives départementales Haute Garonne
ADHM	Archives départementales Haute Marne
ADRA	Archives départementales Rhône Alpes
AMP	Annales médico-psychologiques
AN	Archives nationales
ANF	Archives Nationales Fontainebleau
ANP	Archives Nationales Paris
ARHRA	Agence Régionale de l'Hospitalisation de Rhône-Alpes
BIUM	Bibliothèque interuniversitaire de médecine
CAC	Centre des Archives Contemporaines Fontainebleau
CH	Centre hospitalier
CHAN	Centre historique des archives nationales
CHR	Centre hospitalier régional
CHS	Centre hospitalier spécialisé
CHU	Centre hospitalier universitaire
CIM	Classification internationale des maladies (Also referred to as Bertillon Classification of Causes of Death and the International classification of the nomenclature of diseases and causes of death)
CNRS	Centre national de la recherche scientifique
CRP	Centre Rosenwald, Paris
CRSDP	Croix Rouge, Service de la documentation, Paris

DDASS	Direction Départementale des Affaires Sanitaires et Sociales
ECT	Electro-convulsive therapy
FMHS	French mental hospital system
FNDIRP	Fédération nationale des déportés et internés résistants et patriotes
HP	Hôpital psychiatrique (psychiatric hospital)
IGAE	Inspection générale de l'agriculture, ministère de l'économie et des finances
IHPT	Institut d'histoire du temps présent
INED	Institut national d'études démographiques
INH	Institut national d'hygiène
INSEE	Institut national de la statistique et des études économiques
INSERM	Institut national de la santé et de la recherche médicale
IRDES	Institut de recherche et documentation en économie de la santé
JO	Journal official
MAGF	Ministère de l'Intérieur, Administration générale, Ministère d'état à la famille et à la Santé
MC	Médecin-chef-de-service (MC psychiatrist in charge of a group of patients, by classification of pathology and their living quarters)
MCO	Médicine Chirurgie Obstétrique
MD	Médecin-directeur (MD Medical director or Superintendent psychiatrist)
OPHS	Office Publique d'Hygiène Sociale
PMSI	Projet de Médicalisation du Système d'Information
POW	Prisoner of war
RCB	The British Red Cross Archives, London
SERPSY	Soins, Étude et Recherche en psychiatrie
SGF	Statistiques générale de France
SH	Société d'hygiène
SMP	Société médico-psychologique

TH	Study target psychiatric hospital
UHAALC	Unclassified hospital archives Ainay-le-Château
UHABS	Unclassified hospital archives Bon-Sauveur
UHAGM	Unclassified hospital archives Gérard Marchant
UHASD	Unclassified hospital archives Saint-Dizier
UHASJD	Unclassified hospital archives Saint-Jean-de-Dieu
UHAB	Unclassified hospital archives Bassens Savoie

Definitions

CIM	Referred to as Bertillon Classification of Causes of Death and the International classification of the nomenclature of diseases and causes of death
Conseil général	County councillors (a president of the Conseil is elected by the councillors)
Conseil municipal	Assembly elected by direct general elections in each village or town who thenb elect the mayor (for 25000 inhabitants)
Département	Similar to an English county
Indigents	State funded patients
Patient dossiers	Patient case history – the physical folders which contain admission questionnaire, psychiatrists' notes, letters from relatives and patient, and various articles owned or collected by nurses or the psychiatrist in charge of the patient
Pensionnaires	Private paying patients
Préfet	Prefect or senior civil servant representing the authority of the state in a department recommended to President of France by le Ministère de l'Intérieur (Home Office Minister), has administrative powers and supervises the police although not in Paris and larger towns where there are two prefects

Chapter 1 The French psychiatric hospital system and the German occupation

In 1838, France became the first nation to promote national support and public funding for the provision of asylums for the insane with the passing of the *Loi sur les aliénés no. 7443 du 30 juin 1838* (asylum law).[1] When the German armies invaded France in 1940 the asylum had been renamed psychiatric hospital and doctors with an interest in the brain – alienists - had been retitled psychiatrists, but very little else had changed in an institutional system that was underfunded, overcrowded, understaffed: in need of total reform. The system was nearly a hundred and fifty years old before the 1838 law was fully revised.[2] However, the need for reform, demanded by psychiatrists since before the 1920s, was dramatically demonstrated by the inadequacies of the institutional system of mental care during the Occupation and came at great price: over 40 to 45000 mentally ill hospitalised patients died between 1939 and 1944.[3] The Occupation

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[1] In order to retain the authenticity of historical identity, this study follows the example of scholars such as Ann Digby and Pamela Michael whose use traditional terms of reference both for the mentally ill and mental illness, such terms and phrases as asylum, which was in general use until the mid-1950s: insane, imbecile, idiot, retarded, dements and softening of the brain. They were part of the classification of mental diseases admitted to the asylum. Their method adds texture and reality to this study.
E. Lonchampt and Charles de Picamilh, *Bulletin des lois du Royaume de France IXe série. Règne de Louis-Philippe 1e roi des Français. Premier semestre de 1838*, (Paris: Imprimerie Royale, 1838), pp. 1005-20; France Meslé and Jacques Vallin,'La population des établissements psychiatriques: Evolution de la morbidité ou changement de stratégie médicale?', *Population,* 36, (1981), 1035-68; Also see Ascodocpsy, 'Textes officiels historiques' <http://www.ascodocpsy.org/trouver-de-linformation/textes-officiels-historiques/> [Accessed 1 December 2016] ; Martin Gittelman,'The French Mental Health System', *International Journal of Mental Health,* 38, (2009), 5-24 (p. 7).

[2] Bulletin officiel de l'état au ministère de la santé publique. Circulaire Rucart de 13 octobre 1937 relative à la réorganisation de l'Assistance psychiatrique dans le cadre départemental, adressé au préfets.

[3] François Chapireau, Documents de Travail: La mortalité des malades mentaux hospitalisés en France pendant la deuxième guerre mondiale, 146, 2007; Nicolas Henckes,'Narratives of change

and Vichy were influential in these deaths and after the Liberation, many psychiatrists who had personal experience of all that was archaic and inhumane about the *Assistance psychiatrique*, part of the state welfare system originally encompassing the asylum system, renamed French mental hospital system (FMHS), renewed their calls for reform.[4]

After the Liberation, many in society: people with mental health problems, their relatives and the professions with which mental healthcare services were associated, repeated the call for much-needed reform of psychiatric practice and a restructuring of treatment and care facilities.[5] However reform, under the term *sectorisation*, or deinstitutionalisation of psychiatric services, was long in the making. Not until the 1960s, was there a dramatic shift in the principle of the asylum system as a carceral institution, still defined by the 1838 law. Care of the mentally ill was removed from the traditional closed institution to community-based psychiatric services units with facilities for patients and their families.[6]

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and reform processes: Global and local transactions in French psychiatric hospital reform after the Second World War', *Social Science & Medicine,* 68, (2009), 511-18; Nicolas Henckes,'Between tutelage and assistance: The debate over the reform of the 1838 French law on insane people from the 1870s to the 1910s', *Sciences Sociales et Sante,* 35, (2017), 81-108.

[4] Nicolas Henckes, 'Le nouveau monde de la psychiatrie français; les psychiatres, l'Etat et le réforme de l'après-guerre aux années 1970', (doctoral thesis, Ecole des hautes études en sciences sociales (EHESS), 2007), pp. 162-3. Among those reformers were: Henri Ey, Louis Anglade, Paul Balvet, Louis Le Guillant, Lucien Bonnfé, François Tosquelles, Georges Daumézon and Paul Sérieux; Isabelle von Bueltzingsloewen,'Le militantisme en psychiatrie, de la Libération à nos jours. Quelle histoire?!', *Sud/Nord,* 1, (2010), 13-26.

[5] Nicolas Henckes,'Reforming psychiatric institutions in the mid-twentieth century: a framework for analysis', *History of Psychiatry,* 22, (2011), 164-81 (p. 164).

[6] Magali Coldefy,'L'évolution des dispositifs de soins psychiatriques en Allemagne, Angleterre, France et Italie: similitudes et divergences', *Questions d'économie de la Santé (IRDES)*, (2012), 1-8 (p. 2); Nicolas Henckes, 'French Deinstitutionalisation or the Irony of Success: Psychiatrists, the State and the Transformation of the French Pyschiatric System, 1945-2010', in *Deinstitutionalisation and After: Post-War Psychiatry in the Western World,* ed. by Despo Kritsotaki, Vicky Long, and Matthew Smith (Cham, Switzerland: Springer, 2016), pp. 115-34; Emilia Vynnycky and Paul E. M. Fine,' Lifetime Risks, Incubation Period, and Serial Interval of Tuberculosis', *American Journal of Epidemiology,* 152 (2000), 247-63; Helen Killaspy,'From the asylum to community care: learning from experience', *British Medical Bulletin,* 79-80, (2006), 245-58.

However, despite measures and initiatives to improve the quality of life for those with mental health issues, a term which replaced insanity and mental illness, marked disparities in financial resources and in the geographical offer of care facilities, were still much in evidence at the beginning of the twenty-first century.[7]

In 2001, an initiative entitled, '*Santé Mentale: l'usager au centre d'un dispositif à 'rénover*'' (Mental Health: the user at the core of an organisation in need of renovation), as if reinforcing significant gaps in provision of care, was one of several national programmes aimed at remodelling French mental health structures and management for those with mental issues.[8] Mental health was still low on the political agenda but current trends in scholarship on the Occupation years addressing victims of the Holocaust and the need for commemoration in France opened a new narrative. In November 2013, a petition was presented to the President of the French republic by Charles Gardou, professor of anthropology at the université de Lyon (Lumière Lyon 2).[9] Together with Maryvonne Lyadzid,

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[7] Magali Coldefy, Philippe Le Fur, Véronique Lucas-Gabrielli, and Julien Mousquès, Fifty Years of Deinstitutionalisation Policy of Psychiatric Services in France: Persistent Inequalities in Terms of Resources and Organisation Between Psychiatric Sectors, 145, 2009; Magali Coldefy, 'De l'asile à la ville: une géographie de la prise en charge de la maladie mentale en France', (doctoral thesis, université Paris 1 Panthéon-Sorbonne, 2010); Raphaël Gourevitch, Clara Brichant-Petitjean, Marc-Antoine Crocq, and François Petitjean,'Law & Psychiatry: The Evolution of Laws Regulating Psychiatric Commitment in France', *Psychiatric Services,* 64, (2013), 609-12; Jean Louis Senon, Carol Jonas, and Michel Botbol,'The New French Mental Health Law Regarding Psychiatric Involuntary Treatment', *British Journal of Psychiatry International,* 13, (2016), 13-15; K. Oshima and Y. Abe,'French psychiatric therapeutic system for adults, an overview of mental health legislations', *Seishin Shinkeigaku Zasshi,* 114, (2012), 396-407; I. Laffont and R. G. Priest,'A comparison of French and British mental health legislation', *Psychological Medicine,* 22, (1992), 843-50; For futher work on sectorisation see: V. Kovess, B. Boisguérin, D. Antoine, and M. Reynauld,'Has the sectorization of psychiatric services in France really been effective?', *Social Psychiatry and Psychiatric Epidemiology,* 30, (1995), 132-8.

[8] Plan santé mentale: L'usager au centre d'un dispostif à rénover; Also see: Dominique Provost and Andrée Bauer,'Trends and Developments in Public Psychiatry in France since 1975', *Acta Psychiatrica Scandinavica,* 104, (2001), 63-68 (p. 68).

[9] Unknown, 'Allocution de M. Jacques Chirac, Président de la République, et les responsabilités de l'État français (25 august 2014 Le Monde 18 July 1995 6,11)' <http://www.lemonde.fr/revision-du-bac/annales-bac/histoire-terminale/jacques-chirac-president-de-la-republique-et-les-

president of the Association des mouvement pour une société inclusive, they collected over 94,000 signatories for a memorial in homage to all handicapped victims of the Nazi regime and Vichy. Government ministers, Marisol Touraine, Ségolène Neuville, and Jean-Marc Todeschini, commissioned historian Jean-Pierre Azéma to investigate claims in the petition.[10]

As president of the committee for the celebration of the seventieth anniversary of the Allied landings in France, Azéma analysed the latest scholarship on the drama experienced by people in psychiatric hospitals (HPs) and hospices in order to clarify the situation for the public powers.[11] Media coverage and patient and family advocacy groups were fired to revive and revisit the history of those who died in psychiatric hospitals during the years 1939 to 1944. In February 2015, President François Hollande sanctioned the demand for commemoration of the mentally ill

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responsabilites-de-l-etat-francais_t-hrde125.html#udA3lBt9uP1Ybtc1.99> [Accessed 2016] ; Unknown, 'Allocution de M. Jacques Chirac, président de la République, prononcée le 16 juillet 1995, lors des cérémonies commémorant la grande rafle des 16 et 17 juillet 1942' <http:www.jacqueschirac-asso.fr/archives-elysee.fr/elysee.fr/francais/interventions/discours_et_declarations/1995/juillet/fi003812.html> [Accessed 2016]

[10] Marisol Touraine was ministre des affaires sociales, de la santé et des droits des femmes, Ségolène Neuville, secrétaire d'État chargée des personnes handicapées et de la lutte contre l'exclusion, and Jean-Marc Todeschini, secrétaire d'État aux anciens combattants et à la mémoire.

[11] Jean-Pierre Azéma, Mission sur le drame que les personnes handicapées mentales ou malades psychiques ont connu dans les hôpitaux psychiatriques et les hospices français entre 1941 et 1945, 2015; Secrétariat d'État chargé des personnes handicapées et de la lutte contre l'exclusion auprès de la ministre des affaires sociales de la santé et des droits des femmes Secrétariat d'Etat chargé des anciens combattants et de la mémoire auprès du ministre de la Défense, 'Remise de rapport Jean-Pierre Azéma', ed. by Ségolène Neuville and Jean-Marc Todeschini (Ministère de la Défense. Salle de Presse, 2015). ; For the full report see Azéma, Mission sur le drame; Robert O. Paxton, *Vichy France: Old Guard and New Order 1940-1944*, (New York and Chichester: Columbia University Press, 1972); Brigitte Keriven,'France during World War II. Historiographic analysis based upon the Annual bibliography of the French history (Bibliographie annuelle de l'histoire de France) 1964-2010', *5th Conference on European Historical Bibliographies, Prague, 7-8 november 2013*, 2013 10; Olivier Wieviorka, *La mémoire désunie: Le souvenir politique des années sombres de la Libération à nos jours*, (Paris: Seuil, 2010); Azéma, Mission sur le drame; Paxton, *Old Guard and New Order*; Keriven, 5th Conference on European Historical Bibliographies. France during World War II, p. 10; Azéma, Mission sur le drame.

in the system that miserably failed them during the German occupation and the Vichy period. This undertaking was in part a continuation of the theme of President Jacques Chirac's acknowledgement in 1995 of the part played by the state in the victimisation and deportation of 76000 Jews.

As part of the politics and practices of commemoration and reparation, Azéma, entitled his report, 'Mission sur le drame que les personnes handicapées mentales ou malades psychiques ont connu dans les hôpitaux psychiatriques et les hospices français entre 1941 et 1945'. He presented historical facts of the fate of many handicapped people; minority groups such as the elderly, physically handicapped, and especially those in psychiatric hospitals. His study led to a proposal for the erection of a monument in the Place des droits de l'homme, Saint-Denis, Paris, and a commemorative plaque outside each psychiatric hospital functioning during the Occupation. Until such an open political stand and increased public pressure given to the fate of those marginalised from society by mental illness there had been little academic attention from historians of psychiatry or social scientists on the practice of psychiatry under Vichy.

1.1 Historiography

This study takes a sociological perspective from existing historiography of scholars like Roy Porter, who reject the control and discipline Foucauldian interpretation, seeing instead the asylum as a place of disease and treatment as a progression of care and refuge given by Church through religious orders and communities, and progressing towards a medicalisation of the insane and the state's involvement with asylum facilities, within the humane concepts of treating insanity in early alienist thought: partly benevolent and partly medical imperative to learn more of

the causes and treatment of insanity and a desire to humanise the internment of the insane.[12]

This study is set within both the lively historiography of alienism and the development of French psychiatry which is much more developed in the French language than in English and the social history of Vichy which is well-established in both languages. The study draws on scholarship of historians of medicine and medical and social sciences, Dora Weiner, Colin Jones, Hervé Guillemain, and Jan Goldstein, among others who offer invaluable insight into the nature and origins of how insanity was conceived and treated, or more precisely managed.[13] They

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[12] M. Masson and M-L. Bourgeois,'La médicalisation de l'intuition charitable: De Saint Jean de Dieu à Philippe Pinel', *Annales médico-psychologiques,* 164, (2006), 237-43; Guy Le Gaufey and Gérard Bleandonu,'Naissance des asiles d'aliénés (Auxerre-Paris)', *Annales, Économies, Sociétés, Civilisations*, (1975), 93-121; Roy Porter, *The Greatest Benefit To Mankind : A Medical History of Humanity from Antiquity to the Present*, (London: HarperCollins, 1997); Roy Porter and Mark S. Micale, *Introduction: Reflection on Psychiatry and its Histories*, (Oxford: Oxford University Press, 1994); Roy Porter and David Wright, 'The Confinement of the Insane: International Perspectives, 1800-1965', (Cambridge: Cambridge University Press, 2003); Gérard Cholvy and Yves-Marie Hilaire, *Histoire religieuse de la France contemporaine, 1933-1988*, (Paris: Bibliothèque historique Privat, 1988).

[13] Dora B. Weiner, *Comprendre et soigner: Philippe Pinel, 1745-1826: la médecine de l'esprit*, (Paris: Fayard, 1999); Dora B. Weiner, 'The Madman in the Light of Reason. Enlightenment Psychiatry: Part I. Custody, Therapy, Theory and the Need for Reform', in *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-Body Relation,* ed. by John Gach Edwin R. Wallace (New York: Springer, 2010), pp. 255-80; Dora B. Weiner,'The Brothers of Charity and the Mentally Ill in Pre-Revolutionary France', *Social History of Medicine,* 2, (1989), 321-37; Colin Jones, *The Charitable Imperative: Hospitals and Nursing in Ancien Régime and Revolutionary France*, (New York: Routledge, 1989); Colin Jones,'The Treatment of the Insane in Eighteenth and Early Nineteenth-Century Montpellier. A Contribution to the Prehistory of the Lunatic Asylum in Provincial France', *Medical History,* 24, (1980), 371-90; Colin Jones,'Sisters of Charity and the Ailing Poor', *Social History of Medicine,* 2, (1989), 339-48; Hervé Guillemain, *Diriger les consciences, guérir les âmes. Une histoire comparée des pratiques thérapeutiques et religieuses (1830-1939)*, (Paris: La Découverte, 2006); Hervé Guillemain,'Médecine et religion au XIXe siècle: Le traitement moral de la folie dans les asiles de l'Ordre de Saint-Jean-de Dieu (1830-1860)', *Le Mouvement Social*, (2006), 35-49; Jan Goldstein, *Console and classify: The French psychiatric profession in the nineteenth century*, (Cambridge: Cambridge University Press, 1987); Masson and Bourgeois, La médicalisation de l'intuition charitable; Marc Masson, 'Soins et assistance prodigués aux aliénés par les Frères de Saint-Jean-de-Dieu dans la France du XVIIIe siècle: pour une contribution à la réflexion sur la place de l'humanisme dans la pratique psychiatrique', (doctoral thesis, université de Bordeaux 2, 1999).

interpret the care and welfare given to the insane as originally embodied grounded in religion and humanitarianism.[14]

Historiography of the development of the asylum system was originally Whiggish, a medically dominated perspective, in which the asylum was a place for the medicalisation of the insane by physicians with Enlightenment ideas of scientific progress, written mainly by alienists themselves. They include founders of the system, Phillipe Pinel (1745-1826), Jean-Etienne-Dominique Esquirol (1777-1840), and like-minded physicians interested in the brain.[15] Although even within the newly formed discipline there were conflicting ideas of the direction of treatment which was mostly centred on classification and observation with very little individual care for the insane person.

From the 1900s onwards, there were few major medical works on the progress of French psychiatry in broad terms such as Emmanuel Régis' *Précis de la psychiatrie* and Henri Baruk's *La psychiatrie de Pinel à nos jours,* while alienists such as Edouard Toulouse and Paul Sérieux focused on alternative methods of managing the insane and on reform of the asylum system already deemed as archaic.[16] By

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[14] Gladys Swain, *Le sujet de la folie: naissance de la psychiatrie*, (Toulouse: Privat, 1977).
[15] Philippe Pinel, *Traité médico-philosophique sur l'aliénation mentale ou la manie*, (Paris: Richard, Caille et Ravier, 1801); Etienne Esquirol, *Des établissements des aliénés en France, et des moyens d'améliorer le sort de ces infortunés. Mémoire présenté à son excellence le ministre de l'Intérieur, en septembre 1818 par le dr Esquirol, médecin de la Salpêtrière*, (Paris: Madame Hazard, 1819); Others include: V. Magnan, *De l'alcoolisme, des diverses formes de délire alcoolique et de leur traitment*, (Paris: Delahaye, 1874); For works on other alienist historians see: Thierry Haustgen,'Les psychiatres historiens', *Evolution Psychiatrique* 82, (2017), 483-99.
[16] Emmanuel Régis, *Précis de Psychiatrie*, 5th edn (Paris: Doin, 1914); H. Baruk, *La psychiatrie française de Pinel à nos jours*, (Paris: PUF, 1967); Edouard Toulouse,'L'Open-door en Écosse', *Revue de Psychiatrie: médecine mentale, neurologie, psychologie*, (1898); Edouard Toulouse,'Organisation sociale de l'hygiène mentale', *La Revue philanthropique. Revue de l'Assistance. Bulletin de la société internationale pour l'étude des questions d'Assistance*, (1920), 354-5; Paul Sérieux, *L'assistance des aliénés en France, en Allemagne, en Italie et en Suisse*, (Paris: Imprimerie municipale, 1903); Paul Sérieux and Lucien Libert,'Le régime des aliénés en France au XVIIIe siècle d'après des documents inédits', *Annales médico-psychologiques,* 7, (1916), 74-98; Also see the works of: Jacques Postel and

the 1960s, a system over a hundred and twenty years old had attracted a powerful anti-psychiatry movement and both psychiatry and the FMHS entered the public domain, in large part due to the work of Michel Foucault.[17] He labelled the asylum as part of the 'Great confinement'. He and other punishment and discipline theorists argued that the asylum system was political economy, a control mechanism with which to protect society and lock up deviants, vagrants, prostitutes and the insane.[18] Such scholars of an anti-psychiatry opinion include philosopher Robert Castel and although not seen greatly in French historiography, Thomas Szasz, Erving Goffman and lastly Andrew Scull with his revisionist approach typified in one of his works, *Museums of Madness*.

Psychiatry was attacked for its abuse of patients' rights, and terrible conditions in which patients were incarcerated and treated. An anti-psychiatry culture brought to the fore a deep malaise within the FMHS with a proliferation of psychiatric narrative and calls for renewal of the reform plan.[19]

Claude Quétel, *Nouvelle histoire de la psychiatrie. La naissance de la psychiatrie au début du XIX siècle*, (Toulouse: Privat, 1983); Robert Nye,'Médecins, éthique médicale et État en France 1789-1947', *Le Mouvement Social,* 1, (2006), 19-36; Claude Quétel, *Histoire de la folie de l'Antiquité à nos jours*, (Paris: Tallandier, 2009); Henri Vermorel and André Meylan, *Cent ans de psychiatrie: Essai sur l'histoire des institutions psychiatriques en France de 1870 à nos jours*, (Paris: Editions du Scarabée, 1969).

[17] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, 1st edn., Naissance de la Clinique, Paris: PUF, (1963) edn (London: Tavistock, 1973); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, (London: Routledge, 1999).

[18] Robert Castel, *L'ordre psychiatrique. L'âge d'or de l'aliénisme*, (Paris: Minuit, 1976); Guillemain, Médecine et religion au XIXe siècle; Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, (New York: Paladin, 1961); Irvine Goffman, *Asylums: Essays on the social situation of mental patients and other inmates*, (Garden City, New York: Doubleday & Co., Anchor Books, 1961); Andrew T. Scull, *Museums of Madness: the social organization of insanity in nineteenth-century England*, (London: Allen Lane, 1979); Also see: Ian R. Dowbiggin, *Inheriting Madness: Professionalisation and Psychiatric Knowledge in Nineteenth Century France*, (Berkeley, Los Angeles and Oxford: University of California Press, 1991); R.D. Laing, *The Divided Self: An Existential Study in Sanity and Madness*, (London: Taverstock, 1960); David Cooper and R.D. Laing, 'Psychiatry and Anti-Psychiatry', (Boulder Colorado: Paladin, 1967).

[19] Jacques Postel and David F. Allen, 'History and Anti-Psychiatry in France', in *Discovering the History of Psychiatry,* ed. by Mark S. Micale and Roy Porter (Oxford Oxford University Press, 1994),

Although by the 1970s *sectorisation* or deinstitutionalisation of the hospital system had been initiated by the state, little tangible effect had been seen by psychiatrists, patients or their families. This produced a deep malaise within the profession.[20] Undoubtedly, the anti-psychiatry period of the 1970s questioned psychiatric theory and practice and the validity and integrity of the profession itself. But, no deliberation or disclosure produced such dramatic and confrontational provocation as the publication in 1987 of *Extermination Douce,* by Max Lafont, intern in psychiatry in HP Le Vinatier, Bron, in Lyon.[21] It was the catalyst of a far-reaching and meaningful consideration by both mental health service authorities and the profession of psychiatry. The book ignited criticism and controversy, contradiction and, although to a small degree, concurrence to Lafont's *dénuement* of alarming events in HPs during the Occupation. The publication was based on his 1981 medical thesis at Vinatier, the second largest HP in France with around 2700-2800 patients in 1939.[22] Lafont's claims are polemic, rebellious and sweeping, but within his work, there are certain thought-provoking arguments, reflective of much psychiatric debate from well before the 1940s. However, his medical and statistical allegations are poorly researched and inadequately referenced and considerably weak for robust historical scrutiny. His work shouts of frustration with a strong

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pp. 384-414; M. Verpeaux, 'Genèse de la notion de sectorisation en psychiatrie', (doctoral thesis, université de Dijon, 1975).

[20] Helena Medeiros, David McDaid, and Martin Knapp, *Shifting care from hospital to the community in Europe: Economic challenges and opportunities*, (London: Personal Social Services Research Unit, London School of Economics and Political Science, 2008).

[21] Max Lafont, *L'Extermination douce: la Mort de 40.000 malades mentaux dans les hôpitaux psychiatriques en France, sous le régime de Vichy*, (Ligné: Arefppi, 1987).

[22] Max Lafont, 'Déterminisme sacrificiel et victimisation des malades mentaux: Enquête et réflexions au sujet de la mortalité liée aux privations dans les hôpitaux psychiatriques français pendant la Seconde Guerre mondiale', (doctoral thesis, université de Claude Bernard, Lyon I, 1981); Isabelle von Bueltzingsloewen,'Les « aliénés » morts de faim dans les hôpitaux psychiatriques français sous l'Occupation', *Vingtième Siècle. Revue d'histoire,* 4, (2002), 99-115 (p. 28); Isabelle von Bueltzingsloewen, Dossier de Presse: Destin des fous: La famine dans les hôpitaux psychiatriques français sous l'Occupation: L'exemple de l'hôpital du Vinatier, 2003.

anti-psychiatry tone. He criticises the state's lethargy in establishing long-awaited reform and restructuring of facilities for mental health care.[23]

Lafont's thesis is centred on a large increase in mortality in Vinatier, which he claims was caused mainly by Vichy's collaborationist stance and its inadequate rationing programme. He accuses Vichy of a covert eugenic policy towards the mentally ill, firstly juxtaposing the fate of French mentally ill people with that of those in Germany, and secondly, French psychiatrists to their counterparts in Germany who were complicit in the Third Reich's slaughter of the disabled and mentally ill: active actors in the T4 Aktion euthanasia programme.[24] He argues that French patients were neglected and allowed to die from cold and hunger within an antiquated hospital system that was presided over by a divided and apathetic profession, hampered by social ignorance of the needs of the mentally ill. He argued that 2000 patients more than should have been expected died in his teaching hospital. Clarifying his accusations that psychiatrists were indifferent at least and culpable at worst, Lafont claimed after the Liberation there was collective amnesia: a medical silence tantamount to disinterest in the situation of the mentally ill during the German occupation, inferring a cover-up.[25]

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[23] Isabelle von Bueltzingsloewen, 'Morts d'inanition: Famine et exclusions en France sous l'Occupation', (Rennes: Presses universitaires de Rennes, 2005), pp. 51-63,); Senon, Jonas, and Botbol, The New French Mental Health Law Regarding Psychiatric Involuntary Treatment; Coldefy, et al, Fifty Years of Deinstitutionalisation Policy of Psychiatric Services in France; Henckes, Reforming psychiatric institutions in the mid-twenthieth century; Hélène Verdoux,'The current state of adult mental health care in France', *European Archive of Psychiatry and Clinical Neuroscience,* 257, (2007), 64-70.

[24] Michael Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-1945*, (London: Pan MacMillan, 2002), p. 281; E. Fuller Torrey and Robert H. Yolken,'Psychiatric Genocide: Nazi Attempts to Eradicate Schizophrenia', *Schizophrenia Bulletin,* 36, (2010), 26-32; Thomas Roeder, *Psychiatrists - The Men Behind Hitler: The Architects of Horror*, (California: Freedom Publishing, 1995).

[25] Lafont, *L'Extermination douce (1987),* p. 122 and 31.Bonnafé speaks to Lafont of 'une grande conspiration du silence'.

There was an immediate response to Lafont's claims, but only within a psychiatric audience. Psychiatrist, Charles Brisset, opined that on the whole Lafont's work was honest if rather disorganised but, refuted Lafont's allegations.[26] He argued that while most psychiatrists during the Occupation were not heroes, many did as much as they could to help their patients, with the limited resources available to them. He laid bare the cold reality of psychiatric care in 1939: ninety-six psychiatric hospitals with 103,000 inpatients and 200 psychiatrists for all of France. The profession was faced with an onerous task. This statistic equates to a ratio of 1: 500 doctor/patients and many hospitals had over three times the recommended patient numbers stipulated by the then current legislation. Here we see at best a lack of funding by the government and at worse methodical institutional discrimination against a minority group. Psychiatrist Gérard Massé insisted that the occupier was to blame for increased deaths and defended the strategy of many psychiatrists of whom he claimed, certain were involved in the Resistance movement, proof in his opinion of their commitment to humanity.[27] However, most refutations like Massé's were only published within the closed confines of psychiatry. But there was a demonstrable collective willingness by many in psychiatry to address the darkest period in its history during the Occupation years and to use this period and tragic events to draw attention to the reality of the FMHS as not fit for purpose, as many had done before the 1940s. Psychiatry took the situation to intensify demands for the completion of the deinstitutionalisation programme for the mentally ill, specifically as the system was judged by many to be a key factor in high mortality in HPs between 1940 and 1945.

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[26] Charles Brisset,'A propos de l'extermination douce de M. Lafont: Un scandaleux amalgame du journal Le Monde', *Evolution psychiatrique,* 52, (1987), 959-65 (p. 961).
[27] Gérard Massé,'Nuit et brouillard en psychiatrie?', *Nervure,* 4, (1991), 7.

However, the impact of the Occupation and the Vichy regime on psychiatry and the FMHS cannot be taken in isolation. The reality of life and death in the target hospitals will be contextualised with experiences of the general population taken from social and cultural histories in English and French scholarship. Throughout social history literature for this period, scholars have aligned their work to key themes. The shift in historiography of Vichy is significant, from collaboration and resistance to institutions of power such as banking and the coal industry to local towns and groups of people. For this study certain approaches and interpretations are significant and will function as core themes.

Robert Gildea focused on civilian experiences of Chinon, a small town in the Loire valley, along with the tangible effects of the socio-economic conditions that were experienced by the 6000 inhabitants. He mixes fact with testimony to give a fuller, more intimate knowledge of life and his work encourages a closer interpretation of human behaviour and attitudes.[28] He argues that local intrigues and conflicts underpinned methods of adaption taken by many locals with activities motivated by practicality rather than political bent or idealism. Social historians argue that attitudes and human behaviour were influenced by the conditions of everyday life and while some citizens were sympathetic there were others who acted selfishly.[29] Conversely historian Ian Ousby argues that with the passing of time many in society got used to the horror of the German presence, 'In public places where daily life went on, it [German presence} was taken for granted. It grew invisible.[30]

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[28] Robert Gildea, *Marianne in Chains: In Search of the German Occupation, 1940-1945*, (London: Macmillan, 2002).
[29] Kenneth Mouré,'Economic Choice in Dark Times. The Vichy Economy', *French Politics, Culture and Society,* 25, (2007), 108-30; John F. Sweets, *Choices in Vichy France: The French under Nazi Occupation*, (Oxford: Oxford University Press, 1994); Philippe Burrin, *La France à l'heure allemande, 1940-1944*, (Paris: Seuil, 1995).
[30] Ian Ousby, *Occupation: The ordeal of France 1940-1944*, (London: Random House, 1999), p. 170.

The most substantial consequence of Vichy's *Ravitaillement général* (rationing system) and by default German quotas, were the effects on the health of the French people. Scholars Kenneth Mouré, Ina Zweiniger-Bargielowska, Rachel Duffett, and Alain Drouard focus on the physical and psychological consequences of a new controlled economy and rationing system, especially that of restriction of resources.[31] Their work develops a picture of an undernourished and ailing nation. That there were serious and fatal consequences to Vichy's incompetent rationing services is clearly analysed in works on the surge of diseases and increased civilian mortality seen in historian Jean-Pierre Le Crom's work. He catalogues the many maladies which beset the population; increased gastroenteritis, skeletal deformities, reduced growth, and dental caries to name but a few. Mortality from Tuberculosis (TB), which showed a promising decline in the interwar years, soared by 1941, primarily due to poor nutrition.[32]

Within the theme of individual and collective behaviours the scholarship of Phillipe Burrin, Nicole Dombrowski and Shannon Fogg stand out for their evaluation of every-day relationships.[33] Using a bottom-up approach of social history they illuminated major motivations describing life as revolving around not only heroism and humanity but also suspicions of unfairness which led to open or low-burning insidious confrontation and conflict, where every act was perceived by some as treasonable or by others as justifiable in the circumstances. Fogg also demonstrates that people placed more importance on material aspects on life:

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[31] Ina Zweiniger-Bargielowska, Rachel Duffett, Alain Drouard, and Hugh Freeman, 'Food and War in Twentieth Century Europe', (Farnham: Ashgate, 2011).
[32] Jean-Pierre Le Crom, 'Lutter contre la faim: le rôle du Secours national', in *Morts d'inanition: Famine et exclusions en France sous l'Occupation,* ed. by Isabelle Von Bueltzingsloewen (Rennes: Presses universitaires de Rennes, 2005), pp. 249-62 (p. 250).
[33] Zweiniger-Bargielowska, et al, Food and War; Burrin, *La France à l'heure allemande*; Nicole Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival*, (Cambridge: Cambridge University Press, 2012); Shannon L. Fogg, *The Politics of Everyday Life in Vichy France*, (New York: Cambridge University Press, 2009).

their wallets, their hunger, their family than on political ideologies.[34] Human behaviours are also expanded as a focus on daily life by historian, John Sweets, although he challenges certain narratives taken solely from archival evidence.[35] From his research in Clermont-Ferrand he argues there are contradictions between official material such as prefects' reports and the reality of opinions and attitudes of local residents. One such example is a report that civilians demonstrated a strong devotion to *le Maréchal* whereas for Sweets the reality of people's behaviour is difficult to assess and many civilians rejected the New Order of Pétain.

Such arguments of human conduct are apposite to the examination of individual behaviours in the target psychiatric hospitals and those connected to them during the Occupation. Regarding decisions made by psychiatrists in HPs, again the work of Mouré gives insight into the pressures of living with the occupier, of making moral and material choices that could determine personal, professional, or family survival. He argues that individuals adapted and 'responded to short-term opportunities in a context of anxiety, uncertainty, and ambiguity'.[36] This idea will inform the consideration of the German effect that is the proximity of German troops to the four target hospitals. The concept of the commonplace and of mentally blocking-out the unacceptable will be adapted to view the attitudes of psychiatrists and personnel towards seeing patients in various forms of malnourishment daily and an inability to act.

A major theme of scholarship is one of the ambiguity of life and the multiplicity of experiences under German rule.[37] There were times of joy amidst the gloom and

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[34] Fogg, *Politics of everyday life, 2009,* p. 190.
[35] Sweets, *Choices in Vichy France, 1994*.
[36] Mouré, The Vichy Economy, p. 126.
[37] Eric Alary, B. Vergez-Chaignon, and G. Gauvin, 'Les Français au quotidien 1939–1949', (Paris: Perrin, 2006); Gildea, *Marianne in Chains*; Richard Vinen, *The Unfree French: Life under the Occupation*, (London: Allan Lane, 2006).

despair of daily life. Historian Richard Vinen is rather negative in his interpretation arguing that 'people during 1940 and 1944 were miserable', painting a grimmer picture of many in society than other scholars such as Gildea.[38] Gildea argues that, 'far from going hungry the French managed to keep themselves fed and even enjoy themselves while historian Dominique Veillon identifies that while there was disruption to everyday life there was also solidarity. [39] Burrin's scholarship on accommodation holds true against these later studies. Given the core components of Vichy's policies of oppression and control, discrimination and exclusion he argues that adjustment to life was essential, whether it was about 'making the best of it' and adapting as in the examples of life in Paris, Veillon's *la mode* or using *le système D* (se débrouiller).[40] Not knowing where the next meal was coming from or queueing for half a day or more only to find no supplies or prices beyond one's pocket was miserable but part of daily life.[41]

What is most notable in much of this literature are the continued revelations and contrasting human experiences, from an increasingly micro-historiographical approach to the Vichy years. Undoubtedly, there is merit in a sustained examination of the life and experiences of more of what in his latest work, 'Fighters in the shadows' Gildea calls 'overlooked' people.[42] Gildea's approach sits well with recent narratives of the mentally ill; to be discussed shortly, similarly considered as

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[38] Richard Vinen,'The French Coal Industry during the Occupation', *Historical Journal,* 33, (1990), 105-30 (p. 367 and 74).
[39] Alary, Vergez-Chaignon, and Gauvin, Les Français au quotidien 1939–1949; Gildea, *Marianne in Chains,* p. 1; Vinen, *The Unfree French,* p. 367; ibid. p. 374; Dominique Veillon, *Vivre et survivre en France, 1939-1947*, (Paris: Payot, 1995).
[40] Kenneth Mouré and Paula Schwartz,'On vit mal: Food Shortages and Popular Culture in Occupied France, 1940-44', *Food, Culture and Society,* 10, (2007), 262-95; Dominique Veillon, *La mode sous l'Occupation*, (Paris: Payot, 1990).
[41] Alary, Vergez-Chaignon, and Gauvin, Les Français au quotidien 1939–1949, pp. 59-61.
[42] Robert Gildea, *Fighters in the Shadows: A New History of the French Resistance*, (Faber and Faber, 2015).

'overlooked' people of the Occupation years and chimes with this current research study on the experiences of such marginalised people in the target hospitals.

Within the sub-genre of micro-history, narratives in relation to locality and experiences of the Occupation have taken diverse paths and that of locality, like Gildea's work on Chinon, has taken a new dimension as 'historically meaningful sites of memory', drawing on the work of Pierre Nora, *Les lieux de mémoire*.[43] Oradur-sur-Glane in the Limousin region and Schirmeck in Alsace are two sites of the extreme brutality of war explored by historian Elizabeth Vlossak.[44] She examines the complex interplay of Second World War remembrance and argues that despite the 'over-politicising' of sites of *mémoire*, such as Oradour, 'locative thinking' can embrace particularity of historical place and experience as a basis for the public sharing of memory in future time. Locality has also become important in Normandy where the beaches are now potent sites of memory particularly with the 70th anniversary of Allied landings.[45] In fact, many departments have taken up the theme of commemoration and location such as Seine-Saint-Denis with its

[43] Pierre Nora,'Between Memory and History: Les lieux de mémoire', *Representations* 26, (1989), 7-24; Joan Tumblety, *Memory and History: Understanding Memory as Source and Subject*, (Abingdon: Routledge, 2013); Scott Soo,'Putting Memory to Work: A Comparative Study of Three Associations Dedicated to the Memory of the Spanish Republican Exile in France', *Histoires et Sociétés,* 6, (2005), 109-20; Rosemarie Scullion,'Unforgettable: History, Memory, and the Vichy Syndrome', *Studies in 20th Century Literature,* 23, (1999), 1-18 (p. 18); Susan Zuccotti, *The Holocaust, the French, and the Jews*, (Nebraska: University of Nebraska Press, 1999).

[44] Elizabeth Vlossak, 'Remembering Oradour and Schirmeck: Struggles of Regional Memory and National Commemation', in *Place and Locality in Modern France,* ed. by Philip Whalen and Patrick Young (London, New York, Sydney and Delhi: Bloomsbury Publishing, 2014), pp. 114-24 (p. 122).

[45] Michael Dolski, Sam Edwards, and John Buckley, 'D-Day in History and Memory: The Normandy Landings in International Remembrance and Commemoration', (Texas: University of North Texas Press, 2014), pp. Dolski is historian with the U.S. Joint Prisoner of War-Missing in Action Accounting Command's Central Identification Laboratory).

promotion of *Patrimoine de mémoire* and 'historically meaningful sites' of its wartime prison camps.[46]

These themes of Vichy and the Occupation are apposite to this study, despite claims of journalist-historian, Eric Conan and historian Henry Rousso. They argue that the history of Vichy has been given disproportionate importance in the annals of French history, even though they themselves had written profusely on the subject of Vichy, though less now.[47] Indeed, in her analysis of historiography, Brigitte Keriven, researcher at the Centre national de la recherche scientifique and the Ecole normale supériere (CNRS/ENS), claims that by 2000 works on Vichy represented more than 53% of all entries in the *Bibliographie annuelle de l'Histoire de France* (BAHF) 1964-2010.[48] That Rousso's claim is a little less than convincing is borne out by historian K. H. Adler's argument that Rousso's desire for national closure would 'shut down the useful and painful discussions that demonstrate how far France, like any other healthy society, is divided''.[49] Similarly, historian, Isabelle von Bueltzingsloewen claims that the chapter on the history of psychiatry in the twentieth century, which embraces the 'darkest years' of psychiatry during the Occupation, has still to be written.[50] The argument of these scholars is impetus for this, another study of the Vichy period and the consequences of the German occupation.

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[46] Tourist Board Seine-Saint-sur-Denis, 'Patrimoine de mémoire. Les lieux de mémoire de la seconde guerre mondiale en Seine-Saint-Denis de l'internement et de la déportation en Seine-Saint-sur-Denis 2016' <http://www.tourisme93.com/patrimoine-de-memoire.html> [Accessed 2016]
[47] Eric Conan and Henry Rousso, *Vichy: An Ever-Present Past*, (Hanover and London: University Press of New England, 1998); Keriven, 5th Conference on European Historical Bibliographies. France during World War II, pp. 3,6; David Drake,'Du rutabaga et encore du rutabaga: Daily life in Vichy France', *Modern & Contemporary France,* 15, (2007), 351-56.
[48] Keriven, 5th Conference on European Historical Bibliographies. France during World War II.
[49] K. H. Adler,'Vichy Specificities: Repositioning the French Past', *Contemporary European History,* 9, (2000), 475-88 (p. 487).
[50] Isabelle von Bueltzingsloewen,'The mentally ill who died of starvation in French psychiatric hospitals during the German occupation in World War II', *Vingtième Siècle,* 4, (2002), 99-115.

Chapter 1

From the more current historiography of psychiatry in the twenty-first century, undoubtedly due to the far-reaching revelations of events in many HPs, and running parallel to social histories of Vichy, there has been a proliferation of identity discourses on institutions and administrations and narratives on the challenges and changing attitudes in medicine and society towards mental disability and facilities and care. An important new genre has emerged in the historiography of psychiatry: that of the identity history of hospitals during the Occupation. This was chiefly instigated by the directors of Vinatier and local authorities. The identity of Vinatier, the focus of Lafont's publication, as a psychiatric institution had been questioned and there was a need to validate its credence and its image within the local community, the FMHS, and psychiatry. They addressed Lafont's claims with an in-depth inquiry which had as objective to examine the role and character of the HP and those who worked in it during the Occupation.

In a move towards transparency and to learn of its character and distinctiveness as a facility of the FMHS, Vinatier's administration commissioned a cross-disciplinary research study. Von Bueltzingsloewen from the université Lumière- Lyon2 led a team of researchers: historians, social scientists, medical- and practitioner-historians, ethnographers, demographers, and statisticians. Bringing a new dynamic of historical enquiry to the subjective work of Lafont, this broad field of scholarship offered distinctive perspectives. Their aim was to interrogate and interpret evidence of the catastrophe in Vinatier and to review and define the hospital's practices, duties and identity during the war years, as well as to investigate the alleged neglect of mental patients. This was a two-year tri-financed programme, supported by the City of Lyon, the Conseil général, the Direction régionale des affaires culturelles de Rhône-Alpes and the Institut d'histoire du temps présent (IHTP): a substantial group indicating a strong ethos of the state authorities and academic commitment to the history of the mentally ill.

The foremost result of research at Vinatier was the publication of *Morts d'Inanition* (Starved to death), edited by von Bueltzingsloewen.[51] It forms a collection of studies centring on the Occupation years contextualising and analysing mortality and morbidity in HPs and contrasting these with other marginalised groups in society: TB patients in sanatoria, the young and the elderly. Von Bueltzingsloewen prefaces her publication emphasising the difficulty of identifying victims of Vichy's rationing and discrimination policies. Nevertheless, research studies have also focused on minority or marginalised groups; these include Jews, other victims of German racial ideology and Vichy's discrimination policies such as prisoners, refugees, and gypsies in prisons and internment camps, demonstrating atrocious conditions in which inmates were kept.[52] Historian Pierre Pédron argues that the effects on daily life of an increase in detainees were considerable and prison numbers grew: from 18,000 in 1939 to 55,000 by 1943.[53] Although HPs were called hospitals they came under the Minstry of the Interior as penal institutions.

As a corrective to Lafont's claim of a Nazi policy enacted by Vichy, von Bueltzingsloewen argues that given German authorities' obsessiveness in their strict attention to detail such as, cataloguing and classifying the T4 Aktion

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[51] Bueltzingsloewen, Morts d'inanition, 2005. Historians, geographers, demographers, psychiatrists, and directors of research at the Centre national de la recherche (CNRS) and Institut d'histoire du temps présent (IHTP) in Paris,are all contrtibutors to the book.

[52] Scullion, Unforgettable: History, Memory, and the Vichy Syndrome; Anne Boitel and Michel Cadé, *Le camp de Rivesaltes: 1941-1942: du centre d'hébergement au 'Drancy de la zone libre'*, (Perpignan: Presses universitaires de Perpignan, 2000); Denis Peschanski, *La France des camps. L'internement (1938-1946)*, (Paris: Gallimard, 2002); Eric Malo,'Le camp de Récébédou Haute Garonne 1940-1942', *Société des études du Comminges, la revue du Comminges Saint Gaudens,* tome 115, (1999), 261-94; Marc-André Fabre, *Dans les prisons de Vichy*, (Paris: A. Michel, 1995); Corinne Jaladieu, 'Les centrales sous le gouvernement de Vichy', (doctoral thesis, université de Rennes 2, 2004); Zuccotti, *The Holocaust, the French, and the Jews, 1999*; Donna Ryan, *The Holocaust and the Jews of Marseille*, (Urbana and Chicago: University of Illinois Press, 1996).

[53] Pierre Pédron, *La prison sous Vichy*, (Paris: Atelier, 1993); Peschanski, *La France des camps*; Serge Klarsfeld and André Delahaye, *La spoliation dans les camps de Province: Mission d'étude sur la spoliation des Juifs de France*, (Paris: La documentation Française, 2000); Anne Grynberg, *Les camps de la honte: les internés juifs des camps français, 1934-1944*, (1999).

programme, confiscating Jewish businesses and property, weighing gold from prisoners teeth, and collecting spectacles, some documentation would be found from her extensive archive searches both in France and Germany she claims no evidence exists.[54] However, there was heated public disagreement and dissention with her claims of no Vichy policy of death by starvation, especially from journalist Armand Azjenberg and psychiatrist Lucien Bonnafé, the former initiated an internet petition for restitution for the victims of Vichy, still running today.[55]

More recently, works by psychiatrists are more academic and questioning than emotional and accusative have appeared in journals of medicine, mental health, and social sciences, but within a medico-legal-statistical paradigm. *The Mentally ill Under Nazi Occupation in France* is a generalised, three-dimensional question and answer work by psychiatrist, Pierre Bailly-Salin concerning increased mortality.[56] This work presents a background to the historical, ideological and sociological aspects of the events in HPs during the Occupation, and of collective reactions of psychiatry to it. He argues that many French psychiatrists held an anti-German attitude demonstrated in their dismissal of the negative eugenicist policy in German and even the dismissal of certain German classification terminology. His work weakens theories that psychiatrists followed the German psychiatrist line that

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[54] Bueltzingsloewen, Morts d'inanition, 2005, p. 58; Caroline Jost, 'Les malades mentaux dans la tourmente 1939-1945', (diploma of Nursing, Centre hospitalier spécialisé de Brumath, 1990); Christian Vedié, S. Moser, and P. Paulin,'Surmortalité dans un hôpital psychiatrique pendant la guerre (Leyme) : cas particulier ou representatif?', *Annales Médico-psychologiques,* 164, (2006), 512-16; Michel Caire, 'Un établissement du dispositif de la Seine: l'hôpital psychiatrique de Maison-Blanche', in *Morts d'inanition: Famine et exclusions en France sous l'Occupation,* ed. by Isabelle von Bueltzingsloewen (Paris: Presses Universitaires de Rennes, 2005), pp. 95-108.

[55] Samuel Odier,'La surmortalité des asiles d'aliénés français durant la Seconde Guerre mondiale (1940-1945)', *Frenia,* 7, (2007), 146-66; Armand Ajzenberg, 'Pour que douleur s'achève », lancée le 1er mars 2001, réclamant la reconnaissance par l'État français de l'abandon à la mort des malades mentaux et l'inscription de cette histoire tragique dans les programmes scolaires.'2001) <http://www.serpsy.org/actualites/fou_guerre.html> [Accessed December 2017

[56] Pierre Bailly-Salin,'The Mentally Ill Under Nazi Occupation in France', *International Journal of Mental Health,* 35, (2007), 11-25.

the most useless in society should be removed. Concerning psychiatrists' lack of public denunciation of the tragedies unfolding in their hospitals he posits that as 'agents of the State', psychiatrists did not see themselves as able to alter the status quo of government parsimony towards the mentally ill.[57] He blames 'bureaucratic inertia' for patients not being moved to establishments in areas with less ration shortages.[58]

However, he does not comment on the physical and emotional trauma of many transferees and that such relocation was often fatal, as in the case of Vinatier and reflected in the fictional work of novelist Pierre Durand's novel, *Le train des fous'*.[59] Bailly-Salin criticises the slackness of internal management and responsibilities of many psychiatrists which led to unsupervised mealtimes during which not only did patients steal from each other but various personnel had ample opportunity to rifle patients' rations. He admonishes hospital administrators for not speaking out against appalling conditions in their HPs and restricted and often insufficient rations for inpatients. He does not, however, discuss either Vichy's firm resolution in dealing with any criticisms of the State or of denunciations made by pro-Vichy colleagues or officials or even relatives if such opinions were voiced.[60]

The statistical approach of François Chapireau, psychiatrist and scientific adviser to DRESS (Direction de la recherché, des études, de l'évaluation et des statistiques) offers a further approach to the historiography of psychiatry.[61] It demonstrates how the development of research fields has moved on from a purely medico-

[57] Alienists were employed by the state and nominated to departmental asylums.
[58] Bailly-Salin, The Mentally Ill Under Nazi Occupation, p. 16.
[59] Pierre Durand, *Le train des fous : 1939-1945 le génocide des malades mentaux en France*, (Paris: Syllepse, 2001 (Original publisher Messidor, Paris: 1988)).
[60] Bailly-Salin, The Mentally Ill Under Nazi Occupation, p. 22.
[61] Chapireau, Documents de travail. DRESS sits within the Ministère des affaires sociales du travail et de la solidarité and Ministère de la santé, de la famille, et des personnes handicappées.

administrative perspective to analyses and interpretation of hospital populations, patient-groups, disease-classification, and causes of death. In his statistical study, Chapireau lays out the harsh reality of mortality as consequence of the Occupation on human life, seen in death of over 45,000 people.

There has been yet a further shift in the historiography of Vichy and the Occupation relevant to this study. Since the turn of the twenty-first century academic research studies now examine small societal groups and communities, sub-cultures and explicit subjects.[62] In parallel to the focus on micro-histories of Vichy by social historians, psychiatric narration has moved on from a broad psychiatry- institutional perspective to the examination of the consequences of the Occupation related to specific hospitals and psychiatrists and officials involved with them. In the light of scholarship, such as Adler's 'sites of historical memory' and Azema's emphasis on the placement of commemorative monuments, many HPs are considered as memorials to those who died in them. This new interpretative approach to the workings of HPs during the Occupation is undoubtedly attributed to the influence of von Bueltzingsloewen. They include doctoral and masters' theses and journal articles by nascent historians, practitioner-historians and historians. Key works and actors include: Samuel Odier HP Saint-Egrève (Isère, Rhône-Alpes), Anne Marescaux HP Saint-Jean-de-Dieu (Lyon), Marc Masson and Jean-Michel Azorin also focused on this HP, Vincent Guérin HP Sainte-Gemmes-sur-Loire, Gaële Nicolas-Quénet, HP Quimper (Côtes d'Armor), Christian Vedié, S. Moser, and P. Paulin, who examine HP Leyme (Cadillac,

[62] Scott Soo,'Ambiguities at Work: Spanish Republican Exiles and the Organisation Todt in Occupied Bordeaux', *Modern and Contemporary France,* 15, (2007), 456-77 ; K.H. Adler,'Gendering Histories of Homes and Homecomings', *Gender and History,* 21, (2009), 455-64; Joan Tumblety, *Remaking the Male Body: Masculinity and the uses of Physical Culture in Interwar and Vichy France* (Oxford: Oxford University Press, 2012); Victoria Le Corre, 'Taking Control: Women of Lorient, France Direct their Lives Despite The German Occupation (1940-May 1945)', (master's thesis, Virginia Polytechnic Institute and State University 2002).

Lot), Marion Rochet HP Saint-Alban-sur-Limagnole (Lozère), Isabel Dupont HP Bon-Sauveur- de-Caen and Jean-Marc Garcia, HP Aix-en-Provence.[63] Scholarship from Michel Caire includes HPs Maison-Blanche and Sainte-Anne, Paris; the latter is also the focus of Marion Breard Master's dissertation.[64] Caire's distinctive approach concentrates on Vichy's discrimination and racial policies examining dossiers of fifty female patients interned in Maison-Blanche during the Occupation, but his work is significantly psychiatry-weighted, and dossiers are studied principally within a framework of psychiatry. [65] He documents the behaviour and actions of psychiatrists under whose care these patients were interned and the processes they went to protect their patients from inevitable deportation if

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[63] Samuel Odier, 'De l'asile Saint-Robert à l'hôpital de Saint-Egrève: Progrès thérapeutiques et malheurs de la Guerre (1930-1960)', (master's thesis, l'université Lyon 2, 1992); Samuel Odier, 'La fin de l'asile d'aliénés dans le Rhône et l'Isère (1930-1955)', (doctoral thesis, université de Jean Moulin Lyon 3, 2006); Anne Marescaux, 'Vie et mort dans les hôpitaux psychiatriques pendant la Seconde Guerre mondiale: l'exemple de Saint-Jean-de-Dieu', (master's dissertation, université de Lyon 2, 2001); Marc Masson and Jean-Michel Azorin,'La surmortalité des malades mentaux à la lumière de l'histoire. L'exemple de l'hôpital Saint-Jean-de-Dieu de Lyon pendant la Deuxième Gerre mondiale', *Évolution Psychiatrique,* 67, (2002), 465-79; Vincent Guérin, 'Ne plus être un monde à part: la transformation d'un hôpital psychiatrique: Sainte Gemmes-sur-Loire (1910-1977)', (doctoral thesis, université d'Angers, 2011); Gaële Nicolas-Quénet, 'La vie quotidienne à l'hôpital psychiatrique de Quimper de 1938 à 1945', (master's dissertation, université de Bretagne Occidentale (Brest), 2000); Christian Védie,'The cemetery associated with Leyme Mental Hospital', *History of Psychiatry,* 16, (2005), 111-15; C. Védie and G. Katz,'Hôpital psychiatrique. Années 1935-1945. Etude informatisée', *Annales Médio-psychologiques,* 149, (1990), 477-85; Jean-Marc Garcia, 'Les conditions de vie des malades mentaux à l'hôpital psychiatrique d'Aix-en-Provence pendant la guerre 1939 - 1945', (doctoral thesis, université d'Aix Marseille 2, 1988); Marion Rochet, 'La vie de l'hôpital psychiatrique de Saint-Alban-sur-Limagnole (Lozère) de septembre 1939 à mai 1945', (master's dissertation, université de Saint-Etienne, 1993); Isabelle Dupont, 'Le mouvement des malades au Bon Sauveur de Caen pendant la seconde guerre mondiale', (doctoral thesis, université de Caen, 1995).

[64] Caire, Un établissement du dispositif; Michel Caire,'A propos de l'hécatombe par carence dans les hôpitaux psychiatriques français sous l'Occupation', *Histoire des Sciences Médicales,* 40, (2006), 313-19; Marion Breard, 'Le centre psychiatrique de Sainte-Anne pendant la seconde guerre mondiale: mouvement et décès des malades de 1937 à 1947', (master's dissertation, université de Paris 1, 2005); Patricia S. Legg, 'Malaise, Maladministration or Malevolence: Increased Mortality in French Psychiatric Hospitals During the German Occupation 1940-1944', (ibid., University of Southampton, 2004).

[65] Michel Caire,'L'hospitalisation des Juifs en psychiatrie sous Vichy dans le département de la Seine', *Histoires des Sciences Médicales,* 4, (2008), 349-58.

discharged from the hospital. This scholarship persuasively challenges claims of psychiatrists' indifference towards inpatients by detractors from the Lafont school. Much of this scholarship applies a medico-centrist or/and a politico-administrative lens examination of effects of occupation on an HP. They lean heavily on official hospital and departmental administrative and medical reports ignoring the raison d'être of the psychiatric hospital: the patient, a mere administrative utility, a factor or statistic in the hospital's daily economy, such as a farm- laundry- maintenance- or kitchen-worker. Similarly, the patient is presented as a medical/psychiatric classification or an admission or discharge, or transfer or even a cure statistic. This is not a criticism of such scholarship but a concern that much work is needed on the human aspect, on non-official narratives and experiences. In the examination of daily life in the HPs under Vichy, the reading of administrative and medical reports must now be made in conjunction with other evidence such as patient notes and family correspondence: little consulted sources.[66]

An analysis of works in this innovative sub-genre confirms that only fourteen have been studied out of the ninety-six hospitals functioning during 1939-45. This is a small number, although since the Liberation some psychiatric hospitals have changed name or closed or amalgamated with general hospitals. Nevertheless, this proportion indicates an opening for more work on individual hospitals in order to gain a broader and more balanced view of experiences and the link between the legacy of the asylum law and the functionality and administration of the HP relative to increased mortality will be exposed.

[66] Rafael Huertas, 'Another History for Another Psychiatry. The Patient's View', *Culture & History Digital Journal,* 2 (2013) <http://dx.doi.org/10.3989/chdj.2013.020>.

1.2 Methodology: A case-study approach

The choice of a case study approach of four target hospitals functioning during the Occupation was determined from initial readings of secondary sources, conference attendance, and formation of ideas, together with experience gained in professional hands-on nursing and management and research undertaken for the Master of Research (MRes) degree in 2004.[67] This work centred on Centre hospitalier spécialisé (CHS) de la Savoie, previously known as Hôpital psychiatrique de Bassens, in the Tarentaise valley not sixty miles HP Vinatier in Lyon.

The dissertation acted as a corrective to the innuendos and accusations of Lafont and contenders of Vichy's culpability in increased mortality in HPs, and contested claims of indifference by hospital psychiatrists pertaining to insufficient rations and increased mortality. As a result of contacts made during my research I was asked to contribute to a publication for the Fédération hospitalier de France, *Les hôpitaux dans la guerre*.[68] Extending the study from one to four hospitals allowed me to show the nuances of institutional daily life, an approach lacking in much scholarship to date. The objective of this study is to determine how the events in the target hospitals and inpatient experiences, patients' relatives, personnel and psychiatrists, were shaped by circumstances in a hospital system which was unprepared for a crisis of such magnitude as the Occupation. This direction extends to examining previously un-researched HPs to interrogate their functionality and structure, and foundational, philosophical and management

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[67] I attended the conference organised by the Groupe de recherche 'Enfermements. Marges et Société' et la FERME du Vinatier. Isabelle von Bueltzingsloewen,'Famine et Exclusions en France sous l'Occupation', *LA FERME*, 20-21 November 2003; Legg, Malaise, Maladministration or Malevolence.

[68] Patricia S. Legg, 'La vulnérablilité des malades mentaux en temps de guerre: l'exemple de l'hôpital psychiatrique de Bassens en Savoie', in *Les hôpitaux dans la guerre,* ed. by Anna Chassaniol (Paris: Le cherche midi, 2008), pp. 54-58.

guidelines, framed by the 1838 law for the insane, the medicalisation of their inmates, and the experiences of carers and cared-for in war and occupation.

Undoubtedly, there has been an expansion of historiography both from the fields of history and social sciences on this highly controversial subject and this study adopts a micro-historical approach offering a distinct perspective on institutional life in individual HPs. According to Professor John Brewer, 'historical writing in the last forty years has made everyday life, the experiences, actions and habits of ordinary people, a legitimate object of historical enquiry' and according to historian Charles Joyner large questions can be asked of small places in micro-histories. Therefore, within an institutional framework of the FMHS this thesis presents the formal and the informal: medico-administrative accounts and patient dossiers, case-notes, and correspondence from family and friends. The latter, although limited compared with formal sources will add a rich view of experiences of daily life. The hospital can then 'be taken as a historical nexus for change and continuity in the texture of everyday life whether at its most banal or most transformative'.

In highlighting inadequacies in the FMHS the study will confirm that post-war psychiatrists were not unreasonable in their demands for deinstitutionalisation thus extending the knowledge base of persistent theories of the need to reform institutional care and facilities for the mentally ill which led to sectorisation, the closure of expensive inpatient care and foundation of community-based services of the mid-to-late twentieth century. By doing so the study engages with and extends present scholarship in the field of French psychiatry during the Occupation using methods borrowed from past and present scholarship and advances in

medical humanities studies and the understanding of the processes of institutional life and experiences of health and illness.

Drawing from the work of social scientists, Robert Yin and Sarah Crowe et al., a case-study approach will allow an understanding of real-life experiences.[69] John Gerring opines that case-studies are applicable when a deeper understanding is required about individual behaviour and attitudes, perceptions, needs, and routines in specific settings.[70] It will tease out the internal workings of the institutions under investigation; of the interplay between theory and practice in psychiatric care, of patterns such as changes over time highlighting possible causal links between variables in hospitals run by the state and by religious orders.[71]

The study is characterised by a rational, interpretivist approach focusing on the 'meaning-making' practices of human subjects, the why, how, or by what means, people do what they do which will aid in discerning the range of ideas and emotions suggested in the written word.[72] It captures quantitative data through current scholarship of individual establishments and national sources allowing for some glimpses of facilities and function of the target hospitals set against the larger picture of the FMHS. This gives a distinct advantage in revealing more of

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[69] R. K. Yin,'Enhancing the quality of case studies in health services research', *Health Service Research,* 34, (1999), 1209-24 pp. 13-4); Sarah Crowe, Kathrin Cresswell, Ann Robertson, Guro Huby, Anthony Avery, and Aziz Sheikh,'The case study approach', *BMC Medical Research Methodology,* 11, (2011), 100-10.

[70] John Gerring, *Case Study Research: Principles and Practices*, (Cambridge University Press, 2006), p. 50; Also see: Zaidah Zainal,'Case study as a research method', *Jurnal Kemanusiaan,* 9, (2007).

[71] John W. Creswell and Vicki L. Plano Clark, 'Designing and Conducting Mixed Methods Research 2nd edition', (Thousand Oaks, California Sage, 2011).

[72] Sharan B. Merriam, *Qualitative Research: A Guide to Design and Implementation. Revised and Expanded from Qualitative Research and Case Study Applications in Education*, (San Francisco: Jossey-Bass, 2009); C. Robson, *Real World Research: a resource for Social Scienitists and Practitioner-researchers*, (Oxford: Blackwell, 1993).

'history from below' and offers an alternative dimension to national and even local statistics.[73]

This approach is in line with a more sociological method to the history of psychiatry, which has realigned its position from the institution, medicine, and the 'medical man' to that of the patient. This is due in no small measure to the work of scholars like Roy Porter and his advocacy of medical history from below as historical narrative as an alternative history of medicine.[74] He argues that the 'physician-centred account of the rise [of the history] of medicine may involve a major distortion': he opines that it takes two for a medical encounter, the doctor and the sick person, and in many medical events there is often three as the family is also involved in the patient's experiences. Although a large proportion of the history of the HPs during the Occupation is medico-administrative, it is the aim of this study, through correspondence and doctors' notes found in patient dossiers, to add a further dimension to daily life experiences for personnel, patients' families and patients with that of official accounts.

From her critique of scholarship on the history of psychiatry, historian Anne Digby asserts that an imbalanced identity of asylum patients is partly a product of relying on traditional and documentary material.[75] Through evidence found in casebooks, patient records, and an Attendant's personal papers, her study of the York Retreat reveals a different history of being insane, although leadership of the asylum was

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[73] Roy Porter,'The Patient's View: Doing Medical History from Below', *Theory and Society,* 14, (1985), 175-98 ; E.P. Thompson,'History from Below', *The Times Literary Supplement* (Thursday, 7 April 1966), 279.
[74] Porter, The Patient's View, p. 175; Jeremy Black and Donald M. MacRaild, *Studying History. Third Edition*, (Basingstoke: Palgrave Macmillan, 2007); E.P. Thompson, *The Making of the English Working Class*, (London: Victor Gollancz Ltd, Vintage Books, 1963); Lucien Febvre founder, together with Marc Bloch, first used the phrase,'histoire vue d'en bas et non d'en haut. Ibid.; Also see, Thompson, History from Below. His essay was the starting point for a 'people's history' in the UK.
[75] Anne Digby, *Madness, morality, and medicine: A study of the York Retreat, 1796-1914*, (Cambridge and New York: Cambridge University Press, 1985).

an important factor in results and celebrity of the Retreat, especially within the approach of psychotherapy.[76]

Psychiatrist-historian Allan Beveridge's study on over 1000 written letters by inpatients in the Royal Edinburgh Asylum, Morningside, between 1873 and 1908, whilst historian Dale Peterson uses accounts taken from twenty-six histories written by mad people after discharge.[77] But both authors argue that patient chronicles present a virtually unique record of asylum life.[78] Historian Hazel Morrison's case-studies on Gartnavel asylum, Glasgow, give a view of patient-life taken from an official perspective - physician records to analyse the progression of 'dynamic psychiatry' (group staff/patient meetings. The patient narrative of illness is presented through their recorded thoughts, opinions, and perspectives.[79] However, the reliability of patients' narrative and competence of those who transcribed the meetings can be questioned. Ana Antić's work on psychiatry in occupied

[76] Also see the work of: Pamela Michael, *Care and Treatment of the Mentally Ill in North Wales, 1800-2000*, (Cardiff: University of Wales Press, 2003).

[77] Allan Beveridge,'Life in the Asylum: patients' letters from Morningside, 1873-1908', *History of Psychiatry,* 9, (1998), 431-69 (p. 461); Dale Peterson, *A Mad People's History of Madness*, (Pittsburgh University of Pittsburgh Press, 1982); Also see his other work: A. Beveridge,'Voices of the mad: patients' letters from the Royal Edinburgh Asylum, 1873-1908', *Psychological Medicine,* 27, (1997), 899-908.

[78] Also see: Angela MCCarthy, Catharine Coleborne, Maree O'Connor, and Elspeth Knewstubb,'Lives in the Asylum Record, 1864 to 1910: Utilising Large Data Collection for Histories of Psychiatry and Mental Health', *Medical History,* 61, (2017).

[79] Hazel Morrison,'Constructing Patient Stories: 'Dynamic' Case Notes and Clinical Encounters at Glasgow's Gartnavel Mental Hospital, 1921–32', ibid.60, (2016), 67-86; Hazel Morrison, Margaret, Catherine, 'Unearthing the 'Clinical Encounter': Gartnavel Mental Hospital, 1921-1932. Exploring the Intersection of Scientific and Social Discourses which Negotiated the Boundaries of Psychiatric Diagnoses', (doctoral thesis, University of Glasgow, 2014); Jonathan Andrews,'Case Notes, Case Histories and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine,* 11, (1998), 255-81. Hazel Morrison,'Conversing with the Psychiatrist: Patient Narratives within Glasgow's Royal Asylum 1921-1929', *Journal of Literature and Science,* 6, (2013), 18-37. Morrison, Constructing Patient Stories: 'Dynamic' Case Notes and Clinical Encounters at Glasgow's Gartnavel Mental Hospital, 1921–32. Group therapy meetings, an innovative approach to psychotherapy, formed part of dynamic psychiatry which was based on the study of emotional processes, their origins, and the mental mechanisms underlying them.

Yugoslavia narrates the patients' voice. In similar vein to Morrison, she argues that war-related patient-experiences noted in case-files, psychiatric meetings, and discussions, may have led Yugoslav psychiatrists to re-consider their previously solid beliefs in a hereditary and constitutional nature of schizophrenia.[80]

The present case-study would have been enhanced had there been the extensive archival material similar to that found by these scholars. In this study, limited source material from patient dossiers cannot fully give access to the patient voice, however, previously unseen and uncited evidence which includes: hand-written letters and correspondence from relatives and friends to the MC or the patient, letters and replies from MCs, letters from patients, still in their dossier not sent or not intended to be sent, post-cards, drawings, religious mementoes, stamps, dried flowers, photographs and even hospital money.[81] Although a third party observation, this data and correspondence reveal a view of life in the target hospitals, reveal some of the experiences of institutional everyday life and also of life outside the hospital. Medical historian, Jonathan Andrews posits, patient case-notes afford a 'welter of insights into medical treatment and practice' and case-notes found in the target hospitals will give an awareness of institutional and professional practice, the inner workings of the institution and the role of psychiatrist and personnel during the Occupation.[82] And Petter Aaslestad professor of narrative theory argues that narrative structures like letters and

[80] Ana Antić,'Mental Illness under Occupation. Psychiatric Revisions of 'Normality' and 'Pathology', 1941–1945', *Годишњак за друштвену историју (Serbian Annual for Social History),* 3, (2012), 65-89; Ana Antić, 'Psychiatry at War: Psychiatric Culture and Political Ideology in Yugoslavia under the Nazi Occupation', (doctoral thesis, Columbia University, 2012).Through patient histories Antic demonstates changing ideas of psychiatry from a biological to the dynamic approach of psychoanalysis and group therapy.

[81] This was often produced by the hospital and given to patients in lieu of standard currency. It was standard practice in most HPs in order to prevent stealing by members of the staff and by other patients.

[82] Andrews, Case Notes, Case Histories and the Patient's Experience, p. 255.

doctors' notes allow us to depict characters or causes of events or reasons for events or non-events.[83]

Correspondence found in the dossiers endorses and refutes various issues about mental illness in the twentieth century. Many letters demonstrate interconnecting relationships of psychiatrist, personnel, patient and family and give insight into the then current theories and trends in treatment and relatives' understanding of such treatment.[84] We should also not forget to interrogate the silence in communication which does not necessarily mean nobody cared. For other cases, in which no correspondence was be found could be due to family indifference or as Michael Burleigh argues, families knew mental illness was a 'problem' and the state was 'solving' it.[85]

Patient dossiers often held alternative information than found in admission processes: household family units, the length of toleration-time - the period relatives coped before requesting admission or before even admitting that the loved one needed more care than they could give with their increasing old age or infirmity. Dossiers also provide us with different attitudes of society to the mentally ill, of the tolerance or otherwise of neighbours and the stigma and fear of such

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[83] Petter Aaslestad, *The Patient as Text: The Role of the Narrator in Psychiatric Notes, 1890-1990*, (Oxford and New York: Radcliffe, 2009).

[84] UHAGM, Patient dossier Monsieur P. R. admitted 28 April 1939. The patient's mother questions the MC as to the efficacy of Cadiazol or Stovarsol injections, medication he suggests for her son; UHAGM, Patient dossier Monsieur A. M. admitted 14 October 1938 died 23 August 1940. The patient's sister writes to the MC stating Cardiazol had helped her brother in the past; For scholarship on confinement and family involvement in patient care see: David Wright,'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Society for the Social History of Medicine,* 10, (1997), 137-55; Peterson, *A Mad People's History of Madness*; Nicole Baur,'Family Influence and Psychiatric Care: Physical Treatments in Devon Mental Hospitals c1920 to the 1970s', *Endeavour,* 37, (2013), 172-83.

[85] Burleigh, *Death and Deliverance,* pp. 100-2. Families were indoctrinated into believing they were doing their duty and aiding the state in sending their mentally defective child to an asylum. Burdensome children were a costly entity to the state. Also see: Roeder, *Psychiatrists - The Men Behind Hitler: The Architects of Horror*.

illness and its inherent danger. In agricultural areas, keeping the mentally ill relative at home when harvests were due or when income depended on all members of the family, is demonstrated in the seasonality of admissions.

On the other hand, clinical case-notes reveal the evolution of patients' medical and mental history and therapy, with psychiatrist's hand-written notes and nursing notes reflecting daily, weekly, or monthly, and sometimes only annual MC/patient/nurse contact. We see daily routine, nutrition, weight loss and gain, sleep patterns, leisure and labour, discharge and death. Conversely, official records and administrative reports to the prefect are formulaic and have an emphasis on the dynamics of the institution and medicine rather than patient care. Patient case-notes are less unfettered by medical language and official perspectives which govern official documentation. This is seen in some of the MCs' 'unofficial' remarks in case-notes, revealing a more compassionate tone. They give a hint of the personal stance of certain psychiatrists on therapy and recovery in their attempts to prepare patients for a return to society, demonstrating a willingness to help patients and having their well-being at heart.[86] At other times, MCs' notes can display a moralistic attitude, sarcasm, facetiousness, or just amusement, such as the handwritten note, '*bonne carrière*!' (His exclamation mark not mine), written beside a long catalogue of a female patient's medical and personal history, of diagnoses of her male friends with various 'medical conditions' and the large number of her offspring.[87]

Documentation found in the target hospitals permits a re-evaluation of experiences in HPs during the twentieth century and the Occupation. The impact

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[86] Louise Wannell,'Patients' relatives and psychiatric doctors : letter writing in the York Retreat 1875-1910', *Social History of Medicine,* 20, (2007), 297-313.

[87] UHAGM, Patient dossier, Madame A. B. age 40 admitted 28 June 1943 discharged 14 December 1943.

of such intimate accounts on our understanding of history of the target hospitals is all the more important as there is so little of them hitherto found or developed. This study will interrogate and synthesise patients' dossiers to demonstrate there is no one reality of daily life during the Occupation for inpatients or personnel, but many. It will comply, in part, to Porter's call to 'lower the historical gaze onto the sufferers' and permit a more human viewpoint which until recently has only minimally entered French historiography of the FMHS under the Occupation.[88]

Undoubtedly, oral history would have enriched the archival material for this study, and reliance on this approach has been used effectively by historians: H.R. Kedward, Sarah Fishman, Megan Koreman, and more recently, Daniel Lee and his work on Pétain's Jewish Children.[89] Gildea's scholarship reopens the controversial debate on the myth surrounding Resistance with first-hand accounts, memoires diaries, letters and interviews.[90]

Interviews were considered in this study as an alternative method but during research at Vinatier, von Bueltzingsloewen experienced certain limitations with interviews and witness testimony.[91] She noted reluctance by former hospital staff to speak of past colleagues or patients or offer personal memories, suggesting

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[88] Porter, The Patient's View, p. 192; Aude Fauvel, 'Témoins aliénés et "Bastilles modernes" : une histoire politique, sociale et culturelle des asiles en France (1800-1914)', (doctoral thesis, École des Hautes Etudes en Sciences Sociales, 2005). Fauvel uses collective actions like revolts in asylums and written testimonies from patients demonstrating against 'Bastille' like conditions during the anti-alienism period 1860s.

[89] H.R. Kedward, *In Search of the Maquis : Rural Resistance in Southern France, 1942-1944*, (Oxford: Clarendon Press, 1993); Sarah Fishman, *We Will Wait: The Wives of French Prisoners of War, 1940-1945*, (New Haven and London: Yale University Press, 1991); Daniel Lee, *Pétain's Jewish Children: French Jewish Youth and the Vichy Regime, 1940-1942*, (Oxford: Oxford University Press, 2014); Megan Koreman, *The Expectation of Justice: France, 1944-1946*, (Durham and London: Duke University Press, 1999).

[90] Gildea, *Fighters in the Shadows: A New History of the French Resistance*.

[91] Isabelle von Bueltzingsloewen, *L'hécatombe des fous. La famine dans les hôpitaux psychiatriques français sous l'Occupation*, (Paris: Aubier Flammarion, 2007).

some feeling of culpability, moral obligation to confidentiality, or to vestigial hierarchical influences. Negative responses could also have been due to hospital staff being upset by Lafont and Lemoine targeting Vinatier, their own workplace, in their individual works. With this in mind and with ethical restraints requested by the target hospital directors to protect patients and family rights an oral history approach was not considered an option.

Nevertheless, during the research period in France, the occasion arose for a small number of informal and unstructured interviews, within the boundaries of privacy, they are analysed and documented. Interviews were given by relatives of psychiatrists working during the war, psychiatrists who worked in psychiatric hospitals immediately after the war, and a daughter of *nourriciers* (foster-parents) in Ainay, one of the target hospitals. Her parents lodged patients for forty years, including the war years: she followed the family tradition and had done so for many decades.[92] Patient-centred daily life experiences are rare in the history of psychiatry and non-existent in administrative-medico-legal approaches to hospital reporting. To date there are virtually no personal histories of the occupation years in France from within psychiatric hospitals, and fictional works lean towards an anti-psychiatry position or highlighting specific mental conditions such as Lemoine's Droit d'asiles and Durand's Le train des fous.[93]

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[92] Interview with Dr Paul Broussolle (retired Médecin-chef de service Centre hospitalier spécialisé Le Vinatier, Lyon) by Patricia S. Legg at his residence in Lyon on 21 October 2003 18.00h ; Interview with Dr Jacques Postel (psychiatrist and historian of psychiatry) by Patricia S. Legg at his personal residence in Paris on 20 August 2013 14.00h; Interview with Dr Michel Mori (retired Médecin-chef de service Centre hospitalier spécialisé Saint-Dizier, Allier) by Patricia S. Legg at his personal residence in Saint Dizier on 26 August 2007 19.00h; Interview with Madame M. at her residence in Ainay-le-Château, Allier on 28 April 2007 14.00h by Patricia S. Legg.

[93] Charles Juliet, *Lambeaux*, (Paris: POL, 1995); Milos Forman, 'One Flew Over the Cucukoo's Nest', (United Artists, 1975). ; Tonino Cervi, 'Nest of Vipers', (1978). ; Durand, *Le train des fous*; Patrick Lemoine, *Droit d'asiles*, (Paris: Odile Jacob, 1998); André Soubrian, *Bedlam*, (London: W.H. Allen, 1956); Curtis Hanson, 'The Hand That Rocks the Cradle', (Buena Vista Pictures, 1992).

1.3 Research design

After an inventory of available sources, data and theoretic strategies from scholarship already discussed, a research plan was designed centering on the examination of four target hospitals. The research design was refined from my M.Res degree to establish a chain of events that took place in each of the hospitals within their medico-legal histories. This includes the foundation of the target hospitals and the philosophies of care embedded within the 1838 law for the insane and comparison with other psychiatric hospitals studied by past and current psychiatrists and historians.[94]

A data-collection system was designed prior to the initial contact stage of visits to the national archives in Paris and Fontainebleau and departmental archives in which the four chosen HPs were located, and the HPs. (Appendix B). The objective was to capture and identify issues and themes linked to the theoretical framework, or the 'idea context', and to develop research questions, ensuring coherence of data to be collected and of conclusions to be drawn.[95] The collecting system consisted of a database to aid in grouping, codifying, and editing material thus

[94] These will include HPs by: Odier, De l'asile Saint-Robert à l'hôpital de Saint-Egrève: Progrès thérapeutiques et malheurs de la Guerre (1930-1960); Odier, La fin de l'asile d'aliénés dans le Rhône et l'Isère (1930-1955); Marescaux, Vie et mort dans les hôpitaux psychiatriques; Guérin, Ne plus être un monde à part: la transformation d'un hôpital psychiatrique: Sainte Gemmes-sur-Loire (1910-1977); Ève Jullien, 'Le Centre hospitalier spécialisé de Sainte-Gemmes-sur-Loire 1838-1992 et l'Ecole d'infirmier 1932-1993: Inventaire détaillée 1933-1994', (master's dissertation, Centre de santé mentale Angevin (CESAME), 2006); Rochet, La vie de l'hôpital psychiatrique de Saint-Alban-sur-Limagnole (Lozère) de septembre 1939 à mai 1945; Marc Masson, 'Soins et assistance prodigués de Saint Jean de Dieu dans la France du XVIIIème siècle: Pour une contribution à la réflexion sur la place de l'humanisme dans la pratique psychiatrique', (doctoral thesis, université de Bordeaux 2, 1999); Guérin, Ne plus être un monde à part: la transformation d'un hôpital psychiatrique: Sainte Gemmes-sur-Loire (1910-1977); Nicolas-Quénet, La vie quotidienne à l'hôpital psychiatrique de Quimper de 1938 à 1945.

[95] J. A. Maxwell, *Qualitative research design: An interactive approach*, (Thousand Oaks, California: Sage, 2005).

making it readily retrievable.[96] A numerical coding system was given to all patient information to retain total patient and family confidentiality.

Archival material found seemed evidence for the research questions and were compared with existing literature to ascertain if they concurred with or disputed what had already been published in the field of psychiatry and the Occupation. Computer-assisted qualitative data analysis software (CAQDAS) such as NVivo was investigated. Yin states, 'narrative text needs much 'post-computer' thinking and analyses', and indeed, researchers are not agreed on whether such systems improve the quality of analysis and the software can skew the analysis.[97] Due to time restraints of learning a new system before scheduled visits to France it was not considered.

A set of parameters was established to allow as wide a base and as open a sample as possible for the target hospitals from across all French departments. Considerations included rural or urban geographical location and whether the institution was run by religious orders or the state. Scholars demonstrate that rural and clerical hospitals appear to have fared a little better in terms of total mortality regardless of geographical setting or whether the hospital lay within the occupied (ZO) or unoccupied zones (ZNO).[98] Also, size was germane: small fared better than large, the former classed as up to 500 beds, the latter 2-4,000 beds. Another consideration was gender- and disease-specific hospitals. For example, HP Maison-Blanche, in Paris, was a TB single-sex sanatorium admitting women. Other hospitals

[96] R. K. Yin, *Case study research: Design and methods. 4th edition*, (London: SAGE, 2008), p. 120.
[97] F. C. Zamawe,'The Implication of Using NVivo Software in Qualitative Data Analysis: Evidence-Based Reflections', *Malawi Medical Journal,* 27, (2015), 13-15; Yin, *Case study research: Design and methods. 4th edition,* p. 108.
[98] Bueltzingsloewen, *L'hécatombe des fous*.

which have already had academic investigation were excluded in a desire to proffer knowledge of other sites of interest.

The rationale for hospital choice was decided by which institutions replied favourably allowing full access to the researcher, with specified extant archives, location was within a department that had sufficient archival documentation. As 'total occupation' of France occurred in November 1942, it was not thought imperative to choose hospitals specifically in the occupied zone or non-occupied zone although some comparison is made with HP Marchant, initially in the non-occupied zone. The HPs were also chosen with attention to what will be referred to as the 'German effect'. This covers two major factors: the overall result of troop placements in close proximity to the HPs and effects on daily life for personnel and staff and secondly, enforced evacuation of hospital patients for troop hospitalisation or occupation for German administrative matters. Such enforced dispatch whether with malicious intent or not involved the transfer of many physically and psychologically fragile patients, often with disastrous results. This issue is significant in the analysis of influences on mortality in HPs.

1.4 Access and ethical considerations

Due to the highly sensitive setting of mental health and the nature of the subject matter, a research proposal was presented to the University of Southampton ethics committee, and in a professional capacity constraints were adhered to within the guidelines of the Nursing and Midwifery Council for the UK.[99] The gathering of primary data during this study was dependant on gaining access to appropriate sources at national and departmental archive level together with the HPs. Access

[99] Nursing and Midwifery Council UK, *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*, (London: Nursing and Midwifery Council UK, 2015).

to French mental health records are linked to a scale of closure ranging from one hundred and fifty years to sixty years after the date of birth of the person concerned, although in certain research situations a request can be logged with the Director of the Archives de France in Paris and to individual hospitals. For this study, authorisation, in the form of a *dérogation* was sought to consult psychiatric records, which involved agreeing to protect those under examination by anonymising individuals. At departmental level, archives are strict on access and require the presentation of a list of archive series and subject titles intended to be studied (with an accompanying request for permission to research and a copy of a *dérogation* issued by the Directeur des archives nationales de France). Considerable examination of archival data for the period of the German occupation and psychiatric institutions is essential to cover material from diverse sources that would be fruitful. With numerous name changes of ministries and ministers responsible for *Assistance* (welfare and asylum facilities) during the 1900s, posed a catch-22 situation.

Even with sufficient knowledge of archival cataloguing and coding very often *cartons* did not always contain what was catalogued as being in them nor did content titles necessarily match up with what was detailed to be inside. This lack of attention to detail is now well-documented within the framework of the history of psychiatry. Indeed, Caire states that research, especially in medicine and social sciences, is attempted with considerable difficulty: absence of cataloguing and coding of documents concerning psychiatry is disseminated in many heterogeneous cartons and lacks methodological and systematic classifying.[100]

[100] Michel Caire,'Histoire de la psychiatrie: Programme de l'année 2003-2004: Les sources de l'histoire de la psychiatrie Parisienne aux Archives nationales, les 1er et 3e jeudis 16 à 18h.', *École pratique des hautes études. Section des sciences historiques et philologiques. Livret-Annuaire 19,* 136, (2005), 398-405; Personal communication by email from Isabelle von Bueltzingsloewen to Patricia S.

1.5 National and departmental archives

With permission granted and correspondence entered into with various organisations, scholars, and hospital personnel an initial online search was made. Material for the study was held in: the Archives nationales Paris (AN) and the *Centre des archives contemporaines*, Fontainebleau (CAC), Archives de la préfecture de police, and Archives de Paris (which has regrouped the Archives départementales de la Seine and the Archives municipales de la ville).[101] Sources from government departments include the Ministère de l'Intérieur, Administration Générale, Ministère d'État à la Famille et à la Santé, Inspection Générale de l'Agriculture, Ministère de l'Economie et des Finance. Documentation was also found at the *Assistance Publique - Hôpitaux de Paris* (AP-HP), the Bibliothéque Nationale de France (BNF), the Institut d'Histoire du Temps Présent (IHTP), Institut national de la statistique et des études économiques (INSEE), Institut national d'Etudes Démographiques (INED) and the Centre national de la recherche scientifique (CNRS).

Another excellent source is the History of Psychiatry website, compiled by Michel Caire offering a wealth of accurate and referenced data on the history and treatment of the insane, asylum legislation, and prominent psychiatrists. [102] The site also holds many current and past medical theses on the history of psychiatry, especially the Occupation years. Caire is also lead psychiatrist for Les jeudis de la

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Legg 21 March 2002. ; Bruno Delmas and Gilles Morin,'Les archives en France. Bouleversements et controverses', *Histoire @ Politique,* 5, (2008).

[101] For an exellent anaylsis of archival sources in psychiatry see: Thierry Haustgen,'Les archives et l'histoire de la psychiatrie. Première parti: les sources et les trauvaux', *Psychiatrie, sciences humains, neurosciences,* 11, (2103), 69-90; Also see: Brigitte Blanc, Henry Rousso, and Chantal de Tourtier-Bonazzi, *La Seconde guerre mondiale: guide des sources conservées en France*, (Archives nationales de Paris: Direction des Archives de Paris, 1994).

[102] Michel Caire, 'Histoire de la psychiatrie' <http://psychiatrie.histoire.free.fr/psyhist/heca.htm> [Accessed 24 April 2007]

BUIM, a programme of monthly conferences with a large programme of issues in psychiatry and its history.[103]

For research at departmental level, it was essential to establish if these departments had pertinent data for the Occupation years relative to *Ravitaillement général* (rationing and provisioning) and *Rapports aux préfets* (administrative reports to the prefect). They contain a rich vein of information with full details of provisioning services, public opinion along with policing, general population registers, and public health facilities. On application to all of the ninety-six departmental archives it was a little surprising, but most gratifying, to receive a 100% response. Communication included kind offers of further personal contact, suggestions of relevant reading and theses, current and past literature of interest, public conferences and presentations related to other academic work of this period.

Although open to academic research, departmental and regional archives are often limited in terms of extensive details on individual psychiatric hospitals and their personnel or on the fundamental existence and daily care of patients. What was quite surprising was that after researching in the departmental archives I discovered that some hospitals held copies of correspondence sent to the department and regional prefectures that had not been catalogued or found at the department archives. Von Bueltzingsloewen states that with new laws requiring psychiatric hospital archives to be deposited at departmental level some archivists 'disposed' of documents they thought were 'no longer of any interest'.[104]

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[103] Caire Michel, 'Les Jeudis de la BIUM Programme des conférences 2016-2017' <http://psychiatrie.histoire.free.fr/actualite/conferences/2016.htm> [Accessed 15/08/2017] ; Blanc, Rousso, and Tourtier-Bonazzi, *La Seconde guerre mondiale: guide des sources conservées en France*.

[104] Isabelle von Bueltzingsloewen,'Vers un désenclavement de l'histoire de la psychiatrie', *Le Mouvement Social,* 4 (2015), 156-65.

Correspondence and documents found at departmental level often held a lighter more open view of local life whereas national documentation such as prefects' reports are a synthesis of local events and attitudes and are administratively and politically filtered. Care was taken in reading the language of officialdom, in extrapolating intentions and priorities and identifying them as a prism of daily life whilst acknowledging the fact that much was written with an audience in mind and most certainly with considerations of civic duty or job prospects. However, such material leans heavily if not completely on medico-administrative themes and issues.

Once it was established that adequate documentation was held, I classified departments according to paradigms set in the extensive work by scholars Veillon and Flonneau.[105] Their work establishes that departments were vastly different in their ability to provide food and are categorised as *nourrisseur,* with an excess of food and provisions that was able to be exported to other less well supplied departments, or as *affamé*, departments with a monocultural agro-economy entirely unable to be self-sufficient in supplies. This is seen for example in departments with solely beef or dairy farming but which did not produce any wheat or crops or a department whose sole production was wine-growing and whose populace would not survive without food supplies.

The choice of the target hospitals and their location was guided by the studies on the disparities of rationing in specific geographical locations referred to as the 'hazard of location' by Veillon and Flonneau.[106] Additionally, scholars of Vichy's rationing system and the consequences on the nation's health such as Mouré, Paula Schwarz, Michel Cépédé, demographer and historian Alfred Sauvy and E.M.

[105] Dominique Veillon and Jean-Marie Flonneau, *Le temps des restrictions en France : (1939-1949)*, (Paris: Institut d'histoire du temps présent, 1995).
[106] Ibid.

Collingham were also used for contextualisation.[107] Their work allows for a comparison of rationing in various departments for the general population, to that of severe restriction and deprivation of provisions in the target hospitals. Before the final decision was taken as to which HP to research, advice on previous works on HPs was given most graciously by Michel Caire.

1.6 Locating psychiatric hospitals and archival accessibility

To capture as much available archival documentation at hospital level as possible, a list was compiled of all registered hospitals functioning during the Vichy years using: *Le Bottin Administratif*, a reference directory of civil and public administration, listing current hospitals with directors, chief pharmacists, senior medical staff, and websites. Secondly, *Le Guide Rosenwald*, specialists for over 120 years in directories produces similar information but also contains a chronological list of hospitals and administrative and medical staff for the Occupation years.[108] Some material can be found online or in the large tome entitled, *La seconde guerre mondiale: Guide des sources conserves en France* (National archives of Paris) published by the Direction des Archives de Paris.[109]

To verify the availability and condition of hospital archival records for the research period, a formal demand for access to hospital administrative accounts and proceedings and patient dossiers was addressed to 137 psychiatric hospitals,

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[107] Mouré, The Vichy Economy; Mouré and Schwartz, On vit mal; Michel Cépède, *Agriculture et alimentation en France durant la Seconde Guerre Mondiale*, (Paris: Génin, 1961); Alfred Sauvy, *La vie économique des Françaises de 1939 à 1945*, (Paris: Flammarion, 1978); E. M. Collingham, *The Taste of War: World War Two and the Battle for Food*, (London: Allen Lane, 2011).

[108] 'Bottin administratif de Collectif Litec 2005 : Le guide complet de l'administration centrale et territoriale, les structures, les organisations nationales, régionales et départementales.', (Paris: LexisNexis, 2005). ; 'Guide Médical et Pharmacologique Rosenwald (1939 and 1943).', ed. by Le centre Rosenwald (Paris: Commerciales de France).

[109] Blanc, Rousso, and Tourtier-Bonazzi, *La Seconde guerre mondiale: guide des sources conservées en France*.

classed as secular or clerically managed. A search of such breadth was imperative in order to capture as many of the 96 hospitals functioning during the Occupation as possible. Research found that since the Liberation some hospitals had closed, others had amalgamated with general hospitals or changed status or changed name. In order to add more credence to my request for archiving medical data, an *attestation* (letter of authenticity) was obtained from the Director of HP Bassens, my M.Res case-study hospital.[110] Certain hospitals followed up the attestation seeking verification of the professional and confidential status of the author. From the total number of HPs targeted, only 53 replied: eleven hospitals gave an unequivocal positive reply, seven replied with reservations on access to medical and personal documentation, and of the other 35, most replied negatively, some on points of confidentiality or no reason at all and a few stated they were not functioning before 1950. Once replies were received from the HPs each was categorised within the main objectives of the study and within the framework of medical and historical scholarship on psychiatric hospitals during the German occupation.

Surprisingly, in their refusal no two hospital directors quoted the same reference or reasoning. Their stance is somewhat surprising in today's climate of transparency in psychiatry and its institutions with the opening-up of psychiatric hospitals to the public for annual events like the Journées de patrimoine.[111] This appears in part due to a politico-administrative bias, of not wanting to reveal errors or

[110] Interview with Madame Monique Bal (Archiviste) by Patricia S. Legg at the Centre hospitalier spécialisé de la Savoie, Bassens on 10 October, 2007, 16.00h.
[111] Ministère de la Culture Direction générale des patrimoines, 'Journées européennes du patrimoine 16-17 septembre 2017. Jeunesse et Patrimoine'2017) <https://journeesdupatrimoine.culturecommunication.gouv.fr/> [Accessed September 2017]

misjudgements from the past. Some directors gave no reason whilst others quoted various legal documents.[112]

Apart from reasons proffered, there is always the possibility that directors were unwilling to expose their hospital to a detailed analysis of a most traumatic time for psychiatry which resulted in a closing of medico-administrative ranks. One example of administrative obfuscation, and possibly hindrance in view of its exposures, was that of Vinatier. The departmental archivist stated that certain medical dossiers could be found at Vinatier, whereas the hospital's official line stated all documentation was deposited with the departmental archives. It can be assumed that regarding access of confidential documents, the director has a sizeable degree of autonomy and that, regardless of State regulation, personal interpretation of regulations can acutely affect academic study. This was later voiced in interviews with the eventual target hospital directors.

However, for future researchers prospects will be much more agreeable as all French health-care institutions must submit to Accreditation, which not only covers evaluation of efficiency and quality of care but also extends to preservation of documentation and archive retrieval.[113] Historically, each médecin-chef-de-service (hereon referred to as MC) was in charge of a *service*, with a number of living quarters or pavilions housing certain patients diagnoses with mental conditions, the MC maintained his/her own patient records. HPs had no specific Medical Records departments as in English hospitals. Given antagonisms and differing

[112] Article 226-13 of the Penal Code and Article L1111-7 of the Public Health Code of 29 April 2002 asserts that only the person involved can access his/her medical dossier which is not even open to descendants except in very special circumstances.

[113] ,'Government directive of 5 January 1979 no. 79-18 relative to archival holdings.'; Charles Shaw, D., 'Developing hospital accreditation in Europe. Division of Country Support. WHO Regional Office for Europe'2004) <http://www.euro.who.int/__data/assets/pdf_file/0018/240318/E88038.pdf> [Accessed 2016]

opinions on practice within the profession, it is clear from my research that many MCs 'guarded' their patient data for professional or personal reasons.[114] It is certainly the case in the 1930s-40s that MCs held patients' notes in their office. General nursing notes, which were not always as clear as they should be, were kept in locked cabinets in the senior nurse's office along with medicines and basic dressings.[115] As experienced by this researcher many hospitals' archives are in various states of uniformity.

1.7 The four target hospitals

From the research investigation and acknowledgement of the viability and suitable range of archival documents at national and departmental level the following hospitals were chosen. The first of the four is the Centre hospitalier spécialisé (CHS) Gérard Marchant in Toulouse, previously Asile de Braqueville. During the Occupation, Toulouse was in the non-occupied zone until November 1942, and so under Vichy rule, as was Vinatier in Lyon. Marchant was state-run, considered a medium sized hospital with a patient population of over 1500; the largest HP in the study. The Haute Garonne departmental archives held certain useful documentation of the local HPs and a large amount of data on the Occupation period. This included correspondence with local officials of the rationing services to the director of the national services for agriculture and health in Paris. The incumbent director of Marchant was most helpful and willing for the research to take place. He was interested in what would be revealed of Marchant's history,

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[114] Journal Officiel de la République Française,'La loi no. 79-18 du 3 janvier 1979 sur les archives (1)',Legifrance Bases de donnés, 1979. (p. 49); Archives Nationales (AN) Paris, F1a 4514-4598, Inspection générale des services administratifs. Rapport: M. Winter, Inspecteur général des services administratifs (16 décembre 1938). It was reported on the appointment of a new non-medical director Gouzy, MC Madame Piquemal refused to hand over the keys and contents of her office which included her patient case histories.

[115] UHAGM, Letter 18 November 1941 from the director to the prefect. pp. 5, 10.

whatever that might be, but especially as the HP was involved locally and nationally in programmes to promote transparency of the work of the psychiatric hospital and addressing stigma and prejudice attached to mental health issues.

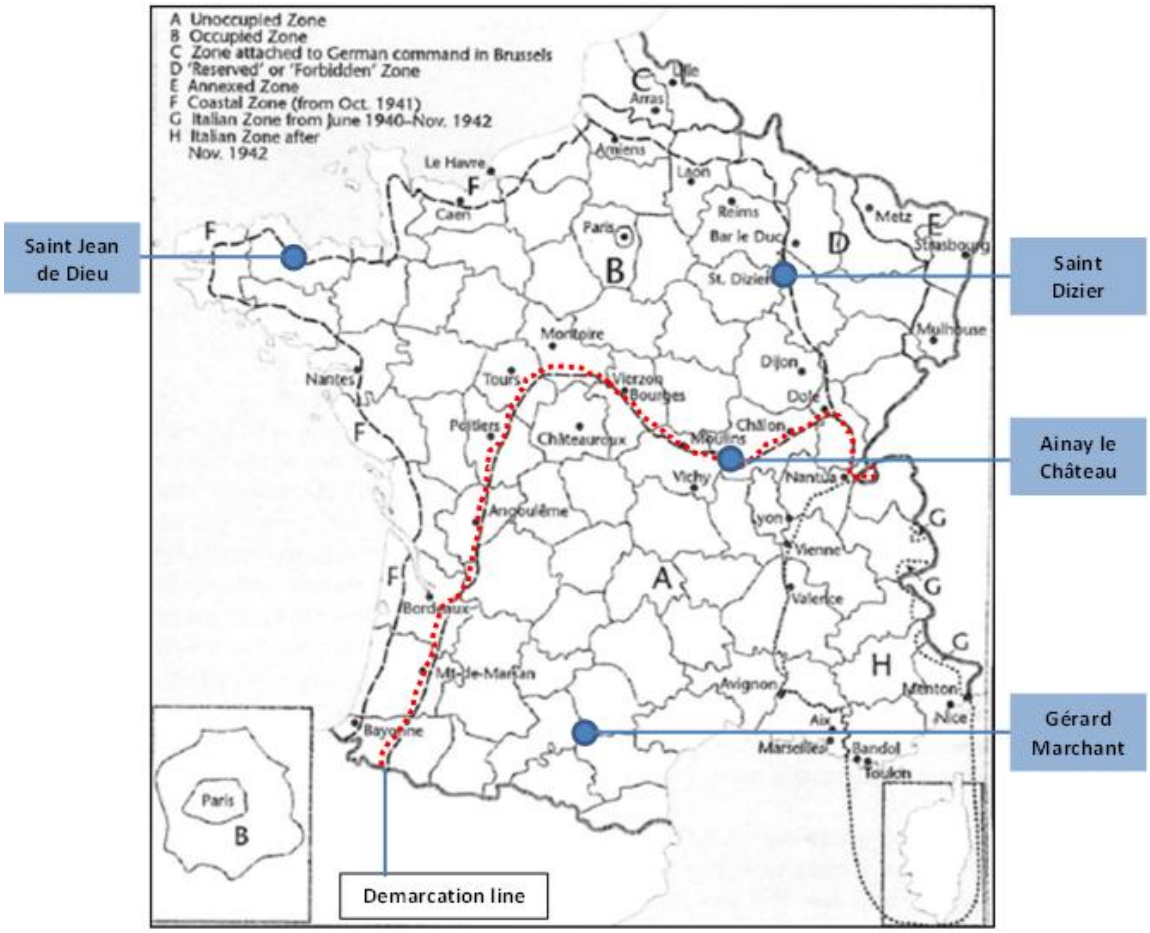

Figure 1 Map of France showing four target hospitals
Source: Julian Jackson, France: The Dark Years, 1940-1944, (2001) p xxi

The second choice is CHS Saint-Jean-de-Dieu, Dinan-Léhon, Côtes-d'Armor, previously Côtes-du-Nord. This HP was run by the Ordre des Frères hospitaliers de Saint-Jean-de-Dieu. Although there are previous studies of its brother-hospital in Lyon HP Dinan-Léhon is without research for the Occupation years. The region was in the occupied zone throughout the Occupation and although smaller than

Marchant, with only 980 inpatients is still considered medium in size. The director was again extremely interested and the archivist helpfully supplied documentation and offered ideas on sources held at Saint-Jean-de-Dieu and the Mother centre in Paris.

Thirdly, is CHS André Breton, Haute Marne, previously known as HP Saint-Dizier (SD). The town of Saint-Dizier was in close proximity to the invasion breakthrough area in June 1940. Departmental archives listed plentiful documentation and a previous MC was allocated to give the author access to hospital archives. HP Saint-Dizier was state-run despite its name and similar in size to Saint-Jean-de-Dieu. The department was in the occupied zone and the HP situated within a kilometre of the town centre, which during the Occupation was a German military base.

The final choice is the CHSI Ainay-le-Château in the Allier region, previously named Colonie familiale d'Ainay-le-Château. It was chosen for its uniqueness within the FMHS. It was one of only a few 'open' institutional facilities, either *colonie familiale* or *colonie agricole*, in which the patients were boarded out in the local community with foster-parents (*nourriciers*). The other three hospitals, as most in France, were classed as 'closed' highlighting their carceral nature where patients were committed and interned by the 1838 law. Around 750 male patients were housed in many of the small communities around Ainay, although an infirmary of thirty beds coped with patients too ill to be nursed in their lodgings by the *nourriceur*. Ainay's geographical location was in the non-occupied zone but only 60 kilometres from the border town of Moulins, one of the main exit points for returning refugees after the exodus and later a conduit for trade and citizens moving between zones. It was also only 100 kilometres from the town of Vichy, seat of the government during the Occupation.

1.8 Local hospital source material

Primarily the target hospitals' archives held all compulsory records according to the law of 1838. These include: *Procès-verbaux des délibérations de la Commission de surveillance* (minutes of the meetings of the hospital committee/board members) who sat on a monthly basis. Members included local dignitaries headed by the prefect. However, indicating the ever changing and difficult conditions during the Occupation, these meetings were less frequent over time, and with fewer members present. The *Cahier d'admission journalière* (daily admission notebook) detailed admissions which were later transferred to one of the official legal leather-bound *Livres de la loi*. One such register was the *Livre du mouvement de la population* (Admissions register) documenting all admissions with patient profile, name, address, age, date of birth, marital status, sex, profession, religion, and geographical origin (an essential factor for the daily tariff payment by the patients' department of origin). Discharges were registered specifying 'cure', or 'part cure', trial home visits, death was classed as a discharge but there was also a *Livre des décès* (Death register) recording patients' details, cause of death and date, with the certifying MC's signature. Such details were inputted by someone other than the patient's MC, or his Intern but I found that the registered cause of death did not always match that recorded in patients' case-notes. In the target hospitals I found very few patient death certificates, most being sent to the prefect's office, but of the few found cause of death differed from that in the register. It is at this point in the patient's 'medical encounter' that data was correlated and could skew statistics of total numbers and causes of death: this will be discussed later.[116]

Largely records found in all such administrative documentation dominate current scholarship and officially-received reading and interpretation of the Occupation

[116] Porter, The Patient's View.

years. They demonstrate clearly that the rise in mortality was greatest in the first two years, although this study does not rely on this nature of documentation alone. Further documentation in the target hospitals included, *Rapports administratifs et médicaux* were written for the local prefect's office on an annual basis by the MD or non-medical director and the MCs in charge of male or female patient services. (Appendix D) Annual reports were mostly typed and sent to the prefect but there were handwritten copies with in-the-margin-corrections remaining in the archives. However, in all four target hospitals individual annual reports for the years 1940 through to 1944 were missing, and copies were not found in the departmental archives either. However, four- year printed reports were found in the target hospitals. It is this record which is referred to as unclassified hospital archives of each target hospital (UHAGM, UHASD, UHASJDD, UHAALC).

Indication of the importance of the institution from a legal and financial perspective is illustrated in these reports with a large proportion taken up with administrative accountability. The administrative section referred to the daily workings or production of hospital services: the farm and agricultural lands and their produce mostly consumed in-house rendering many of the HPs self-sufficient. Other services included maintenance and building, laundering, dressmaking, rope and sabot making (wooden clog), mattress-making, and catering services. Nursing and ancillary staff were included along with details of the hospital budget and justification of expenses in relation to the daily tariff charged for patients. However, only about a quarter of the report afforded to the medical and hygiene aspect of the HP. Both reports had little mention of patients as individuals they were mainly presented as statistical appraisals. Both administrative and medical reports and communications written by MDs and/or MCs reflect the landscape in which they operated and offer a view of the complex administrative decision-making processes at work institutional practice and day-to-day clinical management. They also manifest the complexities of an institution as a system of power as well as

political and medical attitudes to insanity, the involvement of the actors, and the meaning attached to being classified as 'mad' in the mid-twentieth century. Such material dominates current scholarship in an officially-received reading and interpretation of the years of the Occupation.

Statistics gathered for an analysis of life and death in the four hospitals is based on 3435 records taken from admission and death registers. Unexpectedly, but not surprisingly, given my background in nursing and management, I felt there should also be something physical remaining from the 'medical event' of the patient's history under the 'clinical encounter' that traced the patient's admission, diagnosis, internment and treatment.[117] In three of the hospitals I found patient dossiers and case notes (*Dossier de malade*) totalling 1133. In certain instances, it was possible to triangulate these with primary sources taken from departmental archives. Of the total number of patient dossiers found, 312 (27%), although a small percentage, held material applied in this study to convey multiple perspectives and complexities of institutional life. Although historical correspondence has limitations as a primary source or as a true view of the experiences of patient and family these records provide glimpses of the experiences of life in the institution: a patient-oriented history as Porter calls it, evidence until now unmapped and unknown.[118]

The inherent limitations in this study were non-availability of some pertinent archival documentation. Searches revealed that certain data was destroyed during the war in bombing attacks, lost in hurried evacuation of patients when hospitals were requisitioned by the Germans or is retained by the State and has, as yet, not been allowed into the public domain. Some historians maintain the latter is a 'paradoxical problematic' and argue that access often remains limited or privileged,

[117] Ibid.
[118] Ibid. p. 181.

thus preventing independent historical work.[119] In Saint-Dizier, a major proportion of patient dossiers were missing, only a few were available and catalogued at the departmental archives. However, these nuisances did not compromise the overall research; rather it led to an adjustment of the approach from a balanced consideration of four hospitals to focusing on Marchant and Saint-Jean-de-Dieu, and using the evidence from the other two hospitals in comparative perspective. Saint-Dizier was retained in the research because it held key evidence for the period of the German invasion in June 1940.

Despite assurances from departmental archivists and hospital director that suitable documentation was available at Ainay-le-Château, evidence from patient dossiers and daily life is sparse. It appeared that unless the patient was admitted to the infirmary for acute medical assessment, information of patients' daily life was kept in the lodgings, written by the *infirmier-visiteurs* (mainly trained nurses or social assistants or Interns attached to the hospital) on their bi-weekly or monthly visit. Furthermore, unlike closed institutions, most communication between patients and relatives was posted to their lodgings and became the property of the patient, and only a small quantity of material has been saved by *nourriciers* or relatives.

However, Ainay's potential significance to the analysis of mortality was sufficient to retain it for study. Ainay holds an important key in the assessment of life during the Occupation acting as a comparator, and as an example of some of the beneficial effects of what was nascent deinstitutionalisation, which for many inpatients in closed institutions did not come until thirty or more years after the Liberation of France.

[119] Caire, Histoire de la psychiatrie.

1.9 Conclusion

This chapter has introduced the methodology on which the study is based and outlined the development of the research strategy and data collection design and how it was achieved. Drawn from different fields of academic research the methodological and contextual framework has been developed and using a case-study approach the study brings, through the reading of official hospital documentation and unofficial material, a precious source of the contents of patient dossiers, a new dimension to the events that occurred in HPs during the darkest years of the history of psychiatry. The significance of this study is in the examination and conclusions of the drama that unfolded in four more HPs under Vichy, but also of its importance to contemporary directors, personnel, patients and relatives, who have shown such interest in learning of the history of their hospital even of such a painful and tragic period. Consideration of the intellectual works on psychiatry and daily life under the Occupation has determined the direction of this study and fashioned major fundamental questions. Moreover, there are many parallels to be taken from the inadequacies of the state system and shortcomings in psychiatric care.

In the early twentieth century and interwar years having a mental illness and being committed to the asylum was fraught with challenges for carers and cared-for. With the Occupation and a harsh rationing system under the Vichy regime the balance of whatever stability there was in the psychiatric hospital system was shattered with disastrous effects for all inpatients and personnel. Certain scholars opine that the Occupation was a major factor in spearheading a reform movement

of the FHMS after the Liberation.[120] Psychiatrists who practiced during the Occupation demanded a revision of the inhumanity that the system generated. From the exposition of many experiences encountered in the target hospitals during the Occupation this study accentuates the imperative for institutional reform in the mid-twentieth century.

To conclude this methodology, a brief summary of the following chapters is given.

Chapter 2 will present the traditional Christian philosophies for care, the medicalisation of insanity, the development of alienist profession, institutional practices, prevailing theories in social and mental hygiene in state or clerical hospitals, and whether they had any bearing on experiences of daily life. The four target hospitals are set within their historical and legal context. The chapter continues with an interrogation of twentieth- century psychiatric thought through the prism of reformer Edouard Toulouse and ideas of institutional practice and new modes of treatment.

Chapter 3 will answer the research question: Were the target psychiatric hospitals prepared for the crisis of World War II and the Occupation? These chapter analyses efforts made to upgrade facilities and to improve patient care during the interwar years. The unpreparedness of these institutions is illustrated in the crisis that unfolded during the first six months of the German occupation.

Chapter 4 will answer the research question: Did the consequences of the Occupation, tip the balance of the physical and mental friability of the mentally ill? The foremost all-encompassing factor in daily life both for citizens and inpatients

[120] Bueltzingsloewen, Le militantisme en psychiatrie, de la Libération à nos jours. Quelle histoire?!, p. 10; Henckes, Reforming psychiatric institutions in the mid-twenthieth century; Henckes, Le nouveau monde de la psychiatrie français.

was relentless restriction of rationing for both foodstuffs and resources and it will be seen that malnutrition was the major factor in mortality.

Chapter 5 will answer the research question: What were the responses of MDs, MCs, and Vichy authorities to experiences in psychiatric hospitals; were they adequate or purposefully tardy? The chapter advances an interpretation of the attitudes of MCs to the deteriorating health of their patients and their reactions. It also, alarmingly, establishes the inadequacies of a psychiatric hospital system that was more about the institution than the raison d'être of psychiatric care – the patient.

Chapter 6 draws the preceding chapters and their arguments together and provides disturbing evidence of the deaths of the mentally ill in the target hospitals. As well as the numbers involved, the chapter analyses how marital status, age, social class and gender relate to patients' chances of survival in the crisis that was the Occupation. The need for reform and restructuring of the antiquated asylum system, well over 100 years, is evidenced throughout all chapters in this study and significant in the last chapter.

Chapter 2 The Church and the Medicalisation of insanity

The tragic circumstances of the German occupation experienced in the target psychiatric hospitals compounded factors intrinsic to the hospitals themselves: their status, history, foundational purpose and philosophy, and administrative and professional practice. Consideration of how these factors influenced the care and welfare of patients will deepen knowledge of the course of events in the hospitals during 1940-44.

This chapter sets the four target hospitals, representative of early provision of facilities and care for the insane, within the broader national framework of their legal and historical context. In France, there was little state welfare for the poor, ill or mentally disturbed and the Catholic Church was the main care-giver. The chapter will give an insight into religious beliefs of causes of insanity and the approach of the Catholic Church to healing troubled minds and more generally care for the mentally ill.

It will also examine models of care, features of management, and the evolution of hospices and asylums for the insane to psychiatric hospitals and alienists, doctors interested in the brain, to psychiatrists within the 'medicalisation' of insanity.[121] This saw the emergence of the new discipline of psychiatry and the institutionalisation

[121] Isabelle von Bueltzingsloewen,'Confessionnalisation et medicalisation des soins aux malades au XIX siècle', *Revue d'histoire moderne et contemporaine,* 43, (1996), 632-51; Thomas Szasz, *The Medicalization of Everyday Life: Selected Essays*, (New York: Syracuse University Press, 2007); Goldstein, *Console and classify*; Roy Porter, *The Cambridge History of Medicine*, (New York: Cambridge University Press, 2006), p. 277.

of the insane in a new network of state asylums.[122] The law of 1838 concerning the insane is explained within its judicial and administrative setting.

However, the law of 1838 produced unforeseen outcomes, not only in significant disparate services, especially in funding, attributable to decentralisation of asylum services from Paris, but also in tension between alienist therapeutic imperatives and custodial enforcement detrimental to both institutional and professional practice. This rapidly deteriorated led to overcrowding, chronicity (long-stay patients), and inadequate facilities of care and welfare. Asylum psychiatrists were accused of malpractice and asylums were called little more than Bastilles. However, there were psychiatrists concerned with this situation and they sought to find alternatives to institutionalising people who were not able to be cured in the asylum, as originally hoped, and not exactly suitable for incarceration, and so the last of the target hospitals was founded, Ainay-le-Château.

As an ideal platform from which to explore issues associated with the Occupation, the second part of this chapter discusses the work of psychiatrist-psychologist, eugenicist and hospital reformer, Edouard Toulouse (1865-1947). His career provides a model for viewing the influence of public health, social and mental hygiene and eugenic theories on twentieth-century medicine and politics, and the degree to which they affected psychiatric thought and institutional practice. In view of certain claims of psychiatry's involvement in the deaths of so many inpatients during the Occupation an exploration of these influences are pertinent.[123]

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[122] Andreas Marneros,'Psychiatry's 200th birthday', *British Journal of Psychiatry,* 193, (2008), 1-3 (p. 1). 'Psychiatrist' is a term first coined in 1808 by German physician-psychiatrist Johann Christian Reil (1759-1813); 'alienist' refers to early doctors interested in the brain and its function.

[123] Lafont, Déterminisme sacrificiel et victimisation; Armand Ajzenberg and André Castelli, *L'abandon à la mort de 76 000 fous par le régime de Vichy : Suivi d'un hôpital psychiatrique sous Vichy (1940-1945)*, (Paris: Harmattan, 2012).

Although the thesis is focused on the enormous increase in mortality during the German occupation, the wider and persistent problems on the one hand of inadequate provision of facilities and welfare for the mentally ill, and on the other enforcement of law and order, are significant.

2.1 Provision of care for the insane: Catholic and Medical approaches

In France, from the medieval period to the nineteenth century, the Catholic Church held dominance over institutions for the sick, destitute and insane.[124] The Church was the traditional provider of charity, and the antecedent of state welfare (*Assistance publique*) in France.[125] Although such provision was small in size and scattered in nature, there was very little else for such displaced and disenfranchised people, there was only prison, the work-house.[126] The Church did not, however, claim to cure but to offer solace and human kindness.[127] A religious philosophy of charity was the bedrock of care given principally by religious orders and communities. In Paris alone there were more than forty hospitals and houses of charity, 140 convents and monasteries to which 1000 monks, 2500 nuns and 1200 parish priests belonged.[128] Religious orders and congregations included the Augustines, the Benedictines, and the Order of Saint-Jean-de-Dieu, known as the

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[124] Dorothy Porter, *Health, Civilisation and the State: A history of public health from ancient to modern times*, (London: Routledge, 1999); Georges Rosen, *A History of Public Health* (Baltimore: John Hopkins University Press, 1993), pp. 29, 39.

[125] Charles E. Bagwell,'"Respectful Image" Revenge of the Barber Surgeon', *Annales of Surgery,* 241, (2005), 872-78 (p. 874); Porter, *Health, Civilisation and the State*; Rosen, *A History of Public Health* pp. 29, 39; Jones, *The Charitable Imperative*; Jones, Sisters of Charity.

[126] E. H. Ackerknecht,'Political Prisoners in French Mental Institutions before 1789, during the Revolution, and under Napoleon I', *Medical History,* 19, (1975), 250-55; Weiner, The Brothers of Charity, p. 328.

[127] Jones, The Treatment of the Insane in Montpellier; Jones, *The Charitable Imperative*.

[128] 'Institut de Recherche et Documentation en Economie de la Santé (IRDES) Historiques des réformes hospitalières en France. Marie-Odile Safon', <www.irdes.fr/espacedoc/index.htm> [Accessed September 2015] ; Tim McHugh, *Hospital Politics in Seventeenth-Century France, The Crown, Urban Elites and the Poor*, (Farnham: Ashgate, 2007), p. 335. Lisa DiCaprio, *The Origins of the Welfare State: Women, Work, and the French Revolution* (Illinois: University of Illinois Press, 2007), pp. 34-5, 43-5. ibid.

Frères de charité; their tenets and care models formed fundamental stepping stones for other religious establishments such as the Sisters of Charity, founded by Vincent de Paul with Louise de Merillac.[129] With no state welfare, their works were supported principally by philanthropists.[130]

Clerical establishments had no physician attendance, although some members of certain religious orders were surgically experienced like lithotomists, others were medically and pharmaceutically trained in Mother Houses in Lyon or Paris.[131] Care-management in many clerical establishments was both efficient and practical, religious personnel would admit, diagnose, prescribe medication, treat wounds, and provide pharmaceutical care for the inmates.[132] However, charitable establishments could take only limited numbers of the many mentally disturbed people, the rest were confined in insalubrious and inhumane state prisons or workhouses.[133] In 1818, in a study of facilities for the insane throughout France, alienist Esquirol described conditions as, 'frightful and even worse than those in

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[129] Mark S. Micale and Roy Porter, *Discovering the History of Psychiatry*, (New York: Oxford University Press, 1994). In 1825, Esquirol became medical director of Charenton; he and his mentor alienist Pinel were the main architects of the new French asylum system and the law of 1838. ; Weiner, The Brothers of Charity, p. 321; Adeline Fride, 'Charenton ou la chronique de la vie d'un asile de la naissance de la psychiatrie à la sectorisation', (doctoral thesis, université Paris 5, 1983); Masson and Bourgeois, La médicalisation de l'intuition charitable, p. 239; Geoffrey Blainey, *A Short History of Christianity*, (Melbourne: Viking, 2011).

[130] Laurence Brockliss and Colin Jones, *The Medical World of Early Modern France*, (Oxford: Clarendon Press, 1997); Jones, The Treatment of the Insane in Montpellier. Gary B. Ferngren,'Early Christianity as a Religion of Healing', *Bulletin of the History of Medicine,* 66, (1992), 1-15 (p. 10); Andrew Wear, *Knowledge and Practice in English Medicine, 1550-1680*, (Cambridge: Cambridge University Press, 2000), p. 30; Sister Katarina Schuth,'Transmission of the Catholic Social Teaching in Gaudium et Spes: The Role of Seminaries in Preparing Knowledgeable Priests', *The Call to Justice: The Legacy of Gaudium et spes 40 Years Later (March 16-18 2005*, 2005.

[131] Weiner, The Brothers of Charity.

[132] Jones, The Treatment of the Insane in Montpellier, p. 378; Katrin Schultheiss,'La véritable médecine des femmes: Anna Hamilton and the Politics of Nursing Reform in Bordeaux, 1900-1914', *French Historical Studies,* 19, (1995), 183-214; Masson and Bourgeois, La médicalisation de l'intuition charitable. Pierre Morel and Claude Quétel, *Du Bon Sauveur au CHS: Deux siècles et demi de psychiatrie caennaise*, (Caen: Editions Du Lys, 1992), p. 55. Jones, Sisters of Charity, p. 339.

[133] Ackerknecht, Political Prisoners in French Mental Institutions before 1789, during the Revolution, and under Napoleon I; Weiner, The Brothers of Charity, p. 328.

Paris'.[134] In the age of enlightened knowledge and scientific and medical advances, major theorists of insanity called for reform of the inhumane treatment of the insane. Alienists and like-minded scholars embraced the social needs of the lower classes and acknowledged an obligation for intervention, care, prevention and reform for the insane.[135] French *philosophe,* Denis Diderot claimed of the growing numbers of insane in Paris in 1818: 'il serait plus important de travailler à prévenir la misère qu'à multiplier les asiles'.[136]

Such verdicts, ideas, and government lobbying by the major contributors to new theories on the management of insanity, Pinel and Esquirol, saw a slow but determined shift in the status of madness framed by a medical and socio-political perspective. Their proposal for a new method of managing the insane eventually saw the passing of the 1838 law.[137] Alienists envisaged repositioning the custodial system of penal confinement for the insane to a revolutionary curative asylum system.[138] Insanity was promoted as a medical model of illness and, as such, required expert treatment. Cementing this concept and giving substance to the

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[134] Esquirol, *Des établissements des aliénés*; Margaret Gywynne Lloyd and Michel Bénézech,'The French mental health legislation of 1838 and its reform', *Journal of Forensic Psychiatry,* 3, (1992), 235-50 (p. 237).

[135] Pinel, *Traité médico-philosophique*; G. Ferrus, *Des aliénés: Considérations sur l'état des maisons qui leur sont destinées tant en France qu'en Angleterre, sur la nécessité d'en créer de nouvelles en France et sur le mode de construction à préférer pour ces maisons; sur le régime hygiénique et moral auquel ces malades doivent être soumis ; sur quelques questions de médecine légale ou de législation relatives à leur état civil*, (Paris: P. Huzard, 1834); Esquirol, *Des établissements des aliénés*. Goldstein, *Console and classify,* p. 12; John Hedley Brooke, 'Science and Religion', in *The Cambridge History of Science: Volume 4, Eighteenth-Century Science,* ed. by Roy Porter (Cambridge, New Yor, Melbourne, Madrid, Cape Town: Cambridge University Press, 2003), pp. 741-61 (p. 741).

[136] Denis Diderot, *Oeuvres de Denis Diderot. Volume 2 1ère partie*, (Paris: Belin 1818), p. 664.

[137] Joseph Melling and Bill Forsythe, 'Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective', (London: Routledge, 1999); Jones, *The Charitable Imperative,* p. 372; Edwin Wallace and John Gach, *History of Psychiatry and Medical Psychology: With an Epilogue on Psychiatry and the Mind-body Relation*, (New York: Springer, 2008), p. 309.

[138] Lawrence I. Conrad, Michael Neve, Vivian Nutton, Roy Porter, and Andrew Wear, *The Western Medical Tradition: 800 BC to AD 1800*, (Cambridge: Cambridge University Press, 1995); Goldstein, *Console and classify,* p. 56. Guillemain, Médecine et religion au XIXe siècle; Laffont and Priest, A comparison of French and British mental health legislation, p. 843; Pinel, *Traité médico-philosophique*.

collective identity of the infant profession of alienism, the Société médico-psychologique (SMP) was formed in 1852. The medical journal, *Annales médico-psychologiques*, had already been founded in 1843, giving members a platform for psychiatric debate. However, published articles also illustrate divisions within society and divergent interpretations of mental pathologies, which would be a continued weakness of the profession.[139] The complexities of medical ideas on insanity would be a stumbling block to cohesive care into the twentieth century.[140]

As a theoretical clinician, Pinel's *traitement moral* (humane treatment) proposed a psychosocial approach to management emphasising both medical and moral (principled) duty and cessation of violent methods. His theories were to inspire scores of English, French and German alienists for generations.[141] However, his ideas were rooted in the province of religion and religious institutions.[142] In his personal copy of his work, *Traité médico-philosophique sur l'aliénation mentale ou la manie* (1800), references to the methods of care for the insane in the early Spanish Catholic asylum in Zaragosa are heavily underlined, an indication of his keen interest in this approach to care.[143] It is probable, moreover, that such notions of the importance of the humane aspect of treating the insane came from his early years of training in the priesthood and his respect for the compassionate

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[139] Jean-Christophe Coffin,'La médecine mentale et la révolution de 1848: la création de la Société médico-psychologique', *Revue d'histoire du XIXe siècle*, (1998); Dowbiggin, *Inheriting Madness,* pp. 6, 76-92.
[140] Marcia Webb,'Toward a Theology of Mental Illness', *Journal of Religion, Disability & Health,* 16, (2012), 49-73.
[141] Goldstein, *Console and classify*; Swain, *Le sujet de la folie: naissance de la psychiatrie*; Pinel, *Traité médico-philosophique*; T. Morman, 'George Rosen and the History of Mental Illness', in *Discovering the History of Psychiatry,* ed. by Roy Porter Mark S. Micale (Oxford: Oxford University Press, 1994); Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, (Chichester and New York: Wiley, 1997), pp. 10-14, 216.
[142] Micale and Porter, *Discovering the History of Psychiatry,* p. 235.
[143] Weiner, *Comprendre et soigner: Philippe Pinel, 1745-1826: la médecine de l'esprit,* p. 258; José-Javier Plumed Domingo and Antonio Rey-Gonzalez,'The treatment of madness in Spain in the second half of the 19th century: conceptual aspects', *History of Psychiatry,* 17, (2006), 139-58; Wallace and Gach, *History of Psychiatry and Medical Psychology,* pp. 269-70; Micale and Porter, *Discovering the History of Psychiatry,* p. 20.

working principles of Jean-Baptiste Pussin, his chief non-medical warder and ex-patient who cared for the 600 insane in Bicêtre.[144] Pussin's progress from patient to carer was a route seen not infrequently in recovering asylum patients.[145] His involvement and contribution to the humanising ideas advocated by Pinel have been seriously overlooked in medical history.[146]

The essential ingredients of this treatment comprised severance from external stimuli, eschewing physical confinement in chains and brutality, treating patients with dignity and respect, talking to them to gain their confidence, giving them timely, appetising meals, and upholding good hygiene. He also advocated patients be occupied in purposeful work, and there was an emphasis on the social values of family, as well as family placements for the harmless insane.[147] At the end of the nineteenth century, a time when many of these ideals had been swamped by overcrowded asylums, the latter became a reality with the establishment of a Colonie familiale in Ainay (Allier). We will return later to this establishment, as it is the fourth in the case-study hospitals.

There were two major themes to Esquirol's reform programme. Firstly, he advocated institutionalisation of the insane in special establishments set up for their treatment. They were to be 'un instrument de guérison entre les mains d'un

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[144] Wallace and Gach, *History of Psychiatry and Medical Psychology,* p. 305. Postel genese 1998

[145] UHAGM, Patient dossier, Monsieur F. S. age 19 admitted 22 May 1943 discharged 2 December 1943. Letter from the MC 19 August 1943, 'He works at the moment with little jobs to help the staff and is very good with his fellow patients with washing and mobilising'; Regarding Pussin and his tenets for caring for the insane see: Goldstein, *Console and classify,* p. 60; Marcel Gauchet and Gladys Swain, *Madness and democracy : The Modern Psychiatric Universe*, (Princeton, N J: Princeton University Press, 2012), p. 130.

[146] Dora Weiner,'The Apprenticeship of Philippe Pinel: A New Document: Observations of Citizen Pussin on the Insane', *American Journal of Psychiatry,* 135, (1979), 1128-34; Lloyd and Bénézech, Legislation 1838; Postel and Quétel, *Nouvelle histoire de la psychiatrie.*

[147] G. Mora, 'History of psychiatry', in *Comprehensive text book of psychiatry,* ed. by Benjamin J. Sadock, Virginia A. Sadock, and Harold I. Kaplan (Lippincott: Williams & Wilkins, 2005).

médecin habile', a healing space in the hands of a skilled alienist.[148] Esquirol insisted that, 'The physician must be the vital head of a lunatic asylum. It is he who should set everything in motion; [he] should be invested with an authority from which no one is exempt'.[149] Secondly, he claimed a physical environment would aid in the treatment of insanity. Implicit in both theories was that the asylum would support the practice of the new medical specialty. With the passing of the 1838 law, however, asylum alienists became state employees and within the *Assistance publique* (Public welfare) were not considered mainstream compared with hospital physicians and general practitioners.[150] In turn, this meant asylum patients were considered at the lowest level of welfare. The new system became increasingly focused on the legalities of protecting society from the disruptive and dangerous rather than on therapeutic care.

A strong concept of curability can be seen in treaties, guidelines and later medical journal articles produced by other reform-minded Catholic alienists Guillaume-Marie Falret and Max Parchappe (1800-1866), national asylum inspectors, wrote copious manuals on all aspects of the new asylum system.[151] In true Esquirolian

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[148] Pierre Pinon, 'Architecture et thérapie: L'hospice de Charenton comme 'instrument de guérison', in *Architecture et psychiatrie. l'hôpital: espace de soin, espace urbain,* ed. by La Ferme du Vinatier (Lyon: La Ferme du Vinatier, 2001), pp. 15-24 (p. 3); Esquirol, *Des établissements des aliénés*; For further reading on asylum architecture see, Lucille Grand,'L'architecture asilaire au XIXe siècle, entre utopie et mensonge ', *Bibliothèque de l'école des chartes,* 163, (2005), 165-96; Leslie Elizabeth Topp, James E. Moran, and Jonathan Andrews, *Madness, architecture and the built environment : psychiatric spaces in historical context*, (New York ; London: Routledge, 2007); Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States*, (Minneapolis: University of Minnesota Press, 2007).

[149] Micale and Porter, *Discovering the History of Psychiatry,* p. 222.

[150] Asylum MDs and MCs were nominated by the Minister of the Interior (not the Minister of Health and Family), therefore became employees of the state.

[151] Henri Falret, *De la construction et de l'organisation des établissements d'aliénés*, (Paris: J-B Bailliere, 1852); Ferrus, *Des aliénés: Considérations sur l'état des maisons qui leur sont destinées tant en France qu'en Angleterre, sur la nécessité d'en créer de nouvelles en France et sur le mode de construction à préférer pour ces maisons; sur le régime hygiénique et moral auquel ces malades doivent être soumis ; sur quelques questions de médecine légale ou de législation relatives à leur état civil*; Max Parchappe, *Des principes à suivre dans la fondation et la construction des asiles d'aliénés*, (Paris: Masson, 1853).

style, they included desired geographic location, architectural style and internal environment, ideal bed capacity, segregation of sexes, classification of various conditions of insanity, and hygiene. A major treatise describes, 'how to govern the mad' and, demonstrating a strong conviction of their expertise, 'how to heal them in asylums'.[152] However, this Utopian ideal would falter with the application of the 1838 law as departmental authorities, the holders of the budget decentralised from Paris, took a strong lead in the admission of anyone they considered a burden to society or a threat to law and order.

However, the new discipline of alienism forwarded no consistent ideas of causality or treatment of madness, demonstrating the incomplete state of mental pathology, some alienists attributed insanity to physical lesions, biological or organic causes while others argued for somatic causes, while still others saw madness through a spiritual dimension.[153] Catholic beliefs of causality varied according to theological views although the era and cultural and social attitude and the character of the local ecclesiastical presence also played a part. Sickness and insanity were treated dependant on the severity or behavioural condition of the patients with religious practices, considered as therapeutic. Collective prayers and confession, religious readings and hymns, reputedly imposed a sense of calm and normalisation and harmony of the visual, auditory, and olfactory senses.[154]

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[152] Esquirol, *Des établissements des aliénés*; Henri Falret,'On the Construction and Organisation of Establishments for the insane (translated from the French)', *American Journal of Insanity,* 10, (1854), 218-67; Daniel Hickey, *Local Hospitals in Ancien Régime France: Rationalization, Resistance, Renewal, 1530-1789*, (Montreal and Kingston, London and Buffalo: McGill-Queen's Press, 1997); Grand, L'architecture asilaire au XIXe siècle; Shorter, *From the Era of the Asylum to the Age of Prozac*.

[153] Greg Eghigian, *From Madness to Mental Health: Psychiatric Disorder and Its Treatment in Western Civilization*, (New Brunswick: Rutgers University Press, 2009), p. 7; Herman Westerink,'Demonic possession and the historical construction of melancholy and hysteria', *History of Psychiatry,* 25, (2014), 335-49 (p. 335); Dowbiggin, *Inheriting Madness,* p. 51.

[154] Hervé Guillemain,'Déments ou Démons? L'Exorcisme face aux sciences psychiques (XIXe-XXe siecles)', *Revue d'histoire de l'Eglise de France,* 87, (2001), 439-71 (p. 47).

Religious and psychiatric approaches to the pathology of madness thus shaped a complex relationship between alienist and priest. Traditional Catholic healers of the insane argued that alienists had no special skills in administering a non-corporeal remedy. With the medicalising of insanity and the separation of the state and Church many Catholics saw psychiatry as a threat to the idea of the primacy of the soul reducing spiritual experiences to purely psychological ones. Conversely, priests and nursing orders challenged medical authority in the asylums.[155] Indeed, in France such disputes between alienists and clerics continued until well into the twentieth century exacerbated by the anticlerical policies of the Third Republic and the separation of the Church and state in education and schools.[156]

From the Medieval period, Catholic views of madness have been traditionally seen through a theological lens. Certain scholars of religion held varying views on suffering and diseases, which it was claimed could appear as a consequence of demonic possession while others suggested madness as divinely inspired, as a chastisement of the wicked, but the Church also developed a healing mission.[157] Orations like those of the Sermon on the Mount formed the foundations of the Catholic Church's participation in hospitals and healthcare.[158] If these beliefs are looked at more closely it appears there were shared beliefs and little serious conflict between catholic faith and psychiatry; contested boundaries were more about the extent of the boundaries than the boundaries themselves.[159] Indeed

[155] Dowbiggin, *Inheriting Madness,* p. 20. Goldstein, *Console and classify*.
[156] Goldstein, *Console and classify*.
[157] Porter, *Greatest benefit,* p. 87 and 112.
[158] Blainey, *A Short History of Christianity*.
[159] Morel and Quétel, *Du Bon Sauveur*; Hervé Guillemain,'Le prêtre et l'aliéniste. Autour d'une <scène> de la psychiatrie au XIXe : la bénédiction de la chapelle de l'asile de Quatre-Mares', *Evolution Psychiatrique,* 73, (2008), 1000-16.

psychiatric principles and practice in the 1900s were reconciled with the basic tenets of catholic faith and medicine, seen in the following cases.[160]

Firstly, we will take the example of Catholic alienist Esquirol. At Charenton asylum he actively encouraged chaplains in their religious practices in the asylum, and when practicing at Salpêtrière, he claimed religious beliefs and practices were a therapeutic technique and an occasional means of emotional support for the sick and the senile.[161] He also instigated an old asylum building to be renovated for use as a chapel. Other Catholic alienists such as asylum inspectors, Falret and Jules Lunier (1822-1885), instructed that religious activities be used in state asylums.[162] Falret stated that Catholic spirituality completed a healing aspect during mental suffering. A further example of liaison between priest and psychiatrist is the benediction of the chapel of the asylum Quatre-Mares near Rouen. Asylum director, chaplain, and local Church dignitaries celebrated the amicable relationship of religion and psychiatry in a public gesture illustrating 'an active co-operation' of religious practices within a state asylum and on a broader scale that there was no linear or uniform secularisation between Church and religion.[163]

We come next to the Société de Saint-Luc, Saints Côme et Damien which underlines a rapport between the contested boundaries of church and medicine.[164] The society's aim was to present a cohesive front against growing materialism and the anti-clericalism stance of many medical men and to advance both medical and

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[160] J. Vanderveldt and R. Odenwald, *Psychiatry and Catholicism*, (New York: McGraw-Hill Book Company, 1957).
[161] Mark S. Micale,'The Salpêtrière in the Age of Charcot: An Institutional Perspective on Medical History in the Late Nineteenth Century', *Contemporary History,* 20, (1985), 703-31 (p. 711).
[162] Hervé Guillemain,' Le soin en psychiatrie dans la France des années 1930. Une observation à partir des dossiers de patients et des manuels de formation infirmière', *Histoire, médecine et santé,* 7, (2015), 77-90.
[163] Guillemain, Le prêtre et l'aliéniste. Autour d'une <scène> de la psychiatrie au XIXe : la bénédiction de la chapelle de l'asile de Quatre-Mares, p. 4.
[164] Guillemain, Médecine et religion au XIXe siècle; Guillemain, Déments ou Démons? L'Exorcisme face aux sciences psychiques (XIXe-XXe siecles), p. 463.

ecclesiastical methods of treatment and diagnosis at the cusp of the twentieth century. Members included leading psychiatrists some specialising in possession, exorcism, psychoanalysis and neurology, all areas of medicine which gave rise to tension between religion and medicine.[165] However, a proliferation of writing on the relationship between science and faith testifies to confidence in a synergy between faith and medicine. Conversely, many of these works illustrate the suspicions of certain priests and exorcists for scientific psychology but there remain similarities between the two the two professions in the treatment of mental illnesses.

Much of Pinel's *traitement moral* was an extension of Catholic beliefs and chimed with early concepts and philosophies of the founders of religious initiatives and communities, such as the Brothers of Saint-Jean-de-Dieu. However, Catholic and medical notions of insanity and its management differed in one main aspect: religious bodies saw their asylums as a refuge for the destitute and insane, whereas alienist-reformers claimed medical management in the disciplined environment of an asylum was a means of cure.[166] There were medical ideas which gave rise to Catholic disagreement such as the psychological theories and personal belief systems of physicians Carl Jung and Sigmund Freud.[167] The Church was uneasy with the concept of the practice of hypnotism which modified the image of

[165] Guillemain, Déments ou Démons? L'Exorcisme face aux sciences psychiques (XIXe-XXe siecles), p. 461.

[166] UHASJDD, Rapports et délibérations: Conseil général des Côtes-de-Nord Session Ordinaire de 1857. Recueil des Décisions, Avis et Voeux du Conseil Général; Georges Hamon, 'Contribution à l'étude de l'histoire de l'hôpital psychiatrique de Léhon', (doctoral thesis, université de Rennes, 1971), pp. 90-3; Also see Clifford Beers, *A Mind That Found Itself*, (Pittsburgh and London: University of Pittsburgh Press, 1981).

[167] Pravin Thevathasan, *Catholicism and Mental Health*, (London: Catholic Truth Society Publishers to the Holy See, 2014); Elisabeth Roudinesco, *Histoire de la psychanalyse en France; Jacques Lacan : esquisse d'une vie, histoire d'un système de pensée* (Paris: Librairie générale française, 2009).

consciousness and further medical discoveries in neurology provoked a breach in the doctrinal corpus of Christianity by relativising consciousness and free-will.[168]

In the early twentieth century, alienists took a renewed interest in exorcism and in a particular form of Catholic thinking that certain types of mental disturbances were caused by demonic possession. Traditionally, a scriptural approach to treatment relied upon exorcism of unwanted spirits. A priest would perform an exorcism, defined as prayer, ritual, and holy water for patients thought to have irrational ideas or to be possessed by evil spirits.[169] This idea was equated by certain alienist neurologists with hysteria treated with hypnosis.[170] Continuing the search for cure and treatment for mental ills, there was a reappearance of religious pilgrimages for healing of the body and the mind. This initiated ideas that the Catholic Church needed to work in partnership with medical men. A medical bureau was established at Lourdes to verify medically cures. A distinct connection of religion with psychotherapy now becomes more obvious. Ruth Harris places the Lourdes shrine at the centre of the debate on science and Catholic religion.[171]

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[168] Webb, Toward a Theology of Mental Illness, p. 53.
[169] Jones, The Treatment of the Insane in Montpellier, p. 374.
[170] Guillemain, Déments ou Démons? L'Exorcisme face aux sciences psychiques (XIXe-XXe siecles), p. 449.
[171] Ruth Harris,'The ''Unconscious'' and Catholicism in France', *Historical Journal,* 47 (2004), 331-54; Van Tine Osselaer, Henk de Smaele, and Kaat Wils, 'Sign or Symptom?: Exceptional Corporeal Phenomena in Religion and Medicine in the 19th and 20th Centuries', (Leuven: Leuven University Press, 2017).

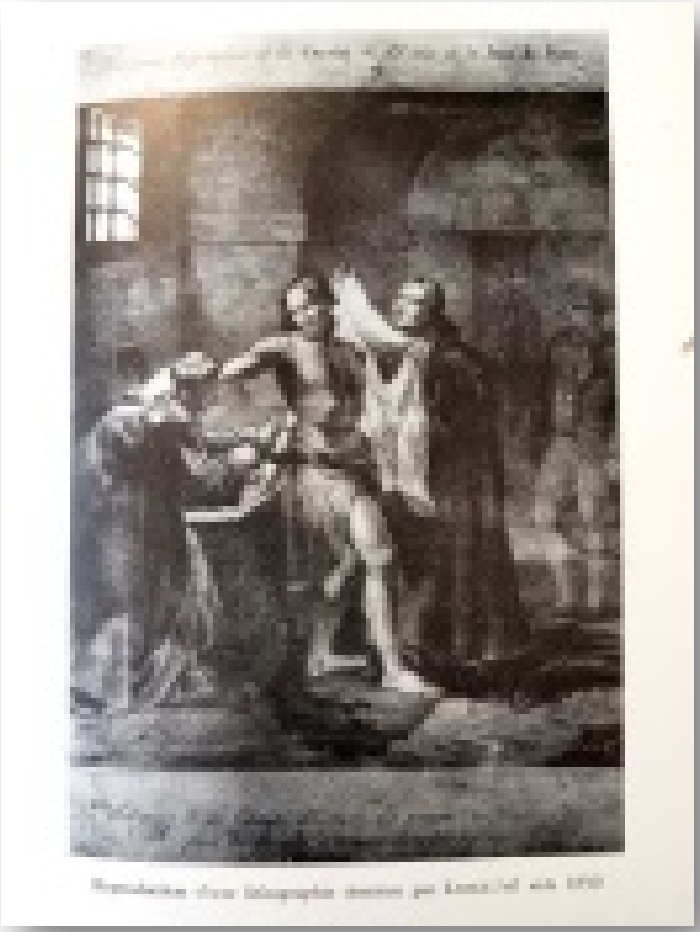

Figure 2 Brothers of Saint-Jean-de-Dieu releasing a lunatic from his chains
Source : Jean Caradec Cousson, 1959 page 145.

The image of two Brothers of Saint-Jean in the lithograph above is similar to the scene of the famous painting, 'Pinel releases the prisoners from Salpêtrière', around the 1790s.[172] It represents an overlapping of psychiatry and catholic attitudes towards madness and its treatment. The same lithograph appears in a

[172] In 1876, Robert-Fleury painted this representation of Philippe Pinel at the Salpêtrière, depicting the famed Father of modern psychiatry among the inmates. In 1795, Pinel had been named chief doctor at the asylum; he instituted more charitable and rational treatments without chains. This is a copy from the original book by Coussan. It was most kindly sent by Brother Finnian of the Order of Saint John of God in Ireland.

nursing manual written by alienist Franz Adam in the 1930s. During the Occupation Adam was MD of HP Rouffach in the Haut-Rhin where psychiatrists evacuated their patients to save them from the advancing German armies. This type of humane attitude is also seen in the accord of Catholic paternalism and psychiatry in the practice of psychiatrists working in HPs in the same period: Henri Ey, HP Bonneval, Louis Anglade, HP Mans, Balvet and Tosqelles HP Saint-Alban.[173]

Religion and medicine in many places of refuge for the insane co-existed within diverse interpretations of insanity and ideas of treatment for both soul and body seen clearly in the Order of Saint-Jean-de-Dieu.[174] Religion and psychiatry drew on traditions of attempting to heal a range of human behaviours. In many asylums, chaplains gave a spiritual dimension to daily life for patients and staff and alienists worked in collaboration to bring a medico-social and religious normalisation to patients.[175] However, such co-operation as examined so far cannot be seen as a major theological change or reversal of Catholic beliefs but depended on location, individual characters, and significantly on religious orders as in the case of the Order of Saint-Jean-de-Dieu. From the origins of the medicalising of insanity, the Brothers had a presence not only in the asylums but were representative of alienism and moral treatment.[176]

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[173] Guillemain, Le soin en psychiatrie dans la France des années 1930, p. 84.
[174] Emilio Mordini, 'Roman Catholic Perspectives on Psychiatric Ethics', in *The Oxford Handbook of Psychiatric Ethics,* ed. by K. W. M. Fulford John Z. Sadler, and Werdie (C.W.) van Staden (Oxford: Oxford University Press, 2015), pp. 539-58; Jones, The Treatment of the Insane in Montpellier; Weiner, The Brothers of Charity, p. 328.
[175] Guillemain, Médecine et religion au XIXe siècle, p. 9 and 43. In 1859, Esquirol's survey found religious practices and therapies in 40% of state asylums giving a medico-religious aspect to the asylum.
[176] Ibid.

2.2 The foundation of the Asile de Saint-Jean-de-Dieu

The first of the four target hospitals is the Asile de Saint-Jean-de-Dieu, established in 1830 by the Catholic Order of Saint-Jean-de-Dieu.[177] The asylum represented prevailing religious conventions of care circumscribed within **theological beliefs** in the relief of human misery and in the worth of the individual.[178] The Order dates back to Marie de Médicis, who, learning of their charitable acts of compassion for the needy brought them to France from Spain in 1602.[179] In a century and a half the *Hospitaliers* created a total of forty establishments: a gauge of their influence and that of the attitude of the Catholic Church to confinement and social welfare of the underprivileged and the insane.

Their most famous asylum, La Maison de la Charité, Charenton, was a pioneering facility built in 1645 specifically for the insane, almost two centuries before the law of 1838.[180] Under the Brothers' management it acquired a good reputation and was mentioned in government reports, as 'le plus parfait de la capitale'.[181] In 1852,

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[177] UHASJDD, Rapports et délibérations: Conseil général des Côtes-de-Nord Session Ordinaire de 1857. Recueil des Décisions, Avis et Voeux du Conseil Général. For the oldest manuscipt on the Order see André Chagny, *L'Ordre hospitalier de Saint Jean-de-Dieu en France: Les Frères de la Charité 1602-1792*, (unknown, 1792).

[178] Louis Saglier, *Vie de saint Jean-de-Dieu, avec l'histoire sommaire de la fondation et du développement de son ordre*, (Paris: E. Plon, 1877). Fauvel, Témoins aliénés et "Bastilles modernes"; Paul Dreyfus, *Saint Jean de Dieu: Le père de l'hôpital moderne 1495-1550*, (Paris: Bayard Centurion, 1995).

[179] Chagny, *L'Ordre hospitalier de Saint Jean-de-Dieu en France,* pp. 24-6; Jean Monval, *Les Frères hospitaliers de Saint Jean de Dieu*, (Paris: Grasset, 1936); Paul Dreyfus, *Infirmier par amour: Paul de Magallon 1784-1859*, (Paris: Le Centurion, 1993), p. 94; Unknown, *Fondation d'une maison hospitalière de l'ordre de Saint-Jean de Dieu, à Dinan, Côtes-du-Nord: principalement destinée au traitement des aliénés (hommes) des divers départements de la Bretagne*, (Brest: Come et Boneteau, 1815).

[180] Fride, Charenton ; Jeanne Mesmin D'estienne,'La Maison de Charenton du XVIIe au XXe siècle : construction du discours sur l'asile', *Revue d'histoire de la protection sociale,* 1, (2008), 19-35; Chagny, *L'Ordre hospitalier de Saint Jean-de-Dieu en France*; Goldstein, *Console and classify,* pp. 139,98,201; Frère Corentin Cousson,'Les Frères hospitaliers de St-Jean-de-Dieu et le traitment des aliénés', *International Nursing Review,* 2 (1931).

[181] Masson and Bourgeois, La médicalisation de l'intuition charitable, p. 238. Jacques-René Tenon, *Mémoires sur les hôpitaux de Paris*, (Paris: P.-D. Pierres, 1788); Also see, Masson and Bourgeois, La médicalisation de l'intuition charitable, p. 238.

Steven Prentice, an English journalist, while writing of the terrible conditions in Hanwell asylum in England, referring to Charenton asylum as an example, 'de compétence et de bienveillance'.[182] Indication of the enduring quality of care and well-run establishments, with the 1905 separation law the Order was allowed to remain functioning.[183] There was probably also a political social implication here as Charenton asylum was a major teaching hospital as well as its large capacity. In this study, during the German occupation effective application and practice of management and care-giving in straightened circumstances was crucial differentiating patient welfare and mortality in state-run and clerical hospitals.

The history of the Order's involvement in the care of the mentally ill demonstrates a Christian obligation to alleviate social despair especially among the lower classes, prominent in the Order's basic values of humanitarianism.[184] Although humanitarianism may be contradicted in practice, the Brothers had impressive hospital administrative skills and managerial capacities and patient care was tightly supervised.[185] Governed by vows of obedience, chastity and poverty, the order's philosophy was strongly influenced by the life of its founder Jean Cuidad, the 'Father of the Poor', himself an ex-sufferer from mental illness, who had dedicated his life to the sick and destitute.[186] This attitude supports the theory that 'Christianity displayed a marked philanthropic imperative that manifested itself in both personal and corporate concern for those in need'.[187]

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[182] Frère Corentin Cousson,'La formation professionnelle chez les religieux hospitaliers de Saint-Jean-de-Dieu en France', *La Grenade*, (1935), 39-73; Marescaux, Vie et mort dans les hôpitaux psychiatriques, pp. 28-9.
[183] Guillemain, Médecine et religion au XIXe siècle.
[184] Guillemain, Le soin en psychiatrie dans la France des années 1930; Masson, Soins et assistance prodigués de Saint Jean de Dieu.
[185] Weiner, The Madman in the Light of Reason, p. 262.
[186] Dreyfus, *Saint Jean de Dieu*.
[187] Masson and Bourgeois, La médicalisation de l'intuition charitable, p. 238.

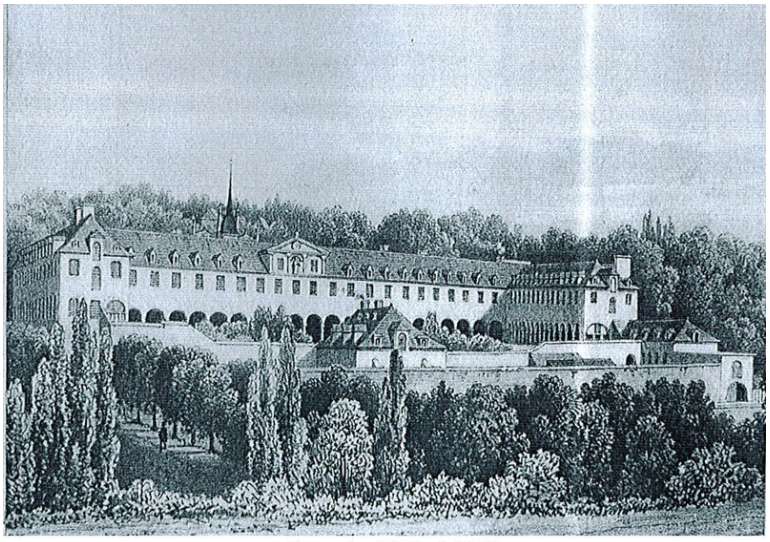

Figure 3 Asile de Saint-Jean-de-Dieu between 1851-1860
Source: UHASJDD verified by hospital archivist

In 1830, the Catholic Bishop of Saint-Brieuc, Monseigneur Le Groing-de-Romagère, aware of the work of the Order and the Brothers' reputation for good management and humane care requested they establish a refuge for the local insane in Dinan-Léhon.[188] Charitable acts rather than custodial imperatives were at the heart of the Order's belief and practice.[189] Initially, the Brothers took over a deserted hospice previously run by the Cistercians of Saint-Aubin. As demand grew, the Brothers acquired the Abbey of Saint-Aubin-des-Bois and bought

[188] Dreyfus, *Infirmier par amour,* pp. 130-1; Roy Porter, *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics*, (Stroud UK: Tempus 2006); Weiner, The Brothers of Charity; Goldstein, *Console and classify,* p. 14.
[189] Malo-Joseph de Garaby, *Vie de Mgr le Groing de la Romagère, évêque de Saint-Brieuc, suivie d'une notice sur M. le Mée, son successeur*, (Saint-Brieuc: Le Maout, 1841).Weiner, The Brothers of Charity; Masson and Bourgeois, La médicalisation de l'intuition charitable; Malo-Joseph de Garaby, *Vie de Mgr le Groing de la Romagère, évêque de Saint-Brieuc, suivie d'une notice sur M. le Mée, son successeur*, (Saint-Brieuc: Le Maout, 1841).

adjacent farmland.[190] The Catholic Church was at the centre of community life and the Brothers' charitable work and work-ethic and commitment became embedded within that daily life. Their attitude towards the care of the insane was one of giving value to life in a family environment.[191] They served, with local Church leaders, those in need: the local community, patients and families. Over time, the Brothers, together with many inpatients, restored and constructed several buildings to expand facilities for the local insane. The asylum had a family atmosphere, a similar approach to Englishman, Quaker William Tuke (1732-1822), which resonates with a theme to be examined in one of the other target hospitals, the Colonie familiale d'Ainay-le-Château.[192]

Figure 4 Saint Aubin: original building for the insane

[190] ADCA, 1X 114 Saint Aubin. Letter from Paul de Magallon to the prefect of the Côtes-de-Nord 8 January 1834.
[191] Attale Frère Lutz, 'Prieur de Dinan: Un frère de la Charité: Frère Robert Cortial (1866-1940) de l'Ordre de Saint Jean de Dieu (1938-1953)', (1970), pp. 45-55. ; Cousson, Les Frères hospitaliers de St-Jean-de-Dieu et le traitment des aliénés.
[192] Digby, *A study of the York Retreat, 1985*.

Source : Archives Provinciales de l'Ordre de Saint-Jean-de-Dieu Paris non-classified

With its Prior-directors and religious personnel, the asylum had a distinctive moral and religious dimension to daily life, and had a reputation for adhering to the Order's philosophy of care uniting carers, patients and their relatives.[193] All positions of authority, administration, nursing, laundering, catering, building maintenance, gardening, and farm management were filled by skilled Brothers. This formed a significant difference to state asylums in which master craftsmen, although experts in their field were not employed for their empathy or their training in managing the insane.[194] From the very opening of the asylum at Dinan-Léhon, the Prior developed a good relationship with local Catholic physicians with an interest in the mad, initially who attended when the Priot requested: Dr Bedel de Lamballe was non-resident and Dr Ducrey, *médecin-adjoint* (intern), resided in the asylum. With the continual expansion of the asylum to cover increased requests for admission, a further intern was appointed and the physicians were required to be resident.[195]

The Prior's approach to include physicians in the clinical care of patients is somewhat different to other religious orders like Sainte-Marie-de-l'Assomption. In this group of six asylums the Mother Superior vetted and gave only limited access to patients by a physician of her choice. There was much suspicion that physicians would exploit patients and had a less humanitarian interest in patient-care.[196] Such

[193] Cousson, Les Frères hospitaliers de St-Jean-de-Dieu et le traitment des aliénés.
[194] UHAGM, Rapport médical 1915 du Dr Dubuisson.
[195] UHASJDD, Liste des médecin-chefs de l'asile 1834-1945.
[196] Olivier Bonnet, 'Un réseau en action: les asiles privés de la congrégation Sainte-Marie de l'Assomption', in *Morts d'inanition: Famine et exclusions en France sous l'Occupation,* ed. by Isabelle von Bueltzingsloewen (Rennes: Presses universitaires de Rennes, 2005), pp. 109-26; Olivier Bonnet, 'Servir Dieu, servir le fous. Les religieuses dans les asiles d'aliénés au XIXe siècle', in *Religion et enfermements (XVIIe-XXe siècles),* ed. by Bernard Depal and Olivier Faure (Rennes: Presses universitaires de Rennes, 2005), pp. 131-51; Geertje Boschma, *The Rise of Mental Health Nursing | A*

mentality clouds the issue as to whether the attitude of Catholic authorities to psychiatry was negative or positive, but in the case of Saint-Jean-de-Dieu, as we shall see, there is certainly an indication of Catholic positivity to nascent psychiatric ideas of treatment for the insane.[197]

Figure 5 Saint-Jean-de-Dieu: extending facilities 1936
Source: Archives UHASJDD

Manuals and documentation in Saint-Jean-de-Dieu indicate the Brothers looked after the patients' physical needs and worked with the *aumonier* (chaplain) who looked after their spiritual needs, their soul.[198] The latter's duties included

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History of Psychiatric Care in Dutch Asylums | 1890-1920, (Amsterdam: Amsterdam University Press, 2003).

[197] Guillemain, *Diriger les consciences, guérir les âmes*.

[198] ADCA, 109W 69, Asile de Léhon Personnel 1906-1947; UHASJDD, Patient dossier, Monsieur D., age 72, admitted 7 September 1940 died 30 September 1940; Guillemain, *Diriger les consciences, guérir les âmes*.

organising mass and Sunday services, he also oversaw funerals and burials, as well as meeting and corresponding with relatives.[199]

2.3 Origins of the asylums of Saint-Dizier and Braqueville

Figure 6 Asile de Saint-Dizier circa 1900
Source: UHASD confirmed by retired MC Michel Mori

The history of the two target asylums of Braqueville and Saint-Dizier are situated within the context of Enlightenment thought and the multi-functional institutions established by Louis XIV, such as the *hôpital général* and *dépôt de mendicité*, as well as the broad development of the 1838 law.[200] Although they lack the strong traditional theological foundation of Saint-Jean-de-Dieu, these two asylums grew

[199] UHASJDD, Patient dossier, Monsieur D., age 72, admitted 7 September 1940 died 30 September 1940.

[200] Archives de l'AP-HP, Lettres patentes, arrêts du Parlement et du Conseil d'État, actes royaux, lettres, ordonnances et règlements relatifs à l'activité de l'Hôpital Général des hôpitaux et des maisons qui en dépendent, à leurs administrateurs et aux délits commis à l'encontre de l'institution, 1547-1786. (Hôpital général liasses 11-26).

from similar origins of concept, space, and supply and demand, reflecting certain visions of charity and aid for the poor admixed with civic duty.[201]

The asylum of Saint-Dizier, in the town of Saint-Dizier in the Haute Marne region, originated from a disused foundry, which was taken over as a *dépôt de mendicité* housing vagrants and the destitute. In 1849, funds were provided by a bourgeois family from Orléans to convert the *dépôt* to a house solely for the insane.[202]

In Toulouse the asylum of Braqueville metamorphosed from an original leper refuge on the outskirts of the city. The refuge, named Saint-Joseph-de-la-Grave (La Grave), was established with funding by civil dignitaries and charitable donors.[203] The coexistence of municipal authorities and religious communities is evidenced in both of these facilities.

In Saint-Dizier, the local civic authorities appointed the long-standing religious community Les-Filles-de-Saint-Vincent-de-Paul to administer nursing care and give instruction to lay personnel.[204] At La-Grave, Les-Filles- de-la-Sagesse fulfilled these roles.[205] There is limited archived material on the early development of facilities in Saint-Dizier, but La-Grave offers valuable insight into the evolution of provision for the insane, together with an issue which progressively and

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[201] John H. Weiss,' Origins of the French Welfare State: Poor Relief in the Third Republic, 1871-1914', *French Historical Studies,* 13, (1983), 47-78; Ackerknecht, Political Prisoners in French Mental Institutions before 1789, during the Revolution, and under Napoleon I, p. 250; Dowbiggin, *Inheriting Madness,* p. 3; S. Amanda Eurich, 'Curing Body and Soul : Health Care in Early Modern Orange', in *The Reformation of Charity: The Secular and the Religious in Early Modern Poor Relief,* ed. by Thomas Max Safley (Boston: Brill Academic Publishers, 2003), pp. 154-75 (p. 174).

[202] Pierre Berthier, *Excursions scientifiques dans les asiles d'aliénés. Premier série par le Dr P. Berthier médecin en chef des Asiles de Bourg (Ain)*, (Paris and Lyon: Savy, 1862); UHASD, Letter to Dr H. Duchene, Institut National d'Hygiène 20 février 1948, from the director of HP Saint Dizier regarding the establishement of the dépôt de mendicité in 1811.

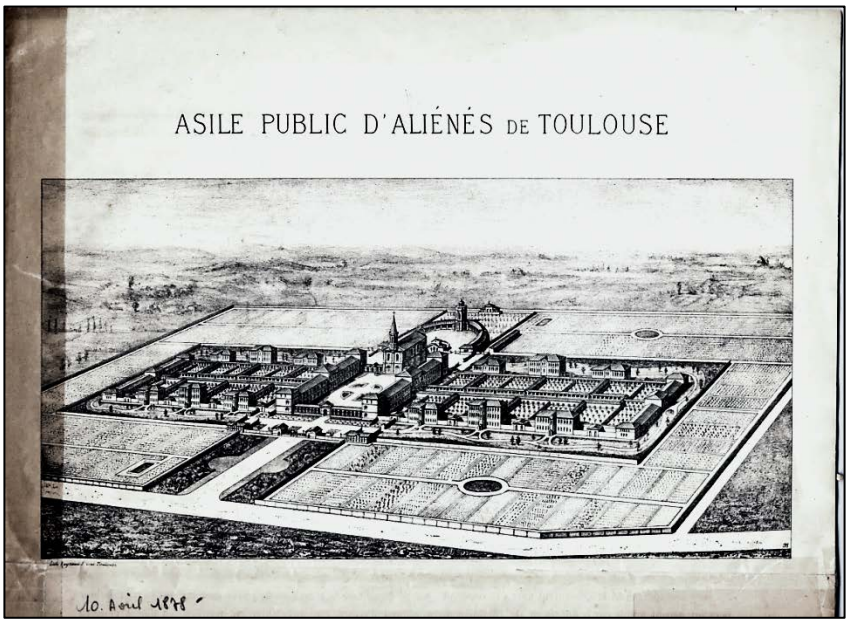
[203] Archives Nationales (AN) Paris, F15 397, Hospices et Secours Hôpital. Saint-Joseph de la Grave à Toulouse.

[204] Compte moral, administratif et médical pour l'année 1857 Rendu par M. A. Guérin du Grandlaunay, Directeur-médecin, 1858; Berthier, *Excursions scientifiques dans les asiles d'aliénés*.

[205] Gérard Marchant, Rapport statistique et médical sur l'Asile public d'aliénés de Toulouse pendant l'année 1868 par le docteur Gérard Marchant, 1870.

relentlessly overwhelmed welfare for the ill and insane in France: the demand for admissions.

In a manner reflecting a progressive approach to facilities for the insane local, authorities in Toulouse commissioned a new state-of-the-art asylum on the rural outskirts of Toulouse. However, as with many state projects, problems with funding slowed completion for 12 years: a harbinger of serious problems in provision for the insane to come, not only in Toulouse but in most departments in France. In 1858, 260 interned people of both sexes were transferred from La-Grave to the new Braqueville asylum, with Dr Gérard Marchant, a fervent devotee of Pinel, as MD.[206] He was aided by two medical interns, les-Filles-de-la-Sagesse, male lay nurses, and attendants.[207]



[206] J. Biéder,'Gérard Marchant (11 mars 1813 - 21 juillet 1881)', *Annales Médico-psychologiques,* 162, (2004), 169-70.

[207] ADHG, Série X272, Comptes administratifs, moraux et médicaux (1839-1944); Françoise Jacob,'Braqueville, asile d'aliénés de la Haute Garonne (1858-1937)', *Congrés national des sociétés savants colloque sur l'histoire de la sécurité sociale Avignon (9-12 avril) 1990. Actes du 115ème*, 1990.

Figure 7 Asile public d'aliénés de Toulouse
Source : UHAGM Livret d'Accueil de la Maison de Santé de Braqueville 1878

The architecture of the new asylum resonated with guidelines of alienists Esquirol and Jean-Pierre Falret (1794-1870), and today is classed as a building of historic interest. The administrative buildings and chapel reinforce through architecture the asylum's penal image in the local community as well as the cultural and moral values of the community.[208] Alienists believed that architectural structure by its conformity and rectilinear space represented order and reason influencing behaviour and curing insanity.[209] The physical bearing of the institution should be majestic, restorative, ordered and set apart from the clamour and disorder of urban life and society, while also balancing security with healing.[210]

An edifice commanding such authority was intended to demonstrate the city's contribution to centuries of traditional charitable works. Such architectural style was framed within the concept of 'environmental determinism' and the buildings and objects contained therein reflected the shared values of reformers and alienists, with possibly with a touch of self-aggrandisement by the authorities

[208] Odile Foucaud,'L'architecte toulousain Jacques-Jean Esquié (1817-1884) et le rationalisme architectural du XIXe siècle', *Annales du Midi,* 98, (1986), 237-55.
[209] Falret, *De la construction et de l'organisation*; Jean-Etienne-Dominique Esquirol, *Mémoire historique et statistique sur la Maison royale de Charenton*, (Paris: Renouard, 1835).
[210] Grand, L'architecture asilaire au XIXe siècle; Juliet L. H. Foster,'What can Social Psychologists Learn from Architecture? The Asylum as Example', *Theory of Social Behaviour,* 44, (2014), 131-47; Anne-Marie Léger,'Les murs de la folie : utopies asilaires et architectures psychiatriques', *Revue de la Société française d'histoire des hôpitaux*, (2008), 27-66; Pinon, Architecture et thérapie: L'hospice de Charenton comme 'instrument de guérison; Laure Murat, *The Man Who Thought He Was Napoleon: Toward a Political History of Madness*, (Chicago: University of Chicago Press, 2014), p. 224; Topp, Moran, and Andrews, *Madness, architecture and the built environment : psychiatric spaces in historical context*. J.T. Arlidge,'Insanity in France, and the Condition of the Parisian Hospitals for the Insane', *British Journal of Psychiatry,* 9, (1863), 92-113; F. Petitjean, J-P. Bonnefoy, F. Caroli, and G. Massé,'Le secteur et la loi du 30 juin 1838', *Annales médico-psychologiques,* 140, (1983), 301-19.

themselves.[211] Art historian, Odile Foucaud opines that Braqueville was commissioned and designed by a Toulousain architect 'in response to the law of 1838 and in honour of Esquirol who was born in Toulouse'.[212] It will be shown that asylum architecture promoted by the founders and so admired and expedited by the authorities would prove a key drawback during the Occupation.

Conceived, constructed or renovated in compliance with the law of 1838, the establishment of both asylums comprised a two-fold event: a legislative event concerning the welfare of the insane, and a philanthropic event as response to the local disenfranchised. Conversely, Saint-Jean-de-Dieu was established from a long tradition of religiosity juxtaposed with a philosophy of care well before legislation in 1838. Nevertheless, all became part of the asylum system, itself the forerunner of the French mental healthcare services.

2.4 State provision for the insane: the law of 1838

Pinel's influence on care policy and Esquirol's vision of a 'machine à guérir', with the support of philanthropists and other alienists, led to the passing of La loi sur les aliénées No.7443 du 30 juin 1838.[213] It represented intention and ideas of liberal medical reformers and constituted a radical change not only to administrative

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[211] Gauchet and Swain, *Madness and democracy : The Modern Psychiatric Universe,* p. 103. Yanni, *The Architecture of Madness: Insane Asylums in the United States,* pp. 28, 35; Benoît Majerus,'La baignoire, le lit et la porte. La vie sociale des objets de la psychaitrie', *Genèses,* 82, (2011), 95-119.
[212] Foucaud, L'architecte toulousain Jacques-Jean Esquié (1817-1884) et le rationalisme architectural du XIXe siècle, pp. 237-8; Odile Foucaud, *Jacques-Jean Esquié, architecte de fonction toulousain, 1817-1884*, (Toulouse: Musée Paul Dupuy, 1992).
[213] For full details of the 1838 law see Caire's website: Caire; G. Landron,'Du fou social au fou médical. Genèse parlementaire de la loi du 30 juin 1838 sur les aliénés', *Déviance et société,* 19, (1995), 3-21; ,'Ministère de l'Intérieur Circulaire N° 3 le 23 juillet 1838. La loi du 30 juin 1838 sur les asiles des aliénés: Ordonnance royale portant règlement sur les établissements publics et privés consacrés aux aliénés, 18 décembre 1839 du Ministre de l'Intérieur, Montalivet.',Paris; Caire's website has the full articles of the law of 1838. Caire; For other works see: Idelette de Bures,'A propos de la Loi sur les aliénés du 30 juin 1838', *Histoire des sciences médicales,* 40, (2006), 301-04; Porter and Wright, The Confinement of the Insane; Lloyd and Bénézech, Legislation 1838; Jones, The Treatment of the Insane in Montpellier, p. 371.

procedures of compulsory confinement of the insane, but also to the provision of facilities. The main mechanism of the law was the exclusion of the judiciary in the committal process. Whereas previously the judiciary had total control of law and order measures, after 1838 authority was shared between the prefect and the asylum alienist.[214] The law of 1838 established a national network of state-funded asylums throughout France.[215] Religious asylums came under the state control too. Medicine penetrated the heart of the Church as it did all of society.

Each of the existing 86 departments was obligated to provide specific facilities to contain their local insane or, failing that, to contract the work to neighbouring departments with such facilities.[216] The functionality of an asylum was divided into institutional-legal processes of confinement of the insane and clinical responsibilities of treatment. However, the two factors did not sit well together. By the twentieth-century, psychiatric theory and state legislation would collide, causing the premise of the asylum as a place of cure to weaken with overcrowded asylums, to the detriment of patients, families and the psychiatric profession. Asylums had little independence to adapt to local conditions and demands, an issue which would have serious consequences for the target hospitals during the Occupation.

2.5 Judicial management of the insane: modes of commitment

Compulsory modalities (factors and circumstances) were fixed for admissions. The first was *placement d'office* (official committal) for instances of self-harm or endangerment of others. Committal in these cases was by the court or the

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[214] Lloyd and Bénézech, Legislation 1838, p. 239; Shorter, *From the Era of the Asylum to the Age of Prozac,* pp. 40-1; Wright, Getting out of the Asylum, p. 138.
[215] Jones, The Treatment of the Insane in Montpellier, p. 371; Jack Juchet,'L'<empirique> et le médecin dans la genèse de l'asile', *Mots*, (1991), 109-20.
[216] Weiner, The Madman in the Light of Reason, p. 309; Bures, A propos de la loi sur les aliénés; Goldstein, *Console and classify,* p. 195.

prefect.[217] The second method of commitment was *placement volontaire*, in which the patient was taken to the asylum by a third party (without consent of the person concerned) with a written request from a relative or friend and a medical certificate.[218] Until the law of 1838, the rich, if deemed insane by family or relatives, were confined to asylums on the strength of a family request and/or medical evidence. However, indigents (those without financial means) were often incarcerated for no valid reason other than causing an affray or as a 'policing' issue to protect society.[219]

It will be seen later from admission registers and medical reports that many of those admitted were not clinically insane within classifications of alienist theories of insanity, although coming within the legislative divisions as disturbers of the peace. One such case is a vagrant 'wandering the streets with no memory' and another was admission for 'irrational and noisy behaviour'.[220] However, from the number of such admissions to the target hospitals, for many civic authorities, the choice of prison or asylum in matters of public security fell more easily on the latter. Given that many saw the asylum as custodial rather than a therapeutic institution this is probable. There is in these two processes of confinement a noticeable ambiguity that blurs the edges of a medical notion of the curability of mental illness and a political imperative to separate the dangerous or criminal from society, or, as Foucault argues, separating 'difference' from society's 'normal'.[221]

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[217] R.G. Priest,''Editorial' A Comparison of French and British Mental Health Legislation', *Psychological Medicine,* 22, (1992), 843-50 (p. 844).
[218] Patricia E. Prestwich, 'Family Strategies and medical power: 'voluntary' committal in a Parisian asylum, 1876-1914', in *The Confinement of the Insane: International Perspectives, 1800–1965* ed. by Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), pp. 79-99 pp. 80-1).
[219] Lloyd and Bénézech, Legislation 1838, p. 236; Juchet, L'<empirique>; Gourevitch, et al, Law & Psychiatry: The Evolution of Laws Regulating Psychiatric Commitment in France.
[220] UHAGM, Patient dossier Madame E. M., age 64 admitted 18 October 1919 died 24 September 1933; UHAGM, Patient dossier Monsieur Henri L., age 32 admitted 31 August 1939 discharged 11 December 1939; UHAGM, Patient dossier, Mademoiselle O. M., age 58 admitted 8 June 1940 died 14 September 1943.
[221] Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*.

2.6 Administration and management

Authority for departmental asylums was placed in the hands of the prefect, who was ultimately responsible to the Minister of the Interior. All asylum psychiatrists, MD and MCs, were appointed at government level by the Minister of the Interior.[222] Powers were granted for local taxation to fund asylums, although there was substantial variation in the allocation of funding for the mentally ill dependent on location and the attitude of local authorities to state and clerical asylums. The prefect was required to preside over a *Comité de surveillance* (House Committee or Asylum Board) for each asylum. Conventionally, members of the committee consisted of local dignitaries such as the Public Prosecutor and Justice of the Peace, who 'perceived their role as a means of attaining civic status or as a religious-charitable gesture'.[223] They were required to sit monthly and pass their reports to the asylum *Médecin directeur* (hereafter referred to as MD) for response, action and liaison with national asylum inspectors. This inspectorate was established to oversee the application of the law and to verify asylum management, examining petitions and possible patient or family complaints.[224] State-run asylums were placed under the 'direction' of the prefect for all aspects of management, business and budget strategy.[225] Clerically-run asylums, however, were placed under the '*surveillance*' of the public authorities which in practice meant less state involvement in administration of the asylum and fewer visits by the authorities.[226] For example, state-run asylums were to be visited at least once each semester and clerical asylums to be visited at least once each trimester.

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[222] Article 3 of the 1838 law. Ministère de l'Intérieur Circulaire N° 3 le 23 juillet 1838. La loi du 30 juin 1838 sur les asiles des aliénés: Ordonnance royale portant règlement sur les établissements publics et privés consacrés aux aliénés, 18 décembre 1839 du Ministre de l'Intérieur, Montalivet.
[223] Brockliss and Jones, *The Medical World of Early Modern France,* p. 707.
[224] Article 3 of the 1838 law.
[225] Article 2 of the 1838 law.
[226] Article 3 of the 1838 law.

The prefect, hospital committee and MD developed each individual asylum's *Règlement* (hospital rules and regulations), outlining job descriptions, responsibilities and guidelines for daily routine and patient care, down to opening and closing times of the hospital grounds. Catering protocols were detailed, with specific menus for patients and personnel, right down to the quantities of salt and pepper to be used.[227] Most asylums had large estates with arable lands and herds of cattle, poultry and pigs, run by a *chef de culture* (farm manager) together with *travailleurs* (worker patients). Many asylum farms made the asylum self-reliant through the production of basic daily foodstuffs for consumption by patients and staff. In addition, in-house services, such as general building maintenance, plumbing, rope-making, carpentry, cabinet-making, painting and decorating, tailoring, dressmaking and mattress-making gave the institution further autonomy. These services were managed by a *chef d'atelier* (master craftsman) or, for female-designated duties, by trained Sisters of the religious community attached to the asylum. Many patients worked in one of the aforementioned units, although within strict segregation of the sexes which extended to the pavilions, leisure and exercise areas; gender segregation was even enforced for all staff.

The day-to-day management and organisation of the budget, therapy and care was in the hands of the MD. It was he who directed the *médecin-chef-de-service* (MC, resident alienist usually a man, but very occasionally a woman). Clinical responsibility was in the hands of the MC. In small asylums with fewer than 1000 patients, the MD not only managed daily administration but also undertook the supervision of several patient lodging units, known as pavilions. But in larger asylums, a MC had overall charge of a group of case-specific sex-specific pavilions. The typical bed capacity for most pavilions was forty, but more often held more

[227] Préfecture de la Haute Garonne, *Règlement de l'Hôpital psychiatrique départemental de Saint-Dizier (Précture de la Haute Marne 1ère Division 2ème Bureau 1941)*, (Saint Dizier: André Brulliard, 1941).

than sixty patients.[228] Each pavilion was designated for a range of classifications of insanity: tranquil, senile, psychotic, or violent. This early method of classifying the insane may have had a medical rationale, especially when most staff were untrained, but for patients labelled as such there was little consideration of physical or psychological needs. Thus, physically fit patients with a mild psychosis, or those drying out from alcohol abuse, would share living and sleeping quarters with the severely mentally confused or violent. MCs were responsible for all certification and documentation relating to the admitted person's mental and physical state, the need to remain in care, and justification for discharge.

At patient-care level, a *surveillant/surveillante* (charge nurse or female matron), usually trained to diploma level, was responsible for the daily management of each pavilion and supervising duties of *infirmiers/infirmières* (male/female nurses) and auxiliary attendants.[229] Female staff were mostly recruits from domestic service, while farm labourers and ex-military men were often employed merely for their physical strength to deal with violent or dangerous patients.[230]

2.7 Unanticipated outcomes of the 1838 law

As has been described, all three asylums came within the law of 1838, in which legislators believed facilities for the insane would provide a better life and treatment, and in many cases a cure, for those afflicted with insanity. However, unanticipated outcomes of the 1838 law are reflected unmistakably in the history of each of the three target hospitals. Evidence from a diverse collection of official

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[228] Edouard Toulouse, Rapport sur le service des aliénés du département de la Seine pendant l'année 1899, 1900.

[229] Katrin Schultheiss, *Bodies and Souls: Politics and the Professionalization of Nursing in France, 1880-1922*, (Cambridge MA: Harvard University Press, 2001), p. 138; State training courses and examinations for mental nursing were in their infancy even by the 1930s. Also see, Véronique Leroux Hugon, Jacques Poirier, and Philippe Ricou,'L'histoire de l'Ecole d'infirmiers de la Salpêtrière', *Histoire des sciences médicales,* 31, (1997), 189-99.

[230] Schultheiss, *Bodies and Souls,* p. 158.

documentation shows that since the early foundation of the asylum system asylum management and patient-care were beset by a steadily growing catalogue of problems. In particular, two major and interrelated problems arose, both of which would have diverse repercussions on many psychiatric hospitals during the Occupation.

Firstly, as touched on briefly already, the devolvement of asylum services to departmental level, a major component of the 1838 legislation, gave rise to significant diversity in the application and execution of asylum facilities and management, leading to varied experiences which rebounded on the quality of patient-care.[231] Secondly, the attitude of local authorities, such as the prefect and members of the asylum committee, and their beliefs in the need for welfare for the insane, impacted on the asylum and its delivery of care. Given that some department prefects had a long-established relationship with providers, as was the case with Saint-Jean-de-Dieu, this asylum-prefect relationship was not always problematic. However, other prefects with less interest in improving the lot of the insane and intent on using funds for more 'needy causes', would have few qualms in maintaining a low daily tariff, with significant implications on the asylum budget especially on patient facilities. Indeed, certain departments without their own asylums and who, therefore, had to send their insane to other departments, were perpetually bad payers, leaving the receiving asylum in deficit budget, while in other departments it was not uncommon that, 'une fois l'asile inauguré, les plans et surtout le programme sont souvent oublié'.[232]

[231] Prestwich, Family strategies and medical power, p. 80.
[232] UHAGM, Rapport sur la Commission de Surveillance (1937-1943); Grand, L'architecture asilaire au XIXe siècle, pp. 176, 89; André Ortet, *Un asile d'aliénés Saint-Lizier 1811-1969*, (Graulhet: Escourbiac, 2004), p. 32.

2.8 The anti-alienism movement

The utopian ideal of nineteenth-century alienists had neither a steady nor uneventful progression; serious setbacks to the efficiency and effectiveness of the asylum system were extensive. During the late 1870s, political events, religious shifts, social transformation, and often bitter battles between leading alienists, physicians, neurologists, anatomists and physiologists, regarding the correct source and treatment of insanity, were brought to a head with the anti-alienist movement. The judiciary, unhappy about being elbowed out of committal processes, added to the controversy with enflamed accusations of malpractice and arbitrary committal. However, these developments were primarily centred within Paris-region asylums predominantly politically and media oriented. This involved claims of abuse of the rights of the insane and arbitrary and indiscriminate committal involving collusion between psychiatrists and patients' relatives.[233] Two examples stand out: the Puyparlier affair in 1869, in which a wife was accused of colluding with an alienist in order to have her husband committed; and a case involving a lawyer, Janson Sandon, who, it was alleged, had been arbitrarily interned.[234]

Not all accusations were from outside the profession. An anti-alienist stance was demonstrated by certain alienists themselves unhappy with the situation in their

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[233] Dowbiggin, *Inheriting Madness,* p. 101; Robert K. Ax and Thomas J. Fagan, *Corrections, Mental Health, and Social Policy: International Perspectives* (Illinois: Charles C. Thomas, 2007); Goldstein, *Console and classify,* pp. 352-4, 59; Jean-Noël Missa,'La psychopharmacologie et la naissance de la psychiatrie biologique', *Les Cahiers du Centre Georges Canguilhem,* 2, (2008), 131-45.

[234] Aude Fauvel,'Le crime de Clermont et la remise en cause des asiles en 1880', *Revue d'histoire moderne et contemporaine,* 1, (2001), 195-216; On the two 'affaires' see: Sylvie Navel, 'Les « Anti-aliénistes » sous le Second Empire', (doctoral thesis, université de Paris-5 Cochin, 1984); Dowbiggin, *Inheriting Madness,* pp. 97-8, 104; Lloyd and Bénézech, Legislation 1838, p. 241; Goldstein, *Console and classify,* p. 354; Jacqueline Thirard,'Les aliénistes et leur opposition sous le Second Empire', *Psychanalyse à l'université,* 2, (1977), 321-38; Robert A. Nye, *Crime, Madness & Politics in Modern France - The Medical Concept of National Decline*, (Princeton: Princeton University Press, 1984), p. 33.

asylums.[235] Some alienists described asylums as overcrowded, insalubrious emporia and *dépôts*, a reference to the obsolete facilities in which the insane had been incarcerated before the asylum law. The anti-alienist movement and the press, always on the look-out for sensationalism, likened asylums to *Bastilles modernes*.[236]

It is not without reason to suppose that high-profile cases raised the bar on the anti-alienist campaign, with questions of the legitimacy of the asylum and professional practice and with accusations of patients being treated inhumanly, even murdered. This accusation applies to the asylum of Clermont-de-l'Oise and what was called *L'affaire Estoret*. In punishment for an undisclosed 'crime', an inpatient named Appert was severely beaten by the *surveillant général*. Appert was later murdered by the *surveillant* to prevent his injuries being detected by the MC.[237] The prominent publicity this case aroused led to other patients and relatives speaking out against the horrors of internment and daily life in an asylum. The press described the affair, 'the symbol of the weakness of the system adopted in 1838'.[238]

This incident, and the earlier cases of Puyparlier and Sandon, was instrumental in highlighting that institutionalisation proved to be no more than a transient answer to treating insanity. Evidence of this lies in national statistics which demonstrate that by 1900 only 12 new asylums had been built, although total patient numbers in the 108 national asylums had risen sharply from 10,539 in 1838 to 78,428 by

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[235] Porter, *Greatest benefit*.Greatest Benefit. Dide and others AD archives etc

[236] Patricia E. Prestwich,'Drinkers, Drunkards and Degenerates: The Alcoholic Population of a Parisian Asylum', *Social History,* 27, (1994), 321-35 (p. 324); Dowbiggin, *Inheriting Madness,* p. 96; Also see Michel Foucault and Arlette Farges, 'Le Désordre des familles. Lettres de cachet des archives de la Bastille au XVIIIe siècle', (Paris: Gallimard-Julliard, 1982); Fauvel gives an excellent and unique analysis of the anti-alienism movement in the 1870s to the beginning of the First World War.Fauvel, Témoins aliénés et "Bastilles modernes"; Archives Bibliothéque Interuniversitaire de Santé (BIUM) Paris. Cote: 113433. Sûreté de Bicêtre, 1893. Charles Etlinger, L'anti-aliéniste: n°1 - 5.

[237] Fauvel, Témoins aliénés et "Bastilles modernes", p. 38.

[238] Fauvel, Le crime de Clermont, pp. 195-9; Dowbiggin, *Inheriting Madness,* p. 4.

1900.[239] The asylum system had metamorphosed from a utopian dream of curing insanity, to a depository for the mentally retarded and senile, civic disturbers, chronic recidivists, end-of-life alcoholics and syphilitics.[240] Indeed, in one Parisian asylum alone, Salpêtrière, overcrowding was rampant and inpatient numbers had risen over twelvefold by 1900: from 120 patients in 1820 to 1,500. [241]

For alienists, attacked by the press, frustrated by therapy stagnation, lacking an explanation for their inability to cure insanity, confronted with serious overcrowding, and surrounded by internal discord, alternative approaches were needed not only to address chronicity in asylums and reduce overcrowding but also to bolster the profession's weakened standing. It is clear that psychiatry was defending a weak position throughout the mid to late nineteenth century.[242]

However, Paris-region alienists, such as Armand-Victor-Auguste Marie (1865-1934), Evariste Marandon-de-Montyel (1851-1908), and Raimond-Paul Sérieux (1864-1947), made their discontentment with current asylum practices obvious; they advanced their theories for reforming facilities to reduce overcrowding through measures separating of chronic long-stay cases permitting more space and staff

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[239] Archives Nationales (AN) Paris, SAN 70846, Documents statistiques anciens et divers (1835-1961) Travail de l'Institut National d'Hygiène présenteé par H. Duchêne p. 1.

[240] Porter, *Greatest benefit,* p. 510. Weiss, Origins of the French Welfare State; Andrew Scull, *The Asylum as Utopia (Psychology Revivals): W.A.F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry*, (London: Routledge, 2014), p. 101.

[241] Paul Sérieux, *L'Internat des asiles d'aliénés de la Seine: nécessité de sa réorganisation*, (Évreux: C. Hérissey, 1896); Archives Nationales (AN) Fontainebleau, SAN 70847, Statistique des institutions d'Assistance. Assistés, mouvement hospitalier, statistique psychiatrique, années 1949-1954 (Ministère des finances et des affaires économiques, Institut national de la statistique et des études économiques). Evolution du nombre de malades hospitalisés dans les établissements psychiatriques au 31 décembre de chaque année. Sources de 1900 à 1954: Statistiques des institutions d'assistance, années 1949 à 1954. INSEE 1958. p. 81; Gauchet and Swain, *Madness and democracy : The Modern Psychiatric Universe,* p. 296; Henri Colin,'Chronique. L'Encombrement des asiles de la Seine', *Annales médicales psychologiques,* 82, (1924), 289-96.

[242] Micale and Porter, *Discovering the History of Psychiatry,* pp. 8-9; William F. Bynum, Roy Porter, and Michael Shepherd, *The Anatomy of Madness: Essays in the History of Psychiatry* (Abingdon: Taylor & Francis, 2004), pp. 2-3.

time to be devoted to acute cases.[243] Reformism was an emergent current in many medical and psychiatric circles by the late nineteenth- and early twentieth-century. However, demand for reform was not a new phenomenon, but a cyclical event. In his historical research, Sérieux observed that each generation of alienists had reformist ideas, and noted striking continuities and recurrences in approaches to mental illness from the *ancien régime* onwards.[244]

At the beginning of the twentieth-century, these major figures stand out as prominent models of reformist attitudes that were growing in strength if not in practical application. Although only a minor example of political efforts to address asylum overcrowding, the Seine *Conseil général* financed studies of European methods of asylum care in Scotland and the Flemish town of Gheel. Both locations ran care for the harmless insane on a community-care concept, in which patients were lodged in foster homes.[245] Marie's report in 1892 on Scottish asylums found the 'Open-Door' or 'Cottage' system most favourable and cost effective'.[246] For alienists seeking methods to reduce overcrowding, Gheel was identified as an exemplar of an alternative mode of treatment to institutionalisation; indeed, Gheel

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[243] Sérieux, *L'Internat des asiles d'aliénés de la Seine*; Jacques Vié, *Le placement familial des aliénés et des psychopathes: sa portée médicale et sociale (Extrait des Annales médico-psychologiques 1-2-3 1940: 1-2-3, 45, 1941)*, (Paris: Masson et Cie, 1941), p. 23; Also see: Gaufey and Bleandonu, Naissance des asiles d'aliénés (Auxerre-Paris).

[244] Sérieux and Libert, Le régime des aliénés en France au XVIIIe siècle d'après des documents inédits, pp. 76-77; Eugène Garsonnet, *La loi des aliénés, nécessité d'une réforme*, (Paris: Ernest Thorin, 1869).

[245] Jules Duval, *Gheel ou une colonie d'aliénés vivant en famille et en liberté. Etude sur le patronage familial appliqué au traitement des maladies mentales (Avec une carte de la commune de Gheel*, (Paris: Hachette et Ce, 1867); Mike Jay,'The Gheel Question', *The Pyschologist,* 28, (2015), 776-79.

[246] Armand Victor Auguste Marie, *L'Assistance des aliénés en Écosse (Direction des affaires départementales de la Seine, service des aliénés)*, (Paris: Librairies-Imprimeries réunies, 1892); Ed. Toulouse, Conseil général de la Seine : Rapport au nom de la sous-commission chargée d'étudier l'assistance des aliénés en Angleterre et en Ecosse, 1898 17; Edouard Toulouse,'Rapport au Conseil général de la Seine, sur l'Assistance des aliénés en Angleterre et en Ecosse', *Revue de psychiatrie : médecine mentale, neurologie, psychologie*, (1898); Edouard Toulouse,'La prophylaxie et l'hygiène mentale', *La Prophylaxie mentale,* 6, (1930), 333-45.In his report to the Seine authoirites Toulouse noted the cost implications of treating and caring for 'incurables' which cannot be taken out of context that he also wrote that it was a social and moral duty to do so; Toulouse, L'Open-door en Écosse.

became a symbol of 'anti-asylumdom'.[247] Marie's study, and those by Sérieux and Marandon, met with the *Conseil and* Minister of the Interior's approval, they agreed on the creation of a similar experimental establishment, a *Colonie familiale*.[248] In a move to ease pressure on Paris asylums' beds, the *colonie* for women in Dun-sur-Auron (Cher) was established and, in 1898, the Colonie familiale d'Ainay-le-Château for men was opened, 23 kilometres from the former.

2.9 Colonie familiale d'Ainay-le-Château

[247] Auguste-Armand Marie, *La réforme de l'assistance aux aliénés. Préface de Justin Godart*, (Paris: Editions médicales, 1902); Wallace and Gach, *History of Psychiatry and Medical Psychology,* p. 219; Jean-Christophe Coffin, ''Misery' and 'Revolution': The organisation of French Psychiatry, 1900-1980', in *Psychiatric Cultures Compared,* ed. by Marijke Gijswift-Hofstra (Amsterdam: University Press of Amsterdam, 2006), pp. 225-47. Since the fourteenth century, the insane had been taken on pilgrimages to Gheel to the shrine of Sainte Dymphna (Patron saint of victims of nervous diseases) for healing and the village had become the first to receive and lodge the insane with local families. Henry C. Burdett, Sir, *Hospitals and asylums of the world, their origin, history, construction, administration, management, and legislation; with plans of the chief medical institutions accurately drawn to a uniform scale in addition to those of all the hospitals of London in the jubilee year of Queen Victoria's reign*, (London: J. & A. Churchill; Whiting & Co, 1891).

[248] Evariste Marandon de Montyel, Rapport au Préfet de la Seine: Procès-verbaux de la commision de surveillance des asiles d'aliénés de la Seine 1892; Evariste Marandon de Montyel,'L'hospitalisation de la folie et les nouveaux asiles ouverts pour aliénés', *Annales d'hygiène publique et de médicine légale,* 3, (1895), 411-34; Evariste Marandon de Montyel,'Asiles d'aliénés à portes ouvertes', *Annales médicales psychologiques,* 2, (1896), 390-412.

Figure 8 Ainay Administrative building 1902
Source: UHAALC

The innovative *colonie familiale* was an important departure from the standard French regulatory medical and judicial committal of the insane. However, it divided medical and political opinion.[249] There was disagreement about the concept of alternative methods of looking after long-stay patients, even in the face of the observable reality of overcrowded asylums. The largest proportion of asylum patients were chronic, many were inpatients for more than two years, with some institutionalised for up to 10-20 years, and most patients received very little in the way of active 'treatment'.[250] Despite the declared advantages of decluttering the Seine asylums and economic savings, this new facility caused some legal fretting. The *colonie* was atypical of 'closed' institutions that confined patients in accordance with the letter of the 1838 law; Ainay's patients had a *demi-liberté* (limited freedom) and lodged with local residents named *nourriciers* (foster parents). But circumventing legislation, a decree in 1896 assimilated the facility of a *colonie familiale* into the asylum system, with patients legally classed as transferees or 'on discharge' from the Seine asylums and therefore still under the umbrella of the 1838 law.

However, there was also professional dissent. Certain alienists believed this new approach of separating acute cases from long-stay cases would limit career prospects.[251] Alienist narrative suggested there would be a two-tier system, and

[249] Prestwich, Family strategies and medical power, p. 93; Jules Morel,'Progress of Psychiatry in 1902 (Belgium)', *Journal of Mental Science,* 49, (1903), 335-49 pp. 335, 37); Coffin, 'Misery' and 'Revolution', p. 225.
[250] UHAALC, Rapport médical Colonie familiale d'Ainay-le-Château (Allier) du docteur Paul Sivadon, année 1938.
[251] Gregory M. Thomas,'Open Psychiatric Services in Interwar France', *History of Psychiatry,* 15, (2004), 131-53 (p. 148).

asylum alienists feared they would be relegated to the backwaters of the asylum system while others would occupy eminent positions in the 'new' acute asylums in major cities.[252] Furthermore, taking a medico-centrist stance, some alienists voiced the opinion that other professions, such as psychology and social work, both of which were growing in stature, would be involved in the future of a *colonie* facility, perceived as detrimental to doctor-patient contact, a rather narrow view considering blatant asylum overcrowding, prohibiting such ideal practice. Alienist Edouard Toulouse, although a campaigner for improvement in asylum conditions, was skeptical of the *colonie* as an answer to overcrowding.[253] Preferring to keep alienism under the psychiatric umbrella and a scientific power, yet ignoring low cure rates and chronicity, he opined: 'n'est-il pas un mode d'Assistance sentimentale et humanitaire, certes, mais empirique? Les malades y bénéficient-ils des progrès de la science et n'échappent-t-ils pas à son étude?'[254]

Other alienists, in the early years of the asylum law, had argued for institutionalisation of the insane, maintaining that treatment for insanity and liberty did not sit well together. Demonstrating his bias against alternative care for chronic cases, alienist Falret wrote in the AMP, with more than a little cynicism towards the more successful English Open-door asylum system, 'Pour les aliénés, traitement et liberté ne peuvent aller ensemble [...] Vouloir disperser les aliénés dans les colonies au milieu de la campagne, ce sont là des rêveries anglaises'.[255] Reference to 'English dreams' may have been dismissive of the improved facilities

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[252] Jean-Bernard Wojciechowski, *Hygiène mentale et hygiène sociale: La ligue d'hygiène et de prophylaxie mentale et l'action du docteur Edouard Toulouse (1865-1947) au cours de l'entre-deux-guerres*, (Paris: Harmattan, 1997), p. 51; Vié, *Le placement familial* p. 21; Dowbiggin, *Inheriting Madness*; Ian Robert Dowbiggin, *Keeping America sane: psychiatry and eugenics in the United States and Canada, 1880-1940*, (Ithaca, New York and London: Cornell University Press, 1997).
[253] Edouard Toulouse, Conseil général de la Seine: Rapport sur l'Assistance aux aliénés en Angleterre et en Ecosse, 1898.
[254] Vié, *Le placement familial* p. 163.
[255] Jules Gabriel François Baillarger and Cerise de Moreau (de Tours), *Annales médico-psychologiques: Revue psychiatrique; bulletin officiel de la Société médico-psychologique*, (Paris: Elsevier Masson, 1861).

for the insane reported by alienists on their study visits to asylums in England. However, more progressive alienists, such as Henri Girard-de-Cailleux (1814-1884) MD of asylums Auxerre (Yonne) and later Ville-Evrard (Paris), proposed early discharge for many patients, while Falret, despite his negative opinion of Open-Door approaches, founded the Société de patronage to provide support for female patients discharged from his asylum, Salpêtrière.[256]

Deinstitutionalisation, although not called as such at the early twentieth century or even during the interwar years, flourished as an idea to relieve chronicity and to unclog asylums from long-stay cases. Theories abounded on the separation of mentally subnormal and chronic epileptic patients from those acute cases that were considered to have a good chance of cure.[257] However, this approach was not new. Esquirol had declared that 'les épileptiques ne doivent pas habiter pêle mêle avec les aliénés', and the MD of Saint-Dizier stated in 1857 that it was a considerable inconvenience to the improvement of curable cases that epileptic patients were admitted to the asylum.[258]

The establishment of the *colonie* at Ainay represented a complete rupture with traditional state facilities for the insane at the end of the nineteenth century.[259] The significance of this mode of facility over the other three case-study hospitals lies in the degree of liberty (*demi-liberté)* of its patients. As a prototype and its

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[256] M. Febvré and A. Marie,'Patronage des aliénés convalescents', *Revue municipale,* 11, (1899), 1451-55. La Société de Patronage pour les Aliénés sortis guéris de l'Hôpital de la Salpêtrière"). The name of this society was subsequently changed to "The Falret Charity" ("L'Œuvre Falret").
[257] M Gourevitch and J. Postel,'Actualité de l'oeuvre d'Edouard Toulouse', *Information psychiatrique,* 3, (1967), 271-301.
[258] Rapport général présenté à M. le préfet sur les travaux des conseils d'hygiène publique et de salubrité du département pendant l'année 1869 par le Dr Gilbert-Camille Bergeon, Département de l'Allier. p. 52. Pierre-Louis Laget,'Naissance et évolution du plan pavillonnaire dans les asiles d'aliénés', *Livraisons d'histoire de l'architecture,* 7, (2004), 51-70; Esquirol, *Des établissements des aliénés*; Guérin du Grandlaunay, Compte moral, administratif et médical pour l'année 1857 Rendu par M. A. Guérin du Grandlaunay, Directeur-médecin.
[259] Pierre Marcel Espinasse, *L'Assistance familiale des aliénés (colonie d'Ainay-le-Château, Allier)*, (Paris: Vigot frères, 1901).

uniqueness within the FMHS, the *colonie* requires a fuller explanation of the management structure and protocols. The value of such a model and whether an 'open' system protected patients from high mortality experienced in the other three closed target hospitals during the German Occupation will be examined in later chapters.

However, Ainay embraced key roles of alienist therapy. It gave benefits of the countryside and tranquillity and fresh air, in sharp contrast to the insalubrity of urban life which was perceived as a causative factor in madness. In rural areas a daily tariff for patients was economical in comparison with Paris: in 1901 it was 2 francs, whereas for a lodger in the colonie at Ainay it was 1.10 francs.[260] Given that the number of chronic patients in Saint-Jean-de-Dieu was as high as 90%, and that this was not atypical of many state asylums, savings could be considerable.[261]

Furthermore, in economic terms, the *colonie* and its patients offered a lifeline to many local villagers. Agricultural and industrial activity had hit hard times in the area: vineyards had been affected with *pholloxera*, and local iron mines had been exhausted, leading to unemployment and rural exodus. The *colonie* was, therefore, considered to be a 'phénomène démographique et social'; with its establishment, lodging the insane providing new economic opportunities and reversed the area's depopulation.[262] It can be argued that for the local communities, the *colonie* was viewed as an entirely monetary incentive: insanity was a business. Homes with more than one lodger might have been seeking monetary gain, and that even the recorded efforts to conform to the colonie's regulations may have been as much through fear of losing income as they were of making patients welcome and

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[260] Vié, *Le placement familial* p. 34; UHAALC, Rapport administratif et médical et moral année 1908.
[261] Guillemain, Médecine et religion au XIXe siècle, p. 39; UHASJDD, Compte moral et administratif et rapports médicaux pour les années 1938 à 1945.
[262] Vié, *Le placement familial* pp. 38-9, 83, 142-2, 45; Denise Jodelet, *Madness and Social Representations. Living with the Mad in one French community*, (Berkeley, CA: University of California Press, 1991), p. 36.

comfortable.[263] Ainay's sociological impact on the community illustrates that early twentieth-century social prejudice was tempered by a need for placements. Monetary incentive overcame any reluctance of *nourriciers* to lodge patients, demonstrating the 'twin motor of social institutions: unease in the presence of the mentally ill and economic interest in their acceptance'.[264] According to official reports only rarely in thirty years were sanctions taken against *nourriciers* for noncompliance with regulations, although occasionally patients did ask to move lodgings.[265] Some patients indicated they disliked the *nourricier*, others wanted to lodge with a friend, and others displaying certain symptoms of their mental illness such as distrust or obsession, constantly asked to move. Conversely, monetary rewards were given to *nourriciers* who demonstrated their good parenting and whose homes were considered to be well-maintained and with whom patients were happy to remain.[266]

2.10 Administration in the Colonie d'Ainay

Facilities at Ainay followed the basic design of most asylums built in the nineteenth-century: a central administrative building with various services and offices, accommodation for the MD, his family and *médecin-assistants*, and an infirmary. The eight-bedded infirmary catered for those who were too ill to be nursed at their lodgings.[267] The *salle de réunion* (meeting room) was multipurpose providing outpatient facilities medical and nursing care; those who wished could go daily simply for company or to meet relatives, chat with friends, read the

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[263] Vié, *Le placement familial* ; Jacques Vié,'Vers une psychiatre sociale', *Annales Médico-Psychologiques,* 1-2-3, (1943).
[264] Jodelet, *Madness and Social Representations,* p. 73.
[265] UHAALC, Répetoire alphabétique des nourriciers de la colonie (Ainay, St Bonnet, Valigny) années 1900 à 1930.Répetoire alphabétique.
[266] UHAALC, Rapport Medical Colonie Familiale d'Ainay-le-Château 1938.
[267] Thomas Mueller,'Le placement familial des aliénés en France. Le baron Mundy et l'Exposition universelle de 1867', *Romantisme,* 141, (2008), 37-50; UHAALC, Résultats du traitement familial des aliénés par le Docteur M. Améline (1900-1925) année 1926.

newspapers or borrow books from the library.[268] There were also facilities where patients could partake of a weekly shave or monthly bath and haircut.[269] In 1921, 4016 baths were registered to the patients, an average of eleven baths per patient, so it is probable they took up the monthly bath offer.[270] Public health issues of hygiene were considered important to mental health, and were encouraged in Ainay where very few homes had baths or even running water. Villagers, too, were encouraged to use the facilities, although to what extent is not recorded.[271]

Ainay's patient records and medical reports indicate that most patients were diagnosed as 'incurable', 'idiot' or 'epileptic', suggesting that many patients had been ill-placed in asylums in terms of the therapeutic aspect of the asylum. However, these conditions were included in the classification of mental diseases of the era and as such admitted to an asylum. [272] What is clearly underlined at Ainay is that the incurable and the uneducable were not viewed negatively or as unworthy citizens, but more as people with a child-like mentality given an opportunity to find meaning in their life within a family environment. Despite medical narratives that patients were chosen from the least visited in Paris, MD Dr Jacques Vié reported that certain relatives visited and were aided with a *carte de visite* and train voucher.[273] Patient dossiers have a record of some requests for financial help with transport, as does those of Braqueville containing relatives'

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[268] UHAALC, Rapport administratif et médical et moral année 1908; UHAALC, Résultats du traitement familial des aliénés par le Docteur M. Ameline, Directeur-médecin en chef de la Colonie familiale d'Ainay-le-Château 1900-1925; Interview with Madame M. at Ainay.
[269] Vié, *Le placement familial* pp. 102-3.
[270] D. Améline, Rapport de M. le Dr D. Améline Année 1921, médecin-directeur de la Colonie à Monsieur le préfet. Colonie Familiale d'Ainay-le-Chateau (Allier), p.247.
[271] Interview with Madame M. at Ainay.
[272] UHAALC, Répertoire alphabétisé des nourriciers (1900-1920); UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique au cours des hostilités et de la dernière décade, Dr Maurice Leconte; In 1868 the MD of Braqueville noted that as many of 50% of inpatients were classed as 'incurables' - page 5. Marchant, Rapport statistique et médical sur l'Asile public d'aliénés de Toulouse pendant l'année 1868 par le docteur Gérard Marchant.
[273] UHAALC, Rapport administratif et médical, 1948 par le docteur Jacques Leritz.

letters regarding visits and requesting vouchers.[274] Notes from committee meetings also discuss the possibility of renewing special train vouchers to aid families who wished to visit.[275] This practice indicates a concern for the welfare of patients and practical financial aid for family relatives.

Originally, the *colonie* accommodated thirty-nine non-violent, long-term or chronic patients from the Seine asylums; by 1938 this number had reached 708; an indication of the urgent and essential imperative to unburden Paris-area asylums, increase psychiatric welfare services, and a more rigorous method of classification for admission to the asylum.[276] The first MD, Salamon Lwoff (1900-1914), was an avid supporter of the founder of the *colonie*, Auguste Marie. Lwoff was followed by Marius Améline (1914-1930), who was equally committed to the idea of *demi-liberté* for certain classifications of mental conditions.[277] In 1930, Vié became MD. He had studied under the celebrated alienist-psychotherapist, Theodore Simon of Vaucluse asylum (Paris).[278] Vié wrote extensively in such medical journals as the *AMP* and *Aliéniste français*, concentrating especially on reformist approaches and

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[274] UHAGM, Patient dossier. Monsieur Albert L., age unknown admitted 5 November 1941 discharged 13 February 1942.

[275] UHAGM, Séance du comité de surveillance 4 September 1941.The committe agreed to approach the director of the TCRT to re-establish the service for families.

[276] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier; UHAALC, Résultats du traitement familial des aliénés par le Docteur M. Ameline, Directeur-médecin en chef de la Colonie familiale d'Ainay-le-Château 1900-1925. The Paris-area or Seine asylums, refers to : Sainte Anne, also classified as Bureau d'admission clinque et asile, Ville-Evrard, Vaucluse, Villejuif, Maison Blanche, Moisselles, Bicêtre and La Salpêtrière. The colonies familial of Ainay-le-Château and Dun-sur-Auron were also categorised as part of the Seine asylums.

[277] UHAALC, Résultats du traitement familial des aliénés par le Docteur M. Ameline, Directeur-médecin en chef de la Colonie familiale d'Ainay-le-Château 1900-1925.

[278] A. Binet and T. Simon,'Méthodes nouvelles pour le diagnostic du niveau intellectuel des anormaux', *L'année psychologique,* 11, (1905). Simon is celebrated for his work on abnormal children and the Metric Intelligence Scale (an assessment tool to define and measure children's cognitive levels) devised with Alfred Binet and published in 1905; John Carson, *The Measure of Merit: Talents, Intelligence, and Inequality in the French and American Republics, 1750-1940*, (Princeton NJ: Princeton University Press, 2007), pp. 140-1.

alternatives to institutional incarceration.[279] By 1930, two *médecin-assistants* (interns) assisted the MD; their main responsibilities and areas of care included the infirmary and visiting patients in their lodgings. Male and female i*nfirmier-visiteurs* were recruited locally; some were Paris-trained, others were under instruction by *colonie* personnel.

Infirmier-visiteurs had a triple duty to patients: moral, social and medical. They inspected all aspects of the home: general conditions, patient welfare, medication notes, and hygiene standards. They also encouraged patients to visit the *Salle de réunion* once or often twice a day. Many *nourriciers* were responsible for giving lodgers their medication; this was registered in the *Cahier de visite* (handbook). Originally, patient placement was predominantly with the poorer classes aged between forty and sixty years, and many were widowed. Those *nourriciers* who were not retired or unemployed were often craftsmen, shopkeepers, sabot makers, labourers, or smallholders. Although lodging patients was a local industry, many developed a genuine interest in their charges.[280] For example, Family G. took in their first lodger in July 1900 and when the husband died the widow continued to look after her patient until 1937; Monsieur J. A., a gardener, had two lodgers, one of whom was lodged with him from 1902 until the patient died in 1928 aged sixty-three; one patient, 'un travailleur assez régulier', remained with the same family for thirty-two years despite 'un caractère parfois difficile'.[281] Many *nourriciers* became fond of their charges, viewing them as part of the family, for example, on the death

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[279] Jacques Vié,'Rapport sur les Assistantes sociales psychiatriques', *Annales médico-psychologiques,* 5, 1936; Jacques Vié,'Les classes d'anormaux dans les colonies familiales d'arriérés', *Archives de Neurologie,* 25, (1933); J. Vié and Pierre Quéron,'Productions artistiques des pensionnaires de la colonie familiale d'Ainay-le-Château', *Aesculape,* 23, 266-71.

[280] UHAALC, Répetoire alphabétique des nourriciers de la colonie (Ainay, St Bonnet, Valigny) années 1900 à 1930. p. 88; Vié, *Le placement familial* pp. 38-9; Interview with Madame M. at Ainay.

[281] UHAALC, Patient dossier. Family G. took in their first lodger in July 1900 and when the husband died his wife continued to look after the patient, the last date in the register being 1937; Vié, *Le placement familial* p. 120 By the end of 1934, 6 patients had been placed with the same family for 25-30 years, 24 were of 15-25 years standing and 43 placements were of 1-15 years. ; UHAALC, Patient dossier, Monsieur A., age unknown admitted 1902 died 1928.

of his wife, Monsieur M.-J. requested that the long-standing lodgers remain to keep him company.[282]

2.11 Patient facilities at Ainay

Patients were lodged two and sometimes three per household. Each *nourricier* was required to register with the local commune mayor, who in turn collaborated with the MD.[283] Regulations concerning all aspects of facilities for patients were strictly monitored. Accommodation prerequisites included minimum size of patients' rooms, floor and wall materials, type of bed and furniture, bed linen, heating (wood burning stoves were usual, electricity was rare), and meal regime. Compared with the asylums, the quantity and quality of food for patients was remarkably good. *Infirmier-visiteurs* would often arrive at mealtimes to verify the standard of the meal. Monsieur F. wrote in 1923, 'Ma chère mère, la nourriture est assez bonne nous avons mangé de la viande, avec de la sauce après du macaroni puis de fromage. Le soir nous avons de la soupe des légumes et du fromage, comme boisson du coco'.[284] Whereas correspondence was sometimes censored by MDs in closed asylums, letters from lodgers were often written and posted by patients themselves, ensuring that any coercion by *nourriciers*, or interference in patients' complaints, would be minimal.

Originally, the *colonie* insisted on total integration of the lodger as part of 'family therapy', with family and patients eating together. Over time, this was transmuted in various ways depending not only on the *nourricier*'s cultural background and their perception of the insane, but also on the community's attitude. For instance the level of priority given to lodgers when they shopped: they were served after

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[282] G. Wagner,'Fashion under the Vichy-Regime', *Waffen-Und Kostumkunde,* 40, (1998), 86-87; Interview with Madame M. at Ainay.
[283] Vié, *Le placement familial* pp. 33-4.
[284] UHAALC, Répetoire alphabétique des nourriciers de la colonie (Ainay, St Bonnet, Valigny) années 1900 à 1930.

locals who might well have arrived after them. Psycho-sociologist Denise Jodelet, in her 1985 ethnographical thesis on Ainay, argued that the level of priority accorded to the lodgers in shops is an instance of the lower status and a certain intolerance and discrimination towards lodgers.[285] However, many of Ainay's patients had a low IQ and were perceived as children, and therefore often treated according to their mental age. In the natural order of social and cultural respect, the children of the locals would also have been served second.

Through a consideration of certain day-to-day conversations of the local people, Jodelet has further interpreted 'otherness' towards lodgers. For example, in the butcher's shop a *nourricier* asks for meatballs and the butcher inquires whether they are for the family. The motive for this question is that he presumes the family will eat proper meatballs, but that the lodger would be served blood sausage (made with leftovers).[286] Such conversations do indeed indicate that the trader felt lodgers were not worth spending good money on and that *nourricier*s were in the habit of economising on food for the patients. But with other evidence of good relations between *nourricier* and lodger, there is considerable difference between such examples of frugality and the unequivocal discrimination during the Vichy years. Jodelet's analysis further suggests that such culinary differences were concealed, because patients ate their different fare in a room separate to the family. However, her study is rather biased towards finding evidence of the effects of psychosocial mechanisms in the placement and accommodation of the mentally ill from the early beginnings of the *colonie*. Moreover, her representation does not chime with the interview of a daughter, whose parents were *nourriciers* during the Occupation: Madame M. recalled the fondness shown by her parents to their charges and, as a young teenager, of her personal attachment to and association

[285] Jodelet, *Madness and Social Representations,* pp. 94-5.
[286] Ibid. p. 95.

with the lodgers. She followed her parents into fostering from the 1970s to the 1990s and her lodgers were treated as part of the family by her and her children.[287]

2.12 Twentieth-century influences on psychiatric thought

The mode of administration and facilities at Ainay indicate a new approach of alienist, or psychiatrists as they were more often referred, thought developed out of the weakening status of the profession, the overcrowded asylums and stagnation of progress in curing insanity.[288] As evidenced, by the twentieth-century it is clear that many psychiatrists actively desired reform of the problematical asylum system. Through the prism of the works and ideologies of psychiatrist and hygienist-eugenicist, Edouard Toulouse, this section offers an overview of contemporary trends and influences in medico-scientific fields, initiated by key psychiatrists working chiefly in the major Paris-area asylums. Reform narrative centred on a redefinition of Pinelien ideas of institutionalisation as principal apparatus for the treatment of the insane and on a reduction of cases of mental illness that had been swamping institutions.[289]

Toulouse was a contemporary of alienists, Marie and Sérieux, and his interests addressed many concerns in the profession. With their reform agenda, the three alienists had already been appointed by the *Conseil général* to update the authorities on international psychiatry. Their study reports of asylums abroad were damning: French psychiatry seriously lagged behind its international counterparts.[290] Toulouse's ideas and concepts stand as a significant example of

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[287] Interview with Madame M. at Ainay.
[288] Marie, *L'Assistance des aliénés en Écosse (Direction des affaires départementales de la Seine, service des aliénés)*.
[289] Elizabeth Nelson,'Running in Circles: A Return to an Old Idea about Asylum Reform in Nineteenth-Century France', *Proceedings of the Western Society for French History* 42, 2014
[290] Marie, *L'Assistance des aliénés en Écosse (Direction des affaires départementales de la Seine, service des aliénés)*; Toulouse, Conseil général de la Seine : Rapport au nom de la sous-commission chargée d'étudier l'assistance des aliénés en Angleterre et en Ecosse, p. 17; Toulouse, Rapport au

interwar influences on psychiatry itself.[291] He was a symbolic and controversial figure with an approach that synthesised social and mental hygiene, medical, scientific, and legal issues within a eugenics framework.[292] This hybrid and mixed approach fired the establishment of his mental hygiene movement and the Centre de prophylaxie mentale (Centre for the prevention of mental diseases) in the asylum of Sainte-Anne Paris (later renamed Hôpital Henri-Rousselle).[293]

According to Jean Coffin, 'the beginning of the 1920s was marked by an increasing preoccupation with hygienism as public health and individual health protection'. In response to this fixation, the Ministry of Social Hygiene, Assistance, and Prevention were formed; this later became the Ministry of Public Health. The state was involved in combatting social ills and was identified in France as fundamental to the nation's sanitary and social reforms. For asylum psychiatrists, admissions and death records undeniably recorded such diseases in large numbers, and often

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Conseil général de la Seine, sur l'Assistance des aliénés en Angleterre et en Ecosse; Toulouse, La prophylaxie et l'hygiène mentale.In his report to the Seine authoirites Toulouse noted the cost implications of treating and caring for 'incurables' which cannot be taken out of context that he also wrote that it was a social and moral duty to do so; Toulouse, L'Open-door en Écosse.

[291] For a comprehensive study on the medico-social works of Toulouse see: Maurice Goudemand, *Un tournant dans l'assistance psychiatrique en France : l'oeuvre médico-sociale du docteur Edouard Toulouse*, (Paris: Association des amis du Musée et du Centre historique Sainte-Anne, 1997); Also see: Jean Bernard Wojciechowski, 'Les origines de la prophylaxie en santé mentale: l'action entreprise avant la première guerre mondiale par un médecin des asiles de la Seine : le Docteur Edouard Toulouse (1865-1947)', (master's dissertation, université de Strasbourg).

[292] Michel Huteau, *Psychologie, psychiatrie et société sous la Troisième République: la biocratie d'Edouard Toulouse, 1865-1947*, (Paris: Harmattan, 2002).

[293] Jean Bernard Wojciechowski, 'Hygiène mentale et hygiène sociale; contribution à l'histoire de l'hygiénisme: naissance et développement de l'hygiène mentale en France. La ligue d'hygiène et de prophylaxie mentales (1920 - 1960) et l'action du docteur Edouard Toulouse (1865 - 1947)', (doctoral thesis, université de Strasbourg 2, 1996); Edouard Toulouse, *Les causes de la folie : prophylaxie et assistance*, (Paris: Société d'éditions scientifiques, 1896); Francis Danvers and M. Huteau,'Psychologie, psychiatrie et société sous la Troisième République. La biocratie d'Edouard Toulouse (1856-1947)', *Orientation Scolaire et Professionelle,* 33, (2004), 173-74; Paul Weindling,'L'eugénisme comme médicine social: l'époque de Weimar', *Revue d'histoire de la Shoah,* 183, (2005), 135-42; There were also earlier works by Barthelemy Toussaint, *Etude d'hygiene sociale. Syphilis et sante publique*, (Paris: J-B. Bailliere et fils, 1890); and Henri Colin,'Mental Hygiene and Prophylaxis in France', *Journal of Mental Science,* LXV, (1921), 459-70; For further work on Toulouse see:Annick Ohayon, *L'Impossible rencontre: Psychologie et psychanalyse en France 1919-1969*, (Paris: La Découverte, 1999); Thomas, Open psychiatric services.

indicated strong familial traits, demonstrating their interest specifically in the hereditary nature of mental illness. Social hygiene as a movement had grown as an offshoot of public health measures to fight social and sanitary issues towards the end of nineteenth century. William Schneider describes the movement as representing a framework of reference halfway between the narrow focus on specific disease and the broad, if vague, concern with degeneration. Social hygiene embraced two main objectives: the provision of public assistance/welfare and the fight against the 'collective menaces' of *fléaux sociaux* (social scourges).[294] The movement was chiefly associated with campaigns against tuberculosis, alcoholism, venereal disease and paralysis of the insane, all of which were judged vectors of degeneracy and decline: all closely linked to declining moral values and responsible for painful consequences for the family and future generations.[295] A major government investment in public health in France was tuberculosis dispensaries establishment by the Commission for the Prevention of Tuberculosis, established in 1917 by the Rockefeller foundation.[296]

In 1900, Toulouse became MD of Villejuif asylum Paris where he experienced at first-hand institutional turmoil and the immense pressure overcrowding placed on psychiatrists' shoulders. The workload for asylum MCs was impracticable and

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[294] For more explanation of this terminology see: Bertrand Dargelos,'Genèse d'un problème social. Entre moralisation et médicalisation : la lutte antialcoolique en France (1850-1915)', *Lien Social et Politiques,* 55, (2006), 67-75 (p. 67).

[295] Wojciechowski, *Hygiène mentale et hygiène sociale,* pp. 104-11; A-L. Simonnot and J-P. Liauzu,'Les voies de l'eugénisme', *Information psychiatrique,* 72, (1996), 553-62 (p. 557); Laurent Mucchielli, 'Criminology, Hygienism, and Eugenics in France, 1870-1914 (The Medical Debates on the Elimination of "Incorrigible" Criminals)', in *Criminals and their Scientists: The History of Criminology in International Perspective (German Historical Institute),* ed. by Peter Becker and Richard F. Wetzell (New York: Cambridge University Press, 2009), (p. 207); William H. Schneider, *Quality and Quantity: The Quest for Biological Regeneration in Twentieth Century France*, (Cambridge: Cambridge University Press, 1990), pp. 53, 120-1; Porter, *Health, Civilisation and the State,* pp. 84, 102; Dowbiggin, *Inheriting Madness,* p. 153; Didier Nourrisson,'Aux origines de l'antialcoolisme', *Histoire, économie et société,* 7, (1988), 491-506 (p. 495).

[296] L. Murard and Patrick Zylberman,'La Mission Rockefeller en France et la création du Comité national de défense contre la tuberculose (1917-1923)', *Revue d'Histoire Moderne et Contemporaine,* 34, (1987), 257-81.

unsustainable compromising patient-care. For example, in Villejuif Toulouse noted that twenty-six-bedded quarters were occupied by more than fifty patients and in one year over 800 patients were admitted, assessed, diagnosed, classified, and treated by a single MC.[297] Patient numbers in Paris-region asylums rose from just over 900 in 1801 to 14364 by 1902. Six new asylums of 600 beds each were intended to replace existing ones during Baron Haussmann's reorganisation of Paris, but only three were completed: a stark illustration of political inertia and indifference by local authorities along with financial constraints in the provision of new facilities for the growing numbers of asylum admissions.[298]

2.13 Mental hygiene and prophylaxis

In December 1921, Toulouse's contribution to confronting the *misère sociale* was the creation of the Ligue française de prophylaxie et d'hygiène mentale (French league of mental hygiene and prophylaxis), similar to other leagues such as the Union française antialcoolique, and Ligue nationale française contre le péril vénérien.[299] The singular characteristic of such groups was a willingness to engage in the fight to improve the nation's health.

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[297] Toulouse, Rapport sur le service des aliénés du département de la Seine pendant l'année 1899, p. 274.

[298] Georges Eugène Haussmann, *Mémoires du Baron Haussmann (1890-1893)*, (Paris: V. Havard, 1893); Gaufey and Bleandonu, Naissance des asiles d'aliénés (Auxerre-Paris), pp. 115-6.

[299] Paul-Maurice LeGrain, *Hérédité et alcoolisme : étude psychologique et clinique sur les dégénérés buveurs et les familles d'ivrognes*, (Paris: O. Doin, 1889); Also see a comprehensive work on the development of temperance societies in France by P.E. Prestwich,'French Workers and the Temperance Movement', *International Review of Social History,* 25, (1980), 35-52; Ian Robert Dowbiggin,'Back to the Future: Valentin Magnan, French Psychiatry, and the Classification of Mental Diseases, 1885-1925', *Social History of Medicine,* 9, (1996), 383-408; Patricia E. Prestwich,'Paul-Maurice LeGrain (1860-1939)', *Addition History,* 92, (1997), 1255-63 (p. 1261); Virginie de Luca Barrusse,'Natalisme et hygiènisme en France de 1900 à 1940. L'example de la lutte antivénérienne', *Population-F,* 64, (2009), 531-60; Schneider, *Quality and Quantity,* p. 15 and 179; Just Sicard de Plauzoles, *Principes d'hygiène sociale : cours libre professé à la Sorbonne (1922-1927)*, (Paris: Editions médicales, 1927).Plauzoles's influence was considerable especially through his courses at the Sorbonne.

Toulouse's league was no doubt influenced by his knowledge of the work of American Clifford Whittington Beers, an ex-asylum inpatient.[300] Although certain scholars ascribe the foundation of the mental hygiene movement to Beers, the movement was international and in France, as an institution, it was firmly embedded within French social hygiene by Toulouse and his League.[301] The notion of mental hygiene had emerged and become popular in the early twentieth century as a reforming mode of alternative methods of structuring the *Assistance* and advancing preventative practices in psychiatry. Mental hygiene was a transnational movement addressing psychiatric practice and calling for scientifically-based social reorganisation.

His movement was dynamic, focused on clinical and scientific work that would address pressing health issues associated with mental illness and institutionalisation as treatment.[302] The establishment of the League reveals the breadth of Toulouse's ideology of alternative approaches to treatment and prevention, a mind-set informed by the lack of success of institutionalisation. The target hospitals is this study are evidence of the stagnation of the hospital population with psychiatrists persistently calling for better and more appropriate facilities. With a prescience to embrace new specialisms, Toulouse's objective was to broaden psychiatrists' scientific horizons believing in the policy of integrating psychiatric knowledge with collective discoveries in the fields of psychology,

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[300] José Bertolote,'The roots of the concept of mental health', *World Psychiatry,* 7, (2008), 113-16 pp. 113-4); Gwen Terrenoire,'L'Eugénisme en France avant 1939', *Revue d'Histoire de la Shoah,* 183, (2005), 49-67 (p. 49); Gwen Terrenoire,'Eugenics in France before 1945', *Cloning, Gene Therapy, Human Behaviour, Eugenics*, 2003; Edgar Jones and Simon Wessely,'Forward Psychiatry' in the Military: Its Origins and Effectiveness', *Journal of Traumatic Stress,* 16, (2003), 411-19 (p. 412); Isabelle von Bueltzingsloewen,'Eugénisme et restrictions. Les aliénistes et la famine dans les hôpitaux psychiatriques français sous l'Occupation', *Revue d'histoire de la Shoah,* 2, (2005), 389-402; Coffin, 'Misery' and 'Revolution', p. 227; Wojciechowski, *Hygiène mentale et hygiène sociale,* pp. 44-5, 53.

[301] In 1996, the league became member of the World Federation for Mental Health and renamed La Ligue Française pour la santé mentale (LFSM).Bertolote, The roots of the concept of mental health.

[302] Julien Bogousslavsky, *Following Charcot : A forgotten history of neurology and psychiatry*, (Basel: Karger, 2011), p. 2.

neurology, neuro-physiology, neuroscience (nervous disorders and disorders of the nerves), and biochemistry.[303]

His energetic campaigns for mental prophylaxis and *service libre* (Open-door services) were built on his prolific journalistic flair, experiences of asylums abroad, campaigning at international conferences, government connections and a rigorous and focused lobbying of the Conseil général de la Seine, He is stated as being, 'très écouté des pouvoirs publics et plus particulièrement du Conseil général, journaliste de talent, sachant atteindre le grand public'.[304] Toulouse's programme incorporated a support network for discharge follow-up: home service, social outworkers or assistants, and a patronage committee to help find work for discharged patients.[305] During the economically difficult interwar years, finance was a major concern to cash-strapped departmental officials and a major benefit to the state was that such a service reduced admissions to the high-cost asylums of the Seine.

In June 1922, Toulouse's *Service libre* opened in the grounds of Sainte-Anne asylum, a key development in the progress towards defining new facilities and treatment methods for the mentally ill within the *Assistance publique* and in the restructuring of the profession of psychiatry.[306] It laid the foundations for modern psychiatric services in a framework of demographic-geographical sectorisation, promoting day-hospital facilities for psychiatric treatment and mental hygiene

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[303] Shorter, *From the Era of the Asylum to the Age of Prozac,* p. 69; Nelson, Running in Circles: A Return to an Old Idea about Asylum Reform in Nineteenth-Century France.
[304] Henckes, Le nouveau monde de la psychiatrie français, p. 135; Coffin, 'Misery' and 'Revolution', pp. 228-9; Eugène (Eugeniusz) Minkowski,'Décès de M.M. Paul Sérieux et Edouard Toulouse, anciens présidents', *Annales médico-psychologiques,* 3, (1947), 298-302 (p. 300).
[305] Thomas, Open psychiatric services, p. 139.
[306] Edouard Toulouse, Roger Dupouy, and Adolphe Courtois,'Les Services ouverts pour psychopathes', *La Prophylaxie mentale,* 8, (1932), 543-94 (p. 546); A. Antheaume,'Chronique l'actualité psychiatrique ', *L'Hygiène mentale,* 21, (1926), 1-6 pp. 1-3); Huteau, *La biocratie d'Edouard Toulouse*; Thomas, Open psychiatric services, p. 674.

dispensaries.[307] The *Service libre* was multidimensional, multi-disciplinary, and based on three divergent fields of reform.[308] Firstly, it offered a new mode of care associated with what is today's outpatient psychiatric consultations for acute mental illnesses, with immediate access to inpatient facilities if prescribed, but without recourse to the legalities involved in internment. Toulouse aimed to reduce the attached social stigma of such admissions for both patient and family.[309] Evidence of the awareness and fear of stigma, and the need to address this important cultural issue, is seen in the correspondence of the wife of Monsieur C.[310] In one of nine letters to the Brothers and MC, she asked of her husband's condition and whether she could have a certificate of his admission, as she needed to inform his employer. She goes on to say: 'Also Doctor, please do not mention in the certificate that you are treating him for syphilis, the other doctor put his condition down as *dépressions nerveuses'*.[311]

The second area was the establishment of research laboratories for diagnostics and research into fields, including bio-psychiatry, chemo-biology, and psycho-physiology.[312] The third area of Toulouse's programme had a medical psycho-

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[307] Michel Godfryd, *La Psychiatrie légale*, (Paris: Presses Universitaires de France, 1989), pp. 214-5.
[308] In this article Toulouse gives a full plan of his Service libre and associated fields and disciplines. Edouard Toulouse,'Chronique: Actualité pychiatrique', *Hygiène mentale: L'Informateur des Alienistes et de Neurologistes,* 1, (1926), 1-14.
[309] Wojciechowski, *Hygiène mentale et hygiène sociale,* pp. 79, 169; Henckes, Le nouveau monde de la psychiatrie français, p. 134; Coffin, 'Misery' and 'Revolution', p. 227; Robert J. Sternberg, *International Handbook of Intelligence* (Cambridge UK: Cambridge University Press, 2004), p. 114; Isabelle von Bueltzingsloewen,'Réalités et perspectives de la médicalisation de la folie dans la France de l'entre-deux-guerres', *Genèses,* 82, (2011), 52-74; Gregory Mathew Thomas, *Treating the trauma of the Great War : soldiers, civilians, and psychiatry in France, 1914-1940*, (Baton Rouge: Louisiana State University Press, 2009), p. 147; Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* (Massachusetts: Harvard University Press, 2001).
[310] UHASJDD, Patient dossier Monsieur C. age 28 admitted 11 November 1938 died 23 September 1940.
[311] Ibid.
[312] Edouard Toulouse, Réorganisation de l'hospitalisation des aliénés dans les asiles de la Seine: rapport à la Société médicale des asiles de la Seine, 1920; Harry Oosterhuis, 'Insanity and Other Discomforts: A Century of Outpatient Psychiatry and Mental Health Care in the Netherlands, 1900-2000', in *Psychiatric Cultures Compared : Psychiatry and Mental Health Care in the Twentieth*

pedagogical focus on 'abnormal' and retarded children, who, it was claimed, needed urgent special education programmes to prevent further mental deterioration.[313] In his approach to reform, Toulouse applied the theories of hereditary degeneracy of alienist Bénédict-Augustin Morel (1809-1873), who argued that the unfit would, through *procréation aveuglé*, bring down society with them.[314] This was not dissimilar to a social hygienist position that loss of fit men during the war had left weaker men who had not been involved in combat to procreate. Aided by physiognomy (clinical psychopathology), a further theory expounded by Morel in his attempt to identify underlying forces that shaped mental illnesses, alienists linked 'idiocy' and mental retardation to hereditary traits.[315] The image depicting 'sept frères et soeurs idiots' (Figure 8), reproduced by alienist Emmanuel Régis was intended to support his thesis that certain individuals exhibited inbred mental illnesses, thereby proving a genetic concept to heredity.[316]

Century : Comparisons and Approaches, ed. by Marijke Gijswijt-Hofstra, et al. (Amsterdam, NLD: Amsterdam University Press, 2006), (p. 77); William H. Schneider,'The Scientific Study of Labor in Interwar France', *French Historical Studies,* 17, (1991), 410-46 pp. 410-3). An offshoot of Touoluse's philosophies and the League's applied research was the establishment of a new field of study: psycho-technique, or the psycho-physiology of work, a forerunner of contemporary fields of career guidance, psychological and IQ testing, and ergo-metrics.

[313] Toulouse, *Les causes de la folie : prophylaxie et assistance*; Also see: Sofie Lachapelle,'Educating Idiots: Utopian Ideals and Practical Organisation Regarding Idiocy inside Nineteeth-Century French Asylums', *Science in Context,* 20, (2007), 527-648.

[314] Bénédict-Augustin Morel, *Traité des dégénérescence physiques, intellectuelles, et morales de l'espèce humaine*, (Paris: Ballière, 1857); Claude Quétel, *History of Syphilis*, (Oxford: Polity Press, 1990); Toussaint, *Etude d'hygiene sociale*; R.M. Kaplan,'Syphilis, sex and psychiatry, 1789-1925: Part 2', *Australas Psychiatry,* 1, (2010), 22-7; Karl Feltgen, 'Guérir les ravages de la guerre. Syphilis et tuberculose pendant la Première Geurre mondiale: lutter contre les 'enemies de l'intérieur'', in *Les hôpitaux dans la guerre,* ed. by Anna Chassaniol (Paris: le cherche midi, 2008), pp. 154-62; M. M Tampa, I. Sarbu, C. Matei, V. Benea, and S-R. Georgescu,'Brief History of Syphilis', *Journal of Medical Life,* 7, (2014), 4-10; Thomas, *Treating the trauma of the Great War,* p. 152; Schneider, *Quality and Quantity,* p. 182; Simonnot and Liauzu, Les voies de l'eugénisme, p. 553; Toulouse, *Les causes de la folie : prophylaxie et assistance*.

[315] Morel, *Traité des dégénérescence physiques, intellectuelles, et morales de l'espèce humaine*.

[316] Régis, *Précis de psychiatrie,* pp. 532-3.

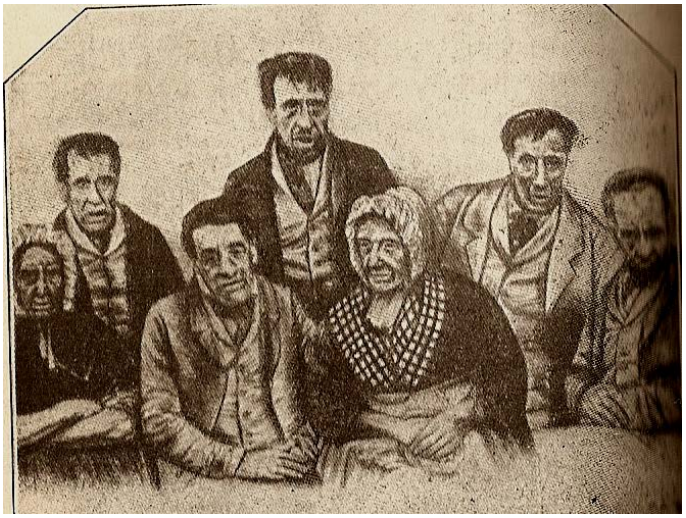

Figure 9 Sept frères et sœurs idiots (d'après Tuke et Bucknell)
Source: Précis de Psychiatrie by 1914 Emmanuel Régis p.532 f.62

In the early 1920s, Admission questionnaires in the target hospitals offer clear evidence that a collective heredity theory still retained value in the early twentieth-century understanding of mental illnesses, although this was not necessarily the belief of all psychiatrists of the day.[317] For example, Question 31 asks: 'Are there in the close family, either on the parental or maternal side persons affected by madness, epilepsy, convulsions, imbecility or those who succumb to drunkenness?'

A major factor in Toulouse's reform plan was his belief that a successful fight against most mental diseases lay in '*prophylaxie mentale*'.[318] Although a vague term, this was a biomedical approach which recognised eugenic theories as the ultimate means to resolve psychiatry's problem, primarily by eliminating the possibility of procreation of the 'unfit' and 'mental deficients'.[319] Toulouse advocated prescriptive

[317] UHAGM, Printed Admission questionaire - completed and dated by admitting doctor 1928.
[318] Toulouse, *Les causes de la folie : prophylaxie et assistance*; Toulouse, La prophylaxie et l'hygiène mentale; Edouard Toulouse, Roger Dupouy, and Adolphe Courtois,'Les Services ouverts pour psychopathes', ibid.8, (1932), 543-94 ; Edouard Toulouse,'La prophylaxie et l'hygiène mentale', ibid.6, (1930), 333-45; Edouard Toulouse, Georges Genil, and René Targowla,'L'Organisation du service libre de prophylaxie mentale à l'asile Sainte-Anne (27 March 1922 meeting of the Société médico-psychologique)', *Annales médicales psychologiques,* 80, (1922), 338-60.
[319] Nye, *Crime, Madness & Politics,* p. 45.

eugenic medicine in the form of sterilisation, which he justified by pointing to the threat of degeneration from dysgenic effects (genetic diseases and disorders).[320] His principal approach echoed policies in countries like America, Sweden and Norway.[321] As Schneider argues, eugenicist theory offered legitimacy and a framework for the nation's problems of decline, and its rise in popularity stemmed from post-war fears over public health and social hygiene fears and a belief in the urgent need for reform.[322] Eugenics entered the field of French public health in the early twentieth century with the Eugenics Society (Société française d'eugénisme), founded in 1913.[323] Eugenics offered an opening for a modern specialty with strong ties to a social hygienist agenda of prevention.[324] The society's principles broadly influenced reformists concerned with health and social diseases. Social and mental hygiene narrative made it clear that eugenics offered powerful solutions to social and public health problems. However, this was a subject to which the Catholic Church intervened demonstrating strong dissent to negative eugenic ideas on sterilisation and interference in procreation with the 1930 Papal edict Casti Connubii (On Christian Marriage) procreation and sterilisation. This stance

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[320] Wojciechowski, *Hygiène mentale et hygiène sociale,* pp. 136, 73; Alain Drouard, *L'eugénisme en questions: L'exemple de l'eugénsime "français"*, (Paris: Ellipses, 1999), pp. 32, 38-9.
[321] Calum MacKellar and Christopher Bechtel, *The Ethics of the New Eugenics*, (New York: Berghahn, 2014), pp. 18-22.
[322] William Schneider, 'The Eugenics Movement in France, 1890-1940', in *The Wellborn Science : Eugenics in Germany, France, Brazil, and Russia,* ed. by Mark B. Adams (New York: Oxford University Press, 1990), pp. 69-110 (p. 71).
[323] A-L. Simonnot,'An Ethic Stake in the XXth Century: The Question of Eugenics', *Annales Médico-psychologiques,* 159, (2001), 23-26; Terrenoire, Eugenics in France.
[324]For scholarship on eugenics in France see: Anne-Laure Simonnot, 'Origines et développements du mouvement hygiéniste français en psychiatrie : Une figure dominante : Edouard Toulouse (1865-1947)', (doctoral thesis, université Paris 13, 1994); Simonnot and Liauzu, Les voies de l'eugénisme; Schneider, The Eugenics Movement in France, 1890-1940; Terrenoire, Eugenics in France; Anne Carol,'Médecine et eugénisme en France, ou le rêve d'une prophylaxie parfaite', *Revue d'histoire moderne et contemporaine,* 43, (1996), 618-31; Cyrille Koupernik,'Eugénisme et psychiatrie', *Annales médico-psychologiques,* 159, (2001), 14-18; Nye, Médecins, éthique médicale et État en France 1789-1947; Andre Pichot, *L'eugénisme ou les généticiens saisis par la philanthrope*, (Paris: Hatier, 1995); Weindling, L'eugénisme comme médicine social; Wojciechowski, *Hygiène mentale et hygiène sociale*.

was further enforced with the edict of 1937, Mit Brennender Sorge (On the Church and the German Reich).[325]

Nevertheless, Toulouse's mental hygiene and eugenicist beliefs were embraced by many in psychiatry, a demonstration of the widespread appeal of mental hygiene theories to solve the problems of overcrowded asylums and lack of progress in psychiatric practice.[326] The impact of positive eugenic approaches is seen in the establishment of organisational (workplace) psychology, anthropometric IQ testing, child psychology, sexology, and expansion of social services and dispensaries to reach patient's homes, schools, workplaces and homeless shelters. The medical profession, many of whom were prominent in the eugenics movement, believed that medico-social problems should be treated within the wider context of the health of the nation as a whole.[327]

However, Toulouse's application of a negative derivative of eugenicist ideology through his preventative measures was less widely supported. Alain Drouard has posited the problematic of eugenics: in theory, negative and positive eugenics present opposites, yet in practice they are often combined at the furthest end of

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[325] Pope Pius XI, 'Casti Connubii (On Christian Marriage) 31 December 1930' <http://www.papalencyclicals.net/pius11/p11casti.htm> [Accessed 16/05/2018] ; Pope Pius XII, 'Mit Brennender Sorge (On the Church and the German Reich)14 March 1937' <http://www.papalencyclicals.net/pius11/p11brenn.htm> [Accessed 16/05/2018]

[326] Toulouse, Genil, and Targowla, L'Organisation du service libre de prophylaxie mentale à l'asile Sainte-Anne (27 March 1922 meeting of the Société médico-psychologique).Other psychiatrists include Maruice le Fleury and Henri Claude. There was also support from ministers in the Ministries of Work, Hygiene and Social Welfare.
Dorothy Porter and Roy Porter, *Doctors, Politics and Society: Historical Essays* (Amsterdam and Atlanta: Rodopi, 1993), pp. 119-21; Coffin, 'Misery' and 'Revolution', p. 225; Wojciechowski, Hygiène mentale et hygiène sociale; contribution à l'histoire de l'hygiénisme: naissance et développement de l'hygiène mentale en France. La ligue d'hygiène et de prophylaxie mentales (1920 - 1960) et l'action du docteur Edouard Toulouse (1865 - 1947); Huteau, *La biocratie d'Edouard Toulouse*; Alain Drouard,'Biocratie, eugénisme et sexologie dans l'œuvre d'Édouard Toulouse', *Sexologies,* 16, (2007), 203-11.

[327] Tumblety, *Remaking the Male Body,* p. 39.

the eugenics spectrum.[328] In France, positive eugenics also promoted the procreation of healthier and stronger progeny while negative eugenics advocated the elimination of undesirable traits in society.[329] However, distinction between the two hardened in the light of a radical approach and negative programmes to the disabled taken by Nazi Germany during the mid-1930s.[330]

Mental hygiene and beliefs in degeneration of the race were taken to the ultimate degree by Nazism, and mental hygienic language was used as a code for what would later come to be called 'ethnic cleansing'. In France, by the late 1930s this proved to be a major factor in the withdrawal of most eugenic ideas for mental hygiene improvements. Whether such ideologies that saw the mentally ill as a burden to the state and useless mouths would have any bearing on attitudes and actions of French psychiatrists when France was dominated by Nazi occupiers will be examined in later chapters.[331] There was undoubtedly an underpinning of racial eugenics and 'racial improvement' in Toulouse's theories, but in practice this was not realised in France. As Schneider argues, this was because of the French

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[328] Alain Drouard,'On the history of French eugenics', *Hippokrates (Helsinki),* 15, (1998), 79-90; Elof Axel Carlson,'Human Imperfection : Unresolved Responses', *The Quarterly Review of Biology,* 67, (1992), 337-41 (p. 341); Alison Bashford and Philippa Levine, 'The Oxford Handbook of the History of Eugenics', (Oxford: Oxford University Press, 2010); Matthew Ramsey, 'Public Health in France', in *The History of Public Health and the Modern State,* ed. by Dorothy Porter (Amsterdam: Rodopi, 1994), pp. 45-118 (p. 53); Gérard Jorland, *Une société à soigner. Hygiène et salubrité publiques en France au XIXème siècle*, (Paris: Gallimard, 2010), p. 361; J-J. Yvorel,'L'Université et l'enfance délinquante: 1939–1945', *Revue d'histoire de l'enfance,* 3, (2000), 137-57; Drouard, *L'eugénisme en questions,* p. 22.

[329] William Schneider,'Toward the Improvement of the Human Race: The History of Eugenics in France', *Journal of Modern History* 54, (1982), 268-91 (p. 278); Philip K. Wilson,'Confronting "Hereditary" Disease Eugenic Attempts to Eliminate Tuberculosis in Progressive Era Merica', *Journal of Medical Humanities,* 27, (2006), 19-37; Etienne Lepicard,'Eugenics and Roman Catholicism. An Encyclical Letter in Context: Casti connubii, December 31, 1930', *Science in Context,* 11, (1998), 527-44; Marius Turda and Aaron Gillette, *Latin Eugenics in Comparative Perspective*, (London and New York: Bloomsbury Publishing, 2014).

[330] Gilles Jeanmonod,'Aspects et développements récents de l'histoire de l'eugénisme', *Gesnerus,* 60, (2003), 83-100 (p. 90); Geoffrey Cocks, 'German Psychiatry, Psychotherapy, and Psychoanalysis during the Nazi Period: Historiographical Reflections', in *Discovering the History of Psychiatry (New York: Oxford University Press, 1994).* ed. by Mark S. Micale and Roy Porter (New York: Oxford University Press, 1994), pp. 311-30.

[331] Burleigh, *Death and Deliverance*.

preoccupation with the more pressing problems of depopulation, the involvement of the Church in a refusal to interfere with procreation, and principally a neo-Lamarckian stance in French medical and scientific circles.[332]

In France, psychiatrists conformed to a traditional neo-Lamarckian approach, whereby hereditary improvements could be passed to future generations if the 'environment' of the disease could be improved.[333] Neo-Lamarckian concepts provided a theoretic link between social hygiene and eugenics, and beliefs in the inheritance of physiological improvements from one generation to the next strongly influenced the manner in which eugenic principles were applied in psychiatry.[334] For example, Darwinian beliefs directed that eugenicists should aid the attack on social evils such as alcoholism, yet to neo-Lamarckians alcoholism was a eugenic issue precisely because it was both a symptom and a result of social ills and because the cycle of causes could be interrupted by social action.[335] There were asylum alienists, such as Maurice Dide, MD of Braqueville asylum, who, as we shall see in chapter three, believed that a medico-biological model was needed to treat the mentally ill and to protect future generations. He applied social hygiene concepts to his practice but he was not, however, influenced by negative eugenic ideas and clearly did not subscribe to them.[336] On matters of intervention and

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[332] Schneider, *Quality and Quantity,* p. 211; Lepicard, Eugenics and Roman Catholicism. An Encyclical Letter in Context: Casti connubii, December 31, 1930.
[333] Schneider, *Quality and Quantity,* pp. 8, 87.
[334] Ramsey, Public Health in France; Mark B. Adams, 'The Wellborn Science : Eugenics in Germany, France, Brazil, and Russia', (USA: Oxford University Press, 1990), (p. 76 and 120); Also see: Dorothy Porter, 'The History of Public Health and the Modern State ', (Amsterdam and Atlanta: Rodopi, 1994).
[335] Adams, The Wellborn Science : Eugenics in Germany, France, Brazil, and Russia, p. 122.
[336] M. Dide and P. Guiraud, *Psychiatrie du médecin praticien*, (Paris: Masson, 1922); Maurice Dide,'L'Assistance doit différer pour les maladies mentales et les infirmités psychiques', *Hygiène Mental,* 1, (1933), 1-8; Schneider, *Quality and Quantity,* p. 46; Nourrisson, Aux origines de l'antialcoolisme, pp. 492, 94; Thomas Bewley, *Madness to Mental Illness: A history of the Royal College of Psychiatrists*, (London: Royal College of Psychiatry Publications, 2008), p. 7; Morel, *Traité des dégénérescence physiques, intellectuelles, et morales de l'espèce humaine,* p. 138; Caroline Mangin-Lazarus, *Maurice Dide (Paris 1873-Buchenwald 1944). Un psychiatre et la guerre*, (Toulouse: Eres, 1994), p. 146.

doctrine, members and supporters of the eugenics movement were often divided among themselves. Some did not agree on all aspects of the movement and demonstrated a robust reticence when faced with the idea of campaigning to achieve eugenicist objectives through legislative means.[337]

However, while Toulouse's negative eugenic thinking places him in the minority among psychiatrists in France; he was a strong believer and promoter in reform of the asylum system.[338] Indeed, scholars have agreed that Toulouse, whatever his affiliations with eugenic theories, was a resolute opponent of Nazism, Fascism, and Communism, and a believer in the Lamarckian theory that acquired characteristics could be inherited.[339] Furthermore, Toulouse's many achievements and his personal focus on reform were widely admired. It was claimed by his students that Toulouse was tyrannical in his work, although alienist Paul Sivadon who worked with Toulouse claimed that despite his reputation Toulouse was most fervent in his wish to change the asylum system. Another of Toulouse's colleagues, Eugene Minkowski (1885-1972), whose well-documented activities with the OSE (Œuvre de secours aux enfants), during the Occupation saved the lives of many Jewish children, said of Toulouse, 'il a su battre en brèche bien des préjugés et réaliser la grande réforme à laquelle de tout son être il était attaché'.[340] This acknowledges

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[337] Terrenoire, L'Eugénisme en France avant 1939, p. 58; Also see William L. l. Parry-Jones,'Asylum for the mentally ill in historical perspective', *The Psychiatrist,* 12, (1988), 407-10; Thomas, Open psychiatric services.

[338] Minkowski, Décès de M.M. Paul Sérieux et Edouard Toulouse, anciens présidents, p. 300; Other historians who have written on Toulouse include: Thomas, Open psychiatric services; Coffin, 'Misery' and 'Revolution'; Henckes, Reforming psychiatric institutions in the mid-twenthieth century; Gourevitch and Postel, Actualité de l'oeuvre d'Edouard Toulouse; Wojciechowski, *Hygiène mentale et hygiène sociale*.

[339] Drouard, *L'eugénisme en questions*.

[340] Toulouse was instrumental in the 'circulaire' of 1939. Bulletin officiel de l'état au ministère de la santé publique. Circulaire Rucart de 13 octobre 1937 relative à la réorganisation de l'Assistance psychiatrique dans le cadre départemental, adressé au préfets; Minkowski, Décès de M.M. Paul Sérieux et Edouard Toulouse, anciens présidents, p. 300; Toulouse is discussed within the context of the mortality of the mentally ill during the German Occupation in: Marc Masson and Jean-Michel Azorin,'The French Mentally Ill in World War II: The Lesson of History', *International Journal of*

Toulouse's humanitarian and innovative reforms in psychiatry. It was his strong lobbying that changed the terminology of *asiles* to *hôpitaux psychiatriques* by the 1937 *circulaire de Rucart*. In 1962, in honour of Toulouse's work, his name was adopted by the Bouches-du-Rhône departmental psychiatric hospital in Marseilles, his birthplace.

2.14 Conclusion

Chapter two presented an overview of the nature, origin and evolution of the four target hospitals. The histories surrounding these institutions illustrate the development of facilities for the insane within civil, medical, and theological approaches. However, although there were significant differences in their foundation and administrative structure and professional practice there were also similarities in their philosophy of care. In the case of Saint-Jean-de-Dieu, the asylum was conceived and run according to a long tradition of Catholic beliefs characterised by the Nicene Creed which advocated responsibility for and duty to the underprivileged, ill and insane. This gave a distinctive moral and religious dimension to daily life. Leadership was under the authority of Priors and Brothers who were trained nurses practicing an individual-centred nursing approach to care, very different to the asylums of Braqueville and Saint-Dizier which were alienist-centrist models, and in which medical research, through observation and classification would facilitate the treatment and cure.

In state asylums, Pinelian/Esquirolian ideas and methods of treating insanity called for a change in barbaric treatment of insane persons in prisons to a humanitarian approach with interaction between doctor and patient, good food, fresh air, and therapy. Elements of these ideals had religious overtones when compared with the

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Mental Health, 35, (2007), 26-39; For further reading see: Gourevitch and Postel, Actualité de l'oeuvre d'Edouard Toulouse.

philosophy of care in Saint-Jean-de-Dieu. Here, patients were treated as individuals and interaction with doctor/patient and close liaison with nursing staff was the standard. However, alienists' Utopian ideas of an asylum as a place of cure with time to treat patients dissolved rapidly with high demand for admissions whilst facilities and staffing deteriorated substantially. However, this situation did not manifest itself to such a degree in Saint-Jean-de-Dieu and devotion to duty and nursing care did not appear to diminish.

With regards to nursing, although many state-run asylums recruited trained staff from charitable associations or religious orders or communities, they were primarily reliant on untrained assistants. To what extent the quality of patient care was affected by the status, either state or clerically run, of the target hospital under the Occupation will be examined in later chapters. The three closed asylums were similar in their architectural structure. Most asylums were built to present civic duty or reflect the shared values of alienists who believed the asylum to be ameliorative, whereas for religious orders the edifice was for the glorification of God. In both state and clerical institutions the structure and location of these buildings isolated both patient and staff from society. However, for Ainay, the asylum main buildings and patient infirmary and meeting rooms were utilitarian, and patients benefited from living in small country cottages with access to the outside world. A small room for two of three patients was the antithesis of high-ceilinged dormitories built for forty and often housing over sixty people. However, whatever the asylum architecture the closed institutions disadvantaged the patients and were not fit for purpose by the war and occupation: they were a factor in increased mortality.

The concept and establishment of the *colonie* at Ainay was part of a wider approach of reform as alienists sought solutions to the very issues raised and the problems surrounding the long-term care of the incurable patient. Although administered by a MD, Ainay had certain parallels in its principles of care with that of Saint-Jean-de-Dieu: a central tenet of the Order was 'care given as from a

mother to her child' and the humanitarian ethos aspired to by alienist Auguste-Marie and others consisted of care within a family milieu.

However, the state did not repeat the creation of more facilities in the style of Ainay and alienists looked to other alternatives to asylum care. Certain of these were presented by alienist-reformer Edouard Toulouse. He addressed overcrowding and lack of therapeutic progress with beliefs that were innovative and attractive to many asylum alienists but were also controversial. Toulouse was part of a larger scientific, medical, and intellectual movement that proposed methods to arrest perceived causes of national decline by eliminating supposedly hereditary conditions associated with insanity. This was to be achieved for future generations by the application of social and mental hygiene measures thereby forging a link between eugenics and methods to treat and cure mental illnesses. Toulouse argued that faced with the failure of alienist theories of institutionalisation as cure there was need for specific acute services and preventative medicine.

But Toulouse's more radical ideas of prescriptive prophylaxis of sterilisation to prevent future generations from developing hereditary diseases, did not sit well with many in medicine or the Catholic Church. This was due to two factors. Firstly, the Catholic Church saw such issues as contrary to Catholic teaching. Two papal encyclicals, one in 1930 and one in 1937 reflected strong condemnation of the use of eugenic theory, in relation to procreation, marriage and the family and euthanasia which had been propagated and embraced by many psychiatrists and none more so than those in Germany with the rise of the National Socialist Party in 1933. However, in France, the influence of the eugenics society especially concerning negative theories had started to wane in light of the dominance of radical German practices.

The second factor was a Neo-Lamarckian tradition in French biology and medicine and belief in the inheritance of acquired characteristics could be improved with favourable environmental conditions. Neo-Lamarckism for alienists provided a

hypothetical link between social hygiene and eugenics in that diseases were seen as hereditary and the future was in making the unfit healthier. The influence of the French eugenics society and its theories, especially negative ideas, weakened with the rise to power of the National Socialist Party and the dominance of eugenics in German psychiatry in the early 1930s. However, it must be noted that Toulouse's work and League was Paris-based and little of such facilities, or time to engage within them, was experienced by asylum psychiatrists in the provinces: they were far from Paris influences and mainly lacked facilities for research or departments willing to finance studies on the insane.

Toulouse was one of many psychiatrists who were proactive in government lobbying and generating reform measures, nevertheless, reform was protracted and minimal. Asylums continued to be underprovided and understaffed. Within such a milieu, the German occupation was to weigh heavily on daily life in the target hospitals and their preparedness for this event will be analysed in the next chapter.

Chapter 3 Conditions in the target hospitals on the eve of war

In order to evaluate the effects of war and occupation chapter three will examine the preparedness of the target hospitals. A close examination of the hierarchy and responsibilities of hospital staff: Medical Director, Prior, Médecin-chefs-de-service, and nursing staff will demonstrate their respective contribution to institutional daily life. This will give a sharper picture of how institutional life changed and allow for greater understanding of the ensuing increase in mortality during the German occupation.

Firstly, the chapter examines the work and leadership of Maurice Dide, MD of Braqueville asylum, renamed HP Gérard Marchant in 1937, and then that of the Priors of Saint-Jean-de-Dieu, MDs of Saint-Dizier and Ainay. It is argued that, still governed and hampered by the legal and institutional framework of the 1838 law, there were significant flaws in the system and shortcomings in psychiatry's approach to treatment and care. The chapter will also demonstrate the positive and determined mind-set of many psychiatrists to improve the lot of their patients.

By the 1930s there was growing concern among psychiatrists that the role of the asylum advocated by the founding-alienists as an ameliorative space was increasingly appropriated by state officials who saw its custodial function as more important. This culture found asylum facilities for inpatients and staff stretched to breaking point as mounting demands for admissions and poor cure and discharge rates led to severe overcrowding. Overcapacity of the infirmary, patients' quarters, especially dormitories, produced immense pressure on staff with medical supervision and discipline almost non-existent. Poor therapeutics success was due principally to diverse and often opposing theories of causality and treatment, and medical and administrative discord in many asylums detracted from

responsibilities of senior staff. During the Occupation this gave rise to serious deficits in patient care and nutrition.

In addition, insufficient budget allocation for hospital expenditure on clinical services, staffing, and material conditions made managing the budget one of the most onerous and contentious duties in terms of resources and time management for the MD. The prefect and hospital committee members, authorities of the state, saw their role as gatekeepers of the HP but with an apparent disregard for the welfare of a vulnerable group in society. This mentality is tangible in MDs' reports and correspondence.[341] In such circumstances, there was little opportunity to attract new professionals to work in the psychiatric system and such parsimony offered little likelihood of attracting nursing staff to an antiquated and stigmatised system in which nurses received little recognition or training and poor wages compared with other establishments like factory-work.[342] On a broader scale, disinterest in the welfare of the mentally ill was evidenced by only a few HPs being built in the twentieth-century and in the target hospitals only minimum building works were undertaken to improve overcrowded facilities for patients or staff.

Following this medico-administrative perspective of the routinisation of institutional and clinical services, the last part of the chapter will peel back the layers of the little-documented life of inpatients and working conditions for those who looked after them. Taken from MCs' handwritten notes and communication from and to patients' relatives, the vignette will give a glimpse of the reality of everyday hospital life on the eve of the Occupation.

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[341] UHAGM, Session du Conseil général de 1900. Il y a certes 'des progrès depuis mon arrivé en 1893, à ce moment, la moyenne était de 3 chaussetttes par malade, impossible de faire un changement regulier, à moins d'être unijambiste'.

[342] Marchant for example was situated across the road from the large chemicals factory on the outskirts of Toulouse.Weiss, Origins of the French Welfare State, p. 65.

3.1 Dide's tenure

In order to understand the administrative routine in the target hospitals, we will take a closer look at the work of Maurice Dide MD of Braqueville from 1909 to 1938. Dide is emblematic of a new breed of twentieth century neuro-psychiatrists. In his hospital administration, research, and scholarship, we see the beginning of a convergence of two schools of thought. One was a rejection of the Pinelian/Esquirolian institutional perspective of treating insanity, which by the early twentieth-century came to be viewed as unsuccessful, and the second was a neurological or organic approach. Dide was of the second school. As an organicist, Dide's argument was that insanity originated in physical causes. However, his was not an entrenched view and he explored many avenues in clinical research, including psycho-somatic and psychological symptoms and emotional influences on insanity, about which he wrote extensively.[343] Dide strongly believed that the role of the asylum required reassessment, much like Edouard Toulouse, who, in Paris, during the interwar years, argued that psychiatry should be repositioned in medicine. Dide was of, 'the new generation [who] wanted to pull psychiatry out of the isolation in which it found itself'.[344]

However, Dide's administration reflects the wider patterns of HP management and important changes within psychiatry itself. The institutional system and psychiatric practice during the early 1900s and his life and work at Marchant reveal both flaws and virtues. He fiercely defended his position of authority, maintaining the Esquirolian belief that the MD was the only person in charge of an asylum. His individualistic thinking and strong convictions about his role did not always allow

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[343] Jennifer Wallis,'Bloody technology: the sphygmograph in asylum practice', *History of Psychiatry,* 28, (2017), 297-310; Maurice Dide, *Les émotions et la guerre: Réactions des individus et des collectivités dans le conflit moderne*, (Paris: Alcan, 1918); M. Dide and R. Courjon,'Le traitement et la gestion rapides dans les centres neurologiques d'armée des troubles fonctionnels hystériques ayant résisté aux traitments de l'intérieur', *Progrès Médical,* 13, (1918), 113.
[344] Coffin, 'Misery' and 'Revolution', p. 225.

for good interpersonal relationships.[345] He never flinched from informing those in authority, at prefectural or ministerial level, of his opinions and ambitions for the future of the asylum and treatment of insanity: but in doing so his manner caused friction.[346]

On the one side, Dide's administration is portrayed through official documentation as fractious and confrontational. On the other, in his firm belief that the role of the asylum had to change, many of his contretemps with both the prefect and hospital committee were due to what Dide considered injustices to his patients and officials' administrative myopia. He argued they were more concerned with the legislative role of the institution and the hospital budget than with patient care.[347] Some psychiatrists under his leadership found his manner overbearing.

Conversely others found him humane and inspiring in his tireless research into the physical causes of mental illness.[348] Dide volunteered his services in the First World War even though he was over the age of 50. He worked as a military psychiatrist in a clinic behind the front-lines. His experiences treating traumatised soldiers reinforced his ideas on the need for new practice methods in acute inpatient

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[345] Françoise Jacob, 'La maladie mentale en Haute Garonne de la fin du XVIIIème siècle à 1950: politique et folie, un essai de psychohistoire', (doctoral thesis, université de Toulouse 2, 1988).

[346] UHAGM, Rapport sur la Commission de Surveillance (1937-1943).Séance 16 janvier 1939; Françoise Jacob and P. Moron,'La place de Toulouse dans l'histoire de la psychiatrie française', *Annales médico-psychologiques,* 151, (1993), 246 - 51 (p. 249); Mangin-Lazarus, *Maurice Dide (Paris 1873-Buchenwald 1944),* p. 140; Archives Nationales (AN) Paris, F1a 4570, Inspection générale des services administratifs. Rapport: M. Sarraz-Bournet Inspecteur général des services administraifs au ministère de l'Intérieur (22 April 1930). Inspector states the conflicts between MD and MCs were continuous and causing disruption to the hospital, in other establishments this was not so noticable. The minister is aware too; ADHG, Série 2848W 9, Nouveau projet de règlement intérieur elaboré par la commission de surveillance et soumis à l'approbation du prèfet et du ministre de la Santé publique (1938-1941). Letter of 7 October 1940 from the prefect to the Minister of the interior states, 'les mésintelligence profonde a divisé la direction et ses confrères'.

[347] ADHG 2848W 9. Letter 13 June 1939 from the prefect to the inspecteur général stating that correspondance with Dide indicated he used funds for improvements to pavilions without authorisation because he considered the budget inadequate.

[348] Dide and Guiraud, *Psychiatrie du médecin praticien*; Albert Londres, *Chez les fous*, (Paris: Michel Albin, 1925), p. 96.Londres wrote that if he ever became mad he wanted to be taken to Dide's asylum. Dide he stated was compassionate and worked with enthusiasm with his patients.

treatment such as psychotherapy, a new approach to therapy of interacting individually with patients although this had been promoted by early founders of alienism.[349] For Dide, immediate action for mental trauma and psychoses was an acute medical issue and positive results upheld those beliefs.[350] However patriotic and committed to his country Dide left Braqueville without a MD during the war years, 1914-1918, fuelling the committee's conviction, already mooted by certain legislators in Paris, that in asylums of over 1,000 patients management and day-to-day administration should be divided between an administrator, not necessarily medically qualified, and MCs would manage mental and medical patients only.[351] When legislation on this issue was promulgated in 1938, it caused discord and disillusionment among the psychiatrists working at Marchant, to the extent that the hospital committee reported that 'a state of indiscipline reigns in HP Marchant'.[352]

As patient numbers continued to grow during the 1930s, the state was sorely short of welfare facilities and overcrowding became rife. MC Henri Ey of HP Bonneval for instance complained that the physical environment in his asylum was outdated and overcrowding was stifling treatment, but officials would do nothing.[353] Overcrowding is clearly reflected in Braqueville's figures for 1939: 1500 patients,

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[349] Jean Oury, *Psychiatrie et psychothérapie institutionnelle*, (Paris: Champ social, 2001); P. Bernard,'Une expérience de psychothérapie collective à l'hôpital psychiatrique: le cercle de malades', *Annales Médico-psychologiques,* 1, (1947), 196-203; Pinel, *Traité médico-philosophique*; Weiner, *Comprendre et soigner: Philippe Pinel, 1745-1826: la médecine de l'esprit*; Mora, History of psychiatry.

[350] Dide, *Les émotions et la guerre*. These opened up the likelihood of treatment for many patients *ex muros*. PIE (proximity immediacy and expectation of recovery) was and is the standard intervention for combat stress reaction, in the early days known as shell shock. Jones and Wessely, Forward Psychiatry' in the Military: Its Origins and Effectiveness, p. 411.

[351] UHAGM, Compte moral et administratif année 1938.
Xavier Tougne, 'Des origines de l'asile de Braqueville et la loi de 1838', (doctoral thesis, université de Toulouse, 2005), p. 100; Bueltzingsloewen, Morts d'inanition, 2005, p. 55 fn11.

[352] UHAGM, Rapport sur la Commission de Surveillance (1937-1943). Séance 21 janvier 1939; ADHG 2848W 9.

[353] Henri Ey,'Rapport du Docteur Henri Ey, 6 février, 1941: Sur les conditions hygiéniques et alimentaires de son service', *Information Psychiatrique,* 75, (1999), 508-12.

accommodated in an establishment intended for 1200. Similarly, the official maximum bed occupancy for Saint-Dizier was 850 in 1939, but 960 patients were registered and this rose to 993 in 1939.

In 1930 the total population of the FMHS across 107 establishments (seventy-two state or public and thirty-five private or clerical) was around 79804 and in 1939 it rose to 107,420 for the same number of asylums.[354] Many admissions were often unsuitable for HPs.[355] Such is the case with patient transfers from the Seine asylums to the *colonie* at Ainay, in 1939: of 187 admissions sixty-five were classed under the mental term *imbecilité* and *debilité profounde,* and 105 of them were single. This is not to say these people did not need care but that they were unsuitably placed in what was intended to be acute medical care in asylums. In fact, many had been incarcerated in asylums for between two and ten years before admission to Ainay.[356]

During his time at Braqueville, Dide was passionate about research, knowledge and teaching. In 1922, with his deputy, Paul Guiraud, he published a highly successful guide for the family doctor, *La Psychiatrie du médecin practicien*.[357] The book illustrates a practical approach and desire to communicate with physicians to increase knowledge of mental illnesses and remove the stigma attached to them, following similar lines of thought to Edouard Toulouse. Confirming Dide's expertise

[354] Archives Nationales (AN) Fontainebleau, SAN 70847, Documents statistiques anciens et divers 1835-1946 pour l'ensemble des hôpitaux psychiatriques 1900-1944. Population des Hôpitaux Psychiatriques (Hommes et Femmes) au 1er janvier de 1900 à 1944. Durée, recensements des lits, statistiques 1934-1946. p. 82.
[355] D. Gouriou,'Une enquête sur les services ouverts: Réponse du Docteur Gouriou', *Alieniste Français Bulletin de l'Association Amicale des Médecins des Etablissements publics d'aliénés,* 1 (1932), 562-64 (p. 564).
[356] UHAALC, Rapport de M. le docteur P. Queron Médecin-directeur par intérim au préfet année 1939 Ainay-le-Château. p. 4.
[357] Dide and Guiraud, *Psychiatrie du médecin praticien*.

and standing, it remained a major psychiatric textbook until well into the 1950s.[358] Dide dedicated himself not only to the improvement of an alienists' care for patients but also of nursing care, He opened a nursing school in 1922.[359]

Dide is an example of a psychiatrist's objective to provide good patient care, but also of the frustration and concern felt by many over the state's lack of investment, interest and action in the provision of facilities for the mentally ill.

Following Dide's retirement in 1938, Marchant no longer had continuity of administrative direction or focus on patient care. By the time of the German invasion in June 1940, the hospital had already seen three directors. The first in 1938, MD Dr Piquemal-Leveque, died tragically after a short time in the post, she was followed by three non-medical local government officials. In October 1940, Xavier Leclainche was made director of Marchant, an official in the Ministry Health in Paris but was deposed by the Minister of the Interior for being not sufficiently supportive of Petain and the Vichy government.[360] He was replaced in 1943 by Marcel Lanquetin, his position as prefect had been revoked by the government 'because of his anti-Vichy political convictions et philosophies'.[361] Both directors left Marchant and continued resistance activities in Lyon. It is possible such a staffing decision employing a non-medical director was made by the Minister of the Interior in view of the intended change in separating administration and medical responsibilities in the asylums. This policy did not foster good working relationships between administrator-director and asylum psychiatrists, and led to fractious working conditions and poor communication.

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[358] Jacob and Moron, La place de Toulouse, p. 250. Tougne, Des origines de l'asile de Braqueville, p. 154.

[359] ADHG, Série 1325W (3-4), Dossiers du personnel (1910-1943). Letter 1 Arpil 1921 from Dide to the prefect concerning the training school and entrance examination for nurses.

[360] Journal Officiel de la République française Lois et décrets. 26 novembre 1940 p. 5831. Secrétariat général à la famille et à la santé.

[361] Personal communication by email from Dr Georges Lanquetin (son of Marcel Lanquetin Director of HP Marchant) to Patricia S. Legg between February 2011 and May 2012.

3.2 A different style of management

We have learned of the leadership of Dide and now we move on to a vastly dissimilar leadership in Saint-Jean-de-Dieu. During the 1930s, Saint-Jean-de-Dieu was directed first by Prior Marie-Antoine Lutz and then Prior Louis-Joseph-Anicet Gillemardais.[362] Both were qualified nurses, each with over thirty years' experience as *chef-infirmier* and hospital administrator. They were noted for their zealous and honourable character, their interpersonal skills and excellent hospital administration. In 1940 the prefect wrote, ''I am entirely pleased with his (Guillemardais) competence in the direction of the hospital'.[363] By dint of his training, it is probable the Prior was more patient-oriented and thus more accessible to both patients and staff than MDs in secular asylums. Indeed, the Prior's rounds of his patients were traditional and appreciated by patients and staff.[364] However, Dide was also well-known for his clinical rounds and the humane approach he took towards his patients, even inviting some of them to his home for musical soirées, but this observation was from a medical perspective.[365]

From a management perspective, Saint-Jean-de-Dieu was deemed the most difficult of any of the Order's asylums and due to this fact Priors were changed every four years.[366] This seems a brief period when considering the continuity of Dide's tenure at Braqueville, but the Order's *Superieur général* held central control

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[362] ADCA 109W 69.Prefect's letter 27 January 1940; Frère Lutz.
[363] Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon; Monval, *Les Frères hospitaliers de Saint Jean de Dieu*; ADCA 109W 69. p. prefect's letter 27 January 1940; Weiner, The Brothers of Charity; Marescaux, Vie et mort dans les hôpitaux psychiatriques, p. 119.
[364] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-De-Dieu dans le Diocèse de Saint-Brieuc et Tréguier 1839-1935*, (Rennes and Paris: Oberthur, 1936); UHASJDD, Patient dossier, Monsieur M. de G., age 51 admitted 8 October 1934 discharged 2 April 1935, readmitted 20 May 1942 died 28 July 1943.
[365] UHAGM, Séance de la commission 14 mai 1929; Mangin-Lazarus, *Maurice Dide (Paris 1873-Buchenwald 1944),* p. 107; UHAGM, Rapport médical 1915 du Dr Dubuisson. As interim director while Dide was on active service Dubuisson continued some of Dide's leisure activies.
[366] Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon, pp. 46-7.

over administrative, financial and medical aspects of the asylum, including Priors' tenure. Compared to the Minister of the Interior, who appointed asylum MDs, and most local authority officials who supervised state asylums, the *Superieur général* was cognisant of and sympathetic to the profound physical, mental, and spiritual burden of asylum work. Unlike Braqueville, frequent changes of a Prior did not weaken the asylum's philosophy of care or cause friction with the MCs, the hospital continuing to operate within the strict rules and framework of the Order.

Clerical establishments enjoyed a higher level of autonomy than those run by the state like Braqueville and Saint-Dizier. According to the law, the former thus saw less official involvement, although the Prior was responsible to the prefect on a departmental level contractually obliged to take the department's indigent patients. Indeed, during the 1930s there is no mention in the Prior's reports to the prefect on financial matters apart from a mention of the daily tariff, this is compared with copious amounts of correspondence and many-paged reports at Braqueville. Given this situation the Prior dedicated more time to staff, patients and relatives. Prior Lutz's brother writes, 'He would visit and speak to each patient individually at least once a week and send personal messages to the relatives if requested'. One patient's sister wrote to the Prior, 'I am so grateful he has arrived with you as I know you personally know the patients and he will be well looked after'.[367] In another case a mother wrote, 'We have tried so many places for our son and so many treatments'. I put my son in your hands as I have heard the Father superior is kind and knows all his patients'.[368] Such an attitude from the head of the asylum may not have made a vast difference to experiences and consequences of the Occupation, but quality of daily life and care may have been enhanced for

[367] Cousson, Les Frères hospitaliers de St-Jean-de-Dieu et le traitment des aliénés, p. 129; Frère Lutz, p. page 53; UHASJDD, Patient dossier Monsieur M. age 45 admitted 27 June 1910 died 31 August 1944.

[368] UHASJDD, Patient dossier Child 0533 age 14 admitted 14 December 1933 died 16 November 1943.

Saint-Jean-de-Dieu's patients. It will be demonstrated in later chapters that mortality figures for this hospital were lower than the state-run institutions of Marchant and Saint-Dizier.

All staff working under the Prior: his deputy, bursar, accountant, and heads of various in-house services such as catering, laundering and the farm were trained or experienced Brothers. This was due to the Order's belief that, as Abbé H. notes, 'not only do staff need devotion, they need competence', and in 1939, most nursing staff in Saint-Jean-de-Dieu had received qualifications and diplomas or in-house training, and those working as assistants were closely monitored by senior staff.[369] The Order was based on a collective philosophy of dedication to the insane and a duty to cope with everything that daily hospital life might bring. This is reflected in letters from relatives. The mother of Monsieur S., wrote to the Prior stating she did not want her son moved to any other establishment, 'we intend to leave him in your care because we know he will not receive such devoted attention or find any better qualified staff and care anywhere'.[370] In 1938 there were five *infirmier-surveillants* supported by fifty-five trained Brothers and their assistants for 975 patients of whom over 280 were *travailleurs* (patients requiring very little nursing care).[371]

Patient dossiers contain documentation which refutes anti-psychiatry theories of exploitation for work as therapy for patients. For many patients work was significant and important to their welfare and morale. An analysis of escapes in Marchant illustrates that workers with free access to the hospital grounds and farmlands were the least likely escapees; life outside perhaps offering less than life

[369] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu,* p. 109.
[370] UHASJDD, Patient dossier, Monsieur S. age 47, admitted 25 September 1917 died 9 March 1938.
[371] UHASJDD, Compte moral 1938 à 1945. p. 2.

inside.[372] This gives weight to the suggestion that those employed were content to remain and work. The value of work is revealed by M. R. T.'s letter to his MC, "I know things are difficult now but I am glad to work in the hospital gardens". In another letter he wrote: "I do like work and when I leave here, please find me a good employer, I liked my last one a lot".[373] The work ethic is noted in Madame M-A. V.'s dossier, the MC wrote: 'Works in the gardens which gives her great pleasure'.[374] The mother of Mlle S, B., expected that patients would do some kind of work, she asked, 'Does my daughter keep busy? She should occupy herself with something. I also wonder if she has finished the pullover, which is to be sent to her friend?'.[375] The MC replies, 'She is fit and working well; when she leaves she would like to find work as a domestic help'.

Patients also performed small tasks around the hospital and gardens like Monsieur A. M. and Madame M-A.[376] Some acted as messengers and saving staff time they were invaluable travelling the sprawling acres from administration buildings to patient quarters or workshops.[377] Such duties were especially helpful when the telephone system failed, which with frequent electricity cuts during the Occupation was quite regular. For there to be blatant exploitation of patients there would have to be complaints of being forced to work, or refusal to work or of penalties for patients' rebellious outbursts or visible financial benefits to MCs and this has not been evidenced so far. Medical and nursing notes indicate that patients who did

[372] UHAGM, Compte moral et administratif année 1938.
[373] UHAGM, Patient dossier, Monsieur R. T., age 25 admitted 20 September 1942 died 4 June 1943.
[374] UHAGM, Patient dossier, Madame M-A. V. age 41, admitted 14 December 1915 died 3 October 1942.
[375] UHAGM, Patient dossier, Madame S. B., age 19, admitted 20 april 1943 discharged 19 November 1943.
[376] UHAGM, Patient dossier Monsieur A. M. admitted 14 October 1938 died 23 August 1940.
[377] UHAGM, Patient dossier, Monsieur F. S. age 19 admitted 22 May 1943 discharged 2 December 1943.

not feel like working remained in their pavilion or in bed.[378] Furthermore, although deemed derisory, work attracted a small remuneration, considerable independence around the HP, a double allowance of tobacco (men only), and supplementary rations.[379]

In administrative or medical reports for Saint-Jean-de-Dieu overcrowding to the extent experienced in Saint-Dizier and Marchant, and recorded in other HPs, is not referred to in the same manner. MC Godard does write to the prefect in connection with reducing overcrowding per se by sending patients back to their original department, but there is not the continual reference to the problems associated with overcrowding as in other target hospitals.[380]

Historically, when patient numbers increased in Saint-Jean-de-Dieu, the Brothers found the means to move to larger premises or extend their buildings as in 1936.[381] This expansion of capacity may have granted relief during the Occupation to Saint-Jean-de-Dieu's patients compared with other HPs that had not enlarged facilities for increasing numbers of admissions.

In establishing leadership and tenure of each of the target hospitals on the eve of war we move to state-run HP Saint-Dizier run by MD Dr Magnand who had been in office since 1920. Little is known of his background but the HP was managed satisfactorily according to the prefect and hospital committee's reports.[382] This may be a reflection of Magnand conforming to institutional policies rather than his

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[378] UHAGM, Patient dossier, Madame C. age 30 admitted with 8 September 1942 died 6 January 1943.

[379] L. Bonnafé,'Quelques précisions théoriques et pratiques sur le travail des malades: valeur thérapeutique de la qualité, du rendement et de la rémunération', *Annales Médico-psychologiques,* 1, (1947), 209.

[380] ADCA, Série 51W 250, Convois, transferts de malades mentaux; états des mouvements des psychopathes (1945-1959).

[381] Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon.

[382] UHAHM, Rapport de la Commission départementale. Procès-Verbaux des séances du conseil 1936; UHASD, Rapports de M. Paul Haag, préfet de la Haute Marne et des chefs de service 1936-1937.

commitment to patient care, although in committee meetings he presented his case strongly for improvement to patient quarters.[383] However, in 1940, he left the hospital without leadership, passing the security keys to a senior nurse with instructions to release all patients leave because of the imminent danger from the invading German armies.[384] On his departure, Saint-Dizier was taken over by two successive non-medical directors, retired prefect, M. Rolin, and M. B. Deschenes, from the Ministry of Health in Paris. However, there were tensions between directors and MCs, over rigid institutional practice and the practical aspect of care and treatment, a situation similar to that in Marchant.

In Ainay, although there was much less infrastructure to management than the other target hospitals, there was administrative stability with MD Jacques Vié (born locally) in position from 1931 until 1938. He was then transferred to HP Maison Blanche, Paris. Then, as at Marchant, there was a quick succession of interim MDs, but all were psychiatrists. Firstly, Paul Sivadon who was mobilised in September 1939 and replaced by his deputy, Dr Queron, who in turn was mobilised in April 1940. Sivadon returned from August 1940 until December 1943, when Maurice Leconte took over. The MDs had some help from a Spanish refugee psychiatrist who joined Ainay in January 1939, after fleeing from Franco's regime, but was forced to escape to the Midi when the German army invaded in June 1940.[385] Initially, Dr Madame Beaussart held the position of MC, then a retired MC, Dr Pages served for the remaining three years with Leconte.

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[383] UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939.

[384] UHASD, Séance de la commission 1 septembre 1940; UHASD, Séance du comité de surveillance 22 December 1940.

[385] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier. p. 2; UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte.

3.3 The medical and clinical aspects of the hospital

In institutional practice clinical services played a vital role in patient care. In most HPs, one MC oversaw a group of pavilions which housed male or female patients with a range of mental conditions, according to alienist theories of insanity causation. He, or in rare cases, she held responsibility for daily patient supervision and treatment, the efficient care of patients by the staff and maintaining a beneficial environment in the pavilions. The MC also had clinical responsibility for all medical resources, including the infirmary, pharmacy, and laboratory. However, in many HPs, the latter was run by an Intern or, as at Marchant, by a Sister of the religious orders. She had been in post for almost fifty years.[386] As will be examined later, the infirmary is a good example of the weakness of facilities for acute medical care. During the Occupation the infirmary would be a vital resource in the medical crisis experienced in HPs.

In Marchant, there was continuity of medical care with MC Perret, who had been at Marchant for three decades; he was joined by MC Parde in 1939. They were assisted by two, and sometimes three, Interns.[387] Nevertheless, the state regulatory ratio of one MC to 400 patients was obviously not adhered to: records show the committee only made cursory comments about improving the situation.

In addition to their hospital duties MCs consulted weekly at local *dispensaires* (centres) for the prevention and treatment of TB.[388] Consultations were part of psychiatry's social hygiene services and demonstrate hospital psychiatrists' commitment to public health issues. However, despite this, prefects and committee

[386] UHAGM, Compte moral et administratif année 1936.
[387] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943. Hôpital Psychiatrique de Gérard Marchant département de la Haute Garonne.
[388] ADCA, 1377W 37, Maladies mentales: Bégard, Léhon : opérations (lobotomies), capacités d'hospitalisation, dépenses, organisation des services d'hygiène mentale, recrutement (personnel médical et secondaire) (1940-1950). Note undated from the Prior to the prefect referring to the MCs' contribution to the local TB dispensaries.

members and indeed state authorities in Paris considered many in psychiatry as insular and fractious: exposing professional disunity. [389] Evidence of this characteristic is seen especially in Dide's many issues at Marchant as discussed.

Although certain Orders and communities of Brothers and Sisters are noted as having little association in their asylums with physicians, at Saint-Jean-de-Dieu, this was not so.[390] Since its inception local generalists interested in the brain visited the asylum and from 1860 physicians were resident and employed full-time. Tenure ranged from twenty-five to forty-one years of service and four out of six were honoured with the *Chevalier de la Légion d'Honneur*.[391] In 1931, Victor Godard joined Saint-Jean-de-Dieu as MC, having previously worked as a generalist in Dinan and part-time at Saint-Jean-de-Dieu. He then retrained in psychiatry in Paris and returned to the asylum. Jean Lalanne followed a similar career path arriving in 1936. Both Godard and Lalanne, like other MCs before them, were Catholics and from local medical families, they were well-known and respected in the area for their compassionate attitude towards those in their care.[392] Furthermore, their background and religious beliefs were said to greatly enhance their practice in psychiatry. They demonstrate that religious faith and psychiatry worked side-by-side, a fact that since the anti-clerical movement mainly instigated by certain psychiatrists in Paris and the separation of the Church with the state in 1905 had become questionable and fractious.[393] Indeed, it is possible Godard and Lalanne's

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[389] Gaufey and Bleandonu, Naissance des asiles d'aliénés (Auxerre-Paris).
[390] Olivier Bonnet, 'De l'asile à l'hôpital psychiatrique: La 'Révolution' des années cinquante à l'hôpital Sainte Marie de l'Assomption à Clermont-Ferrand', in *Questions à la 'Révolution Psychiatrique',* ed. by Isabelle von Bueltzingsloewen (Lyon: La Ferme du Vinatier, 2001), pp. 37-54.
[391] UHASJDD, Letter from the prefet to the Prior on the death of Dr Godard and notice in journal Histoire by Dr Antoine Guennoc MC secteur G06. p. 3.
[392] Guillemain, Médecine et religion au XIXe siècle.
[393] *Liens hospitalier: Revue des frères de Saint Jean de Dieu,* 19ème année, (1953), (p. 584); ADCA 109W 69. Letter 1950 from the prefet to the Prior on the death of Dr Godard recommending that for his exceptional service to the community he should be awarded Chevalier d' Honneur. This was granted by the Ministre de la Santé.

attitude and ideas were similar to members of the Société de Saint-Luc, Saint-Côme et Saint-Damien.[394]

In contrast to medical-assistant cover at Marchant, MCs in Saint-Jean-de-Dieu reported they rarely had Interns, 'being too far from Paris and leading medical faculties'.[395] It may well be that provincial hospitals were not well endowed with a younger generation of doctors; Saint-Dizier is a case in point.[396] However, standard regulations of 1:400 MC to patients were mostly followed in Saint-Jean-de-Dieu; for example for the years 1929 to 1939 the average total population was 855 for two MCs.[397]

Husband and wife, Ch. and R. Deffuant, arrived at HP Saint-Dizier or their first clinical appointment as qualified psychiatrists in September 1938.[398] In addition to their inexperience, like the MCs in Saint-Jean-de-Dieu throughout the Occupation, the Deffuants were not supported by the mandatory number of Interns: doctor/patient ratio of 998 patients in 1939 was 1:499.[399] From 1938 Saint-Dizier had one female Intern until the end of 1940, one male Intern for six months in 1941 and one for five months in 1943.[400] Staff numbers were: seventy-eight male and seventy-six female staff for the male and female medical services, thirty-six male and eleven female staff for in-house services and the farm, and ten male and two female personnel for the administrative services: 218 staff for 998 patients.

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[394] Hervé Guillemain,'Les débuts de la médecine catholique en France. La Société médicale Saint-Luc, Saint-Côme et Saint-Damien (1884-1914)', *Revue d'Histoire du XIXe siècle,* 26/27, (2003), 227-58.
[395] UHASJDD, Registre des délibérations de la Commission de surveillance Séance 29 juillet 1937.
[396] UHASJDD, Compte moral 1938 à 1945; G. Demay,'Un siècle d'Assistance psychiatrique en France', *Annales Médico-psychologiques,* I, (1943), 315-36 pp. 322-3).
[397] ADCA, Série 94W 1, Hôpitaux psychiatriques, généralités, rapports annuels, personnel (1930-1955). p. 37; Guillemain, Médecine et religion au XIXe siècle.
[398] UHASD, Rapport administratif et rapport médical pour les années 1938 à 1945 presenté par B. Deschenes directeur et M. et Mme. les docteurs Deffuant; UHASD, Séance de la commission 1 septembre 1940; UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939.
[399] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. p. 73.
[400] UHASD, Séance 24 September 1938 and Séance April 1940.

For MCs so many patients would have had significant influence on the degree of staff supervision and patient care during the Occupation. There is a possibility that, as in Saint-Jean-de-Dieu, there was a geographical aspect to sparsity of doctors, but the low status of psychiatry and the low number of physicians specialising in psychiatry was a national problem.[401] A disparaging comment commonly made by medical counterparts argues there was 'much dead wood' in psychiatry and psychiatrists were only expert at balancing the books and farm management.[402] But with rigid budgets, attention to all features of the HP was a crucial part of management. Farm production was every MD's principal responsibility and as we shall see in later chapters, it was also imperative to the survival of the hospital's patients and staff.[403]

3.4 Nursing personnel

For MDs and MCs, the shortage of nursing personnel was a constant problem. Archival material on nursing and auxiliary staff in the four target hospitals during this era is mostly sparse. As alluded to, insufficient numbers of qualified mental nurses were linked to low status in mental nursing, the social stigma of mental illnesses, and indeed low remuneration. Medical scholarship from the early twentieth-century onwards tells us little about the lives, training, and experiences of psychiatric nurses. There was of course, the original '*Ecole d'infirmier/ infirmières* established in Salpêtrière by Pinel, where mental nursing training was challenging and classes were taken at the end of a long often twelve-hour shift.[404] As discussed, Dide initiated a diploma training course, preferring the title '*infirmier*' over the original term of '*gardien* thereby symbolically promoting and professionalising

[401] UHASJDD, Compte moral 1938 à 1945. p. 28.
[402] Shorter, *From the Era of the Asylum to the Age of Prozac,* p. 68.
[403] Ibid. p. 65; Pierre Pichot,'Die Geschichte der deutschen Psychiatrie aus der Sicht der französischen Psychiater', *Fortschritte der Neurologie-Psychiatrie,* 60, (1992), 317-28.
[404] Leroux Hugon, Poirier, and Ricou, L'histoire de l'Ecole d'infirmiers de la Salpêtrière.

secondary personnel and enhancing the status of caring for mental patients. Even so, courses were poorly attended, although some training was continued in Marchant even during the Occupation.[405] Ainay's MCs gave courses in basic care but few passed the exams – whether out of lack of ability, or interest is not known.[406] Conversely, the Order of Saint-Jean had long provided training to all novices and Brothers attending its schools in Lyon or Paris.[407] For many state HPs, lack of training on administering treatments and therapies was a severe obstacle to patient care.[408]

However, on a broader scale, in Paris, hospital nurse-training reform was championed by alienist and neurologist Désiré-Magloire Bourneville, Abbé Vinq, and surgeon M. Chicandard promoting a new emphasis to mental nursing as did Daumézon in his 1935 medical thesis on deficient asylum nursing and a need for training.[409] Increasing numbers of nursing manuals also raised awareness of the

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[405] UHAGM, Séance du comité de surveillance 19 June 1941.The committee reported that the nursing course was under way for both male and female staff, but there was not a diploma for such. The commissionagreed to finance a course in the Ecole des Beaux Arts and to give prizes for the most successful students.

[406] UHAALC, Rapport Medical Colonie Familiale d'Ainay-le-Château 1938.

[407] Georges Petit, *Revue des établissements et des oeuvres de bienfaisance*, (Paris: Berger-Levrault, 1933), p. 530; Marescaux, Vie et mort dans les hôpitaux psychiatriques.

[408] There was a basic training diploma for general nursing but many supporting staff were not qualified and merely took orders from the small number of trained staff.

[409] D. M. Bourneville, *Rapport sur l'organisation du personnel médical et administratif des asiles d'aliénés présenté à la commission ministérielle chargée d'étudier les réformes que peuvent comporter la législation et les règlements concernant les asiles d'aliénés* (Paris: Publications du Progrès médical, 1885). Georges Daumézon, 'Considérations statistiques sur la situation du personnel infirmier des asiles d'aliénés ', (doctoral thesis, université de Paris, 1935) Michel Bulletrud and Paul Froissart, *Conseils aux infirmiers*, (Paris: Vigot frères, 1910); Joseph Capuron, *Manuel des dames de charité, ou Formules de remèdes faciles à préparer, en faveur des personnes charitables qui soignent les pauvres des villes et des campagnes.. avec... un Abrégé de la saignée. Nouvelle édition revue et augmentée par J. Capuron*, (Paris: Imprimerie de Mme. V. Perronneau, 1816); Abbé Ch. Vincq and Docteur Chicandard, *Manuel des hospitalières et des gardes-malades. Nouvelle édition de 1874 refondue et mise au courant des progrès de la science*, (Paris J. de Gigord, 1926); Daniel Hickey,'To Improve the Training of Nurses in France: The Manuals Published as Teaching Aids, 1775-1895', *Canadian Bulletin of Medical History,* 27, (2010), 163-84; Monval, *Les Frères hospitaliers de Saint Jean de Dieu*; Burdett, *Hospitals and asylums of the world, their origin, history, construction, administration, management, and legislation; with plans of the chief medical institutions accurately drawn to a*

issue of training and patient care, although manuals had been produced by doctors and clergymen since the mid-1700s.[410] However, regardless of manuals and teaching sessions given by MCs on very much an *ad hoc* basis and often with little enthusiasm from the nurses, nursing care was very basic and with severe overcrowding the logistics and practicality of giving adequate care to all was too slim.[411]

In Saint-Dizier and Braqueville, as in many state-run hospitals, members of female Orders were in charge of nursing female patients. Many of these women were qualified in basic nursing care and gave in-house training to assistants but the common narrative claims a large number of them were illiterate or of low intelligence.[412] However, that does not necessarily mean staff were negligent, but further information is difficult principally because nurses were neglected in the history of psychiatry until the 1930s. In some patient dossiers, there is praise for good practice, indicating that nurses were attentive and kind to patients. One mother wrote, 'my son has been so well-looked after by all the staff, thank you', in another case, the father wrote, 'I am grateful for all the kindness', and a patient's

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uniform scale in addition to those of all the hospitals of London in the jubilee year of Queen Victoria's reign, p. 281.

[410] Georges Daumézon, 'Considérations statistiques sur la situation du personnel infirmier des asiles d'aliénés ', (doctoral thesis, université de Paris, 1935); Bulletrud and Froissart, *Conseils aux infirmiers*; Capuron, *Manuel des dames de charité, ou Formules de remèdes faciles à préparer, en faveur des personnes charitables qui soignent les pauvres des villes et des campagnes.. avec... un Abrégé de la saignée. Nouvelle édition revue et augmentée par J. Capuron*; Vincq and Chicandard, *Manuel des hospitalières et des gardes-malades. Nouvelle édition de 1874 refondue et mise au courant des progrès de la science*; Hickey, To Improve the Training of Nurses in France; Monval, *Les Frères hospitaliers de Saint Jean de Dieu*.

[411] André Meylan, 'L'Infirmier des hôpitaux psychiatriques: Recherche sur les origines de la contribution à l'histoire de sa profession', (doctoral thesis, université de Lyon, 1966); A. Meylan,'L'infirmier des hôpitaux psychiatriques', *Information Psychiatrique,* 51, (1975), 715-20; Louis Le Guillant and Lucien Bonnafe,'Editorial du numéro spécial: La condition du malade à l'hôpital psychiatrique', *Esprit,* 197, (1952), 843-69 (p. 853); M. Bonnet,'Editorial du numéro spécial: Le témoignage d'un infirmier', ibid., 815-20.

[412] Daumézon, La situation du personnel infirmier des asiles d'aliénés; Demay, Un siècle d'Assistance psychiatrique en France, pp. 322-3.

friend wrote, 'she is quite happy with you, she says she thinks with your care she is getting better'.[413]

In addition to staff already discussed, there were visiting physicians and surgeons. In Braqueville the latter visited weekly, although his surgery was deemed by a national inspector as 'cramped with poor sterilisation for instruments', a worrying observation for a setting in which surgical procedures were performed. There were also a visiting optician and dentist who, in the opinion of another hospital inspector, had a better-appointed clinic and an assistant, both of whom were reported as competent and hard-working, although as records have not survived the dentist's contribution for patients' oral care is difficult to assess and as we shall see later, patients' oral hygiene left much to be desired and dental problems often left patients in pain or unable to masticate food. [414] In times of plenty, this may not have caused severe problems, but during the Occupation this would prove fatal in many cases. In Ainay, patients benefited from the services of both dentist and surgeon and it is reported that in 1938 dentist Dr Vaissier completed 57 dental interventions and the surgeon Dr Boulay, reduced fractures and diverse operations including amputations, a prostatectomy and repair of rectal prolapse.[415]

3.5 Hospital budget

However, whatever the leadership in the FMHS clinical services and facilities were governed by the budget, one of the MD's most arduous in terms of resources and

[413] Demay, Un siècle d'Assistance psychiatrique en France; UHASJDD, Patient dossier, Monsieur no. 349, age 38, admitted 21 May 1940 died 29 June 1944; UHASJDD, Patient dossier, Monsieur no. 193, age 26 admitted 3 Februray 1938 died 19 January 1944; UHAGM, Patient dossier, Mademoiselle O-M., age 58 admitted 27 February 1936 died 14 September 1943; UHAGM, Patient dossier, Monsieur J.B., age 37 admitted 18 January 1938 died 18 January 1943; UHAGM, Patient dossier, Mademoiselle G-R. age 26 admitted 22 April 1943 discharged 13 December 1943.

[414] Archives Nationales (AN) Paris, F1a 4514-4598, Inspection générale des services administratifs. Rapport: Armand, Inspecteur général des services administratifs (20 novembre 1919).

[415] UHAALC, Rapport de M. le docteur P. Queron Médecin-directeur par intérim au préfet année 1939 Ainay-le-Château. p. 17.

time. As discussed, basic facilities for the mentally ill were mandatory under the 1838 law, but decentralisation of the system made asylum management problematic, as it depended on the vagaries of the local prefect, as well as the hospital committee's perspective on the asylum in terms of its custodial and therapeutic role and indeed their attitude towards the mentally ill. Psychiatrists were critical of the mentality of the some hospital committee members and also members of the *conseil général* who considered a low tariff as criteria of good management.[416] In much of asylum history, sufficient improvement of facilities for treating and caring for patients was thwarted by state parsimony. The budget was fixed according to anticipated income, the daily tariff, and repayments of government loans and outgoings.[417] These included crucial hospital supplies, particularly for food not produced by the farm, as well as textiles and commodities. Most supplies were fixed annually by tender by the prefect and hospital committee. This left little or no latitude for unforeseen situations like salary claims or price increases, such as those that would be experienced during the Occupation.

Many MDs considered the daily tariff insufficient for maintaining, feeding, clothing, and treating patients.[418] The tariff appears based not on practical needs, locality, size or age of the infrastructure of the buildings. In 1939, the daily tariff was 21.90 francs in Marchant, 16.55 francs, in Saint-Dizier, and 15 francs in both Ainay and Saint-Jean-de-Dieu.[419] Private patient charges ranged from 90 to 150 francs in Saint-Jean-de-Dieu, much more than in Marchant, where the range was 49 to 60 francs, or in Saint-Dizier, where it was 19.15 to 27.55 francs, reflecting the importance of private patients for Saint-Jean-de-Dieu.[420] In the 1930s, private

[416] Le Guillant and Bonnafe, La condition du malade à l'hôpital psychiatrique, p. 855.
[417] ADHG, Série X272, Projet de budget Rapport du Budget 1932. Séance de la Commission de surveillance (10 mai 1910).
[418] ADHG, Série X308, Rapport de Dide sur le budget primitif de l'exercice 1935; UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.
[419] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. p. 14.
[420] UHASJDD, Compte moral 1938 à 1945. pp. 1, 11-12.

payers were up around 30% (275 out of 900) in Saint-Jean-de-Dieu, in GM, 197 out of 1500, Saint-Dizier, 145 out of 900, and Ainay had less than ten private patients dwindling to nothing in the occupation years. Given the large numbers of privately paying patients in Saint-Jean-de-Dieu, the Prior could work with a considerably larger income than GM, although accountability to the *Superieur général* was no less imperative than for state authorities.

When analysing the target hospitals and their administration during the 1930s, the budget must be contextualised within the economic decline following the First World War. The Depression, devaluation of the franc, as well as the growing influence of the *Syndicats* on working conditions all impinged on finance for mental health welfare.[421] The government's attempts to cut back on public expenditure in the 1930s severely affected psychiatric hospitals. Welfare for vulnerable classes was low on the list of priorities. As annual administrative reports illustrate, welfare was allocated a minimal budget with no long-term planning or attempt to encourage better quality staff with viable salaries.[422] Dide's reports reflect many administrative and medical problems with the state's inadequate financial contribution to patient welfare in the 1930s. His comments in his 1938 report illustrate why so many hospitals were still considered inadequate: 'Due to lack of public funds we are unable to do any major works. There is still much to be done. Certain quarters do not conform to the needs of patients or modern hygiene levels'.[423] This was the state of the asylum on the brink of war in 1939.

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[421] Julian Jackson, *The Politics of Depression in France, 1932-1936*, (Cambridge: Cambridge University Press, 1985).

[422] Thomas, Open psychiatric services, pp. 136-7; UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[423] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.Rapport pour l'année 1937 au préfet par le docteur Dide; AN Paris F1a 4570. Rapport: M. Sarraz-Bournet.Very little had changed since Bournet reported that the female quarters 'transforment l'asile au simple néfaste garderie', no running water, the night use of commodes in the middle of corridors, little done since 1924'. This was not only an issue for asylums in France See

Similar levels of tariffs for Ainay and Saint-Jean-de-Dieu are interesting considering the former was established as a less expensive site of provision for the insane and the latter enjoyed the large infrastructure of a psychiatric institution. The authorities considered clerical establishments inexpensive, as they could supplement a low tariff with charitable donations. Indeed, Saint-Jean-de-Dieu was able to call upon local donors and endowments, its network of charitable establishments, its banks and the Mother House in Lyon.[424] During the Occupation, the Prior was 'forced to ask for advances' from its bank and to rely on the goodwill of suppliers in delaying payments while salary increases for ancillary staff were also deferred.[425] Given the charitable status of the Order, a low *prix de jour* was accepted, as high fees paid by private patients subsidised those of the indigents. State institutions had no recourse to such resources, which caused severe hardship for MDs during the GO.[426]

3.6 CGT (Confédération générale du travail)

In the context of budgetary constraints, low tariffs affected staff salaries.[427] Traditionally, working conditions and remuneration for state psychiatric hospital workers were poor and in large part a reason why there was little recruitment in nursing and a movement of staff to better paid institutions. However, during the interwar years, workers' interests were taken up by syndicates such as the CGT (*Confédération générale du travail*). Nationally, the CGT had been instrumental in expanding the law of the eight-hour working day and paid holidays in certain

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Steven Cherry, *Mental Health Care in Modern England: The Norfolk Lunatic Asylum/St. Andrew's Hospital C. 1810-1998*, (Woodbridge Suffolk: Boydell, 2003).

[424] Jean-Pierre Gutton,'Enfermement et charité dans la France de l'Ancien Regime', *Histoire, economie et societe,* 10, (1991), 353-58 (p. 355).

[425] UHASJDD, Compte moral 1938 à 1945. pp. 1-2.

[426] Marescaux, Vie et mort dans les hôpitaux psychiatriques; UHASJDD, Compte moral 1938 à 1945.

[427] Meylan, L'Infirmier des hôpitaux psychiatriques, p. 59.

target hospitals. Union members had slowly established themselves in large mental hospitals, including Marchant and Saint-Dizier.[428]

However, a case at Saint-Dizier in 1937 highlights the two-edged sword of the CGT's involvement.[429] At a hospital committee monthly meeting the question of adherence to the new eight-hour working day law was raised by a union member. To conform to the new law, the committee suggested the hospital reduce staff working-hours by increasing meal breaks meaning the daily tariff need not be raised to pay for increased wages.[430] The union representative was not happy with the committee's idea of circumventing salary increases. Indeed, neither was the MC who was quick to point out that if the committee's suggestion were implemented it would impinge on patient care as staff would be away from their duties for longer and covering for such absences would be difficult in light of the already insufficient number of staff.[431] In this instance, the prefect intervened with an offer to increase the daily tariff to cover increased staff costs. The stance of the prefect is interesting considering the general perception of officials' attitudes suggest they were more interested in maintaining the budget than in patient care or workers' rights. This case, points to the diverse attitudes of officials and the breadth of experiences in HPs.

In Saint-Jean-de-Dieu, there is no mention of union confrontation or salary demands, primarily because clerical staff only received a small stipend in addition to free room and board. It is probable that the CGT were not involved as the Prior encouraged lay staff to subscribe to a *Syndicat chrétien*.[432] Lay staff were strongly

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[428] UHAGM, Rapports et délibérations. Conseil général de la Haute-Garonne 1932. Rapport du M. Armand Guillon Préfet du département, Deuxième session de 1932.
[429] UHASD, Séance de 29 juillet 1937; ADHM, Série 1X 292, Administration: prix de journée 1929-1948.
[430] UHAGM, Rapports et délibérations. Conseil général de la Haute-Garonne 1932. Rapport du M. Armand Guillon Préfet du département, Deuxième session de 1932.
[431] UHASD, Séance de 29 juillet 1937.
[432] Frère Lutz, p. 52.

influenced by the close communication and sense of duty established by the Order which extended to working without anticipated increases during the Occupation which the Prior stated was due to high increases in the cost of living and the low daily tariff given by the state.[433]

3.7 Efforts to improve patient facilities

However, despite wrangling over hospital finances –over salaries with the unions and the tariff there is evidence of a pursuit of qualitative improvements for patient welfare in the target hospitals. This occurred through locating funding within the budget or negotiating with the prefect for loans however meagre for modernisation. In the case of Saint-Jean-de-Dieu, donations and loans were requested from the Order's Mother Houses.[434]

In 1933, the prefect wrote in the *Livre de témoignage*, 'the asylum can be cited as a model asylum', he had just visited Saint-Jean-de-Dieu to view the upgrading of the kitchens with advanced cooking equipment and refrigeration units for preserving most of the farm's produce, new bathing rooms, refectories, new farm outbuildings and workshops, and newly built quarters for privately funded patients, the latter allowed more private patients to be admitted thus increasing revenue for the hospital.[435] Providentially, in 1939, the hospital had just completed extending the infirmary. It was well equipped and had new special rubberised mattresses for incontinent patients. In psychiatry, in the 1930s, this reflected cutting-edge nursing. In most hospitals, general and psychiatric, straw or wool-filled mattresses were customary, with openings in the centre to allow bodily fluids to drain into a

[433] UHASJDD, Compte moral 1938 à 1945. p. 2; Marescaux, Vie et mort dans les hôpitaux psychiatriques; Frère Lutz.
[434] Frère Lutz, p. 49.
[435] UHASJDD, Compte moral 1938 à 1945; Monval, *Les Frères hospitaliers de Saint Jean de Dieu,* p. 182; UHASJDD, Livre de temoinage.The prefect's visit in July 1933.

chamber-pot under the bed.[436] Furthermore, reacting to the needs of the patients and staff, the perennial problem of water at Dinan-Léhon was addressed and new reservoirs were built.[437] Additional aspects of Saint-Jean-de-Dieu's modernisation efforts included improved working conditions for both staff and patient workers in the laundry which had up-to-the-minute machines.[438]An old flour mill deemed impractical was replaced with a new one that could produce flour in the large quantities required for bread and pastries consumed by patients and staff. Conversely, Braqueville's flour mill was disbanded due to disrepair and not replaced. The HP was then reliant on external suppliers, a major setback during the GO. In fact, Saint-Jean-de-Dieu Dinan-Léhon was mentioned in the *Alieniste* medical journal as having recently installed, Nausica washing machines.[439]

At Marchant, under Dide's leadership, certain maintenance and upgrading of facilities for staff and patients had also taken place during the 1930s. This included catering renovation, installation of central heating (some parts of the system ran on oil and others, supplying certain administration buildings and some patient-quarters, on solid fuel), improvements to farm buildings and workshops, and sanitary facilities. The latter enhanced patient dignity with modern WCs, although for a limited number of patients.[440] One modernising project demonstrates the timescale and man-hours required for turning plans into reality in a HP. It is unsurprising that major hospital works were slow in the planning process let alone in their realisation.

In 1929, a plan to upgrade patients' antiquated 'night commodes' with plumbed-in WCs was placed before the prefect who enlisted the professional advice of the

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[436] UHASJDD, Compte moral 1938 à 1945.
[437] Ibid.; Frère Lutz.
[438] Unknown,'Advertisement', *Aliéniste français,* 3, (1940), 1-140.
[439] Ibid.
[440] UHAGM, Séance de la commission 14 mai 1929.

departmental architect.[441] Commodes had to be emptied daily by patients into courtyard communal drains. Modernising sanitation facilities might appear a simple measure, but there was protracted correspondence between the departmental architect and the prefect.[442] The architect submitted numerous questions before he could progress the plans: Would patients use WCs alone or be accompanied by staff? Would the WC controls be manual or automatic? If the latter, how often would they be employed, were they to be used by patients and or staff? For hand basins, should taps open individually or all at the same time, and would the procedure in quarters for the severely manic or mal-adjusted be different? Should WCs be visible to staff at all times or should there be doors? [443]

As might be expected in a custodial institution, the majority of correspondence focused on security rather than issues of patient privacy and dignity. Viewed from the perspective of the MCs, this was a frustrating and time-consuming process, torn as they were between commitment to safety and privacy of their patients. Upgrading was essential but safety measures and dignity were not easily reconciled. The significance of this example is in the dual role of the asylum, custodial and therapeutic, and psychiatrists' responsibilities divided between security issues in keeping society safe from insane criminals and to treat and cure mental illness. For the most part patients were not criminally insane needing care and treatment but were grouped together due to the overarching custodial nature of the asylum. Nevertheless, at Marchant a resolution was eventually found that combined security with the most pressing issue of patients' privacy and dignity: WCs were to be installed with discreet waist-high screens.

However, illustrating the pitfalls of improving outmoded facilities, for this particular modernisation project the hospital faced another dilemma. The hospital sewage

[441] Ibid.
[442] Majerus, La baignoire, le lit et la porte.
[443] Jacob, La maladie mentale en Haute Garonne, pp. 696-7.

system needed improvement in order to carry additional sewage, but the Toulouse sewage system, twenty years in the making, was still to be completed by 1939.[444] By 1940, almost two thirds of communes lacked adequate supplies of drinking water and outhouses were in common use throughout the countryside.

Saint-Dizier also made improvements in the 1930s. Like Marchant, central heating was installed in certain patient and staff quarters, electricity installed in some areas, the laundry and kitchens were enlarged with modern equipment, and WCs were constructed in certain male quarters. However, such a catalogue of improvements masks the true conditions in many HPs. For instance, in Saint-Dizier in 1936, there were 550 male patients and not all would have had access to the newly installed WCs.[445] Therefore it can be reasoned that while sanitary conditions improved for some patients, the vast majority of male patients in other pavilions lived in archaic conditions that were far from hygienic.

In analysing the improvements carried out in the target hospitals, one significant factor arises: there was neither long-term planning nor apart from Saint-Jean-de-Dieu new construction to cope with continual rising patient numbers, instead works were piecemeal and renewals constrained by tight budgetary limits. Overcrowding exacerbated poor facilities and some pavilions held over 50% more patients than was intended.

Demonstrating variations of state officials' actions and attitude, on one of his visits to Braqueville, an inspector was pedantic regarding patients' meals commenting that the menu and quantity and quality were good, but he thought patients were having less fish than they should.[446] On the other hand, the prefect of Saint-Dizier

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[444] Jean Estèbe, *Toulouse 1940-1944*, (Toulouse: Perrin, 1996), p. 17; Ramsey, Public Health in France, p. 91.
[445] UHASD, Registre des délibérations de la commission de surveillance (1935-1950) Séance de 18 septembre 1943.
[446] AN Paris F1a 4570. Rapport: M. Sarraz-Bournet.

arranged a significant state loan for a new and urgently needed 72-bed infirmary.[447] Unfortunately for staff and patients in Saint-Dizier the planned infirmary was shelved due to the advent of war.[448] In the target hospitals, infirmary beds were critical for nursing acute medical cases during the Occupation.

The infrastructure at Ainay, the newest of the target hospitals, was small in comparison, but the administrative buildings had been modernised and the *salle de séjour,* built for only 300, by 1930 was expanded to 700.[449] However, Ainay was affected by France entering the war, as was Saint-Dizier. Works on expanding the infirmary were discontinued in 1939, leaving few facilities for treating acute medical cases or nursing care. As previously discussed, lodging standards for patients and their dietary requirements were regulated and noted in the *Cahiers* de *visite* (Visitors' Notebook). However, no *Cahiers* were found in the hospital archives, making it difficult to assess to what extent patients were more advantaged than those institutionalised in the other target hospitals. Reports indicate, however, that efforts had been made to upgrade homes since the foundation of the *colonie* in 1902. This should be considered in light of inner cities conditions, where many patients previously lived, and where housing and sanitation were far from adequate before wartime bombing and destruction.[450] Furthermore, standards of the *nourriciers'* lodgings may even have been better in terms of facilities and hygiene than those left behind by patients previously housed in the long-outdated asylums of Paris.[451]

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[447] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. p. 2; UHASD, Rapport général du service médical. Service femmes année 1939.
[448] UHASD, Séance de la commission 1 septembre 1940.
[449] UHAALC, Colonie familiale d'Ainay-le-Château année 1938 Rapport par le docteur P. Sivadon MD. p. 20.
[450] UHAALC, Rapport de M. le Dr. Améline, mèdecin-directeur de la Colonie année 1921.
[451] UHASD, Séance 24 September 1938 and Séance April 1940; Toulouse, Genil, and Targowla, L'Organisation du service libre de prophylaxie mentale à l'asile Sainte-Anne (27 March 1922 meeting of the Société médico-psychologique).These alienists campaigned for better conditions in the Seine asylums; Sérieux, *L'Internat des asiles d'aliénés de la Seine*.

3.8 Vignette

Having analysed hospital practice from an administrative and clinical perspective, this chapter concludes with a view of the daily life of carers and cared-for based on both official documents, hospital regulations and patient dossiers, the latter offering a more human touch to life in the asylum. The vignette offers evidence of normalcy and routine, demonstrates the difficulties faced by patients and nursing staff, reflects the stresses and strains encountered in harsh conditions, and highlights institutional flaws as well as support from those outside the HP.

3.8.1 Daily routine

Daily routine was, by dint of the type of institution, run according to the 1838 law governing administrative, clinical, and patient-welfare and the day for hospital staff and patients began at 6am.[452] Staff supervised morning ablutions with care, as unpredictable patients could use chamber pots or other items as offensive weapons. Even the beds were fixed to the floor to prevent them from being moved or thrown and damaging person or property.[453] The day was regulated by the tolling of the church or chapel bell, a constant reminder of religious faith and duty, and a principal component of asylum life. For religious and lay staff, and patients who wished to partake, mass and prayers were held mornings and evenings in the hospital chapel.[454] In the living areas, the atmosphere would, by default, reflect the inmates and their mental conditions – pandemonium and calm, epileptic crises and mute submissiveness.

[452] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier,* p. 16 Section XVI Article 139.
[453] Ibid. p. 18 Section XVIII Article 150; Jones, The Treatment of the Insane in Montpellier, p. 387.
[454] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu*.

Physically-able patients were often up and dressed in their hospital-supplied uniforms, in winter dressed only marginally warmer than summer regardless of severe weather conditions.[455] Some relatives were aware of this, asking: 'Are the staff wrapping him up warmly when he goes out? Would you like me to send you some warm clothes?' or 'Can I send my brother some socks?'[456] Although the small items and the thought were probably not sufficient to keep out the cold, relatives cared enough to write and to offer to do something. Even those confined to their beds were not usually provided with extra bed covers or blankets when temperatures fell dramatically, chiefly due to the inflexibility of the hospital's administrative routine and lack of awareness of the effects of cold weather on patients. This was especially the case when nursing duties were many and too few staff to carry them out.

Patients certified by the MC as fit for manual labour or work in the workshops were also up and out at first light. Male patients were involved in farming, husbandry or work in the hospital service workshops, women performed light domestic duties such as sewing, dressmaking, laundering and ironing. 'When her condition allows Madame S. enjoys working in the sewing rooms and is doing well' stated the MC in a letter to her mother. [457] Madame A., from time to time did little jobs in the laundry and Monsieur R. T., stated, 'When doctor thinks I am ready, I would like to work again doing a job in the kitchens'.[458] This comment might be construed as an

[455] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*.

[456] UHAGM, Patient dossier, Monsieur L. P., age 61 admitted 12 October 1938 died 27 September 1940. Letter 28 April 1940 from sister to MC; UHAGM, Patient dossier Monsieur Paul L. age 28 admitted 30 September 1936 died 1 September 1940.

[457] UHAGM, Patient dossier, Madame S. B., age 19, admitted 20 april 1943 discharged 19 November 1943. Letter from MC to mother 25 October 1943.

[458] UHAGM, Patient dossier, Madame A., G. age 59 admitted 20 April 1943 died 15 September 1943; UHAGM, Patient dossier, Monsieur R. T., age 25 admitted 20 September 1942 died 4 June 1943.

effort to please the doctor but with all other letters in the dossiers it is more likely the patient was keen to be useful.

Traditionally, in all hospitals, there was a large network of workshops for general maintenance and day-to-day services. In-house services were vital for everyday maintenance and in many cases, a source of occupational therapy for patients. Indeed, if patients were not already working in these trades before admission, they were taught crafts and many worked for years with little or no supervision and often went on to teach new patients.[459] At Ainay, as in the three closed target hospitals, many lodgers worked on the land or with the *nourriciers* on their smallholdings. Undoubtedly, the 'social utility' and acceptance of lodgers was linked to their value as workers, even for those *nourriciers* who wanted 'company'.[460] This is especially noticeable after the First World War, with an increased need for workers on the smallholdings to replace the loss of local men. There is little documented evidence of complaints by patients or relatives regarding employment in such jobs.[461] Many worked out of choice and *travailleurs* in closed hospitals had considerable liberty around the hospital and grounds.[462] When asked why they worked, patients' replies varied: some were happy to earn pocket money to buy new clothes, others to pay for travel to see their family, and another, 'to be alone in the fields'. Indeed, during the harvest season, some patients collected a substatial sum of 'a few hundred francs'.[463] For patients and staff remaining in closed hospitals, daily duties in the pavilions consisted of

[459] UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939.
[460] Jodelet, *Madness and Social Representations,* p. 91.
[461] Vié, *Le placement familial* p. 141.
[462] UHAGM, Letter 18 November 1941 from the director to the prefect. p. 4.Travailleurs have more liberty than other patients, they are less supervised and often are permitted to leave the hospital grounds.
[463] Vié, *Le placement familial* pp. 106, 39; Interview with Madame M. at Ainay.

sweeping, with brushes made by the patients, and waxing the refectory and dormitory, often holding many more than the maximum of forty patients.

Although there were rules that the refectory and the *salle de séjour* should be separate facilities in Marchant in the 1930s due to large numbers of extra patients only one room was used for meals and leisure time.[464] Other duties consisted of washing and disinfecting utensils, a fundamental policy of alienists as a prerequisite for promoting good hygiene. There were also many nursing and medical treatments to be carried out including, weekly baths, beard-trimming, and monthly haircuts. Although there were those who were not too keen on haircuts, 'Dear doctor, can you please have a word with the coiffeur and ask him not to cut my hair too short as I suffer from a cold head and also to be a little more careful next time as he nicked my ear'.[465]

Notes from Mlle G.R. and Monsieur F.S.'s dossiers offer examples of the staff's demanding and dangerous duties, of the constant sense of having to be on guard in light of ever-changing patient behaviour.[466] In one case, a patient was, 'found throwing and breaking everything in sight and menacing the staff'.[467] In another case the MC wrote, 'Mlle M.G's mother cannot control her aggressive periods, during her hallucinations she even ransacked the Nun's offices'.[468] In addition, Monsieur J-M., aged 19, a severe epileptic, 'refuses to eat on his own', and was force-fed by staff resulting, understandably, in violent reactions towards them.[469]

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[464] UHAGM, Letter 18 November 1941 from the director to the prefect. p. 5.The director bemoaned the fact that overcorwding meant patients' facilities were not adequate.
[465] UHAGM, Patient dossier, Monsieur J. F. age 49 admitted 6 December 1935 died 15 September 1940.
[466] UHAGM, Patient dossier, Monsieur F. S. age 19 admitted 22 May 1943 discharged 2 December 1943.
[467] UHAGM, Patient dossier, Mademoiselle G-R. age 26 admitted 22 April 1943 discharged 13 December 1943.
[468] UHAGM, Patient dossier, Mademoiselle M-G. age 31 admitted 8 June 1940 died 23 August 1940.
[469] UHAGM, Patient dossier, Monsieur J. M. age 19 admitted 10 July 1937 died 12 October 1942.

Threatening behaviour towards other patients or staff was treated by camisoling, considered a last resort and the only effective method of constraint by psychiatrists, but viewed as inhumane by many. However, this perception might be changed when reading one MC's explanatory note illustrating the reasoning behind such a treatment for Madame A.G.: 'Again very agitated, broke more tiles today to use as missiles against the staff. Prescribed Bromide and a straight-jacket to avoid further self-harm and harm to others'.[470] It is probable that patients were placed in straight-jackets indiscriminately and that patient violence was responded to violently but such actions were strictly against hospital rules.[471] There were severe consequences for abuse to patients, but that would also depend on whether abuse by a member of staff was witnessed. In addition to dangerous or potentially dangerous patients, there were others who needed little supervision, many of them institutionalised for so long they were entrusted with assisting in cleaning duties and aiding other patients unable to help themselves.[472]

Life for many staff members who nursed such patients was undoubtedly harsh, unremitting and frequently life threatening. From some patient dossiers and oral histories, we can see a clear indication of the hazards of nursing the mentally ill in the 1930s. Consider the case of a Brother-chef, alone in the kitchens with a few patient helpers: three or four of them discuss the quality of the soup. 'This soup seems a little bland, how about we put the Brother in the soup to make it better tasting?' On overhearing the conversation, the Brother concurs that the soup could do with improving, but adds that his dirty habit would make it taste unpleasant, so he would go and change and return in a clean one. The patients agree -

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[470] UHAGM, Patient dossier, Madame A- G. age 59 admitted 8 July 1939 died 15 September 1943.
[471] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier,* p. 14 Section XIV Article 115.
[472] UHAGM, Patient dossier, Monsieur F. S. age 19 admitted 22 May 1943 discharged 2 December 1943.

unsurprisingly he did not return.[473] Another 'victim' of patients was MC Lafage in Braqueville. During his morning clinical round, he was shot at by a female patient, the bullet hitting his glasses and piercing his shoulder. In the ensuing report, it was noted that staff were slow to react, and the patient went back to her table and finished her soup before handing over the gun. In the administrative review of the event, it remained 'a mystery' where the gun came from.[474] Lafage was not the only victim of a violent patient; in 1880 MD, Gérard Marchant had been fatally shot by one of his patients and in 1908 the MC of Asile Villejuif, Dr Marie (founder of Ainay *colonie*) survived a narrow miss when shot by a violent patient.[475]

In Saint-Jean-de-Dieu, in 1936, over 250 patients were classified as *gâteux*.[476] This meant they had 'lost not only their mental and physical facilities but even the instinct of cleanliness that an animal possesses', writes Abbé H., a well-respected member of the Order of Saint-Jean-de-Dieu.[477] In present-day terms these would be patients in various degrees of paralysis, or severe dementia, experiencing loss of bodily function, or patients in a 'vegetative state'.[478] In many HPs there were patients with mental conditions that meant they were childlike in their mentality and incapable of doing anything for themselves without supervision.[479]

The belief that the patient is a child of God inherent in the Order of Saint-Jean is in sharp contrast to certain notions that the chronically ill were a burden on society

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[473] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu,* p. 100.
[474] Archives Nationales (AN) Paris, F1a 4553, Inspection générale des services administratifs. Rapport: Roger Capart, Inspecteur général des services administratifs (11 mars 1929).
[475] Unknown,'A l'Asile de Villejuif: Le docteur Marie blessé par un fou', *Le Petit Parisien*, (30 June 1908), Front page.
[476] These patients were classified as senile, elderly, idiots, debilitated.
[477] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu,* p. 117.
[478] Ralf Jox, *Vegetative State: A Paradigmatic Problem of Modern Societies : Medical, Ethical, Legal and Social Perspectives on Chronic Disorders of Consciousness*, (Münster: Verlag, 2012).
[479] UHASJDD, Patient dossier, Monsieur Le H., admitted 14 October 1938 died 28 January 1939. Letter 30 October 1938, 'He cannot do anthing for himself he is like a child. I am grateful for your caring of him'; UHASJDD, Patient dossier Monsieur C. age 28 admitted 11 November 1938 died 23 September 1940. Letter 29 November 1938 from wife to MC, 'The brothers have devotedly looked after him and treated him as their son'.

and HP funding.[480] In Saint-Jean-de-Dieu, the staff accepted that, 'the duty and devotion necessary for caring for such patients is that of a mother for her child'. Again, Abbé H. provides the example of a young Brother who, on being told, 'You really do have a very hard and difficult life and a very sad one', replied, 'Hard, yes, but sad, no. Nothing that one does for the love of God is sad'. [481]

3.8.2 Clinical rounds

After breakfast at 8.30 am, in traditional Pinelian fashion, the MC made his daily round with a retinue of Intern and pavilion *surveillant*. It was her/his responsibility to identify all those in need of medical attention and to inform the MC. The patients' current mental and physical state, recorded prescribed treatment or medications and nurses' daily or weekly observations were scrutinised**.** Later, the MC would visit patients in the infirmary. They were examined and prescribed various treatments or medications. The more dangerous and violent patients were visited in their locked cells. The only treatment available for these patients was isolation in insalubrious cells, sedatives or straight-jackets.[482]

3.8.3 Mealtimes

For most patients, meals were the mainstay of each day. Meals were timed according to the season, with lunch taken at 11 am during winter and at midday in

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[480] Albert Beguin,'Editorial du numéro spécial: Misère de la psychiatrie - Qui est fou?', *Esprit,* 197, (1952), 777-88 (p. 782); Louis Le Guillant and Lucien Bonnafe,'Editorial du numéro spécial: La condition du malade à l'hôpital psychiatrique', ibid., 843-69 (p. 848); Odier, La surmortalité des asiles d'aliénés français durant la Seconde Guerre mondiale (1940-1945).Odier notes the case of E. Herriot radical mayor of the Lyon who stated it was better to pay for the welfare of a child for one year than a patient in Vinatier; Olivier Bonnet and Claude Quétel,'La surmortalité asilaire en France pendant l'Occupation', *Nervure,* 4, (1991), 22-32 (p. 32.).

[481] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu,* p. 117.

[482] UHAGM, Patient dossier, Madame A., G. age 59 admitted 20 April 1943 died 15 September 1943. Note from MC 3 September 1943: Patient violent throwing tiles and despite Bromide still agressive, straightjackt the only method to protect patient and others.

summer, reflecting the importance of agricultural work and production for the HP. The good quality of food was principally due to products from the hospitals' vast farmlands and cattle herds. In Marchant, under the expertise of the Chief Baker, worker-patients produced bread that even made a commercial profit.[483] Patients who were fit collected their food from the main kitchens and those in the infirmary or in bed in their pavilion were given or fed their meals by nursing staff. This in itself was hazardous at times. Patients returned to a communal room and often it would be difficult taking meals due to too many patients crowding in one room.[484] Staff were officially required to eat before or after patients. In certain pavilions, crockery was used, but in view of erratic violence or self-harm in other pavilions it was often replaced by metal utensils.[485]

3.8.4 A limited medical armoury

Although not necessarily a flaw in psychiatry practice, there was little in the psychiatrist's medical armoury for insanity and treatment of its many causes. There is very little documentation from the pharmacy in the target hospitals, but doctor's reports and their notes to relatives build a picture of the limited array of effective medications for mental illnesses and of the preferred means of treatment of MCs in the target hospitals in the 1930s. Most medication was given to treat symptoms rather than causes: barbiturates and Laudanum against agitation and violent behaviour, malaria therapy to produce high fevers in the treatment of syphilis,

[483] UHAGM, Séance du comité de surveillance 21 janvier 1939.
[484] UHASD, Séance du comité de surveillance 22 December 1940.On a visit to Saint-Dizier a hospital inspector commented on the large number of patients in the salle de séjour- the director suggested a remedy was to discharge all the prostitutes.
[485] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*.

insulin to induce coma for severe depression.[486] One mother explains about her son's treatment, 'A priest at Abbaye Kuffles enveloped him for six months in a moist sheet saturated in salt and had his feet in a basin of cold water, but nothing helped. His blood tests were all negative. He has also had violet injections and is taking Gardenal medicine.[487]

Lack of efficacy of treatment and therapies gave rise to increasing numbers of patients remaining in the HP for lack of improvement. Psychiatrists' personal opinions such as poor outcomes and optimism for the only available alternative therapy are reflected in letters to patients' families. One MC wrote in answer to questions posed by the patient's sister regarding the use of Cardiazol injections. 'Your brother still has the symptoms as when you saw him in Paris. The treatment I propose consists of a chemical product that for effect will produce a shock to his whole system. This treatment unfortunately does not always have success but at the present it is one of the only means to treat his psychosis. This treatment lasts for three weeks to a month and I will keep you informed of how it goes'.[488] MCs at both Saint-Jean-de-Dieu and Marchant used injections of Cardiazol and Stovarsol as therapy for depression.[489] In 1931, Dide was successful in obtaining a new innovative Thermaux machine, to induce high fevers, 'with no reported fatalities during trials at Braqueville', as he reported to the committee.[490] In 1941, Saint-Jean-de-Dieu acquired an electroconvulsive therapy machine. The MC comments

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[486] M. Karamanou, I. Liappas, Ch. Antoniou, G. Androutsos, and E. Lykouras,'Julius Wagner-Jauregg (1857-1940): Introducing fever therapy in the treatment of neurosyphilis', *Psychiatriki,* 24, (2013), 208-12.

[487] UHASJDD, Patient dossier Child 0533 age 14 admitted 14 December 1933 died 16 November 1943.

[488] UHAGM, Patient dossier Monsieur A. M. admitted 14 October 1938 died 23 August 1940.Letter dated 12 November 1938 from the MC to the patient's sister.

[489] UHASJDD, Compte moral 1938 à 1945. p. 29; Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon, p. 100; UHAGM, Patient dossier Monsieur A. M. admitted 14 October 1938 died 23 August 1940; UHAGM, Patient dossier Monsieur P. R. admitted 28 April 1939.

[490] UHAGM, Rapports et délibérations. Conseil général de la Haute-Garonne 1932. Rapport du M. Armand Guillon Préfet du département, Deuxième session de 1932; ADHM, Série X271, Aménagement des cuisines; réorganisation d'une buanderie; installation du chauffage central.

that, 'such equipment will offer more patients the possibility of some improvement'.[491] Water was used in large quantities for therapeutic purposes with special rooms equipped with baths. While such treatments were considered barbaric and inhumane at the time, water therapy was considered soothing and beneficial to certain psychotic states although facilities in which they were practised were antiquated in the 1930s.

3.8.5 Evenings and leisure time

After the evening meal, if time or staffing permitted, there was a period of relaxation consisting of watching films, playing billiards or cards, reading or walking in the courtyards or listening to music.[492] With staff, patients in Ainay organised a small theatre company and gave performances to patients and local residents.[493] Some hospitals like Marchant had a small shop in which 'luxuries' such as '*bonbons*', tobacco and writing materials could be bought with wages earnt or money orders sent by relatives.[494] 'I am sending a mandate for my brother to buy tobacco at the boutique'.[495]

3.8.6 Night-time

Night-time in dormitories was onerous for staff and patients. Darkness often provoked fear, elicited screams and cries, moans and nightmares among some patients, and the demented wanderings of others. The possibility of escapes under

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[491] UHASJDD, Compte moral 1938 à 1945. p. 29.
[492] Abbé H., *Notice historique sur l'établissement des frères de Saint-Jean-de-Dieu,* p. 108; UHAALC, Rapport Medical Colonie Familiale d'Ainay-le-Château 1938. p. 15; Micale, The Salpêtrière in the Age of Charcot: An Institutional Perspective on Medical History in the Late Nineteenth Century, p. 718.
[493] UHAALC, Rapport Medical Colonie Familiale d'Ainay-le-Château 1938. p. 15; Vié and Quéron, Productions artistiques des pensionnaires.
[494] UHAGM, Séance de la commission 14 mai 1929.
[495] UHAGM, Patient dossier, Monsieur F. S. age 19 admitted 22 May 1943 discharged 2 December 1943; UHASJDD, Patient dossier, Monsieur B. admitted 17 July 1938 - died 3 October 1939.

cover of darkness was a serious risk with legal ramifications, written reports, interviews with the committee and often fines for staff involved.[496] Night commodes were another danger: they functioned as easily-thrown projectiles, making night-duty perilous at the very least.[497]

3.8.7 Contact with the outside world

Weekends were a time for visits from loved ones; meetings usually took place in the administration buildings or on walks in the hospital grounds. There was also the possibility of home-visits for certain patients. Relatives would request to visit or to have the patient visit home. Requests were granted by the MC if the patient's mental and physical condition were satisfactory, or refused, with a reason provided. For example, a mother wrote to the MC asking about her son's condition and whether she could take him out if the weather was good and this is sanctioned. On another occasion when she asks he states, 'He can go out on Sunday but under your strict control and responsibility. However, in an indication of deterioration in his condition three months later her request is denied, 'your son is catatonic at present so it would be prudent not to take him out for his walks at this time.'[498] Another example is of a MC asking for a daughter to visit, 'Your mother's mental condition remains the same but she is getting weaker day by day, it would be good if you visited'.[499] These two examples indicate that the MCs were conscientious in their duties and concerned about the welfare of the patients.

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[496] UHAGM, Patient dossier, Monsieur L., W. typed report on his escape from his dormitory after 20.00hrs on 20 November 1939. He disappeared over night although there were four nurses on duty: they were all interviewed and had to produce a detailed written report for the commission.

[497] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*.Section XVIII articles 150-159.
UHAGM, Patient dossier, Monsieur B.-J. D. age 42 admitted 5 March 1913 died 21 September 1943.

[498] UHAGM, Patient dossier Monsieur L. B. age 42 admitted 31 August 1940 died 17 September 1940.

[499] UHAGM, Patient dossier Madame A., M. age 60 admitted 16 November 1938 died 4 September 1940. Letter 6 June 1940 from MC to mother.

3.9 Conclusion

The Occupation revealed that the FMHS was fatally unprepared in matters of institutional administration, professional practice and facilities of care and welfare for the mentally ill. This chapter has established that although the four target hospitals functioned within the framework of the asylum law of 1838 there were deep-seated elements to institutional administration and professional practice that were significant in their differences and detrimental to the lives of many inpatients. The examination of the leadership in the four target hospitals highlights a variation in the style of management, the character of the MD, and his approach to asylum care. In Marchant, as a state-run HP, all aspects of hospital practice were governed by the administration of the MD, within a medico-institutional framework but under the governance of state officials. Conversely, the Prior's position in Saint-Jean-de-Dieu, also under state governance, was, although primarily administrative, less management-oriented than Dide's, and the Prior had more focus on patient-centered care and welfare rather than scientific research and balancing the books.

Dide displays an individualism, although not uncommon in psychiatry of the period, leaving the asylum to a deputy while he spent four years in military service, although it can be presumed that he considered that as historically little had changed in asylum management since his appointment in 1909 very little would change during war-time. Whereas Priors were rarely absent in Saint-Jean-de-Dieu, only leaving the asylum to visit the Mother House in Paris or the teaching school and *Superieur général* in Lyon. Teaching was central to the Order's philosophy guaranteeing uniformity and quality of care.[500] The four-year tenure of the Priors, in contrast to the twenty years of Dide's direction, did not interfere with the running of the HP or patient care, nor did it hinder the commitment to the patients

[500] Jones, Sisters of Charity, p. 341. Jones argues this aspect in the work of the Sisters of Charity and their central teaching Mother-house in Paris.

of MCs or staff. Each Prior in Saint-Jean-de-Dieu demonstrates a continuity of standards of care and an unwavering commitment to patients and staff. Although, in a broader perspective, there is little evidence that Priors gave any significant contribution to the study and research of causes and treatment of insanity. Dide's administration of the hospital was considered by his peers as humane and driven but by state authorities as confrontational. This was mainly due to an Esquirolian belief that the MD should be the ultimate authority of the asylum. A belief embedded in the very substance of the 1838 law but which may have had motivation more towards the development of a new profession and the medicalisation of the insane rather than the value systems embedded in the Order's traditional philosophy, which influenced all those under the Prior, including patients and relatives.[501]

In the case of Saint-Dizier hospital, MD Magnand's unilateral act reveals a flagrant contravention of the articles of the 1838 law. In freeing patients he fell short of his professional obligation and put many patients at risk in the outside world, although there were only a few staff to look after them as many had already fled. Was he mindful of a greater danger with the advancing German army or was his action entirely humane? It is unknown. During the Occupation, with the deterioration and dislocation of daily life in HP Saint-Dizier the inexperience of the two newly appointed MCs, directed by a non-medical director, may have led to some weakness in their management of staff which was reflected in patient care and may have had some bearing on outcomes. Given the extraordinary circumstances of the Occupation, it is probable that MCs like Perret at Marchant, and Godard at Saint-Jean-de-Dieu, with many years of clinical and practical experience in administration and treating mental and physical illnesses were more able to draw on their medical expertise than those with little experience.

[501] Masson and Azorin, The French Mentally Ill in World War II, p. 37.

In Marchant, Dide's retirement in 1938 did not stop tension between state officials and MCs: indeed the appointments of non-medical directors exacerbated the situation. Added to continual admissions in an already overcrowded asylum and too few staff to carry out basic nursing duties, psychiatrists and psychiatric practice was sorely tried. General medical duties were neglected and the resultant lack of supervision, of patients and staff, during the Occupation, gave rise to serious deficiencies in patient care and nutrition.

However, there are parallels in the humane intentions of those in charge of psychiatric hospitals. Dide, like others in psychiatry, called for a re-evaluation of the asylum system, viewed by many in medicine and other disciplines as in great need of change, if effective services were to be offered to the mentally ill. The analysis of improvements undertaken in the target hospitals during the 1930s show what was done, but also illustrates that much more needed to be done in terms of providing adequate facilities for the welfare and health of patients. The vulnerability of the hospital system is exposed with the abrupt and dramatic change in daily life.

Suggestive of a distinctive style is the management of overcrowding, MDs and MCs in state hospitals repeatedly complained about overcrowding, but little was done to enlarge facilities sufficiently for increasing numbers,. However, Saint-Jean-de-Dieu is conspicuous in its tradition of moving to larger premises or extending accommodation to suit patient numbers. This was due to its autonomy and the Order's networking mechanics.[502]

However, on closer examination of the founding-fathers' concepts of asylum care there is a noticeable similarity between state and clerical ideas. Pinelien/Esquirolien notions of the unshackling of the insane from inhumane prisons, offering them kindness, doctor-patient communication, tranquillity and good food were the

[502] Guillemain, Médecine et religion au XIXe siècle, p. 38. Saint-Jean-de-Dieu was at the heart of the Catholic network of asylums for the insane.

tenets by which the asylum system was built. This principle is echoed in that of the Order of Saint-Jean and many other religious communities, many who had been established and practicing care long before the law of 1838. However, in many state hospitals by the 1930s such an idealist approach was lost as hospitals became warehouses for the mentally ill. Added to this were persistent problems of insufficient and untrained staff.

The chapter has brought further insight into the significant difference between state and clerical hospitals and modes of care and character and quality of nursing staff. An indication of the quality of service and care given by staff in Saint-Jean-de-Dieu is seen in the praise given by state-asylum psychiatrist Sérieux. He saw in the religiosity and commitment of staff to patients an attribute gravely lacking in most state-run asylums. This ethos would to some extent protect patients from some of the deprivations of food and resources seen in many HPs, during the Occupation. Although in both Marchant and Saint-Dizier all female inpatient services were run by Sisters of the religious order attached to the hospital since its inception, but unlike the Brothers of Saint-Jean-de-Dieu, they had no influence over administration or managerial matters.

Nevertheless, MDs like Dide made some headway in establishing Nurse-training schools, but in the then current situation of overworked, underpaid and de-incentivised staff, uptake was limited. The Order's approach to good care lay in its attention to training at its master training school in Lyon. In Dinan-Léhon, new accommodation for novices was built to provide dedicated staff for the asylum. However, in the rural area of the Haute Marne there was very little training offered at Saint-Dizier.

In all target hospitals the budget was crucial to their existence. In state hospitals it was a major obstacle to sizeable improvement schemes for patient facilties and care. Despite a considerable disparity in the daily tariff between state and clerical-run asylums, the Prior of Saint-Jean-de-Dieu was not hindered sufficiently to note repeatedly problems with state funding as was Dide and MCs at Saint-Dizier. The

Brothers were paid only a small stipend, unlike state hospitals whose staff wages costs were a continual ordeal for MDs.

As with all clerically-run HPs, the state gave a lower daily tariff than the state hospitals considering their charitable status and their private patient income would subsidise them. Ainay's daily tariff was similar to that of Saint-Jean-de-Dieu despite the religious orders hospital having a large infrastructure compared with Ainay. Ainay, the innovation of reformist psychiatrists, was seen by the state as more cost effective but, illustrating the short-sightedness of state authorities, no further similar facilities were built before the Occupation.

The vignette has demonstrated that routinisation to varying degrees was similar, that working in an asylum was far from easy and violence part of daily routine in most hospitals. However, what was different was the reaction to violence in the state hospitals compared with that in Saint-Jean-de-Dieu where Brothers whose mind-set and training gave them the ability to deal with patients with severe psychoses or who were unable of thinking clearly. Psychiatry's armoury against such mental illnesses, from alcoholism to epilepsy, psychosis to vagrancy, was similar in all four TPs and the ineffectiveness of medication and therapies in the 1930s influenced all aspects of institutional policy and patient care.

Chapter three has established the different managerial and philosophical characteristics of leadership in the state-run and clerical-run hospitals. It has outlined the routine of everyday institutional life and exposed the inadequacy of facilities and care for the mentally ill. There were weaknesses in psychiatric practice and clinical responsibilities were neglected due in part to a lack of state support and also the profession's inability to unite in its theories of causality and treatment for mental diseases. Later chapters will aid in understanding whether these factors had any bearing on mortality rates.

Maurice Dide is an exemplar of not only the aspirations of twentieth-century psychiatrists and their desire to improve facilities for the mentally ill, but also the

frustration of many psychiatrists working in a system that showed little interest in the mentally ill and was ill-supported financially. However, although in Dide we see professional competence he also demonstrates the powerlessness of asylum psychiatrists to improve the lot of the mentally ill, but his leadership also demonstrates that many in psychiatry were far from unsympathetic to the needs of patients.

The chapter is disturbing as it underlines many of the shortages and failures of the system but encouraging because of the evidence of efforts made in certain hospitals to improve the situation for patients despite state lethargy, underfunding, and parsimony. The vignette offered in this chapter may have only provided limited examples of daily life but they were not unique for the thousands of patients and staff within the FMHS.

Chapter four will explore the effects of the onset of war for the four target hospitals, from the mobilisation of hospital staff, the German invasion and occupation; the setting up of Vichy's rationing system and the accelerating and unpredictable restrictions on foodstuffs and raw materials.

Chapter 4 The changing landscape of daily life in the target hospitals: war and occupation

Chapter three has given a view of the administration and day-to-day routinisation of the target hospitals. It demonstrated how the legal and institutional system in which the target hospitals were embedded hampered facilities and care for the mentally ill. The vignette gave a small glimpse of daily life from the perspective of personnel and patients. As Alain Drouard notes, 'Wars are not only interruptions to daily life; they deeply influence daily life while provoking severe ruptures and breaks in food production, distribution, and consumption'.[503]

Chapter four argues that the repercussions of France joining the war initiated a downward spiral to daily life in the target hospitals ultimately leading to malnutrition and death. Early preparation for war and mobilisation of able-bodied men, rationing of certain goods to feed the military forces, the defeat and exodus of millions of people to the south fleeing the advancing enemy, the invasion, and occupation by German authorities, impacted on all daily activities. Corrosion of daily life was principally due to the economic crisis brought about by the war and occupation: costs almost quadrupled. Bombing and destruction of property and the division of the country by the demarcation line, restricted transportation making movement of produce, products, and people arduous. It also demonstrates that certain material improvements made before the war had limited advantages in light of the consequences of the Occupation.[504]

To this dreadful catalogue of misery must be added the consequences for the nation's health of Vichy's rationing system with restrictions not only on foodstuffs

[503] Zweiniger-Bargielowska, et al, Food and War, p. xv.
[504] Veillon and Flonneau, *Le temps des restrictions*.

but everyday material resources.[505] An analysis of the rationing system, a system that was inadequately thought-out and discriminatory against disadvantaged social groups, will demonstrate widespread inequalities which were especially felt in the target hospitals which before the war, with large farmlands had been largely self-sufficient. A major factor in the variable food supply, although not the consequence of Vichy or the Occupation was the unusual and extreme weather conditions during the winters of 1940-41 and 1941-1942, and summers of 1941-42.

The chapter continues with an examination of the 'German effect. This incorporates events and developments that impinged on the daily lives of citizens and patients due to the proximity of the German military. The loss or requisition of industrial resources and energy consumables such as electricity and heating and transport fuel, and even machinery, vehicles, and parts, caused further disruption to daily life. To gain greater insight into the relationship of shortages of food and resources the target hospitals are set within their departmental location classified following Veillon and Flonneau's work on disparities of rationing. This will give a further dimension to the realities of daily life for citizens as well as for inpatients and staff in the target hospitals.

Furthermore, in highlighting the extraneous factors of daily life beyond the control of the target hospitals psychiatrists it partly refutes claims made by Lafont

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[505] Michel Margairaz, 'L'Etat et les restrictions en France dans les années 1940', in *Le temps des restrictions en France (1939-1949),* ed. by Dominique Veillon and Jean-Marie Flonneau (Paris: Cahiers de l'IHTP, 1995), pp. 25-41 pp. 25, 13). Hanna Diamond, *Fleeing Hitler: France 1940*, (Oxford: Oxford University Press, 2007), p. 151; Isabelle von Bueltzingsloewen, 'Rationing and Politics: The Academy of Medicine and Food Shortages during the German Occupation and the Vichy Regime', in *Food and War in Twentieth Century Europe,* ed. by Ina Zweiniger-Bargielowska, Rachel Duffett, and Alain Drouard (Farnham: Ashgate, 2011), pp. 155-68 (p. 156 fn9); Hervé Joly, *L'Economie de la zone non-occupée 1940-1942*, (Paris: Comité des Travaux Historiques et Scientifiques, 2007); Kenneth Mouré, 'Réalités cruelles: State Controls and the Black Market for Food in Occupied France', in *Food and War in Twentieth Century Europe,* ed. by Ina Zweiniger-Bargielowska, et al. (Farnham: Ashgate, 2011), pp. 169-83. Kenneth Mouré,'Food Rationing and the Black Market in France (1940-1944)', *French History,* 24, (2010), 262-82 (p. 277).

protagonists of indifference among hospital psychiatrists to the situation relating to restricted foods or Vichy's collaboration with the Nazi occupiers to exterminate the mentally ill.

4.1 Mobilisation

Even before the defeat of France in June 1940, ramifications of joining the Second World War were felt throughout the French nation; five million able-bodied men up to the age of fifty had been mobilised, and many were prisoners of war (up to 450,000 were farmworkers) or were killed.[506] In agriculture, mobilisation divested farms of their workforce: loss of manual labourers led to machinery lying idle, harvests delayed and crops perishing in the fields. The latter was also due to the rigorous and adverse weather conditions both in the winters and summers of 1940-1941 and 1941-1942.[507] Industry and commerce were at a standstill due to severe bombing that damaged large swathes of cities, ruining homes, leaving many to be relocated or homeless.[508]

The absence of men affected all civilian areas of life in France, but a lack of male labour especially affected the target hospitals: master craftsmen in charge of general maintenance of the fabric of the hospital buildings, experienced farm and agricultural workers, in-house services managers in as catering and laundry, all vital to the self-sufficiency of the hospital, were among the mobilised men. Medical, nursing staff and administrative staff were also called up decimating all hospital

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[506] Veillon, *Vivre et survivre en France, 1995,* p. 12; Robert Gildea, Olivier Wieviorka, and Anette Warring, 'Surviving Hitler and Mussolini: Daily Life in Occupied Europe', (Oxford and New York: Berg, 2007), (p. 6).

[507] Martin S. Alexander, *The Republic in Danger: General Maurice Gamelin and the Politics of French Defence, 1933-1940*, (Cambridge: Cambridge University Press, 2003). page 354-5

[508] Claudia Baldoli, Andrew Knapp, and Richard Overy, 'Forgotten Blitzes: France and Italy Under Allied Air Attack, 1940-1945', (London and New York: A&C Black Continuum, 2012), (p. 6); Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival,* pp. 242, 58.

services and exacerbated staff shortages, a long-standing issue in many hospitals, became an even bigger problem.[509] One particularly important role in hospital administration was that of the bursar, although not particularly cited in scholarship of the Occupation in psychiatric hospitals; during this time his sole role was to source food for patients.

In 1939, Marchant employed 369 staff, of whom eighty-eight were involved in general services of farm maintenance and building and catering and 261 were nursing and medical staff looking after 1,513 patients. Due to enlistment Marchant lost 121 male staff, comprising nearly a third of master craftsmen and farm overseers, one Intern and ninety-three nurses, together with general administrative staff which included the bursar and the accountant.[510] Of this total number the director was only able to supplement the workforce with fifty-four temporary staff, which included an accountant who also had to serve as bursar. This double duty, however well-performed, would have adverse effects on administrative efficiency and on acquisition power as the months of the Occupation and severe restrictions turned into years.

In 1939, Saint-Dizier, had 993 patients and staff numbers recorded as 213, this was made up of ten administrative and forty-four general service, farm and maintenance staff and seventy-eight male and seventy-one female nursing staff: of this number forty men were mobilised. As in the other target hospitals, there was severe disruption especially to farm productivity.[511] To replace mobilised men, a few retired male staff were employed but most replacements were female. This replacement did not alleviate the absence of men in the male quarters as the 1838

[509] Masson and Azorin, La surmortalité des malades mentaux, p. 471.
[510] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 41. Tableau no.1.
[511] UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939. p. 4.

law prohibited mixing of the sexes. Male patients, therefore, suffered disproportionately.[512]

Even staff in religious orders were not exempt from mobilisation and Saint-Jean-de-Dieu with over 950 patients, lost almost 50% of its personnel, including 8 senior nursing staff and 45 assistants, auxiliaries, and craftsmen.[513] Retired Brothers were called in to help fill the lack of qualified staff, and local young men unfit for mobilisation were employed as auxiliaries.[514] Both MCs were mobilised but were stationed in the local area and continued their hospital duties. Luckily, some personnel returned to the target hospitals several months after the invasion. Others did not; they were killed or taken as prisoners of war.[515]

Ainay was more fortunate than the other target hospitals because it did not have a large infrastructure of staff and buildings but was still affected by mobilisation at an administrative, medical and nursing level.[516] Most *nourriceurs* were female and the few who were male were mostly widowers and above the age of mobilisation. Nevertheless, leadership and medical care was inconsistent. Given the instability of direction at the colonie *nourriciers* and *infirmier- visiteurs* were left without major leadership there would be increased work pressure on those remaining or were interim staff.

4.2 Selective rationing: an 'invitation'

Concurrent with mobilisation in the preparation for war the Third Republic initiated a form of rationing – or rather, control of supplies. This commenced in December

[512] Article 53; section 8 of 1838 law..
[513] UHASJDD, Compte moral 1938 à 1945. pp. 1-2, 6.
[514] Ibid. p. 6.
[515] ibid.
[516] UHAA, Rapport pour les années de la guerre 1939-1945 annèe 1948 Ainay-le-Château par le docteur Leyrite, J. p. 13.

1939.[517] Citizens were 'invited' to eat less and butchers, then bakers, *patisseries* and *chocolatiers* were only permitted to open on specific days of the week.[518] However, this early system, flouted by many citizens, was immediately taken up by most HP MDs. From administrative reports, it is not possible to interpret whether this initial scheme was adopted by parsimonious hospital committees who saw an opportunity to cut costs, but this may have been the case. Equally, subject to bureaucratic and government controls, most MDs were duty-bound and pressurised by local officials and thus followed the government's agenda.[519]

The effects on patients, although initially only of a psychological nature, were considerable and disrupted their delicate balance of normality even before the Germans arrived on French soil. The first items to be rationed were the little treats: sweetened coffee and homemade conserves, a great delicacy, much to the patients' disappointment and perplexity. Patients asked the staff, 'why is our portion of *bonbons* reduced? we have always had them in the evenings', and 'why do we now have such small portions of meat? [520] For others, reduced portions appeared as a punishment.[521] Even such a small change can affect the state of mind of many mentally unstable patients, as depression or an exacerbation of symptoms often follows crises.[522]

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[517] Veillon and Flonneau, *Le temps des restrictions*; Mouré, Food rationing, p. 265; Justin Godart, *Renseignements généraux sur la France après quatre ans d'occupation ennemie : Le rationnement de ses conséquences. Premier parti*, (Paris: Entr'aide française, 1947).
[518] Veillon, *Vivre et survivre en France, 1995*; Fogg, *Politics of everyday life, 2009,* pp. 22-3.
[519] UHAGM, Séance du comité de surveillance 6 November 1940.The members noted the numbers of staff mobilised and agreed that the hospital should conform to the new rationing.
[520] UHAGM, Patient dossier, Madame A., D. age 55 admitted 31 January 1935 died 13 June 1943.
[521] UHAGM, Patient dossier, Madame M. T. age 68 admitted 13 August 1934 died 21 September 1943.MC notes 12 December 1939, 'she is eating better but wants to know what she has done wrong to be given such small meals she wants more to eat at midi'.
[522] Cheryl Corcoran, Lilianne Mujica-Parodi, Scott Yale, David Leitman, and Dolores Malaspina,'Could Stress Cause Psychosis in Individuals Vulnerable to Schizophrenia?', *CNS Spectrums,* 7, (2002), 33-42; S. Brown,'Meta-Analysis: Excess mortality of schizophrenia. A meta-analysis', *British Journal of Psychiatry,* 171 (1997), 502-08; E. C. Harris and B. Barraclough,'Excess mortality of mental disorder', ibid.173, (1998), 11-53.

4.3 *Ravitaillement général* : Vichy's national rationing system

Following the defeat of France, under the Armistice Agreement, the new regime of Vichy set up a rationing scheme. It was based on a 'ruthless system' in which Germany exploited the agricultural and industrial resources for its war effort and left the French nation with critical health issues.[523] By mid-summer of 1940, harsh regulations on the movement of people and goods, as well as the seizure of all food supply depots throughout the occupied zone by the German army forced Vichy to apply multiple new systems of administration for rationing in an ill-prepared and now divided nation.[524]

Addressing French citizens in October 1940, the newly appointed head of the Vichy government, Marshall, Philippe Pétain stated that rationing was to be 'a painful necessity' in which 'everyone has to make a sacrifice'.[525] While Pétain anticipated an egalitarian system, life under Vichy was not experienced as equal by all, due to location, the disadvantage of certain groups, or because some made greater sacrifices than others.[526]

The *Ravitaillement général,* a system of services set up by the *Secretariat d'état au ravitaillement* became central to daily life under the Occupation.[527] Two main ministries of agriculture and provisions were merged in July 1940.[528] As shown in Appendix A, their principal role was to account for all existing resources, take control of all agricultural produce, and make it obligatory that producers, farmers,

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[523] Mouré and Schwartz, On vit mal, pp. 262, 64.
[524] Ibid. p. 266.
[525] Mouré, Réalités cruelles, p. 169.
[526] Paxton, *Old Guard and New Order*; Bonnet and Quétel, La surmortalité asilaire, p. 30.
[527] André Horacio Reggiano, *God's Eugenicist: Alexis Carrel and Sociobiology of Decline*, (New York: Berghahn, 2007), p. 76.
[528] ADA, Série 959W 1, Ravitaillement général 1940-1946.Communication between the prefecture and the Secretariat d'Etat au ravitaillement and the Ministère de l'agriculture: 25 January 1941 16 April 1941, 15 January 1942.

suppliers, and transporters delivered stock to departmental or regional depots.[529] Rationing ministers were chosen by regional and departmental directors who communicated with the prefects, who in turn liaised with the local commune mayors. Local prefects supervised the multi-member sections of the rationing services, they in turn elected and regulated numerous agencies, intermediaries, professional associations and committees, suppliers, transporters, verifiers, shopkeepers, and, ultimately, consumers.[530] Mouré has labelled the rationing system as 'inept', and 'an irrational assemblage of parts and measures without coherence or competence' with, 'serial failures evident in its continuous administrative reorganisation'.[531] Undoubtedly, modification or refining of government ministries also led to sluggish response and vast discrepancies.[532] With such a weighty and unwieldy system, the centralised governance of Vichy's rationing services was far removed from the consumer, disengaged from reality and incapable of reacting to local supply conditions or public opinion on food shortages. Moreover, the food supplies services were dysfunctional and officials were often inefficient, egocentric, and corrupt.[533] To this situation must be added the loss of imported supplies from the French colonies amounting to 17% of the

[529] Vinen, *The Unfree French,* p. 215.
[530] Veillon, *Vivre et survivre en France, 1995,* p. 8; ADA, 959W 1.
[531] Mouré, Food rationing, pp. 266-7; Also see Zweiniger-Bargielowska, et al, Food and War, p. 263; Andrés Horacio Reggiani, 'Birthing the French Welfare State: Political Crises, Population and Public Health, 1914-1960', (doctoral thesis, University of New York, 1998), pp. 76-7.
[532] ADA, 959W 1 p. 32.Letter from the Secrétaire au ravitaillement 26 October 1942 to to the departmental prefect stating the controllers seem to be out of control and are not giving enough direction to the suppliers. They are not getting their cooperation; Veillon and Flonneau, *Le temps des restrictions*; Margairaz, L'Etat et les restrictions en France dans les années 1940.
[533] Fogg, *Politics of everyday life, 2009,* p. 9; Fabrice Grenard, *La France du marché noir (1940-1949)*, (Paris: Payot, 2008); Fabrice Grenard, *Les scandales du ravitaillement: détournements, corruption, affaires étouffées en France, de l'Occupation à la guerre froide*, (Paris: Payot, 2012); Hanna Diamond, *Women and the Second World War in France, 1939-48: Choices and constraints*, (London: Longman, 1999), p. 108; Veillon and Flonneau, *Le temps des restrictions,* p. 8.

national annual food consumption. This was a loss that affected citizens' diets in quantitative and qualitative terms.[534]

4.4 The rationing premise

The concept of rationing was imprecise. One ministry dealt with food supplies and distribution and another controlled combustibles and raw resources such as oil, coal, and electricity. Rationing was based on erroneous assumptions made by the rationing authorities, firstly, that citizens would queue for their daily supplies, secondly, that national and departmental supplies of food and material goods would be available. Thirdly, it was assumed that citizens would find alternatives, which have been called *le système D* (*se débrouiller*, to manage oneself).[535] If not originally intended, food rationing discriminated against those who could not manage to follow these steps. Disadvantaged and minority groups became fatalities of faulty protocol.[536]

Furthermore, rationing policies did not take into consideration the natural or unnatural (or 'doctored') decrease in the quality of many foods, depending on its process of manufacture and ingredients available. For example, substitutes of lesser quality were added to bread such as maize, rice, milk, and milk products, like cheese, were watered down to make ingredients go further. All such activities

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[534] Alex J. Kay, *Exploitation, Resettlement, Mass Murder : Political and Economic Planning for German Occupation Policy in the Soviet Union, 1940-1941*, (New York and Oxford: Berghahn, 2006), p. 123; Lucie Randoin, *L'Alimentation et la vie: les problèmes actuels de l'alimentation*, (Alençon: Imprimerie Alençonnaise 1941).

[535] Lynne Taylor, *Between Resistance and Collaboration: Popular Protest in Northern France 1940-1945*, (Basingstoke: Macmillan, 2000), p. 105.

[536] Sauvy, *La vie économique des Françaises de 1939 à 1945*; Georges Daumézon,'Les aliénés pendant la guerre: Le malade mental. Qu'en avons-nous fait?', *Présence,* 54, (1956), 65-66; Margairaz, L'Etat et les restrictions en France dans les années 1940, p. 32.

reduced the nutritional value for the consumer.[537] The system did not take into consideration the disparities in social class, nor the consequences to the health of the nation of restrictions of foodstuffs and raw commodities that would become increasingly difficult to obtain at prices that were beyond many people's income. Reduced supplies of electricity, wood or heating fuels, led to food being inadequately cooked. For individuals who were susceptible, especially those with already compromised health, the elderly or the young, partially cooked food did more harm than good, causing gastric and intestinal disorders and problems of dehydration due to fluid loss from diarrhoea and vomiting.[538]

4.5 Nutritional distribution for the general population

To understand fully the implications of Vichy's rationing it is necessary to examine the nutritional guidelines for the 1930s issued by the *Institut national d'hygiène*.[539] It advised that a sedentary adult male required 2400 calories and for those over seventy years of age 2000 calories. Adult females required 2000 calories and those over seventy years of age, 1800 calories.[540] With the establishment of Vichy's rationing system, every French citizen was allowed approximately 1500 calories daily, a considerable reduction from national norms. [541] However, increased daily

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[537] Bueltzingsloewen, *L'hécatombe des fous,* p. 446; Diamond, *Women and the Second World War,* p. 52; Lereboullet M.,'Sur la distribution du lait aux nourrissons', *Bulletin de l'Académie de médecine,* Séance du 7 juillet, (1942), (p. 360).
[538] Z. Siddiqui and A.S. Osayande,'Selected disorders of malabsorption', *Primary Care,* 38, (2011), 395-414.
[539] This study takes the essential components of a balanced diet as being proteins (meat, poultry, and fish), lipids (fats and daily produce), carbohydrates, vitamins, minerals, and water. Klaus Witte and Andrew L. Clark,'Nutritional Abnormalities Contributing to Cachexia in Chronic Illness', *International Journal of Cardiology,* 85, (2002), 23-33; S. Y. Lim, E. J. Kim, A. Kim, H. J. Lee, H. J. Choi, and S. J. Yang,'Nutritional Factors Affecting Mental Health', *Clinical Nutrition Research,* 5, (2016), 143-52.
[540] Bonnet and Quétel, La surmortalité asilaire, p. 24; Godart, *Le rationnement de ses conséquences*.
[541] Paxton, *Old Guard and New Order,* p. 360; Veillon and Flonneau, *Le temps des restrictions,* p. 1; 'Organisation économique et vie matérielle en Savoie de juillet 1940 à novembre 1942', (master's dissertation, université de Savoie, 1992), p. 114; Also see Cépède, *Agriculture et alimentation en France*; Sauvy, *La vie économique des Françaises de 1939 à 1945*; Yves Bravard,'Le ravitaillement

calorie amounts could be achieved with non-rationed food items: these included fruit and vegetables indigenous to France. In Paris, in the occupied zone, and in Toulouse, in the non-occupied zone, an adult in category A was allocated 350 grams of bread and 350 grams of meat weekly, as well as 80 grams of fat, 500 grams of sugar, 300 grams of coffee, and 140 grams of cheese monthly.[542] Statisticians claim the average daily intake from rationed and non-rationed foods was a little over half the consumption of the daily pre-occupation intake, which as stated ranged from between 2500 and 3000 calories.[543] Although Paxton states that comparison of calorific intake in France is 'treacherous ground', he notes that French calorific intake was the lowest in Europe during the Occupation.[544]

4.6 Nutritional policies for psychiatric patients

In the 1930s, national asylum inspectors, Drs Julien Raynier and Henri Beaudouin, proposed a daily intake of 3700 calories for patients in heavy manual labour, 2700 calories for those carrying out moderate labour, and 2100 calories for patients on bedrest.[545] However, as with various sources of historical evidence from psychiatrists' writings and hospital records, it is not made clear whether the figures quoted were averages taken from all classes of patients, private-paying patients or indigents, or for all categories of diet: diabetic, gastric or vegetarian.[546] Diverse

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alimentaire en Savoie sous l'Occupation (juin 1940-août 1944): Un des soucis principaux des Savoyards pendant la Guerre', *Revue Trimestrielle Historique,* 135, (1999), 1-61 (p. 60).

[542] Mouré, Food rationing, p. 267; Ousby, *The ordeal of France,* p. 119.

[543] Ousby, *The ordeal of France,* p. 98; Randoin, *L'Alimentation et la vie: les problèmes actuels de l'alimentation*.

[544] Paxton, *Old Guard and New Order,* pp. 359-60; Sarah Fishman, *The Battle for Children: World War II, Youth Crime, and Juvenile Justice in Twentieth-Century France*, (Cambridge, Massachusetts, and London: Harvard University Press, 2002), p. 54.

[545] Julien Raynier and Henri Beaudouin,'Le régime alimentaire des asiles d'aliénés', *Aliéniste français*, (1934), 139-355 pp. 139-63, 237-66, 327-55); Bonnet and Quétel, La surmortalité asilaire, p. 29.

[546] Henri Ey and J. Cornavin,'L'Activité d'un service psychiatrique en Beauce de 1940-1945', *Annales médico-psychologiques,* 4, (1948), 9-19 (p. 10); Bonnet and Quétel, La surmortalité asilaire, p. 28 fn48; Olivier Bonnet, 'De l'Assistance aux malades mentaux pendant la Second Guerre mondiale: 'Une extermination douce'? L'exemple de l'hôpital psychiatrique Sainte-Marie à Clermont', in *De la*

methods of recording patients' menus pose a problem for comparative analysis; some hospital reports state calories per day, others as daily or weekly proportions. For instance, in Saint-Jean-de-Dieu, daily bread portion for *travailleurs* is recorded as 750 grams, for non-working indigents it was 550 grams and for private patients, 500 grams. Protein in the form of 225 grams of beef, veal, or mutton was served to indigents three times a week, while private patients received 150 grams, with supplementary fish and pork.[547] In Ainay, patients fared better: *travailleurs* received a double portion of vegetables and additional dessert at lunchtimes, but Ainay's patients were also free to find extra food items in the countryside or *nourriciers'* gardens and allotments.[548] This resource was beneficial and helped keep mortality lower than in the other target hospitals as we shall see in chapter six.

The hospital *Règlement* meticulously details all menus and diets for patients and staff and doctors. They state standard weights and amounts before preparation and after cooking, with recommended regulation nutritional values for each class of patient.[549] (Classes 1, 2, and 3, were private paying patients; the other class was indigents, patients funded by the state. The latter was divided into *travailleurs* and *non-travailleurs*. Among the latter group were the medically ill, children, and the elderly.)

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charité médiévale à la securité sociale, ed. by A. Gueslon and P. Guillaume (Paris: Atelier, 1995), pp. 185-93.

[547] UHASJDD, Correspondance avec l'administration période 1939 à 1945.Letter 8 August 1939 from the prefect to the Prior asking for total bread consumption for the hospital as the office interprofessionnels du blé was taking over control of consumption of bread.

[548] UHAA, Rapport pour les années de la guerre 1939-1945 annèe 1948 Ainay-le-Château par le docteur Leyrite, J. pp. 13-14; UHASJDD, Correspondance avec l'administration période 1939 à 1945; Paul Sivadon and P. Queron,'Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château', *Annales médico-psychologiques*, (1941), 217-21; André René Jean Chatelard, 'Contribution à l'étude des troubles carentiels observés chez un certain nombre d'aliénés en période de restrictions alimentaires (analogie avec la forme humide du Béribéri)', (doctoral thesis, université de Strasbourg, 1942).

[549] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*.

Demonstrating the importance afforded to nutrition and diet in psychiatric principles for the treatment of the mentally ill, over 50% of hospital *Règlements* was taken up by catering and nutrition for patients. During the interwar years, the target hospitals provided quite satisfactory meals: one Inspector visiting Marchant noted that 'food [was] prepared with care', although another observed 'some monotony in the menus'.[550] Such comments indicate that individual inspectors had different views of what constituted a satisfactory menu, or that the inspector commenting on the fish did not like meat, or was critical of the cost. But overall, there was a degree of control at hospital level on the provision of patients' meals.

However, demonstrating the differences in opinion on nutritional needs, in the clerically-run Sainte-Marie-de-l'Assomption (Clermont Ferrand), patients received 2650 calories daily in hospitals Bonneval (Eure et Loire) and Leyme (Lot) patients received 3000 calories daily.[551] On the other hand, MC Henri Ey of HP Bonneval complained, 'before the war allocated rations in hospitals was one-twelfth less than normal'.[552] In 1939, the hospital committee in Marchant reported the rebelliousness of intern, Dr Caussé. He had sent plates of patients' food to the MD's door. When asked why, he replied, 'the meals are too small for my patients'. Also he had sent prescriptions to the pharmacy for supplements to patients' meals due to their nutritionally poor quality.[553] Adding weight to this notion, Marchant's MC Perret stated that patients' health was jeopardised and meals were nutritionally deficient.[554] Given this event, we can gather that menus and diets provided to some patients were often inadequate, although as an intern Caussé may not have

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[550] AN Paris F1a 4570. Rapport: M. Sarraz-Bournet.Visit of M. Sarraz-Bournet Inspecteur.
[551] Vedié, Moser, and Paulin, Surmortalité dans un hôpital psychiatrique.
[552] Ey, Rapport du Docteur Henri Ey, 6 février, 1941: Sur les conditions hygiéniques et alimentaires de son service, pp. 508-9.
[553] UHAGM, Séance de committee de surveillance 29 April 1939. He was also reported to have taken more wood than necessary for his apartment and the pharmacy reported him as presribing large quantities of mineral water. 'It is felt he is provoking insubordination'.
[554] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943; Jacob, La maladie mentale en Haute Garonne, p. 790.

had the experience in diets for the mentally ill. His comments could also be understood as indirect criticism of the MD, and or the asylum system. Likewise, Perret may have felt that the regulation diet was indeed rigid and insufficient for certain types of mental disorders. There were those in psychiatry who believed that patients with certain types of mental illness did not masticate adequately enough and their excessive physical movements meant they needed many more calories, or that patients with severe cases of liver cirrhosis did not absorb nutrition to the same degree as those without.

For many patients and relatives, quantity and quality of fare would appear to have been satisfactory as neither a significant number of complaint letters for the interwar years, or documentation of unfavourable comments by patients to a lack of variety were found. It is possible that complaints regarding poor food were destroyed or removed by staff at the time of receipt, but given the copious correspondence of many relatives with the MCs, this is unlikely. For example, in patients' dossiers, themes in the correspondence range from matters concerning the mental and physical condition of loved ones to requests to take a relative for a walk or on weekend leave, or enquiries as to when they might be discharged. Some display knowledge of current medication or interest in the welfare of the patient, or indeed question MC's methods regarding a particular prescribed medication. Further complaints were of articles of missing clothing, another of a nurse's indifferent attitude of, 'bonjour, alors ça va?' to a mother when she arrived to see her dead son'.[555]

[555] UHAGM, Patient dossier, Mademoiselle S. B. age 19 admitted 20 April 1943 discharged 19 November 1943. Letter from mother 5 December 1943 to MC. Is she doing well? Has she finished the pullover I sent her to knit; UHAGM, Patient dossier Monsieur A. M. admitted 14 October 1938 died 23 August 1940; UHAGM, Patient dossier, Mademoiselle J. C. age 20 admitted 1 December 1934 died 19 August 1940; UHASJDD, Patient dossier, Monsieur Le H., admitted 14 October 1938 died 28 January 1939.

In the 1930s, patients in Ainay, whether in their lodgings or as inpatients in the infirmary received locally-available protein-rich produce (equivalent to 1 kilo of fresh meat four days a week) such as chicken, rabbit, eggs, or pork. This formed a basic diet supplemented by a minimum of 4 kilos of bread weekly, a litre of wine, as well as milk, butter, potatoes and cabbage, far more than patients received in closed hospitals.[556] There were no rules on specific weights of foods for the lodgers, but *nourriciers* were given instruction on what constituted nutritional and suitable fare. MD Vié's report states food was 'nutritionally good'.[557] Paul Sivadon, Ainay's MD from 1939 until 1943, speaking about patients' rationing with his colleague Scherrer, MD of HP Auxerre, said he was never concerned that malnutrition was a problem for the lodgers at Ainay as they were well looked after by the *nourriciers*.[558]

Given that Ainay's mortality ran between 3 - 5% annually before the Occupation, lower than the other three hospitals, Vié and Sivadon's confidence in the *nourriciers* was well founded. On his visit in 1908, English psychologist Robert Cunyngham Brown stated, 'Ainay's patients appeared thoroughly content with their food and lodgings'.[559] Such claims are supported by patients' letters previously given of, like Monsieur F., who wrote, 'Chère Maman, la nourriture est assez bonne'.[560] There is also testimony from Madame M., daughter of one of the *nourriciers* during the Occupation, she states, 'The patient-lodgers were like brothers to me and treated as family members and partook of joint meals.[561]

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[556] Vié, *Le placement familial* pp. 34, 143.
[557] Vinen, *The Unfree French,* p. 38.
[558] Pierre Scherrer, *Un hôpital sous l'Occupation: Souvenirs d'un psychiatre*, (Paris: Atelier Alpha Bleue, 1989), p. 55.
[559] R Cunyngham Brown,'The Boarding Out of the Insane in Private Dwellings', *Journal of Mental Science,* 54, (1908), 532-50 (p. 542). He was a psychologist and Commissioner of the English Board of Contorl for Lunacy and Mental Deficiency.
[560] UHASJDD, Patient dossier, Monsieur F., admitted 7 March 1922 unknown date for discharge or death.
[561] Interview with Madame M. at Ainay.

Government regulations, national inspectors' recommendations, and hospital *Règlement* only provide an official perspective and it is not documented whether all patients received their due amounts and diets. But on comparing all three closed hospitals' nutritional recommendations, they appear very similar in fare and size, while mortality was fairly stable for nearly a decade. However, the Occupation and Vichy's rationing system brought enormous change to patients' menus in terms of quantity and quality with serious consequences to health.

4.7 Carte d'alimentation: Ration card

For rationed foodstuffs, citizens were required to register with their local merchants like the butcher and baker; the local mayor would issue each citizen with an individualised ration card with coupons/vouchers.[562] Cards were allocated according to residence, age, and profession within a complex set of eight categories: E, J1, J2, J3, A, T, C, and V. Category A (*adulte*) comprised mainly adults between the ages of twenty-one and seventy who received standard rations, but those within the same age group who were farm workers were classed in Category C (*cultivateur*), manual labourers were Category T (*travailleur*). Categories J1, J2, and J3 covered juveniles from four to twenty years of age, category E denoted (*enfant*) under three years. At the start of the Occupation, the two latter groups received additional allowances of bread and milk, but soon diminished due to shortages of milking cows, fodder, pastureland, and adverse weather conditions.

From September 1940, on admission to a HP, new patients were required to cancel their ration cards at the local mayor's office, the bursar would then add the new patient's' name to the hospital list also registered with the mayor. All purchases of rationed foods would be redeemed against the number of patients and type of

[562] ADA, Série 958W 6, Ravitaillement général. Report 4 April 1942 to the sous-prefect concerning ration cards and fraudulent usage. Reggiani, Birthing the French Welfare State, pp. 78-9.

ration category.[563] The bursar, as previously discussed had the responsibility for sourcing and ordering supplies and the supervision of foodstuffs and menus for patients and staff. There is unfortunately very little archival material on his duties during the Occupation in any of the four target hospitals. However, like many housewives whose daily work entailed sourcing the family's food supplies, he had to be aware of seasonal variations and changes often on a monthly basis of foodstuffs allowances.[564] Ration allowances had innumerable exceptions and exclusions which Mouré refers to as a 'tangled web of changing rules'.[565] Paxton, Ousby, and von Bueltzingsloewen argue that variables in rationing make it almost impossible to understand fully how people fared during the Occupation.[566]

Despite hospital psychiatrists advocating increased calories for patients with certain mental conditions ration cards were issued primarily on age. Ages in HPs ranged from ten to seventy years of age and more, and patients were either classed as A - adult, (even if they did *travail modéré*), or as V - *vieillard* (this group was not insignificant in the target hospitals). Patient profiles indicate that a good number were either J1-3, under the age of twenty-one or elderly, over the age of seventy.[567] Allocation of ration cards by age and not medical/mental condition represented a disadvantage for patients in HPs. Certain patients, those whom the MDs considered physically able to work on the farm or in-house services and workshops were allocated category T - *travailleur* rations.[568] However, these cards had to be requested by the MC, with medical proof, to the rationing services

[563] Caire, L'hospitalisation des Juifs en psychiatrie sous Vichy.
[564] UHASD, Séance de 18 septembre 1943.
[565] Fogg, *Politics of everyday life, 2009,* p. 133.
[566] Bueltzingsloewen, Rationing and Politics; Paxton, *Old Guard and New Order*.
[567] Bailly-Salin, The Mentally Ill Under Nazi Occupation, p. 14.
[568] Bonnet, De l'asile à l'hôpital psychiatrique: La 'Révolution' des années cinquante à l'hôpital Sainte Marie de l'Assomption à Clermont-Ferrand, p. 191.

officials via the prefect.[569] Ration cards proved useless as the Occupation progressed: food shortages grew more frequent and restriction of supplies often meant that for citizens who had queued for half a day their ration cards were useless as there was no stock left or had never arrived from the shopkeeper's suppliers. Indeed, a ration card for patients in HPs were, according to MD Ferdière, 'une condemnation à la mort'.[570]Furthermore in some departments forging or theft of ration cards, often from mayors' offices meant new longwinded procedures had to be initiated leaving many without legitimate cards.[571]

4.8 The impact of departmental location on the target hospitals: Veillon and Flonneau's paradigm

In order to gain a clearer picture of rationing and shortages in the target hospitals we will examine the geographical locations. Departmental studies by historians Veillon and Flonneau on what can be called the 'lottery of location' act as a barometer with which to view rationing experiences of the target hospitals. There was an enormous variation in experiences in the impact of rationing on citizens through the various departments. The examination of the four target hospitals within their geographical location will shed light on whether hospitals were discriminated against by Vichy officials such as the Prefect or rationing services officials, or whether Veillon and Flonneau's 'departmental discrepancies' are explanation enough for shortages of foodstuffs and resources and subsequent hunger and malnutrition experienced by hospital patients. However, in considering any advantages in provisioning for hospitals located in agriculturally rich areas, it

[569] UHASJDD, Letter of 24 February 1941 from Dr Godard to the prefect.His request is for extra 'T' category ration cards for travailleur patients.
[570] Gaston Ferdière,'Rapport sur le fonctionnement de l'hôpital psychiatrique de Rodez du, 23 juillet 1941 au 30 novembre 1942', *Nervure*, (1992), 33 (p. 33).
[571] ADA, 959W 1. Letter from the director of rationing to the mayors on how to use ration cards and new cards will be issued due to fraudulent use.

must be remembered that nationally, total agricultural output fell by 40%: potatoes fell by 50%, butter by 55%, milk by 60%, and sugar by 49%.[572]

Veillon and Flonneau classify departments according to their geographical location and economic situation, resources and deficiencies in terms of food and production: i*ntermédiaire* departments were the most numerous and mainly based around the Parisian region and Western departments, *nourriceur* departments had sufficient resources to be called upon by the rationing services to supply other departments, and lastly *affamé* departments.[573] In this study, the four departments in which the target hospitals were located are assessed as i*ntermédiaire*.

4.9 The Haute Garonne department: HP Gérard Marchant

It might be thought that Marchant, located in the 'safe' ZNO, was sheltered from some of the food issues faced by towns and hospitals in the ZO. However, in November 1942 all of France came under German military rule, and this was no longer so. Before the war, the department was mostly rural and well-endowed with cereal crops, meats, and large poultry production, but it was reliant on other departments for imports of sugar, oils, milk, and potatoes.[574]

However, as early into the Occupation as December 1940, Toulousains found even essential products like cheese, sugar, and potatoes almost unobtainable.[575] In fact, many citizens of Toulouse started the Occupation period with a food deficit as food supplies and commodities were seriously depleted when thousands of

[572] Vinen, *The Unfree French*.For works on food shortages and rationing see; Mouré, Food rationing; Cépède, *Agriculture et alimentation en France*; Sauvy, *La vie économique des Françaises de 1939 à 1945*.
[573] Veillon and Flonneau, *Le temps des restrictions,* pp. 10-11.
[574] Estèbe, *Toulouse 1940-1944,* p. 222; Jean Burguet Bignoux, 'L'hôpital-hospice de Niort durant la 2ème Guerre mondiale (1939-1945) à travers les délibérations de sa Commission administrative', in *Bulletin de la Société Historique et Scientifique des Deux-Sevres,* (1994), pp. 81-190. Plus prefect
[575] Veillon, *Vivre et survivre en France, 1995*; Diamond, *Women and the Second World War,* pp. 52-3.

refugees in the exodus from Paris and the north arrived during June 1940.[576] Additionally, the department relied on food imports from departments in northern France which were closed to all movement of produce. The creation of the demarcation line physically cut off the south from not only food but industrial supplies of fuel, textiles and combustibles.

From the start of the Occupation, a rise in the cost of living was strongly felt by most citizens.[577] From December 1940, prices in Toulouse rose weekly, and on average rose by 17% per year, while wages moved very little and the quality of non-rationed goods like fruit plummeted.[578] Eventually, a large proportion of the local population was unable to buy their minimum rations of 1500 calories a day.[579] In practical terms, with its farm and agricultural lands Marchant had been self-sufficient in terms of food supplies for its patients. Pre-war production included substantial amounts of vegetables and fruit, potatoes, garlic, beans, onions, and gherkins. There was little or no poultry or meat, but it had a sizeable piggery of over 216 animals.[580]

For decades, patients' menus had been well-supplied with various products, from cooked ham to pâté and the favourite of pigs' trotters, to sausages and lard for

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[576] Diamond, *Fleeing Hitler*; Hanna Diamond and Robert Gildea,'The Liberation of France: Histories and Memories International conference, London, June 2014', 2014.

[577] ADHG, Série 1831M 38, Ravitaillement général.Report 1941 of prefect to director of regional rationing, stating citizens are complaining of the high price of food and mayors are resigning due to pressure of rationing system; Also see Estèbe, *Toulouse 1940-1944,* p. 221; Philippe-Jean Hesse and Jean-Pierre Le Crom, *La protection sociale sous le régime de Vichy*, (Rennes: Presses Universitaires de Rennes, 2001).

[578] Ousby, *The ordeal of France*; Estèbe, *Toulouse 1940-1944,* p. 222; Cépède, *Agriculture et alimentation en France,* pp. 367-8.

[579] ADHG, Série M1541, Administration générale et économie. Rapport concernant le ravitaillement des hôpitaux et des hospices 1937-1943.Letter from the prefect to the director of regional rationing stating only patients in general hospitals longer than 30 days have the benefit of the extra rations. Lynne Taylor,'The Black Market in Occupied Northern France, 1940-4', *Contemporary European History,* 6, (1997), 153-76 (p. 154).

[580] UHAGM, Compte moral et administratif année 1936.All produce from the piggery was used in catering for the menus. UHAGM, Compte moral et administratif année 1938.p. 30.

cooking. But by the end of 1941, production of pork as fresh and cooked meats had diminished by over 50% and by the end of 1942, this figure had decreased again by a further 50%. This loss was mainly due to restrictions and shortages of animal feed, hay and oats, reducing the quality of piglets which failed to fatten up and were killed before maturity. From these figures alone it is possible to see that providing protein-rich foods for inpatients posed major problems.[581] In 1939, 5950 tons of oats were produced, but this number dropped by 1941 to 1420 tons, affecting the availability of animal fodder especially for winter feeding. Animal production was vital for protein in patients' diets and a reduction in quantity and quality affected health.[582] Animals in return produced manure, a vital fertiliser for crop-growing.[583]

Unlike certain hospitals such as Saint-Jean-de-Dieu, Marchant did not have the asset of an abattoir. The hospital committee had discussed an installation in 1935, but it was left in abeyance which meant the hospital's reliance on outside suppliers.[584] Unfortunately for Marchant's patients, the hospital flour mill was non-operational leaving the supply of flour for bread-making, a main constituent of patients' daily menus, also reliant on outside suppliers, subject to price hikes and often the fickleness of suppliers.[585] Given the advantages for patients in SJDD, Marchant's committee decision not to install an abattoir or to repair the flour mill was detrimental to patients' health.

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[581] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 pp. 29-30.

[582] UHAGM, Séance de la commission de surveillance 2 avril 1942. The committe noted that horses were urgently needed for farm-work especailly the harvest. It was reported by the farm manager that that one that one horse was very ill and the others could not be feed sufficiently.

[583] UHAGM, Rapport sur la Commission de Surveillance (1937-1943). Letter 10 May 1941 from the director to the prefect stating, 'the quality of foodstuffs is very poor and availability is getting worse'.

[584] UHAGM, Séance du comité de surveillance 25 November 1935.The committee voted not to go ahead with applying for a licence for the abattoir.

[585] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 29.

With increasing difficulties of rations, in each of the target hospitals land laying fallow or for flower-growing was taken over for vegetables, some not normally grown such as Jerusalem artichokes and swede.[586] However, to many patients, this was an affront to their pride, considering them to be animal food, not for human consumption.[587] Production of other varieties of root-vegetables like beetroot was increased. In 1939, 450 kilos were grown but this was reduced by two-thirds in 1941, although further efforts by the farm manager to improve production paid off and beetroot production doubled in 1942. Despite the department's low potato supplies and the two consecutive terrible winters of 1941 and 1942, Marchant's production was successful, rising by 14% in 1941-2. However, to compensate for poor production of other root-crops, cabbages were grown and production rose by 60% in two years.[588] However, in terms of nutritional value patients needed protein and lipids which cabbage does not have, although it does have some minerals and vitamins. However, for patients with compromised digestive systems, cabbage would have done little good apart from filling empty stomachs but only for a short time.[589] As for manpower on the farm and in-house services, in 1940, HP Marchant had 365 *travailleurs* (215 of whom were male). This number increased to 456 (241 male) in 1941, but dipped considerably to 174 in 1942 and 168 in 1943 due mostly to increasing mortality, although *travailleurs* working on the farm are reported to have had extra rations allowed on a 'T' ration card.[590] It is interesting to

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[586] Ibid. p. 28.

[587] UHAGM, Patient dossier, Monsieur A., B. age 22 admitted 11 March 1931 died 4 October 1942. MC notes state, ' has gastro enteritis, mental state varies, complains and refuses to eat what he calls 'animal food'.

[588] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[589] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945.

[590] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 pp. 23, 29; UHASJDD, Letter of 24 February 1941 from Dr Godard to the prefect. He states, 'I wish to make you aware of the situation of our patients although rationing is generally satisfactory there are certain of our patients whose progressive loss of weight is seriously compromising their health. We have asked the direstor for extra rations for them but he is unable

note that all ration cards were honoured in each target hospitals although reports do not document how often there were no supplies, making the cards worthless.

A director's report notes the German authorities made no requisition demands during the Occupation years, unlike at Saint-Dizier.[591] But for the department as whole, requisitions were problematic, affecting especially the disadvantaged, the elderly, the young, and nursing mothers. For example, the supply of milk, a product not plentiful in the department in peacetime, fell relentlessly while prices rose disproportionately. One instance reflecting this is the prefect's request to the Agricultural Minister for increased milk rations. At the same time, he castigates the rationing services for failing to provide sufficient fodder, causing a loss of almost 6000 milk cows in one year; equivalent to a weekly deficit of 12000 litres of milk.[592] This single loss weighed heavily on an already dismal dietary imbalance, serious ill-health in the young and elderly in his region, was reported as a threat to the lives of patients in hospitals.[593] It is not always made clear in narratives of rationing during the Occupation regarding the cumulative consequences on health of material goods and supplies of raw resources electricity, coal, wood and heating fuels, and even house linens and blankets and shoes.

In an effort to economise on restricted resources, the directors of all three target hospitals reduced power outage for heating and lighting. However, reduced lighting compromised security and safety for staff especially when moving about the hospital grounds, although, escapes did not increase significantly with the

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to supply them. I am writing to ask if these patients can be reclassed into category 'T' and that patients with TB also have extra rations of meat and lipids. It well accepted that a larg number of our patients improve and are discharged thus conserving their social worth'.

[591] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 29.

[592] ADHG 1831M 38. Ravitaillement général. December 1941 prefect's report to the minister of agriculture and of Health states the region has lost 5-6,000 milking cows and farmers have no feed for the ones remaining.

[593] Ibid. Letter 31/12/1941 from the prefect to minister of agriculture, 'mayors are giving notice due restrictions on potatoes. Discontent is rife due to rationing problems.

opportunity to abscond under the cover of darkness.[594] The director also asked the prefect to consider purchasing more electricity-efficient catering ovens. Menu making, food preparation, and cooking for nearly a thousand patients and more was made challenging due to scarcity of fuels and electricity. Inadequate washing of foodstuffs and catering utensils, lack of refrigeration compromising facilities for keeping foods long-term, and inadequate cooking times led to nutritional deficiencies.[595]

Electricity demands rose sharply as cooking times had to be increased because vegetables grown as substitutes were very denser had to be cooked longer; a two-edged sword in catering for patients' daily meals.[596] Restrictions to fuel also affected patients' welfare and comfort, especially in the winters of 1940-1941 and 1941-1942.[597] The hospital did not have 'modern' central heating, the MD's term, but wood-burning stoves had been installed in certain of the buildings. However by 1942, wood supplies were depleted and the hospital resorted to coal or left buildings unheated. Marchant was fortunate in having an uninterrupted supply of coal during the Occupation. To compensate for lack of wood, coal orders were increased from the beginning of 1941 and used as a replacement for fuel in the kitchens, bakery, and laundry: three vital services of patient care. In practical terms, the carrying of heavy coals for the kitchens needed physical strength and with many male staff absent and undernourishment being the norm, this duty was an

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[594] UHAGM, Patient dossier, Monsieur L., W. typed report on his escape from his dormitory after 20.00hrs on 20 November 1939. He disappeared over night although there were four nurses on duty: they were all interviewed and had to produce a detailed written report for the commission.
[595] Ronald H. Schmidt and Gary E. Rodrick, 'Food Safety Handbook', (New Jersey: John Wiley & Sons, 2003).On this issue see: ; Manju B. Reddy and Mark Love,'The impact of food processing on the nutritional quality of vitamins and minerals', *Advances in Experimental Medicine and Biology,* 459, (1999), 99-106. MCs in both Marchant and Saint-Dizier report many patients had gastro-intestinal problems.
[596] UHAGM, Letter 18 November 1941 from the director to the prefect. I am asking for an urgent replacement of existing ovens which are too demanding on limited fuel.
[597] Guillaume Sechet, *Quel temps ! Chronique de la metéo de 1900 à nos jours*, (Paris: Hermé, 2005). UHAGM, Séance du comité de surveillance 18 February 1941. The MC reports on the very cold dormitories and low temperatures and that poor rations are causing severe hypothermia.

onerous one. Furthermore, this alternative heating method had a serious impact on the budget as costs rose substantially.

4.10 The Haute Marne department: HP Saint-Dizier

The rural and mainly agricultural department of the Haute Marne produced large quantities of cereals, but lacked cattle and poultry and with its vast vineyards was almost a monoculture area. During the Occupation, the department was unable to import beef in large enough quantities and dairy products were rarely available, leading to a severe protein and lipid deficiency for the general population. This, in turn, is reflected in morbidity and mortality in the hospital.[598] From the early days of the war, the Haute Marne suffered significantly as military conflict caused damage to road and railway infrastructure and civilian property.[599] The town of Saint Dizier was situated close to Robinson airfield, an important and strategic French Air Force base. Enemy bombing attacks on the airbase had already caused large-scale damage to the surrounding agricultural land and the transport system, producing hardships for the townspeople and all in the hospital for the entire Occupation period.[600]

Saint-Dizier town was also strategically placed for the German military; it was close to the German-Franco border and the line of the Z*one interdit*.[601] A German troop control-post was based in the middle of town which was just a short distance from

[598] UHASD, Rapport général du service médical. Service hommes année 1940. p. 51. MC reports male patients are visibly losing weight, presenting with oedema, hypothermia and diarrhoea; Chatelard, Contribution à l'étude des troubles carentiels. In his study Chatelard notes patients' weight loss was due to a deficency of protein.

[599] UHASD, Letter 28 August 1942 from hospital director to prefect stating the German command post was causing considerable disruption to staff who lived in town and some houses of staff had been comandeered for billeting troops.

[600] UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939. The committee were informed that transportation for the rationing services' deliveries was limited and unreliable and there are delays on railway due to severe weather.

[601] This was a zone forming the theoretical border with Germany in the northeast corner of France.

the hospital. Early on in the Occupation the military placed a ban on movement of the local townspeople, and for the hospital bursar who was used to collecting outside supplies, and for staff living in the town, this caused significant hardship. Requests had to be made for a 'permission to circulate' permit a process that proved protracted and exasperating for the hospital director. He spent many hours writing letters and telephoning the prefect and military commander in order to expedite matters.[602]

Before the war, the hospital relied on outside suppliers for a large proportion of provisions which it was unable to grow due to its limited arable lands. Contracts with suppliers and deliverers were agreed almost a year in advance with fixed prices. However, some of the less heavy items were often collected by the bursar, in his own car or in the hospital vehicle which doubled as patient transport. When permits were obtained the bursar had to arrange his food-sourcing trips to return before the night curfew, an added inconvenience for hospital staff changing evening and night shifts. [603]

Due to heavy requisitions by the Germans of wheat, oats, hay, and straw, the MD ordered nine acres extra to be taken for the cultivation of potatoes and a further five acres for vegetables, particularly haricot beans and peas for drying. After the cereal harvest, crop rotation turned to turnips and swede. However, despite the land area under cultivation, *travailleurs* in Saint-Dizier were only permitted C ration cards, not T, the latter would have entitled them to an additional 100 grams of bread and 0.025 litres of wine daily which many *travailleurs* in Marchant and Saint-Jean-de-Dieu received.[604]

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[602] UHASD, Séance 17 avril 1943. He states the importance of urgency for a permit for collecting patients foodsupplies. It is taking too long and as the hospital has over 700patients it should take precedence over small communes in the department; UHASD, Letter from the hospital director to the prefect 11 September 1943.

[603] UHASD, Séance 20 juin 1942. pp. 20-22.

[604] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. pp. 22-24.

From June 1940, the director could not distribute food rations to patients due to supply difficulties and also to non-availability; this applied to meat, bread, fats, carbohydrates, and sugar, all the essential nutritional elements needed for good health and deficiencies in these would lay down health problems due to unrelenting poor nutrition. To compensate, as became the custom in most psychiatric hospitals with food shortages, patients received double quantities of fresh vegetables, increasing from 300 grams to 600 grams daily. But as the Occupation progressed, adequate provisioning for patients reached such a low that, MC Deffuant wrote to the prefect in obvious exasperation, 'Quel serait le sort réservé à nos malades s'ils étaient réduits au treize repas mensuels de Monsieur l'Intendant!'[605]

An analysis of hospital committee meetings during the year of 1941 reveals that for most months, the issue of rationing in connection to the increase in deaths was discussed. In most cases, produce quantities and quality were deemed inadequate or ration allowances were found to be unmet by the rationing services or the suppliers; but little was possible to improve the situation. At the beginning of 1943, additional rations were provided according to the circular of 4 December 1942, which allowed young J1-3 ration card category patients a monthly amount of chocolate, 250 grams of confectionary, 500 grams of jams and 750 grams of sugar. However, this increase did not materialise for patients in Saint-Dizier until the spring months and there are no records to indicate whether all patients received these items in these amounts.

In Saint-Dizier, before the war, patients diagnosed with TB received supplementary rations in accordance with hospital guidelines. Rations were distributed monthly consisting of 13,450 grams of bread, 4,500 grams of meat, 900 grams of fats, 15

[605] UHASD, Registre des délibérations Séance de 18 septembre 1943.

litres of milk and 300 grams of cheese.[606] It is difficult to assess how many patients received these rations as there are no figures for the number of inpatients diagnosed and/or treated for TB during the Occupation years. However, records show that deaths due to TB represented 10% of all deaths in 1938, this number had risen to 51.85%, in 1942, decreased a little in 1943 to 41.7% and again a little during 1945 to 35.2%.[607] Milk, a large part of special diets for patients with TB, was limited throughout the department, and when it was available it went to the German troops first, causing anger and desperation among the townsfolk of Saint Dizier, a familiar complaint of other prefectures.[608]

However, in part, the availability of milk was down to the farmers who were not beyond selling to the highest bidder or fraudulently doctoring their supplies. The latter was the case for Saint-Dizier hospital. Suspicious of the quality of milk supplied to the hospital, the accountant, head chef and farm manager, sent a milk sample to the local laboratory, unlike Marchant and Saint-Jean-de-Dieu, Saint-Dizier had no laboratory facilities. Results indicated that milk was watered down, between 25 and 28%, seriously compromising the health of patients.[609] The committee and director dismissed the supplier stating, 'it will be a deterrent to others with thoughts of attempting fraud on the hospital and patients'. This is an indication that committee members were proactive in patients receiving the best of available rations but somewhat rash if the other suppliers were equally dishonest.

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[606] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier,* p. 28.Régimes spéciaux sur 'Ordonnances médicales'.
[607] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. p. 43.
[608] ADHM, Série 342W 265, Rapport sur la situation agricole dans le département de la Haute Marne 1942. Letter 25 juin 1942 from the sous-prefecture de St Dizier to the Haute Marne prefect, 'There is considerable discontentment in many communes.
[609] UHASD, Séance 27 octobre 1941.

This north-eastern department suffered from adverse weather more than the other hospitals'' departmental location. 'Immense cold in December, January and February', writes the prefect to the Minister of Agriculture, 'has left most of the cereal crops all but destroyed or very damaged and vegetable crops were covered with ice or snow for over 3 months'. In the same months and until the end of April, most transport was at a standstill due to persistent ice on the roads. Furthermore, the remaining cattle are very unhealthy'.[610]

The hospital also suffered significantly from requisitions by the Germans. The farm's livestock was the first to be depleted. From a stock of eleven horses used extensively on the farm, two were taken in 1940; of thirty cows used for milk six were taken along with nine pigs. By the end of 1941, only eleven pigs remained of a total of over ninety, either killed for urgent patient consumption or dead due to lack of feed or exposure to extreme weather conditions. A further four horses were requisitioned in 1943.[611] In addition to the horses, the Germans requisitioned oats: in 1940, they took 7% of the total produced; in 1941 the figure rose to 34% of total yield in 1943 and 25% in 1944. Inadequate winter feed is demonstrated in lack of quality and quantity of pigs from the piggery.[612] These numbers may appear trivial, but when the hospital was struggling to provide for over 900 patients, all protein-rich foods were a precious source of nutrition and with lack of farm machinery all food production suffered.

As with the other target hospitals, a further restriction which impeded patient welfare and health was the dearth of raw materials: electricity and heating materials. Anthracite and coke had traditionally been transported on barges along

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[610] ADHM, Série 342W 265, Rapport sur la situation agricole dans le département de la Haute Marne 1942. Letter January 1941 to the prefect, 'winter was characterise by severe cold –20 to -25degrees with persistent covering of snow from early December. This has stopped all exterier works and transportation'; Sechet, *Quel temps ! Chronique de la metéo de 1900 à nos jours,* pp. 6-7.

[611] UHASD, Séance 20 février 1943.

[612] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. pp. 32-33.

the canal, a tributary of the river Marne, which ran the length of the hospital's property to the east. The hospital consumed 137 tons of coke in 1939 but coke disappeared with the invasion and from an annual tonnage of 415 tons in 1938, anthracite supplies decreased to merely 21 tons in 1943. To compensate for lack of solid fuels to heat certain vital buildings the director was able to increased wood consumption. From using only 150 stairs in 1939, stocks and supplies were augmented by almost 60%. However, it was of very poor quality and did not produce good heat.[613] The hospital relied on electricity for most of its lighting, but as prices soared cost-cutting efforts were increased and wattage was reduced and many light-fittings thought unnecessary were removed.

For the director and hospital committee keeping outgoing-finances within the budget were vital. Whatever the product during the Occupation, the price rose dramatically. Even before the Occupation, the MD complained to the prefect of the struggle to obtain supplies in the 'difficult economic situation'. He also complained about the commandeering of local suppliers' lorries by the French military. [614] According to him, train services as an alternative were 'fraught with delays' and deliveries by a large proportion of the hospital's regular merchants never arrived. In 1941 expenditure on transport mostly for supplies was 25.080 francs and this almost doubled in one year, and by 1943 total expenditure rose to 119.340 francs. Transport difficulties are manifest in all the target hospitals and often the cost of transport exceeded the price of the merchandise what items the hospital budgets could not sustain was not delivered leading to shortages in every area of the hospital.[615]

[613] Ibid. p. 25.
[614] UHASD, Registre des déliberations de la commission de surveillance (1935-1950) Séance 23 December 1939. p. 33.
[615] Guérin, Ne plus être un monde à part: la transformation d'un hôpital psychiatrique: Sainte Gemmes-sur-Loire (1910-1977), p. 314.

4.11 The Allier department : Colonie d'Ainay-le Château

The Allier department was mainly agricultural all surrounded by the largest oak forest in Europe, Tronçais, and dotted with small isolated communes and hamlets.[616] The department did not support any large cities or export large amounts of produce. Local trade around Ainay included small shopkeepers and smallholders. However, the department had been depressed since the early 1900s with closure of its mines, foundries, and sawmills. Given the remoteness of the villages in which many *nourriciers* lived, and the high number of small-holdings, it is probable that various foodstuffs went 'under the radar' of rationing officials.[617] This would have provided an important source of nutrition and a supplement to patients' official ration allowances. With such an expanse of forest it is probable wood-collecting for fires, despite a German ban, would have provided for *nourriciers* and patients during the long winters, preventing some of problems of hypothermia experienced in the target hospitals which had little heating and large barn-type dormitories and refectories.[618] In Ainay, lack of fuel for transport hindered movement of staff and patients, and as prices rocketed; the MD resorted to transporting patients who needed hospital consultations or dental work by horse and cart to Saint-Amand twenty kilometres away or sometimes to Bourges, some fifty kilometres.[619]

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[616] Christine Font, 'La mémoire des temps difficiles: Une enquête orale menée en Aveyron', in *Le Temps Des Restrictions En France : (1939-1949),* ed. by Dominique Veillon and Jean-Marie Flonneau (Paris: Institut d'Histoire du Temps Présent, 1996), pp. 503-26 (p. 505). Vié, *Le placement familial* p. 97.

[617] ADA, Série 958W 7, Ravitaillement: Rapports sur le fonctionnement du Ravitaillement (1940-1945) Service du controle mobile enquêtes sur des personnes soupconnées de marche noir. Rapport au sous-prefect 4 April 1942.

[618] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 35.

[619] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier. p. 19.

Although the *colonie* had no major infrastructure for inpatients as did the other three hospitals, it had many acres of farmland some of which were cultivated for foodstuffs for infirmary patients' daily meals and for other patients who came daily to the meeting rooms. Meat, game, vegetables and fruit were the staple diet.[620] When rations in the local area became scarce in 1942 extra land was taken over for cultivation to feed adequately all day-patients and those in the infirmary. The MD also took on an additional ten patient *travailleurs* to work the land supervised by the farm manager; other patients already worked in the *colonie's* main grounds.[621] Most patients were classed as category A, although a proportion were under 21 and classed as J1 or J2, lodgers who worked on local smallholdings received C or T category rations. In order to verify that patients were receiving their correct rations, MCs would arrive unannounced at the *nourriciers'* home at meal times to verify if patients were receiving their correct rations.[622]

For infirmary patients, rations before the war consisted of 550 grams of bread, but by 1941 this had been reduced to 140 grams; however to compensate rations, the norm of two sardines was increased to three and one peach to two; Camembert cheese was increased from 40 grams to 50 grams, and confectionery increased from 50 grams to 80 grams.[623] In addition, certain infirmary patients were given supplementary rations. Most patients passed through the infirmary at some time during the year for check-ups and extra rations if the MC thought it necessary. Patients who manifested signs or symptoms of TB were transferred to the agricultural *colonie agricol* Chezal-Benôit (Cher).

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[620] Ibid. pp. 13-14.
[621] Ibid. pp. 21,38.
[622] Interview with Madame M. at Ainay.
[623] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier. UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. p. 13.

Although not on the scale of the other three target hospitals, the main administration building, *salle de reunion*, and the infirmary needed heating. Raw resources of coal and wood for heating were used for the infirmary and hospital buildings. The director's report states that neither coal nor wood was in such short supply that they could not heat adequately, a completely different position to the other target hospitals and a large bonus to the well-being and health of patients.[624] The *colonie* administrative buildings, and many of the *nourriciers'* hamlet homes, were not far from the town of Moulins with a German demarcation line check-point. It is interesting that there was little disruption for Ainay's patients despite the proximity and disruption to everyday life brought about by the presence of the German authorities, border patrols and troop encampments. The only reported incidence of patients' involvement with the German military was on a raid in the nearby area of the Tronçais where German troops were searching for clandestine Maquis; two of the *colonie's* patients were shot dead.[625] Out of context, this isolated instance appears dramatic and unnecessary, but it is understood now that during the Occupation resistance fighters and refugees were harboured in the *colonie's* administrative buildings and in cellars under the director's residence.[626] The effect the shooting had on the patients is unknown, but it is certain that the deeply rural aspect of the department with its many remote villages and forests with inhabitants well-versed in self-sufficiency and living off the land provided Ainay's patients with an advantage in surviving the Occupation. We will see in the closing chapter whether these factors protected the patients sufficiently from impending malnutrition and death experienced in the other target hospitals.

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[624] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. p. 15.
[625] Ibid. p. 29.
[626] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier. p. 29.

4.12 The Côtes-du-Nord department: HP Saint-Jean-de-Dieu

Saint-Jean-de-Dieu, located in the Côtes-du-Nord, the northern department of Bretagne was made up chiefly of agricultural communities; small holders and farmers dominated the area. 74% of Bretagne was cultivated and exported cereals, potatoes, and meat, especially pork and milk products.[627] Embedded in this traditional culture Saint-Jean-de-Dieu functioned as a microcosm of the department in terms of reliance on its farmlands and wheat and cereal crops to sustain its patients and staff.

As experienced in Toulouse, during the early part of 1940, the arrival of two waves of refugees required considerable amounts of food and resources. Due to a strong catholic influence in the area with a tradition of compassion for others there was little resentment or hostility towards refugees and most refugees had returned to Paris by the end of the year.[628] For the department, German requisitions caused incessant difficulties. In the first semester of 1942, the Occupation forces took some 4,600 horses, disrupting agriculture and production severely. Considering the department was mostly made up of small farmers, the lack of one horse was a major issue affecting livelihoods, both in terms of growing and harvesting crops and in terms of transport to consumers or market.

Again as in the other departments, the winters of 1940-41 and 1941-42 destroyed vast swathes of agricultural areas growing wheat and potatoes, placing the department in deficit. In order to economise on scarce resources, from early summer 1940, coal and electricity for the department was cut during the day

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[627] Christian Bougeard,'La vie quotidienne des Bretons pendant la guerre : quelques aspects', *Annales de Bretagne et des Pays de l'Ouest* 92, (1985), 79-102; ADCA, Série 1W 14, Rapports sur la situation des communes de l'arrondissement 1941, 1942, 1943; ADCA, Série 1W 29, Service du Ravitaillement: Rapports et statistiques 1943-1944.

[628] Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival,* p. 153 and 343.

except for mealtimes, gas was completely cut except for the hour of mealtimes. In the summer of 1944, electricity was cut all day and only returned at 11 pm. The Prior rescheduled timetables so that preparation and cooking of patient meals and laundry were carried out by night shift staff.[629] Correspondence between the prefect and director regarding rationing services highlights one of a series of issues plaguing rationing in the department: a lack of reality to local need by the rationing authorities, reduced supplies and yield of cereals and animals, transport problems related to lack of fuel, and German quota. They all impact on everyday life for the civilian population.[630]

One example of the centralised rationing services being out of touch with local situations is demonstrated in the prefect's answer regarding unmet quotas of veal from local farmers. His reply, which no doubt was echoed in other prefectures, was precise and centred on three major reasons for shortages.

'Customary veal numbers are down due to serious problems in breeding and rearing these animals, with a well-below normal quality of veal, what is more, there is a lack of transport and fuel to bring them to the rationing services headquarters. In addition, the best quality is taken by the Germans and what is left is second-class'.[631] The prefect's next sentence sums up a national problem for the rationing services, 'Your demands do not match up with the reality of animal production'.

There appears to be no reply from the director of the rationing services in the archives, which suggests no easing of the unrealistic demands of the rationing

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[629] UHASJDD, Compte moral 1938 à 1945. p. 4. The Prior notes, 'In the second semester of 1944 electricity has been cut to two hours at night necessitating us to reorganise staff for night shifts in the laundry and kitchens.

[630] ADCA 1W 29. Report of the consultative committe for rationing 12 Novermber 1943; Also see: Taylor, *Between Resistance and Collaboration,* p. 120.

[631] ADCA, Série 1W 29, Service du Ravitaillement: Rapports et statistiques 1941-1944. Rapport de la réunion du comité consultatif du ravitaillement général 12 novembre 1943 au préfet des Côtes- du-Nord.

services.[632] The prefect's communication highlights major issues that were faced by the other target hospital directors and their farm managers; diminished quality and quantity of livestock due to lack of fodder and poor grazing compounded by limited transportation for sourcing alternatives outside the hospital.

However, despite such problems for prefect and local citizens, Saint-Jean-de-Dieu's provisioning of meat throughout the Occupation is impressive compared with the other target hospitals indicating good foresight and management, in 1939 their herd was over 600 strong.[633] It also illustrates discrepancies in the department's provision of foodstuffs did not interfere greatly with inpatient food and menus. The Prior's report of the Occupation years indicates that, although reduced in quantity and quality, meat was never lacking completely from patient diets: a substantial boost to patients' nutritional input, maintaining some quality of life compared with those whose malnutrition proved fatal. On closer inspection of the Prior's claim of meat being supplied to all patients, the hospital was greatly helped by authorisation from the rationing services authorities to build an abattoir for the slaughter of their own cattle. This authorisation also permitted the bursar to purchase meat directly from a syndicate of butchers, rather than from local suppliers and enabled him to buy supplementary meat at more reasonable prices than local citizens and also vary patients' diets.

While the Prior stated meat was on the menu throughout the Occupation, the hospital still had severe problems of providing an overall nutritionally sound diet from other food supplies demonstrating the need to view the whole nutritional picture for patients' meals. MC Godard reported that patients' diets mostly lacked

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[632] Godart, *Le rationnement de ses conséquences,* p. 65.

[633] UHASJDD, Compte moral 1938 à 1945; Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon, p. 130; UHASJDD, Registre des délibérations de la Commission de surveillance Séance 29 juillet 1937; Interview with Frère Flavien Ruthmann (Président du Consiel administratif de l'hôpital Saint Jean de Dieu) at the Administrative offices of the Centre hospitalier Saint-Jean-de-Dieu, Dinan-Léhon on 7 November 2007, 11.00h by Patricia S. Legg.

lipids, due to reduced egg-laying and production of milk, and of milk products.[634] For the latter, the hospital was reliant on the provisioning services but dairy products were severely affected by German quotas. Another instance of unrealistic food demands is summed up by the prefect, 'In August we were asked for 200 tons of butter, we only had 80 tons and the Germans took 70 tons so there is no possibility of giving the civilian population any butter at all'.[635] Over a three-year period between 1939 and 1942, in Saint-Jean-de-Dieu patients' milk quantities were reduced by two-thirds and the hospital's own egg production decreased from 3,500 dozen to 75 dozen.[636]

Fortuitously, or perhaps due to the Prior's significant experience in hospital administration and an accessibility of monies, Saint-Jean-de-Dieu had rebuilt its ancient flour mill not long before the war. A good wheat crop, which was then milled on-site, was, 'a regular and precious source for the patients'. Bread, a staple food for patients, was available for patients when in local communities and towns went without. Even when wheat production fell in 1944, the Prior was able to substitute patient's bread rations with potatoes.[637] In addition, good production of fruit, 'nous a permi de donner à nos malades des desserts la plus grande partie des années de guerre'.[638] This good harvesting was despite the German effect with troops camping in the grounds and taking advantage of precious resources like water and electricity, which they used indiscriminately.

During the Occupation, availability and variety of patients' rations at Saint-Jean-de-Dieu is in complete contrast to Vinatier in Lyon, for example. Its vast farm and cultivated lands, 150 acres, were classified by the rationing services as a 'producer';

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[634] UHASJDD, Compte moral 1938 à 1945. p. 3.
[635] ADCDN, Série 1W 29, Service du Ravitaillement: Rapports et statistiques 1941-1944. Letter 12 November 1943 from prefect to rationing consultative committee.
[636] UHASJDD, Compte moral 1938 à 1945. p. 13.
[637] Ibid. p. 12.
[638] Ibid. p. 6.

the same category as farmers or commercial enterprises, and as such, German quotas applied to the hospital which was not the case in the four target hospitals.[639] Consequently, a large proportion of Vinatier's cattle and crops were commandeered as part of the rationing quota, or sold by the director. But such transactions were not of benefit to patients and could not prevent the excess deaths of 2,000 during the years 1940-44.[640]

Saint-Jean-de-Dieu demonstrates an autonomy not experienced by Vinatier or indeed Marchant or Saint-Dizier. A report that the bursar of Saint-Jean-de-Dieu, 'went out and found new avenues' could be interpreted as a circumnavigation of the rationing system.[641] Indeed, the Mother Superior of HP Saint-Marie-de-l'Assomption admitted she used 'any means' to provide for her patients.[642] To some extent, the exploits of both the Mother Superior and Saint-Jean-de-Dieu's bursar support Veillon and Flonneau's lottery of location theory but firmly point to the fact that it was not necessarily where one lived but who one knew, and whether money was available to buy what was needed. Even if one had 'country cousins', without the means to get to them, the family would go hungry.[643]

Given the traditional charitable standing of the HP in the community, it is probable that the bursar's job was made easier by its clerical character: it is clear from mortality rates during the Occupation years that 'negotiations' with local farmers diminished results of malnutrition. Indeed, in her study of study of Saint-Jean-de-Dieu, Lyon, Anne Marescaux questions the Prior and Brothers' methods in

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[639] Bueltzingsloewen, Morts d'inanition, 2005, p. 56.
[640] ADRA, 6H 12, Rapport administratif novembre 1940. Letters of 16 January 1942 and 4 April 1942 from the Director of Bassens to the Prefect of the Savoie; Lemoine, *Droit d'asiles*; Lafont, *L'Extermination douce (1987)*.
[641] UHASJDD, Compte moral 1938 à 1945. p. 24.
[642] Bonnet, De l'Assistance aux malades mentaux, p. 190.
[643] Margaret Collins Weitz, *Sisters in the Resistance: How Women Fought to Free France, 1940-1945*, (Chichester: Wiley, 1995).

obtaining food and financing such acquisitions.[644] She notes that during the Occupation, when transport and travel was difficult, they moved easily within departments and zones and went to the town of Vichy several times. She comments on a lack of evidence in Saint-Jean-de-Dieu's archives concerning donations, monies that would have helped in a time of economic crisis for the acquisition of supplies for patients There are no records of donations received in neither Lyon nor Dinan-Léhon but the Prior records in his report to the Prefect in 1945 that, due to budgetary difficulties because of low daily tariffs, he had kept spending to the vital minimum, 'et à demander des avances aux banques'.[645]

4.13 Conclusion

Chapter four has revealed major factors during the Occupation which dramatically changed the lives of all in the target hospitals. Fundamental elements of daily life changed in each of the target hospitals but to differing degrees. Firstly, there was mobilisation, although proportionally all three closed hospitals suffered an important reduction in male personnel. As an all-male hospital Saint-Jean-de-Dieu was the worst hit losing 50% of its nursing and in-house staff complement, but it appears that adequate replacements were found to ensure patient care and wellbeing, unlike the other two closed hospitals. Restrictions and shortages of the two main components of the rationing system: food and resources, caused deprivation and despair although in all four hospitals patients' ration cards were honoured but there is no evidence as to how often supplies were unavailable and patients went without.

Farm produce was vital to the three closed hospitals. Before the war good management made significant difference to availability and production of foods.

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[644] Marescaux, Vie et mort dans les hôpitaux psychiatriques, p. 98.
[645] UHASJDD, Compte moral 1938 à 1945. p. 1.

Saint-Jean-de-Dieu was by far the best equipped with an abattoir and a flour mill. It is interesting that Saint-Dizier, similar in patient-numbers to Saint-Jean-de-Dieu, had neither due to the hospital committee's short-sightedness or reluctance to spend monies, or inexperience or lack of adaptability of the farm manager. Indeed, it was one or more of these factors that left Marchant relying on outside suppliers for items which Saint-Jean-de-Dieu produced in-house. Marchant and Saint-Dizier were the most reliant on outside suppliers who were at best unreliable and with increased prices many products became unattainable. The bursars in Saint-Jean-de-Dieu and Saint-Dizier made a considerable contribution to the sourcing of food but in Marchant the duties of the bursar and accountant were combined but one person could not give full attention to sourcing foods or accounting duties: vital duties normally performed by the bursar were compromised.

The target hospitals' farms all increased their acreage with food shortages but mostly with vegetables which did not replace vital proteins and lipids necessary for a balanced diet. Before the war, Saint-Jean-de-Dieu had a large 600 cattle herd and Marchant had a large piggery but within a year Marchant's stock was reduced by half for lack of fodder, and grazing. However, the 600 herd of cattle at Saint-Jean-de-Dieu was the main-stay of daily menus and patients are reported not having gone without meat, unlike Saint-Dizier and Marchant. Given that before the German occupation patients in Ainay were well-nourished with an ample supply of protein- and lipid-based foodstuffs, it is probable they were more resistant to disease, and went into the deprivations of the Occupation in better physical health than the other hospitals' patients. Ainay's status, as an open establishment would be reflected in morbidity and mortality. By comparison, in view of the department's customary reliance on almost all supplies of beef and dairy products from other departments, Saint-Dizier's patients would have been less nutritionally prepared for war and occupation than the other target hospitals.

The chapter has also illustrated the reality of daily life for the geographical area of each hospital, identifying availability and shortages of food and resources for the

general population. Before the war, departments reliant on others included the Haute Garonne and Haute Marne whereas the Côtes-du-Nord was almost of *nourricier* classification. For the Haute Garonne and the Côtes-du-Nord, milk and dairy products were key products available before the war but in both departments they were the first to be restricted; both departments were more severely hit than those with excess stocks supplies like the Côtes-du-Nord. With the Haute Garonne department in deficit early on in the Occupation, Marchant was unable to provide its patients with dairy products. Saint-Jean-de-Dieu was also affected by shortages of milk but supplemented patients' menus with other foods, although patients' lipid-based foods were problematical.

Restriction of raw materials, especially electricity and heating fuels were all fundamental elements to the welfare and health of inpatients and seriously affected all departments and thus the target hospitals. Lack of hot water and detergents in laundries led to contamination from soiled linens, lack of cooking materials in catering reduced the variety and quality of patients' menus. Many foods were insufficiently cooked and with power cuts often not cooked at all: half-cooked foods are most unsatisfactory for patients whose physical condition was deteriorating due to lack of nutrition. In the target hospitals, the MD or directors reacted to shortages: they economised by reducing electricity outage and prioritised usage. In Saint-Jean-de-Dieu's the Prior adapted more effectively to the severe inconveniences of electricity failures than the other hospitals, he was more flexible and planned and organised the hospital day and night staff shifts displaying an ability to react more effectively than state hospitals.

Location is important in the history of both Saint-Dizier and Saint-Jean-de-Dieu involving the German effect. Saint-Dizier was the most severely hit in terms of proportional disadvantage of both produce and animals requisitioned. The German control post, in such close proximity to the hospital affected staff movement and the bursar's ability to collect supplies. Whereas Saint-Jean-de-Dieu had troops camping in the grounds for four years with their indiscriminate use of electricity

and water, essential components to daily life and treatment for patients. Nevertheless, this issue can be seen more as one of wanton or unthoughtful use of resources rather than a collective malevolent or deliberate political means of discriminating against the mentally ill.

Due to the architectural structure of the three closed hospitals scarcity of heating fuels was a serious element in fighting malnutrition, especially for patients with or susceptible to TB. This was one particular advantage for Ainay's patients whose living accommodation was in the large forest area of the Tronçais with much available wood which would have been a bonus in the cold winters. In the larger scheme of the food crisis during the Occupation the weather must be considered. Saint-Dizier in the far north eastern corner of France and Saint-Jean-de-Dieu in Côtes-du-Nord were affected most by adverse and unusual weather conditions. Added to this, the department the worst hit with electricity shortages was Côtes-du-Nord. However, it is probably that with demands for warm buildings in the severest of winters in the Haute Marne, Saint-Dizier's patients suffered greatly.

Amongst all the disruption to daily life in the target hospitals was the great rise in the cost of living with the financial implications for the target hospitals. Given the tight budget demands before the war it is probably that some items were not purchased and patients were deprived. However, Saint-Jean-de-Dieu appears to have fared better for self-sufficiency and food production but it is probable the networking system for the Order and other religious communities helped.

Chapter five will continue with the issue of Vichy's rationing system and the consequences of unpredictability and limitation and poor quality of foodstuffs and of shortages of resources. It will examine the concerns, responses, and actions, of officials and hospital psychiatrists to all these issues which triggered malnutrition and death for many in the target hospitals.

Chapter 5 Responses of hospital psychiatrists and officials to the growing crisis of occupation

The last chapter established that the German Occupation brought dislocation and disruption to the quality of daily life for the French people and particularly for inpatients in the target hospitals in whichever department they were situated. We have learnt that mobilisation caused severe problems in man-power reflected in the diminution of national agricultural produce and industrial resources and in production on the target hospital farms. For the nation shortages of food became the norm and restrictions on material resources such as electricity and fuel caused more hardship and disruption. Before the war, from a nutritional perspective patients were recorded as receiving adequate diets, however, the effects of Vichy's rationing system, of shortages and restricted supplies, German quotas and requisitions, led to a striking change in the landscape of everyday life which led to hunger malnutrition and death that had not been experienced even in the Great War.[646]

Chapter five will establish the repercussions brought about by Vichy's rationing allowances for the nation. It will argue that the major dynamics of rationing and shortages caused a significant impact on the physiological and psychological health of the mentally ill and that their essential daily needs went predominantly unmet. The chapter examines medical discourse of the Occupation years and evaluates a medical article written in 1941 by MCs at Marchant. It will discuss the extent of the MCs' study into the rise in malnutrition and mortality while teasing out responses to the crisis among psychiatric hospital leaders in order to discover whether the action or inaction of MCs was influenced by negative eugenicist

[646] Bueltzingsloewen, *L'hécatombe des fous,* p. 137.

thought that considered the mentally ill as *non-valuers* (useless mouths) and a burden on society and HPs: leaving patients to starve was an easy method to reduce overcrowding.[647] The article acts as a gauge on two major issues. [648] Firstly, how widespread was concern and response to the increasing health problems of patients and secondly the inadequacies of not only institutional practice and patient facilities but professional failings in four vital areas of patient care and wellbeing; the infirmary, pathology laboratory and pharmacy, catering services and patient living-quarters.

The chapter argues that MCs, in a concern for the health and lives of their patients, were responsive and modified practice where they could. This positive attitude is in stark contrast to particular scholarship that cites a *timidé* of MCs in that they did not act positively to either involve public opinion or to challenge Vichy officials regarding starvation in their hospitals.[649] This is attributed to their 'administrative' role, an implication that empathy did not come with the job, and furthermore to a degree of fatalism in the psychiatric hospital service in which conditions were more than unsatisfactory and overcrowding was rife and where patients came and went in their hundreds; a service in which patients were more classifications of mental illness than individuals, having very little human value.

When confronted by the severe effects of rationing MCs prioritised care and facilities, appealed to Vichy officials and to patients' families. They enabled early discharge for patients and lobbied both their colleagues and government officials for the case of starvation in their hospitals to be heard, but they were undeniably

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[647] Bueltzingsloewen, Le militantisme en psychiatrie, de la Libération à nos jours. Quelle histoire?!, p. 17. Bueltzingsloewen quotes the use of the word non- valeurs'.
[648] Xavier Leclainche, Aimé Perret, and J. Parde,'Manifestations de carence alimentaire observées dans une collectivité hospitalière. Service des hommes de l'hôpital psychiatrique Marchant', *Toulouse Médical*, (1941), 253-84.
[649] Odier, La surmortalité des asiles d'aliénés français durant la Seconde Guerre mondiale (1940-1945), p. 163.

trapped in a mental hospital system that was unprepared for the medical crisis that was the Occupation. Psychiatric hospital patients were denied essential needs: food - suitable nutrition, shelter - a safe environment and protection from the elements, and rest - a quiet environment and good sleep, all traditional features offered to the destitute and insane by charitable associations and religious orders in France for centuries and advocated by the founders of the asylum system.[650]

However, a cohesive and collective response and government lobbying with respect to the tragedy of rising mortality attained some success with the passing of the *Circulaire no. 186 du 4 décembre 1942* which allocated increased rations to psychiatric inpatients. It was pivotal in stemming the disturbing numbers of patients dying from effects of the shortages and restrictions that saw the total deaths in the HPs rise from 9127 in 1939 to 23577 in 1941.[651] For the years of 1943 and 1944 although there was still mortalities mainly from the effects of malnutrition, and concomitant diseases mortality rates showed a distinct downward trend and in the target hospitals had virtually returned to normal by the end of 1944.

Sources for this chapter are taken chiefly from state hospital archives, correspondence with other HPs, Vichy officials, patient dossiers, studies on malnutrition during the Occupation years and scholarship written after the Liberation by psychiatrists who practiced during the Occupation. Unfortunately, representation of these issues in Saint-Jean-de-Dieu is not given due to a lacuna in archival material, leading to the understanding that the Prior and MCs either

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[650] Esquirol, *Des établissements des aliénés*; Pinel, *Traité médico-philosophique*.

[651] AN Fontainebleau SAN 70847 p. 39; Isabelle von Bueltzingsloewen,'Une étape dans la mise en question du modèle asilaire? La famine dans les hôpitaux psychiatriques français sous l'Occupation', *Les Cahiers du Centre Georges Canguilhem,* 1, (2008), 47-61 (p. 51); ,'Circulaire n°186 du 4 décembre 1942 sur dite "Circulaire Bonnafous"',Signée Léon Aublant secrétaire général, au nom du Secrétaire d'Etat à la santé Raymond Grasset est addressé au Directeurs régionaux de la santé et de l'Assistance. Attribution supplémenatire de denrées contingentées aux malades dans les hôpitaux psychiatriques. Service de l'assistance 3e bureau.

corresponded confidentially with other religious communities or the MCs were more aware and had more supervision of all aspects of the hospital. These sources present attitudes and responses to the situation in the target hospitals, their discourse offers experiences that were mirrored in many HPs and demonstrate positive responses to the consequences of shortages. Furthermore, they will act as part corrective to Lafonts' claims that after the Liberation there was a collective amnesia to the events in the HPs.[652]

5.1 Health implications of rationing and restrictions

Just before the German invasion, members of the Académie de Médicine, a public health advisory board to the Third Republic government and a forum for the elite in French medicine, approached the authorities with their concerns over the rationing programme.[653] They addressed the question of health issues involved, 'strict rations (approximately 1,220 calories) and the deficiencies which are being imposed on the population could very well have a negative effect on the present and future health of French youth'. Almost in concert those in the scientific professions, nutritionists and welfare associations, also raised their concern.[654] The official reaction was that ration apportionments were seriously deficient in vital lipids (found in dairy products, meat, nuts, and oils) essential elements for the maintenance of cardiovascular, neurological and dermatological health.

[652] Lafont, *L'Extermination douce (1987),* p. 122.
[653] Archives Nationales (AN) Paris, 72 AJ 1853, Rationnement alimentaire 1940-1942; Ann F. La Berge, *Mission and Method: The Early Nineteenth-Century French Public Health Movement*, (Cambridge MA: Cambridge University Press, 2002), p. 4; Bueltzingsloewen, Rationing and Politics, p. 158.
[654] Godart, *Le rationnement de ses conséquences,* p. 17.

Despite such concerns there was little thought given to implications of rationing by either Third Republic or Vichy officials who took over the system in June 1940.[655] The Academy's prediction revealed itself correct within a year seen in a noticeable deterioration in civilian health due to a combination of poor quality and insufficient quantity and on occasion total absence of a staple diet.[656] Typically, even people in good physical shape were laid low by common infections due to a lack of resistance to diseases and those already vulnerable to illness like the elderly or very young succumbed rapidly. In every city there were to be seen thin, pale, and perpetually tired citizens hobbling around with painful joints caused by anaemia, avitaminosis, or TB. Citizens had reduced immunity and increased respiratory and cardiac diseases.[657] Rickets due to a shortage of vitamin D and/or calcium was rife, as was bad dentition, dull eyes and hair and often both adults and children complained of chilblains and skin infections.[658] In Paris mortality was 42% higher than between the years 1932-1938, and in Marseille in 1941, 72% of the population had considerable weight loss and were considered medically emaciated.[659] France became a nation of hungry, undernourished and unhealthy people.[660] Critically, poor food supplies affected not only the physical but mental health of the general population many of whom exhibited increased anxiety and

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[655] Veillon and Flonneau, *Le temps des restrictions,* p. 27. Mouré, Food rationing, pp. 264, 67; Polymeris Volgis, 'Surviving Hunger', in *Surviving Hitler and Mussolini: Dail Life in Occupied Europe,* ed. by Robert Gildea, Wieviorka Olivier, and Anette Warring (Oxford UK: Berg, 2006), pp. 16-41; Taylor, *Between Resistance and Collaboration,* pp. 56-8.

[656] Cépède, *Agriculture et alimentation en France*; Estèbe, *Toulouse 1940-1944*; ADHG, Série M1514 (4), Rapport mensuel de la Direction régionale de la Santé et de l'Assistance sur évolution de la mortalité dans les hôpitaux psychiatriques, avec graphiques (juillet 1942).

[657] Godart, *Le rationnement de ses conséquences,* p. 25. Randoin, *L'Alimentation et la vie: les problèmes actuels de l'alimentation*.

[658] Reggiano, *God's Eugenicist,* pp. 106-7; Ousby, *The ordeal of France,* pp. 124-5; Frederic Spotts, *The Shameful Peace: How french artists and intellectuals survived the Nazi occupation*, (New Haven and London: Yale University Press, 2010), p. 22.

[659] Bonnet, De l'Assistance aux malades mentaux, p. 193; Godart, *Le rationnement de ses conséquences,* p. 16; Ousby, *The ordeal of France,* p. 125.

[660] Veillon and Flonneau, *Le temps des restrictions,* p. 27. Mouré, Food rationing, pp. 264, 67; Volgis, Surviving Hunger; Taylor, *Between Resistance and Collaboration,* pp. 56-8.

psychoses.[661] The situation was much worse for those already dealing with mental health issues; instability of daily life caused acute suffering at a time when it is claimed that even for citizens, life became a 'dramatic and terrifying present'.[662]

Within a few months of the invasion patients' health in Marchant gave rise to concern. Food rationing had been relatively stringent since early 1940 and by the autumn months patients were receiving considerably less than a third of their usual daily dietary calories. MCs appealed to the local prefect M. Leyritz who responded with a study of his own into the health implications of rationing in the HPs in his region. He makes no effort to conceal increased mortality in HPs was due to malnutrition from shortages, acknowledging that reduced rations, especially animal fats, lowered resistance and pneumonias, cardiac pathology and intestinal diarrhoea sent mortality rates soaring from 6% to 30%.[663]

Leyritz commends the good work of HP staff in their efforts 'to find methods to combat malnutrition and alternative solutions to restricted provisions'.[664] However, he also states that 'mortality is regrettable not only from the viewpoint of the community but also the worrying question of finances for the establishments.' Granted, this is a more administrative approach than empathetic but, like most prefects he was unable to provide such large quantities of food for an HP with a thousand patients or more. That said there is evidence that prefects did circumvent the system on occasions. For example in Saint-Jean-de-Dieu, Dr Godard's letter to the prefect stated,

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[661] Godart, *Le rationnement de ses conséquences,* p. 17; Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival,* p. 119; Fogg, *Politics of everyday life, 2009,* p. 5.
[662] Miranda Pollard, *Reign of virtue : mobilizing gender in Vichy France*, (Chicago and London: University of Chicago Press, 1998), p. 39; Julia Torrie, *For Their Own Good: Civilian Evacuations in France and Germany*, (New York: Berghahn, 2010).
[663] ADHG, Série M1541(4), Administration générale et économie. Prefect's report to the Minister of Agriculture and Minister of Health December 1941. His report included graphics of season increases in mortality for all HPs in the region of Toulouse'.
[664] ADHG M1541. Prefect's letter to psychiatric hospitals and hospices 1941.

'Although rationing in general is satisfactory certain patients display a progressive loss of weight, some are critically ill. These patients by reason of their conditions and in part due to the shortage of heating have need of extra rations, as do patients with TB, in general hospitals. We have asked the Prior but due to the shortages and restrictions he is unable to do this. We are writing to you to have these patients reclassified into Category T'.[665]

This request was approved and 300 category T cards were made available for Godard's patients.[666] What is interesting in this case is that category T ration cards were specifically for *travailleurs* and it is obvious from Godard's letter that the patients to whom he was intending to give extra rations were not *travailleurs*. In arranging this request the prefect reveals his concern for the mentally ill, which others did not have, but also a leeway in the rationing services to obtain specific ration cards. This prefect was more open to helping hospital patients than other prefects not personally involved with HPs. It is also probably the long-standing charitable role of the HP in the area, and the good rapport successive Priors had with the local authorities that helped the situation.

Conversely, historian Samuel Odier presents evidence of what he refers to as a eugenic stance by a Vichy official. After repeated pleadings from MCs for more rations for patients an official reply stated that they must choose between those who might be of use in society, the 'recoverable' patients, and the 'non-recoverable' patients with no social worth.[667] But closer inspection of this unclassified letter found in Saint-Egrève's archives demonstrates that this official had previously visited the hospital and saw personally the hopelessness of many

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[665] UHASJDD, Compte moral 1938 à 1945; UHASJDD, Letter of 24 February 1941 from Dr Godard to the prefect.

[666] UHASJDD, Compte moral 1938 à 1945. p. 4.

[667] Odier, De l'asile Saint-Robert à l'hôpital de Saint-Egrève: Progrès thérapeutiques et malheurs de la Guerre (1930-1960). Letter from the MC of HP Saint Egrève near Grenoble to the Secretary of State, dated 15 April 1942; Henckes, Le nouveau monde de la psychiatrie français.

moribund patients. Moreover, he wrote that the advice to prioritise was a, 'douloureuse et cruelle nécessité certes, mais qui paraît bien inévitable en ce moment'.

The timing of this letter should be contextualised as rationing for the general public was severely compromised due to the severe weather conditions, freezing winters and very dry spring and summers which reduced crop yield and hindered rearing and fattening of livestock.

Indeed, due to serious shortages in all consumer goods and food supplies and a major decline in productivity of coal and gas the Vichy line advocated prioritisation, a 'distributive socialism' in which prefects were urged to use 'good sense', the key criteria being 'need' in the distribution of limited supplies.[668] Certainly on this occasion, the official's interpretation of priority was detrimental to mental patients, but was not specifically aimed at inpatients in psychiatric hospitals. However, prioritising was a significant necessity as seen in the actions and responses of certain MCs to be discussed later. MD Scherrer uses similar language, *cruelles responsabilités*, to describe his distressful duties in coping with the crisis of reduced rations in his HP in Auxerre, however, empathy with his patients is well-documented and his words do not hold a negative eugenicist thought as is implied by Odier's Vichy official.[669]

Demonstrating the vagaries of attitudes to malnutrition and death and MCs' support for patients is the example of Marchant's hospital committee. In response to the director asking yet again for increased rations for patients and reporting increasing deaths, whether a platitude or genuine concern, the committee advised, 'do all you can within your powers to relieve the sad situation of the malnutrition

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[668] Odier, De l'asile Saint-Robert à l'hôpital de Saint-Egrève: Progrès thérapeutiques et malheurs de la Guerre (1930-1960), pp. 85-6; UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943; Sweets, *Choices in Vichy France, 1994,* pp. 11-2.
[669] Scherrer, *Un hôpital sous l'Occupation,* p. 61.

of the patients'.[670] Perhaps a rather vacuous remark in view of the reality of malnutrition and mortality in the MC's report and a certain fatalist attitude is noted here supporting Odier's claim.

5.2 Positive actions to shortages - early discharge for patients

Medical and administrative reports indicate that with the perceived worsening of the nutritional situation for patients MCs attempted to send patients home. MCs approached families to collect their relative or to arrange trial periods at home prior to the patient's complete discharge. Marchant employed social assistants, albeit part-time, who worked with families or helped patients find work when discharged.[671] This was part of a new trend in outpatient social care which was established by Edouard Toulouse's Open-Door services at the Henri Rousselle hospital in the 1920s, as discussed in chapter three.

Mademoiselle S. is one of the patients MC Perret encouraged to be discharged, he wrote to her mother, 'She is a little improved, and still would like to find a job as a ladies' help. We are working with our social assistant and will continue to do so to find her a suitable job when she leaves here'.[672] And Monsieur C.L. age 45 was discharged into his sister's care: she had just lost her husband and was 'glad to have company again'.[673] MC Godard of Saint-Jean-de-Dieu also made the

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[670] UHAGM, Séance du comité de surveillance 31 mars 1941.

[671] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 32; UHAGM, Patient dossier, Madame S. B., age 19, admitted 20 april 1943 discharged 19 November 1943.The MC writes to the mother, 'Nous continuons et notre assistante sociale continuera après sa sortie à s'occuper d'elle'.

[672] UHAGM, Patient dossier, Mademoiselle S. B. age 19 admitted 20 April 1943 discharged 19 November 1943.

[673] UHAGM, Patient dossier, Monsieur C. L., age 45 admitted 6 Jamuary 1942 with hallucinations, alcoholism persecutions discharged 9 May 1942; UHAGM, Patient dossier, Monsieur R- C. age 37 admitted 4 June 1941 with severe depression alcoholism intense auditory hallucinations discharged 8 October 1942; UHAGM, Patient dossier. Monsieur Albert L., age unknown admitted 5 November 1941 discharged 13 February 1942.

conscious effort to discharge more patients than usual but claimed that in part this was due to a more open attitude and tolerance to the mentally ill by family and communities than before the war. He noted too that where male members of the family were absent at war families were more tolerant to their mentally ill relative. This for him had, 'heureuses répercussions' for the re-insertion of the convalescent patient into society.[674]

Records show that during 1940 MCs discharged more patients than was normal; in 1939, seventy-four male and forty-seven female patients in total were discharged, in 1940 this figure rose to 182; 126 men fifty-six women, of these totals sixty-six were in the private payers class, forty-four women and twenty-two were men.[675] These figures indicate that in both years more men were discharged than females, perhaps because families needed male workers following mobilisation of their menfolk, or that there were more men able to be discharged due to their admission diagnosis. Men were admitted in large numbers for various conditions and stages of alcohol abuse which, with periods of abstinence in the hospital, improved their physical and mental health. One such patient demonstrates this point very well. Monsieur H-V., writes after discharge, 'Its been thirty days since leaving Toulouse and I know it was alcohol abuse that put me there. I am going to start a little job and thanks to you doctor I am here at home and so happy.' A month later he writes,

'Dear doctor,

I celebrate my marriage to Mlle B., on 20 June; I do hope my second one will be happier than my first. You will have seen her when she visited me. We would like to have had a big celebration and you would be the guest of honour but I know that

[674] UHASJDD, Compte moral 1938 à 1945. p. 25.
[675] Ibid. p. 45. Tableau 3.

is not possible but we thank you for your good care. I am working now it's not much but at my age it's something. I hope your family are well'.[676]

However, if this idea holds strong then discharges would have been demonstrably higher in the years before the war, but discharge figures for 1937 and 1938 were decidedly lower than in 1940. Nevertheless the trend for discharging patients was similar in the other HPs, although not so marked, but which may also indicate MCs' concern for their patients. On the matter of discharges, MCs also supported requests, which rose in number, from families to have their relative discharged home or into their care.[677] 'When can I come and take my husband home for a trial period?', 'Is my wife ready to come home soon?' were the type of letters MCs received.[678] However, by the end of 1941 discharges lessened as conditions and provisioning for citizens became more difficult.[679] Indeed, on admission to HPs some patients already displayed severe malnutrition and succumbed rapidly to infections once they became inpatients.[680]

5.3 Prioritisation and adaptation

MCs' concern forced them to adapt and prioritise. In certain HPs female staff were placed on male wards in contravention of the hospital *Règlement*. However, demonstrating clearly that the rigid following of hospital rules was more about bureaucracy than patient welfare the director of Saint-Dizier proudly announced in his report that no female nurses were used in male services, but he was non-

[676] UHAGM, Patient dossier, Monsieur V., admitted 15 December 1942 discharged 18 April 1943.
[677] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.
[678] UHAGM, Patient dossier, Mademoiselle S.S. age 21 admitted 26 April 1941 died 9 October 1942; UHAGM, Patient dossier, Madame M. J- S. age 37 admitted 19 July 1916 died 10 January 1943.
[679] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.
[680] L. Justin-Besançon,'Les restrictions alimentaires dans les hôpitaux de Paris pendant l'occupation', *Bulletin de l'Académie nationale de médecine. Séance du 6 février 1945*, (1945), 77-83 (p. 82).

medical, and the implications on patient care of shortages of staff were of little concern for him.[681] In Marchant, patients were moved to warmer living-quarters, although psychiatric protocol for management and care was segregation by mental condition.[682] In consideration for the living and not disrespect for the dead, certain MDs ordered that the dead be buried unclothed, again against all institutional policies and practices, but a necessary infringement as supplies and stock of warm clothing, or any kind of clothing for patients were run-down and in many hospitals exhausted.[683]

MC Godard of Saint-Jean-de-Dieu noted that German blockages on imported textiles meant the hospital's usual replacement orders for bedlinen and materials were not met and maintaining cleanliness and order for beds was difficult.[684] Although Saint-Jean-de-Dieu was well managed and had purchased 'ample supplies' before the war, after four years, 'everything and everyone looked shabby'.[685] Similarly, in and around the villages of Ainay during the Occupation 'patients were seen in the same old dishevelled clothes and wooden shoes'. In this case it was due to the non-arrival of a large consignment of patients' clothes ordered from Paris in June 1940.[686]

Endeavours to improve patient comfort are evident in the target hospitals and in Marchant, the issue of the need for warmer conditions for patients led to some psychiatric beliefs being abandoned and practicality to reign. Patients were moved

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[681] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945.
[682] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 260; Guillemain, Médecine et religion au XIXe siècle, p. 40. Patient quarters were based on separation of patients according to their pathologies.
[683] ADRA, 6H 26, Rapports Administratifs et Rapports des Médecins-chefs (1922-1949). Letter of 6 October 1937 from Dr Stoerr to the Prefect.
[684] UHASJDD, Compte moral 1938 à 1945. p. 4.
[685] Hamon, L'étude de l'histoire de l'hôpital psychiatrique de Léhon.
[686] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. pp. 16-7; Interview with Madame M. at Ainay; Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival,* p. 96; Interview with Madame M. at Ainay.

to more adequately heated quarters.[687] This was an important move although contrary to psychiatric practice and hospital policies. This custom might have been theoretically sound to early alienists with the purpose of observing and classifying mental diseases in the same environment, but in reality it led to a hotchpotch of patients all housed together regardless of age. There were children aged 15 living in close proximity with the elderly aged 90 in Saint-Dizier, and patients with severe physical disabilities mixed with medical conditions such as respiratory and infectious illnesses.[688] It undoubtedly made for better supervision by staff that had to learn to deal with only one specific mental condition, but in view of the multitude of concomitant physical and medical conditions associated with mental illness it is easy to see how malnutrition and hypothermia went unrecognised and unreported by inexperienced and overworked staff. However, this deviation from strict psychiatric protocol illustrates a concern for the welfare of patients and demonstrates a humanitarian stance to a medical exigency; an emergent holistic approach to patient care, the patient considered as an individual not an object to be observed and classified as a mental condition.[689]

In order to facilitate and maintain some normality in wartime and to raise awareness of patient care MCs in Marchant endeavoured to continue in-training for nurses when possible, even if minimal in order to accomplish a better quality of trained staff, eliminating undesirable and mediocre staff.[690] This might have been

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[687] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943; Paxton, *Old Guard and New Order,* p. 237; Also see Chris Pearson, *Scarred landscapes: war and nature in Vichy France*, (Basingstoke: Palgrave Macmillan, 2008); UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[688] UHASD, Rapport général du service médical. Service hommes année 1941. p. 4. page 4.

[689] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier,* p. 2.

[690] UHAGM, Administration of the HP Marchant. Letter 1 July 1941 from director to prefect. 'An effort to improve the quality of personnel and thanks to the new legislation we can eliminate some who are mediocre with bad attitudes and replace them with better educated staff.

window dressing but in view of documented commitment of certain psychiatrists, it is doubtful.[691] Conversely, in other hospitals there was little to no training chiefly due to directors and MCs reticent to give time to staff who they claimed were uneducated, often temporary and those who did attend were uninterested.[692] If there were courses run staff had to attend them after working a 12 hour day.[693] However, in state-run HP Auxerre, MD Scherrer made efforts to encourage staff to attend lessons. He initiated flexible lessons around nursing shifts.[694] He comments on the compassion of the staff and it is probable some saw it as a means of improving care. In Marchant MCs organised training programmes for their unqualified staff but within two years they had to close the course due to no new staff. In part the lack of staff who wished to train was due to a salary structure which did not give any credit for those who had completed courses.

5.4 Family solidarity

Much can be learned from patients' dossiers in terms of support from the family although a lack of correspondence has proven not to mean there was no family contact or that there was a lack of support from relatives. This is brought home strongly in the dossier of Madame C., in which there was no communication whereas in other dossiers there were letters, post-cards, and even patient's' own

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UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[691] Daumézon, La situation du personnel infirmier des asiles d'aliénés; Also see Leroux Hugon, Poirier, and Ricou, L'histoire de l'Ecole d'infirmiers de la Salpêtrière; Marcel Jaeger,'Une histoire de ruptures. La profession d'infirmière en psychiatrie', *Soins*, (1996), 30-32

[692] UHAGM, Séance de la commission de surveillance 18 July 1942. The committee noted there were staff who did not have enough general knowledge to pass the examinations. The director stated it would be a pity to loose these people and suggested a staged training - the committee agreed.

[693] Meylan, L'Infirmier des hôpitaux psychiatriques, pp. 55-9.

[694] Scherrer, *Un hôpital sous l'Occupation,* p. 46.

writings.[695] An inference could easily be made that the family of Madame C. had dumped her in the HP or that relatives were uncaring and indifferent. However, when the patient's nursing notes are correlated with the doctor's notes a different story emerges, demonstrating the difficulty in interpreting the history of hospital inpatients during this period. Hand-written nursing notes on this patient give not only details of nursing care on a weekly basis but also monthly weight-checks. In between these entries is information on when one and sometimes two family members visited, often each month. It is somewhat strange that this information was added to the patient's weight chart, indicating some lack of standardisation of nursing procedures but not necessarily lack of care.

5.5 Non-visitation of families

Close searches of patients' notes also reveal that relatives had valid reasons for not visiting and their absence of visits was not due to indifference. During the Occupation relatives were caught up in the disruption and dislocation to daily life throughout France: difficulties with road and railway systems, evacuating homes due to property requisitioned by the Germans or bomb damage, lack of male labour, or wives with large families and husbands still away or POWs. One mother explains her predicament in not being able to visit, 'With five children I cannot visit, I am breast feeding one'.[696] 'I could not write before, what with all the problems of the war, I have been sick and two close relatives have recently died', wrote a sister.[697] Another sister wrote, 'My son was mobilised, and his wife and son had to be evacuated and now they live with me. I am sending a 20 franc money order for

[695] UHAGM, Patient dossier, Madame C. age 30 admitted with 8 September 1942 died 6 January 1943.
[696] Postel and Quétel, *Nouvelle histoire de la psychiatrie*.
[697] UHASJDD, Patient dossier, Monsieur N., age 24 admitted 8 January 1940 died 4 February 1941.

my brother's tobacco'.[698] In Saint-Jean-de-Dieu, one of many letters from a mother of an epileptic child aged 18, states, 'I'd love to visit but no trains are linking with my town and with four younger children it is difficult, but tell him we love him'.[699]

The patient's admission form with the patient's residence is a good indicator of the possibility or not of visits; the form also gives the names of relatives, if there were any. Many relatives lived in the opposite zone to the hospital and access was often difficult and costly, or they were in temporary accommodation so unable to have a mentally ill relative stay with them. Correspondence and MCs' notes in patients' dossiers signify a growing contact of patient to doctor and relative to doctor that has been little noted to date, indicating compassion and a personal interest taken by certain MCs.[700]

Correspondence from relatives also display loving concern: 'Did he receive the food parcel I sent and also the money order?', 'Does he need any winter clothes?, 'Please be honest with me and tell me how he is doing and if he will get better'.[701] These examples indicate that generalisations of families not visiting or of little family solidarity are too sweeping to be fair and do not acknowledge the families who did care and did visit.[702]

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[698] UHAGM, Patient dossier, Monsieur L. P., age 61 admitted 12 October 1938 died 27 September 1940.
[699] UHASJDD, Patient dossier, Monsieur N., age 24 admitted 8 January 1940 died 4 February 1941.
[700] UHASJDD, Patient dossier Monsieur C. age 28 admitted 11 November 1938 died 23 September 1940; UHAGM, Patient dossier, Monsieur J.B., age 37 admitted 18 January 1938 died 18 January 1943; UHASJDD, Patient dossier Monsieur M. age 45 admitted 27 June 1910 died 31 August 1944; UHAGM, Patient dossier, Monsieur J. F. age 49 admitted 6 December 1935 died 15 September 1940.
[701] UHASJDD, Patient dossier, Child patient X. age 14 admitted 17 October 1938 died 27 March 1941.
[702] Isabelle von Bueltzingsloewen, Projet de Recherche: Destins des fous: Le sort tragique des malades mentaux dans les hôpitaux psychiatriques français sous l'Occupation. Le cas de l'hôpital du Vinatier, 2002.

5.6 Family food parcels

Even before the war some patients received parcels with items of clothing or confectionary or food or money orders. Relatives sometimes wrote asking if their parcel had arrived at the hospital and were responded to promptly by the MCs, often within two to three days of the relatives' letter. 'She has received your food parcel and enjoyed it but sadly it is not enough in the present situation of shortages'.[703] 'We are in receipt of your food parcel but we are giving it to her slowly otherwise she will wolf it down and that is not good for her'. His words indicate that with a nutritional deficit and oedema (excess fluid in the tissues) then food, especially the type that was sent in the post would not be well tolerated or absorbed. 'I am sending him some sausage and ham', these are foods that would not always be beneficial for every patient but there is a possibility that other patients would benefit. 'Now that my mother has died, please be kind enough to give the food parcel I sent to patients who do not have any family, wrote the son of Madame C.P.[704] Although all this correspondence is but a small example it does indicate that attitudes of the family to the plight of their inpatient relative were positive**.** Nevertheless, a trend is noted in each of the target hospitals of fewer letters, visits and discharges to the care of relatives and food parcels, most becoming rare by mid-1942. Contextualising a reduction in food parcels, this is understandable when considering the growing problems of food supplies for citizens. This is evidenced in the letter of the mother of Madame S., she states,' I am sending this little parcel but it is very hard in the town where I live as rations are becoming more and more difficult to buy and find'.[705] This was in part also due

[703] UHAGM, Patient dossier, Mademoiselle A. S., age 34 admitted 8 September 1942 died 10 June 1943. Letter from MC to father 19 November 1942.
[704] UHAGM, Patient dossier, Madame C. P. age 70 admitted 8 September 1942 died 12 October 1942. Letter 21 October 1942 from son to MC.
[705] UHAGM, Patient dossier, Madame S. B., age 19, admitted 20 april 1943 discharged 19 November 1943. Letter 1 July 1943 from mother to MC.

to Vichy restricting family parcels whether by hand or transport with article 7 of the decree of 25 August 1941 limiting parcels to 10 kilos weekly.[706]

In considering what was not sent to patients in the way of letters or extra rations the situational circumstances should also be considered. Food, textiles, and shoes became precious high-priced commodities, and transport costs rose. The scarcity of incidental items such as brown wrapping paper and string to send a parcel was yet another hurdle often too high, and postal services were deficient.[707]

5.7 MC's concern and family response

The situation in the HPs was so bad regarding deficient rations that even after the circular of December 1942 increasing rations, patients were still not receiving enough calories and lipids and proteins to sustain life. MC Dr Bastié at Marchant wrote pleading letters, one of which is below:

'Madame,

Votre sœur Mme R-F est toujours en traitement dans mon service. Elle va mieux mentalement, mais physiquement elle est bien amaigrie par les restrictions extrêmement sévères que nous subissons. Son mari la ravitaille dans la mesure de ses moyens mais cela est tout à fait insuffisant. J'ai pensé faire appel à vous aussi pour lui faire parvenir des colis de pain pommes de terre, etc. que vous pourrez lui envoyer. Comme il y va de la santé et peut-être de la vie d'une sœur, je suis convaincu que vous ferez tout ce qu'il vous sera possible de faire pour lui éviter les affres de la faim.'

[706] ADA 958W 7; ADA 958W 6, ravitaillement général.This was in part also due to Vichy restricting family parcels whether by hand or transport with Article 7 of the decree of 25 August 1941 limited parcels to 10 kilos weekly. Letter to prefect from secretariat au ravitaillement 28 October 1941.
[707] Estèbe, *Toulouse 1940-1944,* p. 256.

Signé Bastié. [708]

His plea was effective. The sister sent food with her reply and the addresses of other relatives, 'so doctor might contact them to see if they too could help'. 'Efforts très méritoires' was how Marchant's MD reported family aid for patients.[709] In another dossier there is a note to the father of Mademoiselle A.,S. asking for food to be sent, 'each day as I do my clinical rounds she calls to me saying she is hungry'.[710]

It was not only MCs in Marchant who displayed concern for patient's welfare. There is evidence from nursing and administrative staff in the example of Madame C., D. In July 1940 she was admitted having been found dishevelled and confused among the exodus refugees that poured into Toulouse, a host department.

Her family had registered her as lost and were looking for her for two months. They contacted the Belgian Red Cross to repatriate her to Belgium. French hospitals, including Marchant, were circulated with her family name, but incorrectly spelt. When the name was not flagged up the family was told that she was 'missing'. However, whether it was an administrative or nursing member of staff is unknown but repeated searches were made among the seven hundred female patients. She was found in the infirmary. Happily for the family, a reunion was eventually accomplished although tragically she was not repatriated as she died three months after admission.[711] But her dossier illustrates that kindness was shown in very difficult times.

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[708] UHAGM, Patient dossier, Madame L-R., age 36 admitted 13 September 1941 died 24 July 1943. Letter from Bastié to sister 16 March 1943; ibid. Letter from sister 12 April, I am, sending the addresses of her brothers and sisters so they too can send her food parcels.

[709] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[710] UHAGM, Patient dossier, Mademoiselle A. S., age 34 admitted 8 September 1942 died 10 June 1943. Letter from MC to father 19 November 1942.

[711] UHAGM, Patient dossier, Madame C. D. age 67 admitted 27 July 1940 died 30 September 1940.

5.8 Vichy's racial and discrimination measures

Conversely, patients and staff in Marchant and Saint-Dizier were adversely affected by Vichy's discrimination measures. From early 1940, Marchant had had to cope with a considerably depleted workforce due to mobilisation and in October staffing was hit again with the statute of *3 octobre 1940*.[712] This deprived naturalised Jewish citizens of public office and employment and forty-five additional staff including certain administrative staff were dismissed.[713] Although some replacements were found for nursing staff, in the main as with mobilisation replacements they were untrained or retired nurses. This impacted further on quality of care with few trained staff to supervise new staff who had little previous contact with mentally ill patients.

As a result of Vichy's discrimination measures and widened legislation in which Jews' professional right to work in law, architecture, universities, and medicine was curtailed, Jewish Intern Dr Andermann at Saint-Dizier was dismissed.[714] These measures were supported by the hospital committee but whether from a xenophobic stance or because they were officials of the state and were doing their duty is not stated and notes from the hospital committee meeting merely state in Andermann's case that 'attention is drawn to the *Journal Officiel* of 16 August 1940'. The committee's stance demonstrates compliance to rigid institutional practice and patients were deprived of medical care.

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[712] Laurent Joly,'The Genesis of Vichy's Jewish Statute of October 1940', *Holocaust and Genocide Studies,* 27, (2013), 276-98 (p. 276); Donna Evleth,'The Ordre des Médecins and the Jews in Vichy France, 1940-1944', *French History,* 20, (2006), 204-22 pp. 204-5).

[713] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943; Michael Curtis, *Verdict on Vichy*, (London: Weidenfeld & Nicolson, 2002), p. 116; Michael Robert Marrus and Robert O. Paxton, *Vichy France and the Jews*, (Stanford California: Stanford University Press, 1995).

[714] Evleth, The Ordre des Médecins, p. 217; UHASD, Séance de la commission 1 septembre 1940. The committee conforms to the law of 16 August 1940 in the JO and gives notice to Andermann. Ryan, *The Holocaust and the Jews,* p. 209. Julie Fette, *Exclusions: Practicing Prejudice in French Law and Medicine, 1920-1945*, (Ithaca US: Cornell University Press, 2012), pp. 5, 165.

MCs Deffuant could ill-afford the absence of an intern but had no say: consequently support for both clinical and nursing staff during the Occupation was reduced.[715] Patient care and welfare would be affected due to the loss of medical staff, already being experienced in both mental and general hospitals. In Paris alone 300 doctors were excluded from work due to Vichy's discrimination measures.[716]

Other HPs and Jewish doctors in psychiatry were caught up in discrimination measures. Gaston Ferdière, MD of HP Rodez (Aveyron) refused an official order to list all personnel belonging to a trade union.[717] Vichy had banned all trade unions but in some HPs, including Marchant and Saint-Dizier, there were staff who were union members and covertly active. For Ferdière, this ban meant nine-tenths of the hospital personnel had to be dismissed as they were all involved in one way or another with a union. However, his list held two names: one an alcoholic, the other was known to despise the patients.[718] This example illustrates two noteworthy points; firstly a hospital psychiatrist was concerned about the welfare of his patients and would not allow the hospital to be denuded of staff and secondly he risked his livelihood to protect his patients.

5.9 MCs' concern for Jewish patients

A different type of issue but equally of importance for inpatients was the concern shown by MCs in HP Maison Blanche, Paris, a psychiatric female TB-specific hospital. Although MCs were not responding specifically to shortages they

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[715] UHASD, Séance de la commission 1 septembre 1940. The MC reports that patient care is difficult due to insufficient trained staff and only intermittent help from interim interns; UHASD, Rapport général du service médical. Service femmes année 1940.
[716] Masson and Azorin, The French Mentally Ill in World War II, p. 29.
[717] Gaston Ferdière, *Les mauvaises fréquentations: mémoires d'un psychiatre*, (Paris: Jean-Claude Simoën, 1978), p. 151.
[718] Gérard Massé,'Exclus parmi les vaincus: les malades mentaux dans la France occupée: mythe et réalité', *Nervure,* 1, (1988), 64-68 (p. 66).

nonetheless made personal and professional choices to protect their patients, in this instance, from racial measures and reveals a small part of the discrimination against Jews in psychiatric hospitals.[719] In Maison Blanche, German officials focused racial measures on patients in an invidious manner. Situated in the Seine-et-Oise department the hospital had a wide catchment area extending over several departments. Movement from one department, even one commune to another was very restricted for Jews, and visiting a relative who was an inpatient was more than difficult. '*Etant israélite, il m'est difficile de quitter le département de la Seine pour lui rendre visite'*, wrote one unhappy relative.[720]

Michel Caire's work on Maison Blanche demonstrates how discrimination against Jewish patients was negated in many instances by the intercession of MCs: conspiracy and manipulation undoubtedly saved patients from probable arrest and deportation. On occasions MCs demonstrated blatant disregard for state official requests in connection with Vichy's exclusion laws. Admission registers called for patients' religious status, and if *Israélite polonaise* was indicated, or even if a patient's belongings inventory list noted an *étoile juif* the patient was at risk of deportation on discharge. Evidence of this is found in one patient's dossier in a letter to the MD from the prefecture of police stating, 'Au cas où l'intéressée viendrait à être remise en liberté, je vous prie de bien vouloir l'inviter à se présenter à la Préfecture [.] pour régularisation de sa situation d'étrangèr'.[721]

Three certificates signed by this patient's MC Henri Beaudouin assert that 'her present state contra-indicates her being fit to be taken to the commissariat of police or be interrogated by les services de police'. MCs were undoubtedly aware of the fate of the Jews and saved many by not discharging them until after the

[719] Caire, L'hospitalisation des Juifs en psychiatrie sous Vichy.
[720] Ibid. p. 350.
[721] Ibid. p. 351.

Liberation.[722] Sadly, this particular patient was also victim to *Opération meuble* during which 38,000 apartments of Jews were looted between 1942 and 1944.[723]

MCs in other hospitals also involved themselves in protecting patients against discrimination. In HP Niort, Deux-Sèvres, MCs set up a safeguarding network for Jewish patients, even working with Vichy officials and police to keep, 'ces malades dans le quartier psychiatrique jusqu'au départ des Allemands'.[724] With the help of many non-Jewish friends and colleagues, psychiatrist Minkowski, worked with clandestine refugees in hospitals Rousselle and Rothschild, Paris, as well as his work with the OSE.[725] The behaviour and attitude of MCs such as these is evidence that many in the profession of psychiatry showed courage and empathy and were willing to do what they considered their duty for their fellowman.

MC Henri Ey, HP Bonneval, on demanding more rations for his patients wrote that it was his, 'impérieux devoir de sauvegarder leurs [patients] existence'.[726] He stands out as upholding the rights of his patients; his belief in the value of the individual and his commitment to the Hippocratic Oath were firm.[727] This is in stark contrast

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[722] Ibid. p. 535. Henri Beaudouin was also an inspector for psychiatric hospitals.
[723] Jean-Marc Dreyfus and Sarah Gensburger, *Nazi Labour camps in Paris*, (New York: Berghahn, 2011), pp. 3, 7 fn7; Jean-Marc Dreyfus, 'Le pillage des biens juifs dans l'Europe occidentale occupé : Belgique, France et Pays-Bas', in *Spoilations et restrictions des biens juifs en Europe,* ed. by Claire Andrieu Constantin Goschler; Philipp Ther (Paris: Autremont, 2007); Anne-Claire Kulig, 'La spoliation des Juifs en France occupée : la mise en œuvre de l'« Opération Meuble » dans le département de l'Aube (1942-1944)', (master's dissertation, l'université de Reims, 2009).
[724] Burguet Bignoux, L'hôpital-hospice de Niort, p. 166.
[725] Jeannine Pilliard, *Eugène Minkowski, 1885-1972 et Françoise Minkowska, 1882-1950: éclats de mémoire*, (Paris: L'Harmattan, 2009); Zuccotti, *The Holocaust, the French, and the Jews, 1999,* p. 217; Katy Hazan, *Le sauvetage des enfants juifs pendant l'Occupation dans les maisons de l'OSE 1938-1945*, (Paris: Somogy, 2008).
[726] Robert-Michel Palem, *La psychiatrie est-elle encore un humanisme?*, (Paris: Harmattan, 2010), p. 38; Ey and Cornavin, L'Activité d'un service psychiatrique en Beauce de 1940-1945, p. 10; Bonnet and Quétel, La surmortalité asilaire, p. 28 fn48; Bonnet, De l'Assistance aux malades mentaux.
[727] After the Liberation, Ey was an important member of the *Groupe de Sèvres* which included Daumézon, Balvet and Tosquelles. They campaigned for reform of the FMHS which they declared to be outmoded and a danger to patients.

to German psychiatrists who had been engaged in killing the mentally ill since the rise of the National Socialist party in Germany.[728]

5.10 The experience at Saint-Dizier

The mentality of the MD of Saint-Dizier is a little more complex to understand, but demonstrates the multiple attitudes and responses to the Occupation by psychiatrists. As previously stated, MD Magnand passed the security keys to his senior personnel giving the extraordinary command to release all patients, and then left with his family. Some eight hundred of the nine hundred and ninety inpatients fled into the surrounding countryside, some joining the exodus and some arriving at such distant areas such as Toulouse. In the mass panic, MC Mrs Deffuant in sole charge of the hospital's medical services, her husband having been mobilised, fled, 'fearful of my life,' with other staff members, leaving very few patients or staff remaining.[729]

This unprecedented action by a MD can be interpreted as ill-advised and unquestionably illegal as all patients were incarcerated according to law and only discharged with much official documentation, examination, and certification by both prefect and MC. However, it could have been, despite its unlawfulness, an act of humanity. Many staff had already deserted the hospital to escape with their family or relatives due to stories of the invading Germans and rumours of atrocities and destruction committed. Given such stories, it is probable the MD thought the fate of his patients would match those of the mentally ill in German asylums since 1933. Whatever the reason, it demonstrates how war and occupation affected and

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[728] Burleigh, *Death and Deliverance*.

[729] UHASD, Séance de la commission 1 septembre 1940.A full report of the event was presented to the committee by MC Deffuant; UHASD, Rapport général du service médical. Service femmes année 1940.Four out of seven pages of the report to the prefect giving the general medical state of the female quarters and patients and female patients was the ' Partie critique' of the events of the 13 June 1940 at 19.30h.

influenced institutions, individuals, and daily life. It was not without repetition. MD Scherrer recounts that before his arrival at HP Auxerre, in mid-June 1940 the interim director warned patients and families of the impending invasion and advised them to collect their relative. He, his wife and most staff, left the HP allowing patients to find their own way. From around 36000 people only 850 remained in Auxerre town, indicating the extent of panic and fear.[730]

5.11 Medical discourse and scientific studies

Within a public health social hygiene context the question of nutrition was a topic of numerous studies in the late 1930s concerned as many were in the medical sciences with the nation's diet and health. During the Occupation, they became even more relevant as rationing especially of foodstuffs deteriorated in quantity and quality. Vichy initiated studies through the INH headed by Professor Chevalier in Marseille, as well as a division of the Carrel foundation in Paris setting up a large nation-wide study into child health and development related to nutrition. Aware of the implications on the family of severe rationing Vichy organised gardens and parks to be dug for vegetables and crops and Vichy permitted the work of nutritionist Edouard de Pomaine who published a book on recipes in times of shortages.[731] Lucy Randoin, nutritional scientist published work on the problems of everyday life and nutrition: it dealt with conjectural calculations on usage and amounts of individual foods but it was of little use for most citizens when suggested items for improved diets in 1941 and 1942 included potatoes, eggs, black sausage, and horsemeat.[732]

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[730] Scherrer, *Un hôpital sous l'Occupation*. page 22.
[731] Edouard de Pomiane, *Cuisine et restrictions*, (Paris: Correa, 1940).
[732] Randoin, *L'Alimentation et la vie: les problèmes actuels de l'alimentation*; Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival,* p. 159.

5.12 Manifestations de carence alimentaire

The article, *Manifestations de carence alimentaire* written by director Leclainche and MCs Aimé Perret and J. Parde at Marchant describe their approach to the growing trend of ill-health in Marchant due to reduced rations and shortages of foodstuffs.[733] Their investigation demonstrates an element of concern for patients and, given other evidence of their compassionate attitude, their actions support the argument that MCs were not indifferent to the tragedy in their HPs. It nevertheless brings into sharp contrast inadequacies in institutional practice and facilities and failings in patient care by MCs.

The first indication of an uncommon trend in deaths came in December 1940 when three patients died in four days in the infirmary; patients too ill to be looked after in their quarters were admitted to the infirmary to be cared for by a MC and trained staff.[734] The only symptoms were progressive weight loss with severe physical weakness. In strict accordance with medical and legal conventions Perret and Parde reported the deaths to the prefect M. Leyritz. His response was prompt calling for a survey relating to food restrictions and consequences of all psychiatric hospitals in the region.[735] He received reports from twenty plus hospitals and local physicians who confirmed that their most disadvantaged patients, the elderly, the young, and cardiac and respiratory patients were already succumbing to the results of six months of official reduced rations.[736]

However, in terms of substantial rations for starving patients there was little practical done. In view of the initial lack of obvious cause, Perret and Parde

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[733] Leclainche, Perret, and Parde, Manifestations de carence alimentaire.
[734] Ibid. p. 253.
[735] ADHG, Série X364, Administration hospitalière, bureaux de bienfaisance et d'assistance, hospices, assistance et prévoyance sociales, assurances sociales, pupilles de la nation (1937-1943). ; ADHG 1831M 38. Ravitaillement général; ADHG X272. Comptes administratifs, moraux et médicaux.
[736] ADHG M1514 (4) Rapport mensuel de la Direction régionale de la Santé et de l'Assistance sur évolution de la mortalité dans les hôpitaux psychiatriques, avec graphiques (juillet 1942).

searched for reasons and at first the infirmary heating stoves were implicated as emitting carbon gases, and then a patient who died in a coma was suspected of having taken an overdose of medication.[737] Both diagnoses were excluded when expert advice was sought from Professors V. Brustier and Fernand Caujolle of the *Faculté de Pharmacie* in *Toulouse*. Laboratory-based enquiries excluded initial ideas and concluded cause of death was associated with reduction in patients' rations and extreme weather conditions during the summer months of 1940 and winter conditions up to December 1940.[738] Perret and Parde set up an all-male patient study with Brustier and Caujolle: 750 male patients were examined: no small feat when reports are numerous on the difficulties involved in the medical examination or treatment of mentally ill patients due to aggression, non-compliance or an inability to verbalise.[739] However, of this number, 124 (16.5%) were found to have asthenia, pallor, hypothermia, hypotension, and bradycardia.[740]

The MCs corresponded with MDs and MCs in sixteen hospitals in the non-occupied zone: eleven replied. Response was prompt, positive, and alarming, indicating the extent of the situation and concern among MCs. Equally they were interested in the phenomenon from a professional point of view rather than a compassionate one.[741] They spoke of the gravity of patients' health and confirmed similar indicators of malnutrition from ration shortages, and diagnoses of the causes of death.[742]

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[737] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 254.
[738] Sechet, *Quel temps ! Chronique de la metéo de 1900 à nos jours,* pp. 81-4; M. A. Viaut,'Mémorial de la Météorologie Nationale: Recueil de données statistiques relatives à la climatologie de la France par J. Sanson. Edition 1945', Paris, 1953. (p. 133); Sadoux, Organisation économique et vie matérielle; Bravard, Le ravitaillement alimentaire en Savoie, p. 25.
[739] Scherrer, *Un hôpital sous l'Occupation*. page 53.
[740] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, pp. 262-6. Asthenia (abnormal physical weakness due to undernourishment), hypothermia (low temperature), hypotension (low blood pressure), and bradycardia (slow pulse-rate).
[741] Ibid. pp. 265-8.
[742] Ibid. p. 256.

Returned replies came from the following HPs: Agen, fourteen patients died in the month of January 1941 alone whereas the annual mortality was thirty; HP Limoux had twenty-one deaths out of 634 patients but gave no explanation of percentage increase; HP Pau gave 'oedema' as the only symptom and quoted thirty deaths out of 650 patients of which seven were female; HP Lannemezan recorded eighty deaths out of 1000 patients in three months, although these deaths were not attributed to the cold as the hospital had an effective electric heating system; HP Saint Lizier's patients displayed similar symptoms to those of Marchant's with twenty-three deaths out of 497 patients; HP Leyme listed symptoms but no mortality figures; HP Montauban noted forty-three deaths in three months but did not elucidate on these figures, HP Mondevergue suffered 120 deaths out of 760 patients.

In contrast to Lannemezan, HP Vinatier chronicled the longest list of symptoms and from a population of 580, quoted morbidity figures of ninety-two, with six deaths: three from sudden death, two from hypothermia and one from a type of dysentery. The figures given from Vinatier are of significant interest as they indicate a low level of mortality yet the figure of 580 patients is only about 25% of Vinatier's total population in 1940.[743] Therefore these statistics are misleading. Recall that Vinatier is the hospital in which Lafont claimed 2,000 patients died in excess of normal during the Occupation. Figures quoted for Perret and Parde's study are clearly for a short period, the first three months of 1941, yet, that period was one of the coldest on record and other HPs also registered elevated numbers of deaths. Saint-Jean-de-Dieu registered fifty-nine deaths in the same period with 850 patients and Saint-Dizier recorded fifty-three deaths out of a similar total

[743] Isabelle von Bueltzingsloewen and Nicole Horassius-Jarrié,'La famine dans les hôpitaux psychiatriques français sous l'Occupation', *Information Psychiatrique,* 83, (2007), 721-5; Max Lafont, *L'Extermination douce: La cause des fous, 40,000 malades mentaux morts de faim dans les hôpitaux sous Vichy*, (Bordeaux: Bord de l'eau, 2000), pp. 29-30.Lafont states there were 2754 patients in 1938.

population.[744] One possibility of inconsistency in Vinatier's mortality figures could be that the correspondent gave figures for only one specific MC's s*ervice*r. There were usually four s*ervices* in each hospital; one for male, one for female patients, two for private payers, male and female, and one for seriously handicapped patients.[745]

HP Marseille gave extensive acute and chronic symptoms and stated that thirty-eight patients died out of 320, of those who did not die, seventy-seven were suffering from nutritional deficiency. These figures were sufficient for the MD to alert the Minister of the Interior and to organise, like Marchant, a medical study. This was carried out by Professor André Chevallier, the first director of the Institute national d'hygiène (INH), precursor of INSERM, in Marseille, and also the first institute for public health and medical research founded under Vichy.[746] This correspondence goes a long way to support the theory of professional individualism and lack of standard reporting which led to confusion over exact causes of death for official statistics at local or government level or any subsequent historical in-depth enquiries. However, it also indicates the extent of the consequences of inadequate rations in the HPs and the documentation of the crisis if not a solution to the situation.

Perret and Parde's enquiries targeted closed institutions, but had they included the *colonie* of Ainay the response would have been enlightening. MD Sivadon had also been observing specifics of health problems of male patients who were admitted

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[744] UHASJDD, Compte moral 1938 à 1945; UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945.

[745] Each MC was responable for a *Service*: a number of patient-quarters buildings based on specific mental conditions in today's hospital a *Service* would be similar to three or four wards.

[746] Jean-François Picard,'The Institut national d'hygiène and Public Health in France, 1940-1946', *Workshop 'European Health and the Second World War : Exile, Occupation and Post-War Reconstruction'*, 2001 5-6.

to his infirmary.[747] This phenomenon was the central theme of a medical thesis by his intern, André Chatelard.[748] Patients in Ainay presented with weight loss, weakness, painful limbs and oedema similar in type to symptoms of Beri-beri.[749] Out of a population of 800 seventy cases were observed in six months, of which forty-one proved fatal, tripling mortality rates in Ainay.

According to Sivadon, no cases with similar symptoms among local residents were reported by local general practitioners. For him, it was not a question of malnutrition per se as patients were placed with local cultivators and farmers, 'et donc la nourriture est restée abondante malgré les restrictions'.[750] He concluded that vulnerability of people with mental conditions and illnesses constituted a particularly favourable terrain in which Beri-beri could manifest itself when associated with a rapid reduction of a normal diet, such as those who were 'gros mangeurs de pain'. Sivadon opined that men were more susceptible than women but men ate much more bread than women. Saint-Jean-de-Dieu was also an all-male institution but a Beri-beri type symptom as cause of death for Godard was due entirely to, 'la mortalité pendant les mois d'hiver des anneés 1941 et 1942 a tenu à la conjugaison des influences nocives du froid et de la sous-alimentation'.[751]

In Marchant, only the most severe cases from 124 patients could be admitted to the infirmary to commence treatment. They included hyper-alimentation, according to the then current medical practice, which involved intensive nourishing diets rich in vitamins and protein. Such a regime included an enormous increase in calories, giving certain patients 3,300 daily (at the beginning of the Occupation

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[747] Sivadon and Queron, Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château.
[748] Chatelard, Contribution à l'étude des troubles carentiels.
[749] A lack of aneuryn compound (vitamin B1).
[750] Sivadon and Queron, Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château, pp. 220-1; Scherrer, *Un hôpital sous l'Occupation,* p. 55.
[751] UHASJDD, Compte moral 1938 à 1945. p. 23.

category A ration card gave approximately 1,500 calories).[752] An enhanced diet was prescribed by the MC but all such prescriptions had to be evaluated by the rationing authorities and in February 1941, they curbed this type of treatment.[753] Whether with worsening food supplies this was a move to clamp down on hyper-alimentation for patients across the spectrum of medical intervention or whether the efficacy of such treatment had proven to hold little positive results is not given.

Indeed, Perret and Parde acknowledged that whatever treatment given to patients already showing severe signs of under-nourishment nothing improved their condition and fatalities continued. They also conceded that the regime was overly high in calories but believed it was justified as certain groups of mental patients were hyperactive whilst others did not masticate sufficiently resulting in ingested nutriments not being as absorbed and therefore not being as beneficial as they should be.[754]

5.13 Clinical services

The infirmary is one area that reflects the inadequacies of the FMHS and of the un-readiness for the effects of war and occupation. Problems of food shortages, malnutrition and death are reported in considerable detail by MDs for the Occupation years yet there is little focus on acute medical and nursing care given in the infirmary. It is clear this service was not considered important; pathology and pharmacy services were more medico-scientifically attractive to psychiatrists.

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[752] Paxton, *Old Guard and New Order,* p. 360; Veillon and Flonneau, *Le temps des restrictions,* p. 1; Organisation économique et vie matérielle, p. 114; Also see Cépède, *Agriculture et alimentation en France*; Sauvy, *La vie économique des Françaises de 1939 à 1945*; Bravard, Le ravitaillement alimentaire en Savoie, p. 60.
[753] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 276.
[754] Ibid. p. 277.

Due to lack of expansion in the 1930s, Marchant, like Saint-Dizier, had insufficient beds to cope with a medical crisis of such dimensions as faced by MCs between 1940- 43.[755] Considering the number of study-patients requiring infirmary admission Marchant's MCs would have had to prioritise as there would have been existing patients in the infirmary. To make room these patients would have had to be discharged, many perhaps early, to their quarters. In which case, the MCs made difficult choices perhaps detrimental to certain patients.

In peacetime many hospitals had large stocks of linens and uniforms, for staff and patients, but they rapidly dwindled as textiles became limited new stock was almost impossible to source, and then only at a price and only with vouchers.[756] For citizens nineteen vouchers were needed for one sheet, twelve vouchers for a nightshirt; most people were only allowed two vouchers a week.[757]

As for nursing and medical procedures, even thermometers were limited as were hyperdermic and intramuscular needles and glass syringes, along with disinfectants. If patients required X-ray facilities, if they were well enough, if there were enough staff to take them, if there was a vehicle, or in the case of Ainay, a horse and cart, they would be taken to the nearest hospital. Saint-Jean-de-Dieu had X-ray facilities but Marchant and Saint-Dizier and Marchant did not, although in 1943 Marchant's director purchased one.[758]

In Marchant, during their study Perret and Parde reviewed the causes of death by hypothermia and took steps to improve ambient temperatures in the infirmary; patients were provided with extra blankets, hot-water bottles, and warm nourishing drinks throughout the day. These procedures were a positive response by MCs but mostly palliative as they were limited to available supplies and

[755] Chatelard, Contribution à l'étude des troubles carentiels, p. 6.
[756] Masson and Azorin, The French Mentally Ill in World War II, p. 29.
[757] Godart, *Le rationnement de ses conséquences*.
[758] UHASD, Rapport Administratif et Rapport Médical pour les années 1938 à 1945. p. 73.

prioritising meant others in the infirmary were denied them.[759] This highlights endemic problems of the consequences of war and occupation and outmoded institutional practice in a system that did not consider the inmate as an individual.

However, in early 1941, the pharmacy and pathology services which had been run by Perret and Parde were taken over by Caujolle. He dispensed medications and lotions, prepared medical dressings and bandages and experimented with animal serum, for intravenous and rectal infusion, as replacement therapy for lipid and protein deficiencies in patients' diets. These duties were crucially needed in a trained staff-deficient hospital where serious issues of patient health and welfare were escalating.[760] Even so, clinical care was hampered due to an ever-dwindling supply of medicinal and pharmaceutical goods, and packaging and glass bottles in which most lotions and tonics were dispensed. Insulin used in certain shock therapies was only available for diabetics and they too had difficulties sourcing their medication.[761]

Saint-Jean-de-Dieu also had a sizeable laboratory and pharmacy run by a qualified pharmacist Brother. Traditionally religious orders were among the first practitioners and apothecaries who prescribed and dispensed medication to their charges.[762] However, reflecting the dissimilarities in services in the target hospitals, at Saint-Dizier, all but the basic laboratory work, such as urinalysis and standard haematology, was sent out to the Laboratoire de Sérologie in Nancy. Since taking

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[759] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 281.

[760] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

[761] Scherrer, *Un hôpital sous l'Occupation,* p. 76; Serge Ricquier,'Souvenirs d'un pharmacien de la banlieue parisienne sous l'Occupation allemande', *Revue d'Histoire de la Pharmacie,* 81, (1993), 463-71; Archives Nationales (AN) Fontainebleau, CAC 200 50593 Art 2, Fonds de Chevallier. Letter 7 November 1940 from the Ministère de l'intéreiur à la famille to M. le directeur de l'enseignement technique, regarding urgent action for medical thermometers in the unoccupied zone.

[762] AN Fontainebleau 200 50593 ART 2. Letter from the American Red Cross, Marseille, 18 October 1941 to Professor Chevalier, ' I understand the list of priority medicines has been sent from the US by special boat'. signed Edward Sparrow; Brockliss and Jones, *The Medical World of Early Modern France*.

up their post in 1938 the Deffuants had repeatedly requested the presence of a pharmacist citing his duties were important in treatment routines, dressings and medications. They even accused the hospital committee of contravening hospital regulations which stated a full-time pharmacist should be on site.[763] An appointment was not made until 1943 and his first duty was a stock-take, pronouncing, not unsurprisingly that the pharmacy was unsafe, 'almost illegal'. Many medicines and lotions were old and had lost their efficacy. He warned that more patients might die without careful control, 'as one had recently, from being given the wrong medication'.[764] His appointment might well have saved patients' lives through attention to detail and supervision of a service that was underprovided in many HPs.

In Marchant, while Caujolle, whom the committee stated, 'il a depassé les espoirs que l'administration préfectorale avait mis dans cette nouvelle organisation de ce service' worked in the laboratory which had been 'excellently equiped' by Dide, Perret and Parde addressed a principal aspect in the health crisis of their patients: the link between undernourishment, catering, and meals.[765] There was little they could do regarding incoming foods supplies in terms of quantity or quality, but once delivered; there could be tighter control of catering services, on cooking, wastage and indeed pilfering by staff and essentially supervision of mealtimes.

5.14 Supervision of in-house services

Standard hospital practice demanded supervision, but as with many aspects of hospitals of the era, it was negligent. Direction and guidance of staff was a large

[763] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*.Section XI articles 89-97.
[764] UHASD, Séance de la commission de surveillance 20 February 1943.Pharmacist's report.
[765] UHAGM, Séance du comité de surveillance 29 January 1942. UHAGM, Letter 18 November 1941 from the director to the prefect. p. 5. The director describes the laboratory as spacious with valuable equipment used for highly specialised tests.

part of the duties of MCs, intended to prevent undisciplined behaviours, not only patients stealing from each other but also to prevent staff 'acquiring' food meant for patients. In some hospitals supervision was non-existent or 'accepted custom' allowed staff to 'buy' items such as food and even raw materials like coal. When MD Ferdière arrived at HP Rodez in July 1941, his first duty was to explain to staff that they could no longer 'vivre de la nourriture de l'hôpital'. In other hospitals, fraudulent removal of farm produce by catering staff was so rife as to be a *marché noir* in itself conducted at the hospital's kitchen door. At HP Clermont-de-l'Oise, with over 5000 patients, the practice of pilfering was so extensive that the local population called the hospital, 'la Samar' short for la Samaritaine. It is not clear if hospital inspectors were aware of such flagrant abuse of rules or blatant pilferage or whether they were reinforcing regulations they felt had become slipshod but in March 1942 a ministerial circular went out demanding ad hoc inspections be made at mealtimes to monitor the distribution of food in hospitals. This strongly supports the theory that due diligence was not always present.

Supervision of catering in Marchant was a major problem due in part to MCs' work-load but also a lack of appreciation of patients' wellbeing from an institutional and nursing perspective. As previously discussed, lack of supervision and control of menus and meals during the Occupation was in part the absence of the bursar, mobilised in 1939, he remained a prisoner-of-war until 1944. A former bursar was seconded to duties of both bursar and accounting clerk, but he too was absent throughout 1940, a crucial period in the development of malnutrition among the patients. Marchant suffered doubly from a lack of acquisition power and also supervision of catering staff and distribution of meals.[766]

[766] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.

Lack of supervision before 1940 was highlighted in a report on a visit by a hospital inspector. He noted this fault at mealtimes and admonished the hospital and its staff.[767] It is apparent little action was taken regarding this issue as Perret and Parde found there was a need, 'to have better surveillance at mealtimes' and also to, 'avoid wastage of foods'. However, there must have been some control as Madame C.R.'s father was told that his daughter 'has a good appetite, so much so that the nurses are obliged to isolate her from her comrades during meals because she steals their bread'.[768]

In Marchant, alternative strategies were attempted to enable the hospital kitchens to function. In Saint-Jean-de-Dieu, although mobilisation took 50% of its male staff, the Brothers fulfilling the duty of bursar and accountant were present throughout the Occupation which advantaged acquisition of supplies, catering and supervision of foodstuffs. Problems experienced in Marchant were not recorded by the Prior or MCs, although as discussed, the Prior revised staffing and timetables to maintain quality care.[769] However, in an environment where strict regimentation and routine were considered essential to the treatment and welfare of patients, their mental state was compromised. The Prior reacted to many such problems, more aware of patients' mental friability with changes to daily life, but for state-run establishments there was little flexibility or numbers of staff or finances to allow this.

With minimal supervision at Marchant it is probable staff took advantage stealing foods and supplies and that some of their colleagues were complicit in the act. Taking food may have been looked upon as compensation for pitiable wages. However, if thefts of material items or food were discovered staff were punished

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[767] AN Paris F1a 4570. Rapport: M. Sarraz-Bournet.
[768] UHAGM, Patient dossier, Madame C. age 30 admitted with 8 September 1942 died 6 January 1943.
[769] UHASJDD, Compte moral 1938 à 1945. p. 2.

severely. At Saint-Dizier, a staff member was demoted and suspended for six months when found with food secreted in her basket as she left the hospital grounds.[770] And at Marchant, a nurse was dismissed for 'the serious act of stealing a sheet'. [771] Not only does this highlight an individual's dishonesty and self-centredness taking from the already much depleted supplies for patients, it also points to the dire circumstances experienced by many in society faced with harsh restrictions on food and clothing and textiles. Such behaviour can be viewed as acts of women who were indifferent to inpatients' plight or of a mother attempting to stop her children from starving or giving them material comfort.[772]

From the supervision of catering, Perret and Parde proceeded to investigate conditions in patients' living quarters. In most HPs, improving basic living needs and the well-being of patients in their pavilions or quarters, was an almost unsurmountable task. The architectural style of Marchant, Saint-Dizier, and Saint-Jean-de-Dieu, although outwardly portraying majesty and tradition, internally did not adapt well to basic living conditions in the 1930s. High ceilings, stone floors and little furnishing, meant dormitories and dayrooms were cold, draughty, and impossible to heat adequately. In Marchant, even improvements and upgrading to heating and the installation of electricity in the 1930s was found wanting in the light of full blown shortages of raw materials of gas, electricity, wood, and coal, during the Occupation. As fuel supplies dwindled the newly modified oil-burning stoves in patients' quarters in Marchant, were left unused. An attempt made to convert them to wood was most unsuccessful as smoke spewed out in the

[770]. UHASD, Séance 14 avril 1942 Discipline sanctions Madame B.
[771] UHAGM, Séance du comité de surveillance 24 December 1942.One nurse has had to be dismissed for stealing a sheet.
[772] Both of these scholars have much to say about choices during the Occupation:Sweets, *Choices in Vichy France, 1994*; Gildea, *Marianne in Chains*.

refectories before it was realised that the chimneys had been blocked off in the modernisation to oil.[773]

Another service area found wanting and lacking nursing supervision was the pavilions. Take for instance regulation issue of blankets. The director of Saint-Dizier observed during one of his rounds that in one dormitory a patient had the standard one blanket while the patient in the next bed had six.[774] Such an example speaks of inadequate and unrealistic senior supervision in the overcrowded facilities of the target hospitals. In Marchant three nurses were found by the director to be leaning up against a wall without any view of the patients, the staff were punished for failing in the their duty. Given this one case it would not have been isolated and general patient care would suffer.[775] However, patients in Saint-Jean-de-Dieu, were better supervised and it is reasonable to assume that an approach of 'family life' was part of this and impossible in state institutions. In Ainay patients were also in a family situation and were less affected by health issues such as hypothermia. The continued presence and strong sense of duty instilled by the Order's philosophy and its observance by MCs and senior Brothers may have prevented inappropriate and selfish use of blankets, food being stolen or staff abusing their position. In support of this notion, the regional prefect of the Haute Garonne, when talking of clerically-run HP Sainte-Marie-de-Bon-Sauveur in Albi, stated, 'average mortality is less raised due to intensive use of farmlands and the well supervised distribution of food'.[776]

However, what MCs could not change was the institutional standardisation of facilities for patients. This was an issue that many in psychiatry saw as a large part

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[773] ADHG, Série X361, Rapport Administratif et médical du docteur Perret (1941).
[774] UHASD, Registre des délibérations de la commission de surveillance Séance 20 janvier 1944.
[775] UHAGM, Séance du comité de surveillance 6 mars 1941; UHASD, Séance de la commission de surveillance 18 July 1942. In Saint-Dizier the director dismissed a nurse being found sleeping in a patient's bed.
[776] ADHG 1831M 38. Ravitaillement général. Hôpital psychiatrique du Bon Sauveur Haute Garonne.

of needed reform of the FMHS. Institutional routine had significant bearing on patients' ability to cope with the very serious situation of the Occupation together with the weather conditions during 1940 - 41. An example of this was the issue of bedding, already touched upon, and uniforms. Summer bedding for patients consisted of one woollen blanket for summer and three for winter.[777] This appears to be a realistic number but bearing in mind blankets were woollen and laundering was not advanced, they would end up half their size with little thermal properties.

Demonstrating more of this unrealistic approach to patient care, in winter only one extra woollen jumper or a woollen suit was issued replacing the summer cotton one and in Marchant, worker patients received an overcoat. Institutional procedure declared that winter started on 1st October and summer on 1st May; the date on which patients returned all winter bedding and clothing to stock and were re-issued with the next season's uniform. This routine was fixed regardless of the excessive changes in weather patterns that occurred during the Occupation.

Perret and Parde's decision to improve patients' care and welfare and the infirmary, catering, and the living quarters, highlight that serious omissions occurred in Marchant. Hospital Rulebooks give a clear list of responsibilities and chain of command.[778] Patients in Ainay had little supervision at mealtimes, although MC or *infirmier-visiteurs* would drop in at mealtimes to check on menus.[779] It is possible, that patients were worried about making complaints regarding meals for fear of reprisals from the *nourriciers*, or that one of the two patients lodging together did

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[777] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier*. Reglement section XVIII articles 150-159.

Ibid. Reglement section XVIII articles 150-159.

[778] Ibid. Articles 48-50, 149.

[779] UHAALC, Répetoire alphabétique des nourriciers de la colonie (Ainay, St Bonnet, Valigny) années 1900 à 1930.

not steal from each other, but on the whole they were healthier than patients in the closed hospitals.

5.15 Collective concern

MCs at Marchant were among the first to write of the health consequences of Vichy's rationing system, but they were not alone. Other MDs and MCs condemned unacceptable increases in patient deaths which they claimed were due to poor rations. Dr K. Sizaret MD HP Mayenne (La Roche-Gandon) wrote to the local prefect in 1941 regarding a 20% increase for male deaths (10% for females). For him, there was no mystery about deaths in his hospital: 'La cause de cette augmentation léthal est unique: la sous-alimentation'.[780]

Evidence given so far is but a small part of daily life and death experiences in the target hospitals and responses were mainly from individual MCs attempting to improve conditions for their patients. There was however, a more collective concern in psychiatry for increasing mortality and a dissatisfaction with the lack of action by the rationing services authorities and Vichy's Ministry of Health. These concerns were projected onto the larger psychiatric scene in October 1942 at the annual congress of the SMP in Montpellier. Discourse at the meeting was heated and compassionate on the part of certain psychiatrists who were experiencing at first hand the results of malnutrition. Many MCs and MDs voiced their anxiety and professional shock at the increasing consequences of the Occupation: Drs Caron, Daumézan (former Ainay MDs) denounced 'l'effroyable hécatombe de malades à laquelle nous avons assisté depuis juin 1940'.[781] This statement is unquestionably

[780] Bonnet and Quétel, La surmortalité asilaire, p. 27.
[781] J. Caron, Georges Daumézon, and D. Léculier,'Augmentation de la mortalité dans un hôpital psychiatrique depuis juin 1940: Ses causes', *Annales Médico-psychologiques,* 1 (1943), 843; Bonnet, De l'Assistance aux malades mentaux, p. 186.

not one of a cover-up of the circumstances in the HPs claimed by Lafont.[782] Their campaign for reform of the institutionalisation of the mentally ill had begun well before the Second World War and grew more urgent following their experiences during the Occupation and Vichy regime.[783]

Despite previous dalliance and inaction by government officials over repeated demands for extra rations for inpatients, the circular of 4 December 1942 unexpectedly granted increased rations to all psychiatric hospital patients.[784] This was similar to that already granted to factory canteens and reduced-price restaurants (a previous Vichy move to ease food shortages for the disadvantaged).

It is presumed that this move was associated in some measure with the lobbying of public officials by the SMP; their regular meetings in Paris were a platform for prominent psychiatrists such as Vié, Bonnafé, and Beaudouin to broadcast the issue of inpatient mortality.[785] Equally, it can be argued that pressure was brought to bear by an individual psychiatrist, Hélène Bonnafous-Sérieux. She worked under MD Scherrer in Auxerre and was the wife of Vichy's Minister for Agriculture and Rationing, Max Bonnafous, a key figure in adopting the circular.[786] She was also the daughter of Paul Sérieux, MD of Ville-Evrard, Paris.[787] However, the debate is still lively on whether this was a political or humanitarian move.[788] Nevertheless,

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[782] Bueltzingsloewen, *L'hécatombe des fous,* pp. 196-8; Also see Dominique Mabin and Renée Mabin, 'Art, folie et surréalisme à l'hôpital psychiatrique de Saint- Alban-sur-Limagnole pendant la guerre de 1939-1945', Mélusine: Cahiers du Centre de Recherche sur le Surréalisme Université Paris III, (2015) <http://melusine-surrealisme.fr/wp/> [Accessed 31 July 2016]

[783] Henckes, Le nouveau monde de la psychiatrie français, p. 226.

[784] Circulaire n°186 du 4 décembre 1942 sur dite "Circulaire Bonnafous".

[785] Vedié, Moser, and Paulin, Surmortalité dans un hôpital psychiatrique, p. 514; Isabelle von Bueltzingsloewen, 'Starvation in French Mental Hospitals under Nazi Occupation Misinterpretations and Instrumentalization since 1945', in *Silence, Scapegoats, Self-reflection: The Shadow of Nazi Medical Crimes on Medicine and Bioethics,* ed. by Sascha Topp Volker Roelcke, Etienne Lepicard (Gottingen: Vandenhoeck & Ruprecht, 2015), pp. 231-42 (p. 235).

[786] Bonnafous took over from Jacques-Leroy Ladurie, the latter resigned in September 1942 over ever-increasing rationing shortages.

[787] Caire, A propos de l'hécatombe, p. 313; Bueltzingsloewen, Morts d'inanition, 2005, p. 59.

[788] Ajzenberg and Castelli, *L'abandon à la mort*.

mortality in HPs started a slow descent from the beginning of 1943 despite the fairly accurate prediction given by Charles Richet, member of the Académie de médecine that two million French citizens were likely to succumb to famine either directly or indirectly as a result of the development of infectious diseases.[789]

At Marchant, despite MCs reacting positively once the crisis of increased deaths was brought to their attention there was little that could be done to save patients who were most vulnerable from succumbing to the consequences of dangerously low rations, poor nutritional quality, restrictions and shortages. In reality, the medical article *Manifestations de carence alimentaire,* exposed institutional failings in the FMHS in which the mentally ill were considered of less worth than other members of society: an attitude of indifference although not necessarily derived from a eugenicist perspective but which underpinned many decisions made by the governing authorities, prefects and hospital committee members.

There were however, those in society and in medicine who had little compassion for the mentally ill. Their attitude reflects significant prejudice and insensitivity. Such is the case of another member of the Académie de médecine, M.H. Martel, who, on hearing of the 1942 circular for increased rations for the mentally ill expressed his strong view that they were less deserving cases to be given extra rations than many workers he knew who were sober and malnourished: stigmatising all mentally ill people as alcoholics.[790] He was not alone in his attitude, the mayor of Lyon Edouard Herriot, questioned the sagacity of spending the same

[789] Charles Richet,'Etude sur le rationnement alimentaire à l'Académie de médecine', *Bulletin de la Société scientifique d'hygiène alimentaire et d'alimentation rationnelle de l'homme,* 29, (1941), 72-79 (p. 59).
[790] M.H. Martel,'Au sujet d'une circulaire qui attribue un supplément de ration alimentaire aux malades internés des hôpitaux psychiatriques', *Bulletin de l'Académie nationale de médecine*, (1943), 6-92 (p. 88).

money for one year's treatment on a patient in HP Vinatier as on raising a child for a year.[791]

In another case, a letter from Marchant's director Leclainche to the prefect regarding the events of December 1940 states, 'The function of medical services has improved dramatically with much attention paid to daily duties and to care of patients according to the Hospital Rulebook. More attention is now given to patients' physical as well as mental condition'.[792] By its very content this statement demonstrates psychiatrists had let down patients in the very fundamental of duties of care, although they had responded to the crisis and made considerable improvements. Also shows a lack of support from state officials for MCs in their management of patients. Moreover, although Leclainche was co-author of the article, *Manifestations de la carence alimentaire* his position and stance leans towards an institutional rather than a medical or humane stance. This could mean he was unconcerned as to the welfare of the mentally ill and was distancing himself from poor medical practice.[793] His stance, if not derived from negative eugenicism, demonstrates a disregard for the needs of the mentally ill. Similar to what Odier suggests in his analysis of the sous-prefect.

Although the article *Manifestations de la carence alimentaire* only represents two psychiatrists and a non-medical director in one individual hospital, it demonstrates how a growing number of hospital psychiatrists reacted to the outcomes of ration

[791] Odier, La surmortalité des asiles d'aliénés français durant la Seconde Guerre mondiale (1940-1945), p. 164. Taken from the ADRA. Procès verbaux du Consiel général du Rhône, séance du 22 octobre 1937.

[792] UHAGM, Report from the director to the prefect 15 august 1941.

[793] Personal communication by email from Dr Georges Lanquetin (son of Marcel Lanquetin Director of HP Marchant) to Patricia S. Legg between February 2011 and May 2012. Leclainche was demoted as a Paris prefect for failing to follow the Vichy line, he was dispatched to Marchant. In 1943 he was replaced by another demoted prefect Marcel Laquetin. Both eventually went to Lyon and were active in the Resistance.

shortages in their HPs.[794] Although whether motivation was of a compassionate nature or more administrative is not clear for available evidence. However, as evidenced in Perret and Parde's study and experimental therapies little improved the quality of patient health and that death was inevitable when malnutrition was of long standing or exacerbated concomitant physiological conditions especially respiratory or cardiac diseases.[795]

Figure 10 Cachectic patient HP Marchant
Source : 'Manifestations de carence alimentaire HP Gérard Marchant Service des hommes de l'hôpital psychiatrique Marchant' Xavier Leclainche, Aimé Perret and J. Parde. *Toulouse Médical* (1941)

[794] Sivadon and Queron, Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château; Chatelard, Contribution à l'étude des troubles carentiels; Maurice Bachet, 'Etude des troubles causés par la dénutrition dans un asile d'aliénés', (ibid., université de Paris, 1943).
[795] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 275.

5.16 Conclusion

Through the examination of the events in the target hospitals during the years 1940 to 1944, chapter five has revealed the principal physiological and psychological health implications of the dynamics of shortages and restrictions: irregular and inferior quality food supplies and scarcities of material resources. This resonated throughout the hospital, including clinical and medical services, infirmary, pathology and pharmacy, catering, laundry; all vital services to the welfare of patients generating relentless pressure on MCs, staff, patients, and families.

Adding to the acute nutritional and medical crisis, in their efforts to control insufficient rations which were exacerbating malnutrition and death MCs were unsupported by the hospital authorities. The chapter underlines a dismissive and negative attitude towards the plight of inpatients by Vichy officials as in the case of Marchant and Saint-Dizier. Certain prefects and hospital committee members were generous in their words, 'do all you can for these unfortunates', but had little insight into patient needs. They were unwilling or unable to provide practical help when faced with increasing hunger of nearly a 1000 people. Others displayed a mentality more judicial than humane, dogmatically following institutional and governmental policies as in the case of Vichy's discriminatory measures against Jewish doctors - to the detriment of patient care. Nevertheless, there were others such as the MCs in Maison-Blanche who risked imprisonment and their livelihoods to keep their Jewish patients from discharge and inevitable deportation.

The article, *Manifestations de la carence alimentaire*, brings strongly to the fore the fallibility and the inadequacies of the FMHS. It highlights complex institutional and profession issues not only in the causes of an unusual increase in deaths in Marchant but of internal mismanagement and omissions of care that might have been less influential on mortality if a more principled approach to patient management had been in process. Hospital routine and psychiatric practice has been demonstrated as weak if not negligent, primarily in the supervision of in-

house catering and in nursing care, especially when many in psychiatry were bemoaning the lack of training and insufficiencies of personnel of staff they knew to be unsuitable in many cases untrained and lacking basic skills.[796] One can also see a disregard for patients' general health with little monitoring of physical conditions in the lack of maintenance of patient case-notes. If there had been more supervision there would have been less corrective measures to be taken when rationing highlighted nutritional problems.

Control of hospital personnel was blatantly poor with more attention placed on administration and psychiatric investigation and scientific research into causes and classification of mental diseases than on patient care. It is clear that a medical model of care was not sufficient in times of crisis than a nursing model as in the HP Saint-Jean-de-Dieu which would have been less counteractive than seen in Marchant. However, one factor underlined in the article is the workload of MCs in many HPs. It is clear that material conditions before the war were seriously defective: over-accumulation of chronic cases, severe overcrowding, too few MCs and qualified nursing staff, inadequate material and environmental conditions: none conducive to good standards of care.[797] It is possible to see how breaches in professional practice occurred in the crisis brought about by the Occupation and rationing which was exacerbated even before the war and occupation then the crisis of Vichy's rationing services and the occupiers. Undoubtedly, there was ambiguity in the MC's position, it was a balancing act: of his/her accountability to the state within the institutional framework of an archaic system that lacked even standard facilities for the mentally ill, with that of a profession that had little unity or adequate training for the rigours of the Occupation crisis.

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[796] Postel and Quétel, *Nouvelle histoire de la psychiatrie,* p. 59.
[797] Chris Ham, Anna Dixon, and Beatrice Brooke, Transforming the delivery of health and social care: The case for fundamental change, 2012; Alan Worthington, Paul Rooney, Ruth Hannan, and Karen Martin, *The Triangle of Care. Carers included: a Guide to Best Practice in Mental Health Care in Scotland*, (London: Carers Trust, 2013).

Although the article *Manifestations de la carence alimentaire* only represents two psychiatrists and a single hospital it demonstrates that Marchant's MCs reacted to the outcomes of ration shortages in their HPs.[798] They reacted in a positive manner, if tardily, and did not display a mentality derived from belief in negative eugenics similar to that of their colleagues in German psychiatry.[799] In many HPs MCs made considerable attempts to prioritise within the limited resources available to them to give a more holistic approach to patient care. They discharged patients earlier than would have been usual and encouraged certain families to take their relatives home. A certain degree of solidarity with the plight of inpatients can be seen in the involvement of families and many responded positively; they sent food items, clothing and money, but there were many patients who had no such support, like the many hundreds of transferees in June 1940 to Marchant from the Rhine region. However, food parcels and prioritising had but a transient effect on a situation that was beyond MCs' control such as rationing inequalities and nutritional restrictions and increasing limited commodities, for many patients too late.[800] As evidenced in Perret and Parde's study, experimental therapies did little to improve the quality of patients' general health and death was inevitable when malnutrition was of long standing or exacerbated by concomitant physiological conditions, especially in respiratory or cardiac diseases.[801]

However, on a larger scale, a collective concern to the crisis was revealed at the congress of psychiatrists in Montpellier, in October 1942, after which certain

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[798] Sivadon and Queron, Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château; Chatelard, Contribution à l'étude des troubles carentiels; Maurice Bachet, 'Etude des troubles causés par la dénutrition dans un asile d'aliénés', (ibid., université de Paris, 1943).
[799] Burleigh, *Death and Deliverance*.
[800] Sivadon and Queron, Sur la sensibilité particulière des malades mentaux à l'avitaminose B1. A propos de l'epidémie de béri-béri de la Colonie familiale d'Ainay-le-Château; Chatelard, Contribution à l'étude des troubles carentiels; Maurice Bachet, 'Etude des troubles causés par la dénutrition dans un asile d'aliénés', (ibid., université de Paris, 1943).
[801] Leclainche, Perret, and Parde, Manifestations de carence alimentaire, p. 275.

congress members intensified their lobbying of government ministers, resulting in the circular of December 1941, giving vital increase in rations to psychiatric hospital patients. If there had been collective indifference to the fate of inpatients, it begs the question as to why such efforts were made in HPs like Marchant to rectify inadequacies and inferior care and flaws in the management of facilities and patient care when the first signs of ill health appeared. It would have been simple in many instances to leave ill patients to die in their inadequate living-quarters effectively reducing overcrowding. However, no documentary evidence was found to confirm this in the target hospitals.

It is unfortunate there is no comparable work from MCs in Saint-Jean-de-Dieu during the 1930-1940s found in the departmental archives or in the hospital at Dinan-Léhon or the Provincial archives of the Order of Saint Jean de Dieu in Paris. They would act as a comparative to questions of mismanagement posed in the article Manifestation. However, from available archival material it has been established there was a significant difference in the philosophy of administrative management, medical practice, and quality of nursing care between state and clerical hospitals.

Chapter six will examine the toll on daily life during the Occupation and give an analysis of mortality as it occurred in the THPs within the context of hospital- and patient-profile, while considering the method of recording statistics within the FMHS and a lack of collective agreement on concepts of insanity and classification of causes of death within the psychiatric profession.

Chapter 6 The significance of the German occupation for patients in the target hospitals

Throughout this study a narrative has been developed of the four target hospitals, their facilities, material conditions, the MDs and MCs, the personnel, and the patients themselves. This gives an albeit small glimpse of 'normalised life' in these institutions, but acts as a starting point from which to examine why mortality rose to such a level during the Occupation. The chapter offers a new perspective and interpretation on the specific mortality increase as experienced in the target hospitals demonstrating multi-causal explanations. Through analysis of annual hospital reports, classifications and terminologies of causes of death, we will learn how many patients died (mortality statistics) and from what patients died (cause of death).

Firstly, the chapter interrogates the auditing of National statistics, referred to by various scholars, questioning the validity of such data, as through the study's research and analysis, and in light of inaccuracies and errors found in all four target hospitals, it is possible this was a widespread issue within the French mental health system. The haziness in certain data presented in local hospital reports could have led to erroneous interpretation at prefectural and national level, which means national figures should be viewed with some wariness. From evaluation of the customs of how mortality and the management of the medical aspect of the hospital was reported it will be demonstrated that, although psychiatrists and directors were representatives of the psychiatric profession and powered by personal influences, they were employees of the state, and as such restricted in their actions. This will shed further light on the research questions of whether mortality was exacerbated by a state system that was discriminatory, uncompromising, archaic and under-funded, or by professional indifference. Mortality causation in the target hospitals is explored less from the negative eugenic stance forwarded by Max Lafont and refuted by several scholars, than

from the perspective of the traumatic and hidden characteristics and consequences of the Occupation period, which were manifested in the lived in experiences in the target hospitals.[802]

Although the chapter will examine statistics on mortality and causes of death, the question as to why inpatients died is linked intrinsically to existing factors that were internal hospital dynamics before the Occupation. These relate firstly to the patients themselves: their mental condition, age, gender, marital status, and socio-economic class, and secondly to hospital status, leadership, size, and geographical location. These elements of hospital life had changed little before the Occupation when average annual mortality was less than 10%. This leads to the premise that normalised life was destabilised by *extra muros* factors, resulting in disruption and distress and the exacerbation of physical and mental ill-health which led to death. They are the corollaries of the Occupation: the unequal and impracticable rationing services, severe restrictions on food and raw resources, the pitiless appropriation of property and hospitals for German military purposes which led to the evacuation of thousands of inpatients and their transfer often across the length of France, and finally, the proximity of German troops to the target hospitals.

There is one further consideration within the context of the Occupation which was exceptional and relentless and that is environmental meteorological conditions.[803] In France, and throughout most of Europe, freak weather conditions in the winters of 1940-41 and 1941-42 advanced many deaths of the military occupying forces and the general population. For many inpatients this decisive factor was consequential and had great bearing on daily life, health and death. However as we shall see mortality was not experienced equally even for hospitals of the same status.

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[802] Bueltzingsloewen, Rationing and Politics.
[803] Claudia Baldoli, Andrew Knapp, and Richard Overy, 'Bombing, States and Peoples in Western Europe 1940-1945', (London and New York: Continuum, 2011).

6.1 National statistics on mortality in psychiatric hospitals

National statistics record that more than 40,000 inpatients died during the Occupation. However, although a sharp rise in mortality can be deduced from national data published by the *Statistique générale de France* (SGF) they are only isolated observations and cloak a disparate reality at local hospital level. The SGF produced vital statistics on the totality of psychiatric establishments which comprised the French asylum system. It recorded annual numbers of patients on 1 January, number of admissions, discharges, deaths and total population on 31 December.[804] However, the complexity of the system of data collection and its generality reveal little of life and death experiences over time or changes and trends on a monthly or even annual basis. National statistics were collated from data sent from each prefect's office which in turn had been gathered from statistics recorded by the administrative staff for the directors of each hospital. This was mandatory under the 1838 law.[805] There were weaknesses in the system; not least, that statistics in psychiatry had been contested since regulations regarding them were laid down by this law. In 1915 the MD of Braqueville (renamed Gérard Marchant in 1937) Louis-Maxime Dubuisson claimed that statistics and graphs were expensive and unnecessary not only for the prefect but also the SGF and that each asylum's methods of reporting, 'varient non seulement dans la forme, mais dans le fond, et surtout dans le nombre'.[806] His observations ring true when hospital reports of the 1930s are examined. There is no doubt that many psychiatrists supported Dubuisson's opinion that nosography, 'ne veulent pas dire grand chose'.[807] However, although basic requirements for hospital reporting or

[804] AN Fontainebleau SAN 70847 p. 39.
[805] Meslé and Vallin, La population des établissements psychiatriques: Evolution de la morbidité ou changement de stratégie médicale?, p. 1036.
[806] UHAGM, Rapport médical 1915 du Dr Dubuisson.
[807] Ibid. Vasia Lekka, *The Neurological Emergence of Epilepsy: The National Hospital for the Paralysed and Epileptic (1870-1895)*, (Springer, 2014), pp. 34-5.

auditing conventions were established under the 1838 law, examination of the target hospitals annual reports reveals considerable scope for interpretation with little uniformity.

The *Règlement* (1941) for HP Saint-Dizier holds all hospital management regulations. Article 20 of this Rulebook establishes the presentation of administrative and medical reports, the first part statistical, recording movement of the population, which included modes of admission and discharge, incidents of escapes, accidents, suicides, causes of death, treatment, giving figures of patients per pavilion, number of day and night staff, regulations regarding *travailleurs*, and indication of the sanitary conditions in the hospital.[808] A second part of the report, a critique with discussion of the presented statistics, annual performance of the hospital and personnel, and desired improvements, the condition of the fabric of the medical services and future medical action.

However, in line with many religious orders Saint-Jean-de-Dieu also followed the General Rules and regulations for charitable institutions in accounting and reporting laid down since before the nineteenth century with the purpose of demonstrating good use of benefactors' monies.[809] Variants in hospital reporting and statistics had long been debated in both medical and psychiatric discourse. In 1939, Daniel O'Brian, member of the International Rockefeller Health Board claimed that French statistics and nosology were, 'confuses et souvent

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[808] Meylan, L'Infirmier des hôpitaux psychiatriques.Articles 20-33, 77-87.

[809] William J. Jackson and Audrey S. Paterson, 'Accounting and the control of Charity: A Uniform Accounting System for Voluntary Hospitals 1870-1915' <http://www.hw.ac.uk/schools/management-languages/documents/research/DP2013-AEF1.pdf> [Accessed 2016] ; Michele Lacombe-Saboly,'Hospital accounts and accounting systems: a study in the French region of Toulouse from the seventeenth to the nineteenth century', *Accounting, Business & Financial History,* 7, (1997), 259-80 pp. 270, 710.); Burdett, *Hospitals and asylums of the world, their origin, history, construction, administration, management, and legislation; with plans of the chief medical institutions accurately drawn to a uniform scale in addition to those of all the hospitals of London in the jubilee year of Queen Victoria's reign,* p. 707; Meylan, L'Infirmier des hôpitaux psychiatriques, pp. 10, 71.

dépassées'.[810] While in his study after the Liberation of France, psychiatrist and epidemiologist Henri Duchêne declared considerable difficulty in collecting and establishing data in an era when many psychiatrists were sceptical of statistics.[811]

In the administrative and medical reports of the target hospitals errors and considerable imprecision in the presentation of statistics are found, along with variances in content and format. Equally important, for clarity and reliability of statistics there was considerable dissimilarity in the terminology used for diagnosis and cause of death making comparative analysis of even four target hospitals demanding. Indeed, in many patients' notes admission diagnosis was not confirmed in subsequent doctors' notes and on occasions the registered cause of death was different again. Essentially, the two themes of hospital audit, imprecision and individualism in psychiatric terminology of illness/cause of death, with 'vague terminologies' and 'tangled meanings', reveal a lack of professional guidelines and disunity within the profession itself.[812] However, it must be noted that even within the civilian population causes of death registered by general practitioners were frequently vague often due to physicians having difficulties in diagnosing causes of death.[813] For instance, in 1943 in the Côtes-du-Nord, from 7,211 deaths only 6,146 were physician-certified, 573 were non-physician-certified and 492 had no cause of death on the certificate.[814]

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[810] 'Quelques jalons pour une histoire de la santé publique en France du XXème siècle à nos jours', Histrecmed, (<http://www.histrecmed.fr/index.php?option=com_content&view=article&id=282&Itemid=221> [Accessed 26 July 2016]

[811] AN SAN 70846, Travail de l'Institut National d'Hygiène. Travail de Henri Duchêne 1947; Nicolas Henckes,'Mistrust of numbers: the difficult development of psychiatric epidemiology in France, 1940–80', *International Journal of Epidemiology,* 43, (2014), 143-52. Henckes has written extensively on post Liberation psychiatry in France.

[812] Bueltzingsloewen, *L'hécatombe des fous,* p. 29; Masson and Azorin, La surmortalité des malades mentaux; Adler, Gendering Histories of Homes and Homecomings, p. 458.

[813] Sadoux, Organisation économique et vie matérielle.

[814] AN Fontainebleau SAN 70847 pp. 72-3, 76-7.

Non-conformity in administrative and medical records raises challenges in analysing causes of death especially when confronted with registers which reveal a myriad of causes for one conditions such as the term cachexia (a wasting disease due to malnutrition with increasing weakness and loss of weight giving rise to hypothermia, oedema, diarrhoea and dehydration, which in turn led to reduced resistance to infections and diseases): organic cachexia, senile cachexia, oedematous cachexia, under-nutrition, nutritional deficiency, and general physical weakness.[815] Informed decisions by the prefect's office staff on the presentation of such a variety of causes to the national authorities would not have been straightforward and could have led to misleading information on the state of a hospital, on mortality, discharge and cure rates. MD Dubuisson also stated, 'Si j'étais Préfet, je retournerais les certificats ainsi libellés et je prierais les auteurs de s'exprimer en langage clair'.[816] Nevertheless, such variety of causes of death found in the Death registers does not prevent a comparison being made with certain analogous data from all four target hospitals. Accepting there are existing lacunae in source materials and data from the hospitals and the difficulty in demographics of studying mortality by cause for this era, it is still possible to offer a summary of the importance and reasoning of mortality and to theorise about what provoked such a tragedy.[817]

[815] Jacques Vallin and Meslé France, *Les causes de décès en France de 1925 à 1978*, (Paris: Institut National d'Etudes Démographiques, Presses Universitaires de France, 1988), pp. 295-327.
[816] UHAGM, Rapport médical 1915 du Dr Dubuisson.
[817] Vallin and France, *Les causes de décès,* pp. 136-7; Jacques Vallin, John H. Pollard, and Larry Heligman, 'Methodologies for the collection and analysis of mortality data: proceedings of a seminar at Dakar, Senegal, July 7-10, 1981. The problem of studying mortality patterns by cause over a long period of time: an example from France, 1925 to 1978', (Liege Belgium: Ordina, 1984), pp. 449-92.

6.2 National guidelines on classification of diseases and causes of death

The overabundance of individual terminology of causes of death was despite clear national guidelines for the classification of sickness and mortality, referred to as the *Classification Internationale des Maladies* (CIM) (International classification of the nomenclature of diseases and causes of death) established in 1893 by statistician and demographer, Jacques Bertillon.[818] Ironically, Bertillon had been inspired by the work of alienism's founder Pinel and his classification of mental diseases, although at the 1909 Paris international meeting on the CIM there was opposition to any change by physicians to such an extent that the meeting was brought to a quick closure: within psychiatry not all agreed with Pinel's classifications.[819] As we have learned, Dide of Braqueville, refused to accept German-defined classifications of 'schizophrenia' favoured by German psychiatrist Emil Kraepelin preferring the illness named by his tutor, Morel, *démence précoce* (schizophrenia).

From primary sources found in the target hospitals' archives, it is clear that little attempt was made by psychiatrists, or indeed physicians, to fall in line with the CIM. Moreover, there was no legal statute despite the fact that all death certificates had to be sent to the prefect. At a meeting of the Académie de médecine in 1924, Drs A. Marie (founder of the *colonie familile* at Ainay-le Château) and V. Kohen

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[818] Jean Garrabé,'La Classification française des troubles mentaux et la Classification international des maladies', *Information Psychiatrique,* 89, (2013), 319-26; Iwao M. Moriyama, Ruth M. Loy, and Alastair H.T. Robb-Smith, *History of the Statistical Classification of Diseases and Causes of Death*, (Washington: National Center for Health Statistics, 2011).

[819] D. Geddings, Report of the Transactions of the International Commission for the Revision of the International Classifictaion of the Nomenclature of Diseases and Causes of Death held in Paris in July, 1909. D. Geddings. Surgeon, United States Public Health and Marine-Hospital Service, September 24, 1909, 24, 1909 140. Jeanne Mesmin d'Estienne,'La folie selon Esquirol. Observations médicales et conceptions de l'aliénisme à Charenton entre 1825 et 1840', *Revue d'histoire du XIXe siècle,* 1, (2010), 95-112; Maurice de Fleury,'Une classification des maladies mentales', *Bulletin de l'Académie nationale de médecine,* 91, (1924), 24.

regretted that statistics and terminologies had to be taken with caution, '*Car elles peuvent varier selon les méthodes, selon les milieux, selon les statistiques et selon les classifications adopté'*. [820] Non-conformity reveals as much of a lack of cohesion within the profession as it does of MCs' individuality. However, it was with such variances in local and national statistics in SGF data with which Duchêne had to work.

In his study, comparing annual pre-war mortality rates with those of the Occupation years he quantified a surfeit of 40,000 deaths in psychiatric hospitals for the years 1940-44.[821] Duchêne's report had only a limited medico-statistical audience, and unsurprisingly such mortality figures for the Occupation did not reach the public domain until 1987 with the publication of *Extermination douce* by Max Lafont. He claimed that 2,000 of the officially quoted 40,000 patients died of starvation under Vichy at his training hospital, Le Vinatier, Lyon.[822] In a historical approach, in 1991, medical historians Bonnet and Quétel claimed more than 76,000 patients died of starvation during the same period while Bonnafé, MC HP Saint-Alban during the Occupation, quotes a total figure of 76, 327. He claimed a pre-war annual average of 27,769 deaths, and stated there was an excess of nearer 50,000 deaths. [823]

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[820] Fleury, Une classification des maladies mentales, p. 45; A. Marie and V. Kohen,'Séance du 29 avril. La paralysie général n'est pas encore en diminution', ibid., (1923), 536-40.
[821] H. Duchêne,'Enquête sur les durées comparées des séjours en hôpital psychiatrique entre 1934 et 1946', *Bulletin de l'Institut National d'Hygiène,* 3, (1948), 216; Also see: Henri Duchêne,'Aspect Démographique', *Esprit,* 197, (1952), 877-88; Coffin, 'Misery' and 'Revolution', p. 236; Bailly-Salin, The Mentally Ill Under Nazi Occupation.
[822] Lafont, Déterminisme sacrificiel et victimisation, pp. 29-31; Also see Lafont, *L'Extermination douce (1987)*.
[823] Bonnet and Quétel, La surmortalité asilaire, p. 27; Chapireau, Documents de travail, p. 5; Margaret MacMillan, *The Uses and Abuses of History*, (London: Profile Books, 2008). MacMillan argues that those who call on history to justify claims or restitution should be viewed with caution. ; Lafont, *L'Extermination douce,* pp. 19-59.

In 2007, *L'Hécatombe des fous,* by von Bueltzingsloewen estimated that total numbers of deaths were between 44,162 and 45,161.[824] Her data is supported by Chapireau.[825] He claims that mortality due to 'starvation and infectious diseases' was between 45,500 and 48,500.[826] However, he does not describe how he assessed the myriad of causes of death registered in hospitals to distinguish those who died specifically of starvation or from which type of infectious diseases.

Nevertheless, Chapireau does claim that methodology of statistics in HPs is questionable: either there is an absence of explanation of method as in the case of the SGF data, or suspect as in Bonnet and Quetel's study, which he states is full of errors, refuting their number of 76,000, which in his estimation should be 78,287.[827] He concludes that von Bueltzingsloewen's work has a more secure methodology in which her estimation of total deaths is taken from two points - the average number of patients at the beginning and end of each year and secondly, the total population nursed during the year, that is, the sum of the patients present on January 1st and those admitted and discharged in the year. Even so, he notes that the one method overestimates and the other underestimates numbers of deaths.

Similarly, there is variation in the quoted number of hospitals functioning during 1940- 45. Chapireau states that, in 1940 there were eighty-seven-six hospitals as three were annexed during the German invasion.[828] Psychiatrist Gerard Massé states there were ninety-six national institutions, seven autonomous hospitals, fourteen hospices, seventeen private hospitals, (but state governed) and fifty-seven departmental hospitals, and of the ninety-six hospitals, twenty-five were closed either by requisition or by destruction.[829] However, what Chapireau or others do

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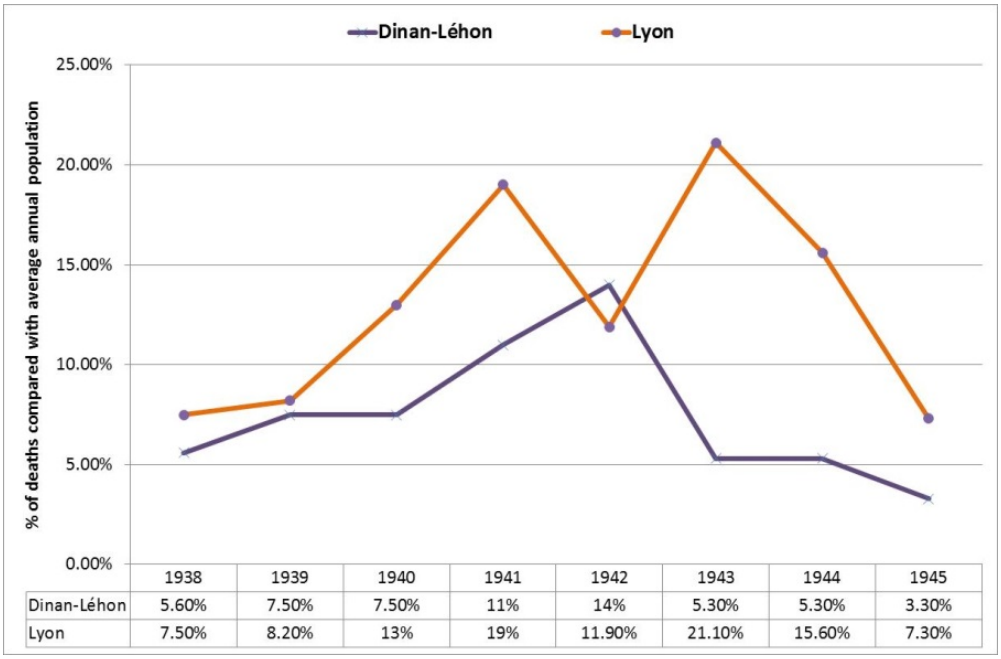
[824] Bueltzingsloewen, *L'hécatombe des fous,* p. 35. Bueltzingsloewen, Morts d'inanition, 2005.
[825] Chapireau, Documents de travail, p. 4.
[826] Ibid. pp. 4, 18.
[827] Ibid. pp. 5, 18.
[828] Ibid. p. 8; AN Fontainebleau SAN 70847 pp. 36, 76.
[829] Massé, Exclus parmi les vaincus, p. 65; AN Fontainebleau SAN 70847 p. 39.

not explore fully is the authenticity of the collection of the original data from which national statistics were formulated. Indeed, while giving a common trend statistics often miss important subtle information on mortality which differs considerably. This is seen in the dissimilarities of two hospitals: Bon-Sauveur, in Bégard (Côtes-de-Nord), where mortality was so minimal during the Occupation years it was hardly mentioned in annual reports, and HP Fleury-les-Aubrais, (Loiret) where mortality rose by 305%.[830] Equally, this is seen in two HPs of the Order of Saint Jean, one the target hospital in Dinan-Léhon the other in Lyon seen in figure 10. These figures vary considerably but are most likely due to location.



	1938	1939	1940	1941	1942	1943	1944	1945
Dinan-Léhon	5.60%	7.50%	7.50%	11%	14%	5.30%	5.30%	3.30%
Lyon	7.50%	8.20%	13%	19%	11.90%	21.10%	15.60%	7.30%

Figure 11 Comparative graph of mortality for two clerically-run hospitals Saint-Jean-de-Dieu, Lyon and Saint-Jean-de-Dieu, Dinan-Léhon
Source: Rapport administratif et médical de Dinan-Léhon 1938-1945 and Anne Marescaux, 'Vie et mort dans les hôpitaux psychiatriques pendant la Seconde Guerre mondiale: l'exemple de Saint-Jean-de-Dieu'

[830] Caron, Daumézon, and Léculier, Augmentation de la mortalité dans un hôpital psychiatrique depuis juin 1940: Ses causes, p. 483.

6.3 Interpreting hospital reports

Interpretation difficulties are highlighted in the director's report of 1939 for Saint-Dizier in which figures for admissions do not include transfers from other hospitals, of which there were many. In Saint-Dizier there were also numerical errors for male and female deaths in MC Deffuant's medical reports. As seen in Figure 11 in Saint-Jean-de-Dieu the chart of mortality is vague and rudimentary giving figures of death with side-totals in tens giving leeway for inaccurate interpretation, while in the administrative report some of these figures do not correspond with the equivalent set of figures in the medical report.[831]

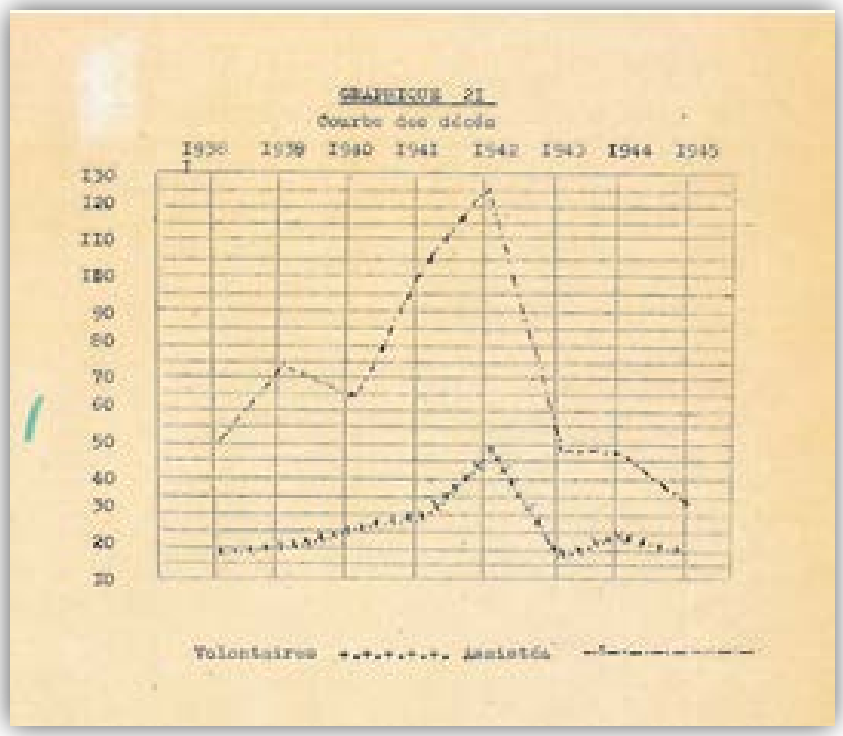


Figure 12 Hand-written chart of mortality HP Saint-Jean-de-Dieu
Source: UHASJDD Rapport administratif et médical 1938-1945 p.30

[831] UHASJDD, Compte moral 1938 à 1945. p. 25.

Psychiatric hospitals were not alone in high levels of mortality. Chapireau presents a comparison of hospices and psychiatric hospitals demonstrating that in hospices mortality struck early and increased by 50% whereas in psychiatric hospitals it tripled.[832] In hospices total mortality reached 27.1% whereas in psychiatric establishments for patients aged 65 and over it was 41.5%. Other custodial institutions such as prisons and internment camps saw mortality rise to levels far above normal. Conditions are described as abysmal and lacking human dignity; privation of food, a devastating lack of hygiene, endemic disease, scarcity of bedding, clothing, and shoes, making life unbearable. In Riom and Poissy men's prisons deaths were reported as high and Internment camps saw 3,000 deaths mostly in the period 1940-42, but there are few firm statistics to make comparisons with psychiatric hospitals.[833] Indeed, other state establishments, for example general hospitals, do not offer any comparison to psychiatric hospitals, either as length of stay was much shorter or because very few statistics are available.[834]

In Marchant statistics in annual reports do not correspond with some found in the departmental archives. These errata are not isolated. In their study of patient deaths in HP Cadillac Dr M. Bénézech et al, found these types of errors and many more. They assert their study was made more difficult by a 'succession, at least twelve over thirty years, of *médecins-chefs*', as well as changes in diagnosis of individual patients often up to nine variously described causes'.[835] But in none of these instances do discrepancies equate with any sense to deceive or to cover up increased deaths, rather it points to human error in calculation in an era of extreme difficulties and professional non-conformity. Historically, MCs listed causes of

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[832] Chapireau, Documents de travail, p. 17.
[833] Jaladieu, Les centrales sous le gouvernement de Vichy, pp. 106-7.
Marrus and Paxton, *Vichy France and the Jews,* p. 176; Fabre, *Dans les prisons de Vichy*; Pédron, *La prison,* p. 55; Peschanski, *La France des camps*.
[834] Chapireau, Documents de travail, p. 17.
[835] Michel Bénézech,'Le malade mental et sa mort à l'hôpital psychiatrique de Cadillac: étude sur 30 ans (1923-1952)', *Annales médico-psychologiques,* 169, (2011), 63-69 pp. 64-5).

death by psychiatric disease classification which, as has been shown, varied considerably and are ambiguous. In the case of Ainay, in 1939, of thirty-six deaths there were nineteen different causes.[836] However, from around the 1930s in the four target hospitals reporting became more uniform and cause of death concentrated on only three major causes: Tuberculosis (TB), Debilitation (weakening condition) and Other. It is not clear as to why alienists did not conform to the CIM but it could in part be due to the lack of psychiatric guidelines or professional regulations. The *Société médico-pyschologique* (SMP), created in 1843, was the principal organ for psychiatry, and almost all psychiatrists were members, but it was a platform for psychiatrists rather than a regulatory body with no direct contact in such matters as hospital audit.[837] Historian George Weisz posits that although the medical profession, which included psychiatry, was regulated by the state there was no specialist certification or specialist governing power in France until after the Second World War.[838]

Opposition to change in psychiatry was strong, seen in the endurance of individualistic nosology. Psychiatric opinion remained firm: the CIM was more for statisticians than for practitioners.[839] This notion may be due to a certain medical resistance or wilfulness concerning bureaucracy. Indeed, there had been five 'revisions' of the CIM from 1900 to 1938, with a further update in 1943, when age groups were modified and included in the CIM.[840] Despite new causes of death based on anatomical or pathology-related pathways, or established through new

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[836] UHAALC, Rapport de M. le docteur P. Queron Médecin-directeur par intérim au préfet année 1939 Ainay-le-Château.

[837] Interview with Dr Paul Broussolle (retired Médecin-chef de service Centre hospitalier spécialisé Le Vinatier, Lyon) by Patricia S. Legg at his residence in Lyon on 21 October 2003 18.00h ; Marc Masson, 'Professional and national guidelines ', ed. by Patricia S. Legg (2012).

[838] George Weisz,'Regulating Specialities in France during the First Half of the Twentieth Century', *Society for the Social History of Medicine*, (2002), pp. 457, 66, 72); Also see Evleth, The Ordre des Médecins.

[839] Vallin and France, *Les causes de décès,* pp. 59, 67.

[840] Ibid. p. 45; Moriyama, Loy, and Robb-Smith, *History of the Statistical Classification*.

discoveries and advances in medicine and the theory of insanity, examination of the target hospitals death registers demonstrate that few of these changes were accepted or adhered to.

6.4 The psychiatric hospital: a dual role

It is probable that many psychiatrists in the 1930s were weary of battling with state authorities regarding overcrowding and such individualism was a protest. Despite French social welfare spending before the war being well above the European average, spending on mental health care was persistently and indisputably deficient and state disinterest in psychiatry was palpable.[841] MC Philippe Langlade wrote, 'C'est le doute qui le saisit, doute sur l'utilité de ce heurt journalier contre l'inertie administrative'. This was echoed by Albert Béguin, editor of the psychiatric revue *Esprit*, 'l'inertie [..] des autorités réduit les médecins à une impuissance désastreuse, les malades à une existence qui annihile toute chance de guérison'.[842]

Escalating overpopulation in the HPs, seen in figure 11, is undeniable when viewed through the SGF's statistics and was a crucial issue for psychiatrists in the early part of twentieth century.[843] Despite the enormous reduction in patient numbers during the Occupation patient occupation rose fairly briskly within a decade following the Liberation and the call from reformist psychiatrists for an overall reform of the system gained more momentum.

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[841] Timothy B. Smith, *Creating the Welfare State in France, 1880-1940*, (Montreal: McGill-Queen's University Press, 2003).

[842] Philippe Paumelle used the psuedonym Langlade for his virulent editorial as he was only an intern at HP Maison Blanche, and in 1952 had not presented his thesis for the psychiatry examination. Philippe Langlade,'Editorial du numéro spécial: Qui sommes nous?', *Esprit,* 197, (1952), 797-800 (p. 799); Albert Beguin,'Editorial du numéro spécial: Misère de la psychiatrie - Qui est fou?', ibid., 777-88 (p. 787).

[843] AN Fontainebleau SAN 70847 p. 20.

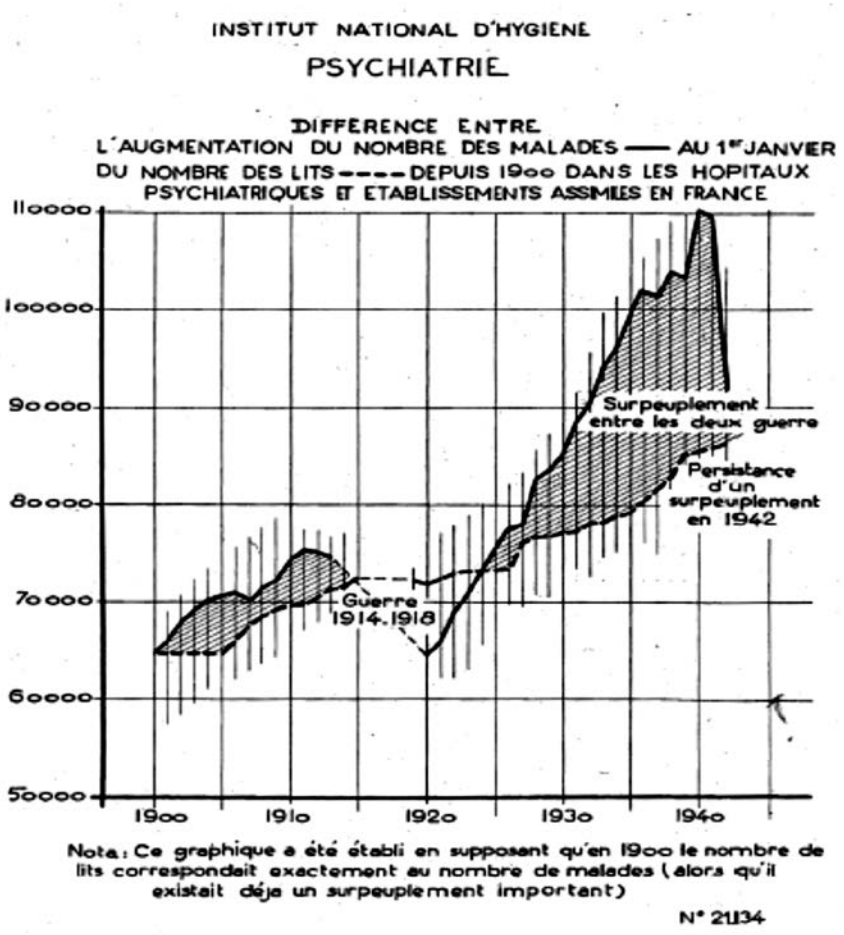

Figure 13 Mortality in the French psychiatric hospital system 1900-1942
Source: SAN 70847, Statistiques pour l'ensemble des hôpitaux psychiatriques:1900-1944

Clearly government inaction, despite available data published by the SGF, fired MCs. They could gain little hope of dealing with overcrowding when, at a state level there was neither investment in building more hospitals nor increase in funding to cope with the upward trend of admissions and few discharges or cures. This resulted in overcrowding and intolerable levels of increase in staff work-load. It was obvious to many psychiatrists that local officials chose to ignore such overcrowding and insalubrious conditions. In Braqueville in 1915 there were 200 patients above the normal bed state of 969 and in just over twenty years the total

population exceeded 1500.[844] Within the hospital asylum system in 1939, 110,188 patients were housed in establishments intended for 85,000.[845]

Overpopulation brought with it inadequate material conditions in most hospitals underlining that many departmental prefects did not enforce public health measures. The law of 15 July 1902 established responsibility for public hygiene measures in the fight against insalubrious accommodation and overcrowding of urban areas with the intention of controlling transmissible diseases and epidemics.[846] National asylum inspectors for the Ministry of the Interior raised such issues in their annual inspections of asylums but it is clear little was done to rectify matters.[847] Such action required financial input but restrictive hospital budgets allowed for little improvement in unhygienic conditions, though patients continued to be committed.[848] Indeed, as previously alluded MCs at Saint-Dizier complained of these very issues stating that the prefect was in violation of the hospital's *Règlement* Article 71, which stated, 'le service médical ne doit pas dépasser 400 malades, sauf exceptions spécialement autorisé par le Ministre'. Not by way of an explanation but rather contextualising mortality increases during the Occupation, psychiatrist Charles Brisset emphasised that only 200 psychiatrists supported 96 mental establishments with 103,000 inpatients - an onerous task at best and in wartime well-nigh humanly impossible.[849] This equates to a ratio of 1: 515 doctor/patient and many hospitals had over three times the statutory patient

[844] UHAGM, Rapport médical 1915 du Dr Dubuisson p. 30.
[845] Chapireau, Documents de travail, p. 5.
[846] Patrick Zylberman,'Making Food Safety an Issue: Internationalized Food Politics and French Public Health from the 1870s to the Present', *Medical History,* 1, (2004), 1-28 (p. 17).
[847] Dowbiggin, *Inheriting Madness,* p. 95.
[848] Grand, L'architecture asilaire au XIXe siècle.
[849] Brisset, A propos de l'extermination douce de M. Lafont: Un scandaleux amalgame du journal Le Monde, p. 961; Bénézech, Le malade mental et sa mort à l'hôpital psychiatrique de Cadillac: étude sur 30 ans (1923-1952); Massé, Exclus parmi les vaincus.

numbers recommended by the then current legislation.[850] Although not exonerating MCs it is easy to see how the criticism of the director of Marchant, Leclainche happened. He wrote to the prefect on the incident of increased deaths in Marchant noting that a patient's dossier had not been filled in since his admission in 1934.[851] This may have been because the patient had not been medically in need of a physician but equally should have had some indication of the man's mental and physical progress. However, during the period 1934 to 1940 the MC in charge of this patient had retired.[852]

As we have learned, in the interwar years admission of unsuitable and untreatable, and often incurable patients, like the mentally retarded, more currently called 'extreme learning difficulties', and the elderly was unquestionably synonymous with overcrowding and tantamount to the deep divide between the principles of the asylum as therapeutic and the state's policies of social control.[853] In SJDD 90% of all patients were chronic cases believed incurable.[854]

In reality, for decades psychiatrists had voiced their displeasure as authorities repeatedly deposited the 'unwanted' in society in asylums.[855] Ironically, with the law of 14 July 1905 based on *l'Assistance*, the state's welfare system for the elderly, infirm and incurable, chronicity and overcrowding intensified.[856] The law became a mechanism whereby the elderly who the state did not or could not accommodate were dispatched to psychiatric hospitals: they were not clinically mentally ill. These factors cloud the accuracy of specific mortality figures for the mentally ill.

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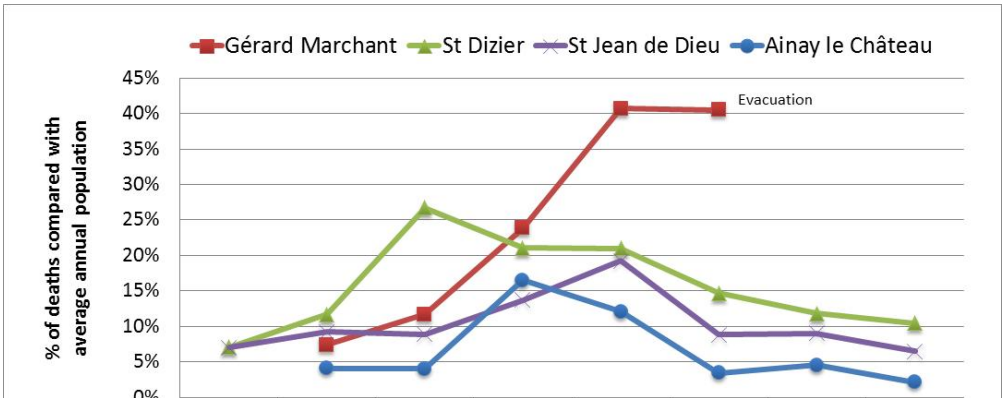
[850] Préfecture de la Haute Garonne, *Précture de la Haute Marne. Règlement de l'hôpital psychiatrique de Saint-Dizier,* p. 9; Meylan, L'Infirmier des hôpitaux psychiatriques. Section IX Article 71; Julien Raynier and Jean Lauzier, *La construction et l'aménagement de l'hôpital psychiatrique et des asiles d'aliénés*, (Paris: François, 1930).
[851] UHAGM, Letter 18 November 1941 from the director to the prefect.
[852] UHAGM, Administration of the HP Marchant.Letter 1 July 1941 from the director to the prefect.
[853] Masson and Azorin, The French Mentally Ill in World War II, p. 27.
[854] Guillemain, Médecine et religion au XIXe siècle, pp. 38-9.
[855] Bonnet, De l'Assistance aux malades mentaux, pp. 192-3; Scull, *Museums of Madness,* p. 240.
[856] Bueltzingsloewen, *L'hécatombe des fous,* p. 250.

Nevertheless, the elderly as a disenfranchised group became victims of the Occupation too.

6.5 Reasoning mortality: predisposing factors

Whatever the motivation for the use of such terminologies, in order to gain a fuller picture of mortality in the target hospitals, demonstrated in figure 12, it is necessary to examine the intra- and extra-mural factors which are reflected in the statistics. As explanation of mortality increase, patterns of mortality taken from the target hospitals' reports indicate an underlying series of predisposing factors as explanation of mortality increase. Hospital and patient profiles will aid in understanding which patients died and in which hospital during which period.



	1938	1939	1940	1941	1942	1943	1944	1945
Gérard Marchant		7.4%	11.7%	23.8%	40.7%	40.5%		
St Dizier	7.1%	11.7%	26.7%	21.1%	21.0%	14.7%	11.8%	10.4%
St Jean de Dieu	7.0%	9.2%	8.9%	13.7%	19.2%	8.8%	9.0%	6.5%
Ainay le Château		4.1%	4.0%	16.5%	12.1%	3.4%	4.5%	2.2%

Figure 14 Mortality in the four target hospitals 1938-1945
Source: Rapport administratif et médical 1938-1945 from the four target hospitals

Firstly, patient profile includes: age, gender, civil or marital state, and socio-economic status. Secondly, hospital profile comprising status, size, leadership, location, environmental conditions and structural features.[857] However, it must be kept in mind that before the Occupation all these factors were present and mortality only ran between 3-10%.

A major issue in mortality in a psychiatric hospital is the friable dynamic surrounding mental health. Medical evidence suggests that certain mental conditions place patients 'at risk' with more likelihood of succumbing to early mortality in the event of a crisis such as disruption to daily routine which in the case of the target hospitals was the stress of the Occupation, restricted rations, deterioration of material resources and seasonal environment factors.[858] In addition, organic mental disorders such as mental retardation are generally susceptible to increased mortality. Admission registers reveal large numbers of such patients in all four target hospitals. In 1939, of 1013 patients admitted to Ainay, 47% were diagnosed as mentally retarded. However, before the Occupation Ainay's mortality was considerably lower than in the other three target hospitals, dismissing the

[857] Stephen Devereux, Famine in the Twentieth Century, 2000 13, 15.
[858] Max Henderson, Matthew Hotopf, Imran Shah, Richard D. Hayes, and Diana Kuh,'Psychiatric disorder in early adulthood and risk of premature mortality in the 1946 British Birth Cohort', *Biomedcentral Psychiatry,* 11, (2011), 11-37; Melanie Abas, Matthew Hotopf, and Martin Prince,'Depression and mortality in a high-risk population II-Year follow-up of the Medical Research Council Elderly Hypertension Trial', *British Journal of Psychiatry,* 181, (2002), 123-28; W. Ressler, W. Hewer, B. F. Atkenheuer, and W. Leffler,'Excess mortality among elderly psychiatric in-patients with organic mental disorder', *British Journal of Psychiatry* 167, (1995), 527-32; K. Laaidi, A. Ung, M. Pascal, and P. Beaudeau,'Vulnérabilité à la chaleur : actualisation des connaissances sur les facteurs de risque', *Bulletin Epidémiologique Hebdomadaire,* 5, (2015), 76-82 (p. 79); Masson and Azorin, The French Mentally Ill in World War II, p. 27; Martin Gittelman,'Mortality, morbidity, and mental illness', *International Journal of Mental Health* 37, (2008), 3-12; S. L. Johnson, A. K. Cuellar, and A. Gershon,'The Influence of Trauma, Life Events, and Social Relationships on Bipolar Depression', *Psychiatric Clinical North America,* 87, (2016), 87-94; Javid Latoo, Minal Mistry, and Francis J. Dunne,'Physical morbidity and mortality in people with mental illness', *British Journal of Medical Practioners,* 6, (2013), 4-6.

premise but supporting the theory that incarcerated patients with this diagnosis were more likely to die than those in Ainay.[859]

Just as diagnosis gave rise to risk factors, so did patient profile. It is not that inpatient profile changed greatly during the Occupation but that extraneous elements exacerbated 'at risk' patients compared with those in a more stable mental health.[860] Scholars have shown that cohorts of age and gender reveal the young and elderly were the first to perish. Even in 'normal' times, this group tend to suffer the greatest absolute rise in deaths during food crises due to an existing weakened physical state and inability to adjust to nutritional deficiencies.[861]

Although gender-related mortality studies demonstrate that females were more resistant than men, due to their ability to store more body fat, female deaths in Marchant and Saint-Dizier do not support this theory.[862] In 1940, female mortality in Saint-Dizier was high, 144 female to eighty-five male patients, perhaps due to a larger proportion of females to males in that particular year. Both sexes were classified as A category and received 1200 calories per day (the general population received 1800 although labourers received many more). Hospital *travailleurs* received extra rations which were hardly adequate for the amount of physical labour they performed. Generally, men and women were allocated category A rations, but even non-active men, and especially the mentally ill, their physiological makeup required many more calories than found in this category. Thus for most male patients health problems were intensified when associated with

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[859] UHAALC, Admissions and Death registers 1920-1944.The main diagnoses were: idiocy, profound mental debilitation, dementia praecox later in the 1930s called schizophrenia, chronic alcoholism, mental confusion, syphilitis, cerberal arteriosclerosis epilepsy, Parkinson's disease, pyschosis and senile psychosis.

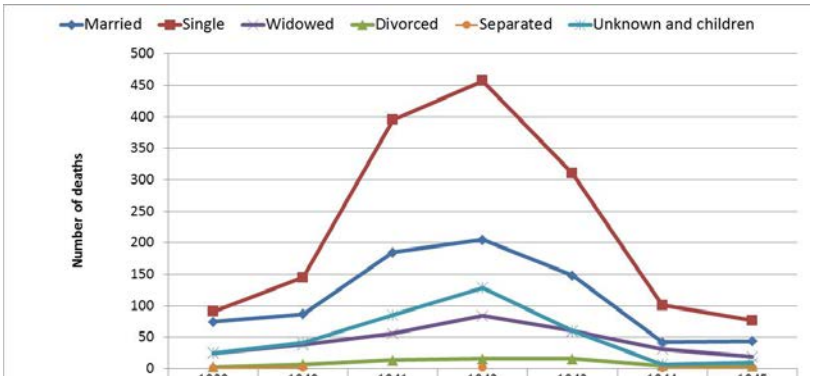
[860] Harris and Barraclough, Excess mortality of mental disorder.

[861] Devereux, Famine in the Twentieth Century, p. 10; Chapireau, Documents de travail, p. 15; Vallin and France, *Les causes de décès*.

[862] Kate Macintyre, 'Famine and the Female Mortality Advantage', in *Famine Demography: Perspectives from the Past and Present,* ed. by Tim Dyson and Cormac O. Grada (Oxford Oxford University Press, 2002), pp. 240-60.

undernourishment and an imbalance between physical exertion and calorific intake requirements.

Evidence in admission registers and patient dossiers expose the relationship of marital state to increased mortality. Not only was low morale a characteristic of many patients with few or no contacts or family visits, but more importantly during the Occupation there were no family food parcels to supplement meagre rations, which for some, may have been the difference between life and death from malnutrition.[863] A striking factor in Ainay is that the *célibataire* group (single) accounted for 60% (616 out of 1013); only 15% were married and 18% had no known civil state. But mortality in this group was lower again than the other three hospitals as seen in figure 14 for marital state.



	1939	1940	1941	1942	1943	1944	1945
Married	75	87	185	205	148	42	44
Single	91	145	395	457	310	101	77
Widowed	25	38	56	84	60	31	19
Divorced	3	7	14	16	16	5	4
Separated	1	2		2		1	2
Unknown and children	25	41	85	129	60	7	10

Figure 15 Mortality by marital state in the four target hospitals
Source: Rapports administrative et médicaux of the four target hospitals

[863] Caire, A propos de l'hécatombe, p. 314.

In demographic studies, socio-economic status-related deaths are not often reported but statistics and data found in death registers are more than adequate to offer an interpretation of this type of death. Social class is distinguished as indigent and *pensionnaire*.[864] However, did patient status decrease or increase the risk of dying? Significantly, underlining the advantages of wealth, indigents as a patient group fared much worse than the undoubtedly smaller number of *pensionnaires*. The most dramatic comparative figures are those of Saint-Dizier and Saint-Jean-de-Dieu. The latter had the largest population of *pensionnaires* and wealth appears to have played a part in their destiny. Between 1939-45, 26% of all deaths were *pensionnaires* compared with 74% indigents, while in Saint-Dizier 7.1% of all deaths were *pensionnaires* compared with 92.9% for indigents. However, it must be born in mind that due to the economic crisis many *pensionnaires* downgraded or became dependant on the state during the Occupation so numbers reduced considerably. Ainay had very few *pensionnaires* whose numbers dwindled during the Occupation.[865]

One noteworthy rationale linking reality in Saint-Dizier and Saint-Jean-de-Dieu is that diseases such as TB and influenza are concomitant with overcrowding, poor hygiene, and malnutrition. The health of many private patients was better protected as they were housed in single or sharing rooms having less contact with infectious diseases and unhygienic conditions encountered by indigents housed in quarters and dormitories intended for sixty or fewer but by the 1930s holding eighty plus.[866]

Moreover, the quantity and nutritional content of menus for private patients was superior to that of the indigents, demonstrated in a 'régime spéciaux and régime

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[864] Vallin and France, *Les causes de décès,* p. 195.
[865] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte.
[866] Bailly-Salin, The Mentally Ill Under Nazi Occupation, p. 17; Vedié, Moser, and Paulin, Surmortalité dans un hôpital psychiatrique, p. 513.

commun'. Nevertheless, in Marchant, when food supplies were compromised during the Occupation *pensionnaires* were placed on the same menu regime as indigents.[867] And when fuel and textiles became almost unobtainable, lighting, heating and bedding – three elements of comfort for *pensionnaires* – were also reduced. Wealth did not always safeguard health and the director of Marchant was not alone in abolishing private patients' facilities, other MDs reacted similarly.[868] In Paris, to economise on electricity, ward temperatures in both the general and psychiatric hospitals were set at 14 degrees at night and 16 degrees in the day and for the elderly who suffered from the cold the most, 12 degrees at night and 14 degrees in the day.[869] If gender to some extent saved some female patients from the initial high rise in mortality, wealth may have safeguarded health for others.

Long periods of hospitalisation are also implicated as a 'risk factor' for psychiatric deaths.[870] Therefore, the longer a patient had been institutionalised the more likely he/she was to die when the Occupation restrictions were enforced. Admission and Death registers correlated with patient dossiers reveal many patients' hospital encounters involved many years either in one stay or repeated admissions.[871]

Scholarship has revealed that both hospital size and status was of paramount importance in the mortality in hospitals. From their very origins asylums were more structural monoliths than patient friendly, more suited to architectural acclaim and

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[867] UHAGM, Séance du comité de surveillance 4 September 1941.Director said in view of of the uincreasing number of deaths and rationing so strict he had no choice but to treat all private payers with regrds to the daily menu the same as indigents. This decision had the full cooperation of the committee; UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.Also documented in :

[868] Bueltzingsloewen, *L'hécatombe des fous,* pp. 152-3.

[869] Robert Vial, *Histoire des hôpitaux de Paris sous l'Occupation: Les blouses blanche dans l'étau de Vichy et l'espoir de Londres*, (Paris: Hartmattan, 1999), p. 158.

[870] Waltraud Ernst,'The Limits Of Comparison: Institutional Mortality Rates, Long-Term Confinement And Causes Of Death During The Early Twentieth Century', *History of Psychiatry,* 23, (2012), 404-18 (p. 409).

[871] Julien Boudant, 'Être malade mental à Bassens: De l'asile à l'hôpital psychiatrique (1900-1970)', (master's dissertation, université de Savoie, 2000); Michael Shepherd,'A Study of the Major Psychoses in an English County', *Maudsley Monographs,* 3, (1957), 19-25 (p. 24).

philanthropic patronage than places of treatment fit for purpose in the 1930s: the axiom, older–colder applied to all asylums. The larger the hospital the higher the mortality: Marchant confirms this theory as the largest of the target hospitals, state-run, synonymous with less autonomy than clerical psychiatric hospitals, with an official capacity of 1200 (although in 1940 it had nearly 1600 patients. The three remaining hospitals each accommodated between 800-900 patients, considered as medium sized. Saint-Dizier was also state-run and its mortality ran below that of Marchant but higher than Saint-Jean-de-Dieu and Ainay.

As a comparator for size, Vinatier was classed as large, with nearly 3,000 patients and the largest hospital, Fleury-les-Aubrais (Loiret) housed 5,400 and mortality was the highest of all hospitals).[872] Establishments of less than 1000 were often managed by a MD although this was not so for Saint-Dizier, and Saint-Jean-de-Dieu managed by the Prior.[873] As for leadership, both Marchant and Saint-Dizier had little continuation of management or doctor relationship with a variety of directors, none of whom were practising psychiatrists. Saint-Jean-de-Dieu was managed by a Prior, as in the case of many clerical establishments a trained nurse, not physician). Therefore, it is reasonable to assume that closer communication and working relationship between director, MCs, personnel and patients gave protection to some degree.

6.6 Reasoning mortality: registered causes of death

As previously discussed, from around the 1930s in most hospital *Rapports* only three causes of death are recorded: TB, Debilitation and Other. That said, in many Death registers and patient admission forms the older classifications were still

[872] Anne Marescaux, 'Un établissement epargné par la famine? L'asile privé Saint-Jean-de-Dieu de Lyon', in *Morts d'inanition famine et exclusions en France sous l'Occupation,* ed. by Isabelle von Bueltzingsloewen (Rennes: Presses Universitaires de Rennes, 2005), pp. 65-76 pp. 9-10).
[873] Bueltzingsloewen, Morts d'inanition, 2005, p. 55 fn11.

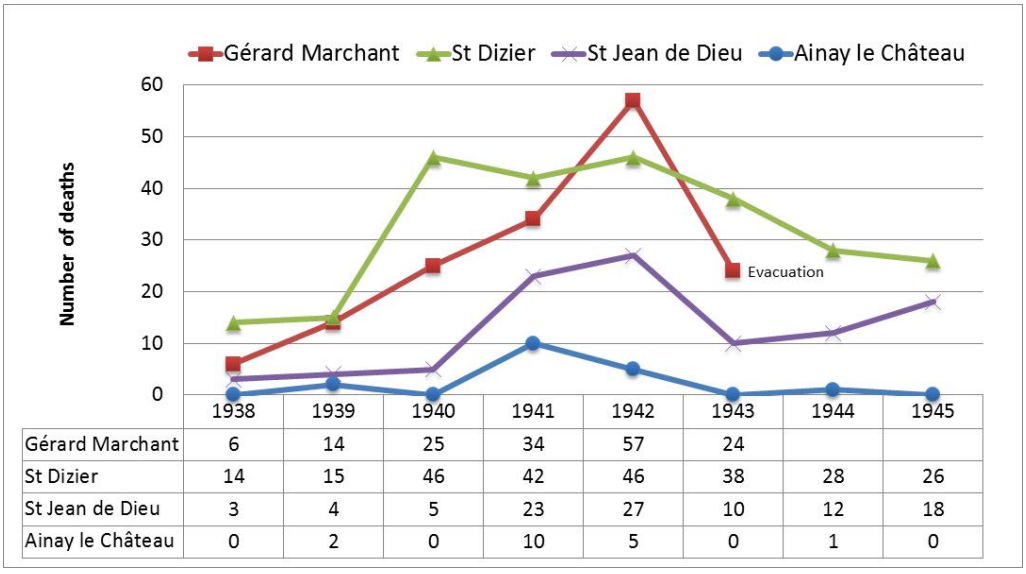
being used. A reason for this change could be due to more public health interest in TB. The disease had not aroused as much medical concern as alcoholism and venereal disease until the early 1900s, and psychiatrists became more aware of the incidences of TB in their overcrowded hospitals.[874] At the beginning of the century, 'la tuberculose est étroitement associée à la ville et à l'insalubrité des logements'.[875] There was also a nationwide public hygiene campaign into the control of TB, posted as the major social scourge of the modern nation, supported by the Rockefeller foundation.[876]

Cause of death TB	**Haute Garonne** total mortality 1940 =9,160 1941 =9,218		**Haute Marne** total mortality 1940 =4,289 1941 =x		**Côtes-du-Nord** total mortality 1940 =10,562 1941 =8,836		**Allier** total mortality 1940 = 8,485 1941 = 6,909	
	Gérard Marchant		**St Dizier**		**Saint Jean de Dieu**		**Ainay**	
Year	1940	1941	1940	1941	1940	1941	1940	1941
Total number	505	589	265	x	1057	1023	629	542
TB as %	5.5%	6.3%	6.1%	x	10%	11.5%	7.4%	7.8%
x = no figures available								

Figure 16 Death from TB in the general population
(four departments of the target hospitals)
Source: Jacques Vallin and Meslé France, Les Causes de décès en France de 1925 à 1978, Travaux et Documents Cahier no.115 (Paris: Institut National d'Etudes Démographiques Presses Universitaires de France, 1988).

[874] Schneider, *Quality and Quantity,* p. 22.
[875] Aude Meunier, Beatrice Bouffard, Julie Debarre, Isabelle Breton, and Francis Chabaud, 'Rapport n° 77, Mars 2002. Observatoire Régional de la Santé du Poitou-Charentes (ORSPEC). Evolution de l'état de santé des populations et de l'offre de soins en Poitou-Charentes de 1900 à 2000. Centenaire de la loi 1902 sur l'hygiène publique', Poitiers Observatoire Régional de la Santé de Poitou-Charentes, (2002)
[876] Jacques Dominique Renevey, 'Contribution à l'étude de la morbidité tuberculeuse asilaire en période de carence', (doctoral thesis, université Paris 1, 1943).

As can be seen in figure 15, mortality from TB is notably high in the Côtes-du-Nord, an area with by far the highest incidence for the years 1940-41, but also with a long-standing alcoholism problem. Allier (Ainay) was second followed by Haute Marne (Saint-Dizier) and the Haute Garonne (Marchant) which had the lowest incidence. This may be explained by its far south position, good weather conditions and clean mountain air. Unfortunately population mortality figures for 1943-44 are missing but if the trend continued upward in the Côtes-du-Nord this might answer the increase of TB in Saint-Jean-de-Dieu for 1944-45 when mortality overall was returning to normal in the other target hospitals as seen in figures 13 and 14. The premise that overcrowding and insanitary conditions increased TB might not fit this scenario as patient numbers were well below those in the first three years of the Occupation and death from TB was low. However, incubation for TB is long, and years of malnutrition would have been a breeding ground for the tubercle bacillus; manifesting itself years later.[877]



	1938	1939	1940	1941	1942	1943	1944	1945
Gérard Marchant	6	14	25	34	57	24		
St Dizier	14	15	46	42	46	38	28	26
St Jean de Dieu	3	4	5	23	27	10	12	18
Ainay le Château	0	2	0	10	5	0	1	0

Figure 17 Deaths from TB in the four target hospitals
Source: Rapport administrative et médical 1938-1945 for the four target hospitals

[877] Vynnycky and Fine, Lifetime Risks, Incubation Period, and Serial Interval of Tuberculosis; S. K. Sharma, S. Mohanan, and A. Sharma,'Relevance of latent TB infection in areas of high TB prevalence', *Chest,* 142, (2012), 761-73.

However, as seen in figures 15, 16, and 17, analysis of the three causes, TB, Debilitation and Other demonstrate that although TB deaths were numerous they were nowhere near as numerous for those reported as Debilitation and Other. Here lies a serious challenge to certain theories and claims that 40,000 mental patients died of starvation. Analysing the records of the four target hospitals it is not possible to state this fact categorically due to the previously discussed questionable validity of documentation, nor would it be sensible so to do. What is obvious is the very few causes registered as *inanition* (malnutrition or starvation) or *mort de famine* (death from starvation), but as *cachexie* (physical debilitation/wasting) and *sous-alimenté* (undernourishment). The major problem with an interpretation of terminology is that in many diseases malnutrition occurs not because the patient is starved of food but that malabsorption occurs or that medical conditions prevents the patient from feeling hungry or even of being able to eat because they are nauseous.[878] In many cases there are concomitant diseases such as respiratory and cardiac diseases and infections, and chronic alcoholism which result in the patient becoming malnourished and literally starved due to physiological disturbance and electrolyte imbalance causing poor osmotic pressure in the tissues leading to severe oedema.[879] Figure 17 shows the image included in the article of Perret and Parde 1941, Manifestations shows grossly oedematous and emaciated patients to underline the seriousness of the situation of malnutrition.

[878] Siddiqui and Osayande, Selected disorders of malabsorption.
[879] RF. Pfeiffer,'Neurologic manifestations of malabsorption syndromes', *Handbook of Clinical Neurology,* 120, (2014), 621-32.

Figure 18 Cachectic patient HP Marchant
Source : 'Manifestations de carence alimentaire HP Gérard Marchant
Service des hommes de l'hôpital psychiatrique Marchant'
Xavier Leclainche Aimé Perret and J.Parde *Toulouse Médical* (1941), 253-84.p3.

It was muted in psychiatric circles and the media that deaths due to starvation were not given in the death registers because MCs wished to camouflage the drama presented in their hospitals. This does not gel with either the documentation in the four target hospitals or the historical use of the host of terminologies used before the Occupation. In addition, starvation in hospitals as von Bueltzingsloewen claims was unimaginable and therefore not considered to be medically applicable to the deaths certified by MCs at the time of severe rationing. The vagueness of diagnoses and causes of death found in many registers might be due to undiagnosed medical disorders (as high as 35%) clouding total figures for causation but supporting the notion that psychiatrists were not deliberately giving inaccurate causes of death.[880] This is reasonable when considering statistics for the

[880] Lawrence D. Holman and Jablensky C.D.J,'Excess cancer mortality in Western Australian psychiatric patients due to higher case fatality rates', *Acta Psychiatrica Scandinavica,* 101, (2000), 382-88.

general population for the Côtes-du-Nord: in 1943 there were 492 undetermined causes in a total of 7,211 physician-certified deaths (14.6%).[881]

Indeed, in this era many doctors admitted difficultly in diagnosing medical conditions in the mentally ill.[882] Patients would refuse to undress, some were too violent to approach, and others were unable or unwilling to produce sputum samples, making laboratory confirmation of TB or other pulmonary infections difficult.[883] Moreover, TB could be latent for many years, certain forms were not apparent on admission and when the patient's condition rapidly deteriorated, an accurate diagnosis or cause of death was not always determined. Diagnosis was also hampered by lack of diagnostic equipment such as laboratories or X-ray.[884] Only a few hospitals had machines before the war and Marchant bought their first X-ray machine in 1942: most hospitals had to send their patients to local hospitals.[885]

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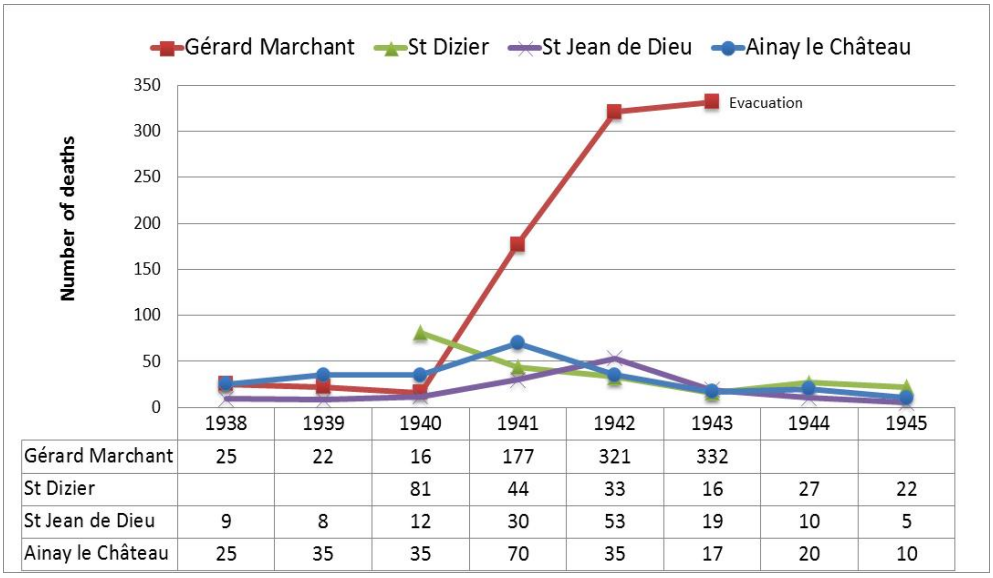
[881] AN Fontainebleau SAN 70847 pp. 72-3, 90-1.
[882] J. Vié, Pierre Bourgeois, Mlle Messin, and M. Armand,'La tuberculose pulmonaire dans les hôpitaux psychiatriques en période de sous-alimentation', *Annales médicales-psychologiques,* 2-3, (1942), 235-44 (p. 236).
[883] See David S. Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (Berkeley: University of California Press, 1995), p. 87.
[884] Gouriou, Une enquête sur les services ouverts: Réponse du Docteur Gouriou, p. 564.
[885] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943. UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte; UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943.



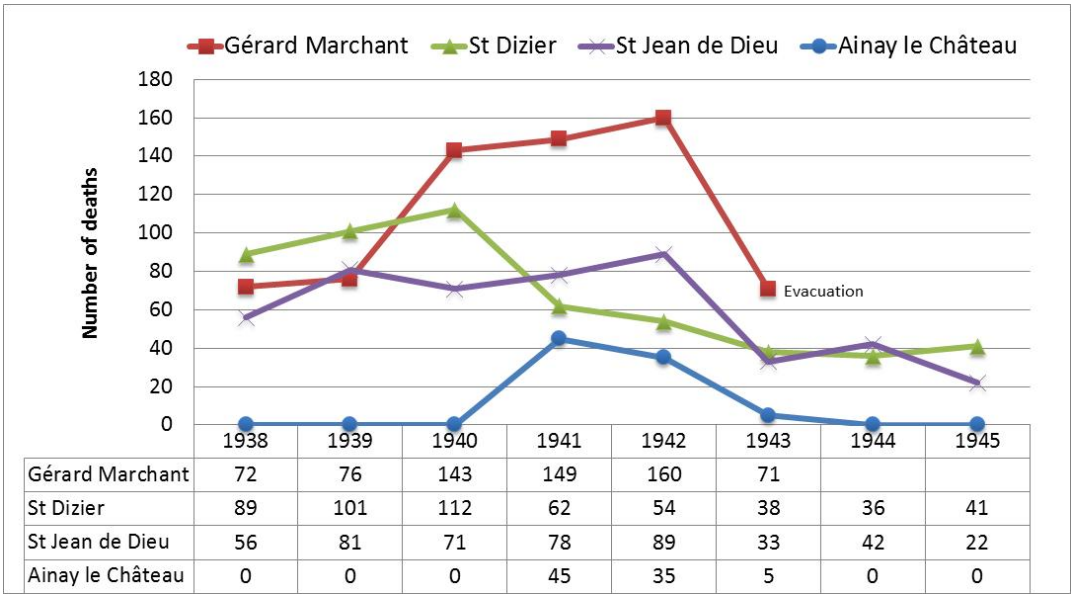
	1938	1939	1940	1941	1942	1943	1944	1945
Gérard Marchant	25	22	16	177	321	332		
St Dizier			81	44	33	16	27	22
St Jean de Dieu	9	8	12	30	53	19	10	5
Ainay le Château	25	35	35	70	35	17	20	10

Figure 19 Deaths from Debilitation in the four target hospitals
Source: Rapport administrative et médical 1938-1945 for the four target hospitals

Debilitation as a primary cause of death does not appear in the CIM, but was reported at Marchant well before the Occupation. This has a certain significance: the use of Debilitation before 1939 was used to define a general wasting or declining physical weakness and not starvation due to lack of nutrition. However, many diseases such as chronic cardiac or renal disease and even malabsorption syndrome can lead to debilitation.[886] It is not known why Debilitation was chosen as a primary cause of the death and not a more classic primary cause such as those mentioned previously. However, with increased numbers of deaths due to Debilitation during the Occupation it is probable that MCs added starvation due to malnutrition to this category, with or without any intention of hiding starvation as a primary cause. As seen in figure 17, causes of mortality at Saint-Dizier during the first two years of the Occupation were considerably different to the other three

[886] Interview with Dr Michel Mori (retired Médecin-chef de service Centre hospitalier spécialisé Saint-Dizier, Allier) by Patricia S. Legg at his personal residence in Saint Dizier on 26 August 2007 19.00h; Interview with Dr Jacques Postel (psychiatrist and historian of psychiatry) by Patricia S. Legg at his personal residence in Paris on 20 August 2013 14.00h; 'Personal communication by email from Dr Henri Vermorel to Patricia S. Legg 18 February 2008'.

target hospitals. Here, serious contagious diseases of typhoid fever and dysentery represented 14% of total deaths for 1940. These two causes are unique to Saint-Dizier in the study and attributable to damage to water supplies and subsequent contamination through military action and bombing in June 1940. However, *Debilitation* as cause did not appear until 1942: previously causes of death were only divided into Pulmonary TB and Other. From 1940 *cachexie* was added, and *debilitation* appeared in 1941 when *cachexie* was not registered. MCs at Saint-Jean-de-Dieu reported deaths as '*débilitation* or *cachexie demétielle* as the second official cause of death. For the duration of the Occupation, Ainay catalogues three causes of death: TB. Debilitation and Other all of which are lower than for the other target hospitals seen in figures 17 and 18.[887]



	1938	1939	1940	1941	1942	1943	1944	1945
Gérard Marchant	72	76	143	149	160	71		
St Dizier	89	101	112	62	54	38	36	41
St Jean de Dieu	56	81	71	78	89	33	42	22
Ainay le Château	0	0	0	45	35	5	0	0

Figure 20 Deaths from Other in the four target hospitals
Source: Rapport administrative et médical 1938-1945 for the four target hospitals

[887] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte.

Other as a category poses the same problem as already discussed there was no guidance for psychiatrists or similar documents as to what mix of causes should go into this group. Nonetheless there is sufficient data to give a comparison of two of the major causes of death in the four target hospitals. It is unfortunate that Other masks so many other causes of death as they might have been enlightening too. The complexities of causes of death however must not cloud the issue of what truly was the vector of death in the hospitals: the Occupation. Were the three foremost causes of death similar in the four target hospitals? The answer is somewhat obscure due to the copious terms used by psychiatrists to register death but possible using medical advice and opinion.[888]

Simply from an analysis of death registers rather than administrative and medical reports it is clear that mentally and physically handicapped patients, the most vulnerable, were among the first to die, and were grouped in either Debilitation or Other for official statistics. Mortality figures of the four target hospitals point unequivocally to the fact that for the first two years of the Occupation, food allocations were at a dangerous enough level to compromise health, and increased rations in December 1942 provided a reversal, if slow, of high mortality. What is clear and what is the more important in terms of the research question of this thesis is to determine what were the exacerbating causes of so many deaths: who died and why they died, rather than how they died in terms of strict cause of death which is difficult to establish.

[888] Personal communication by email from Dr Henri Vermorel to Patricia S. Legg 18 February 2008; Interview with Dr Paul Broussolle (retired Médecin-chef de service Centre hospitalier spécialisé Le Vinatier, Lyon) by Patricia S. Legg at his residence in Lyon on 21 October 2003 18.00h ; Interview with Dr Michel Mori (retired Médecin-chef de service Centre hospitalier spécialisé Saint-Dizier, Allier) by Patricia S. Legg at his personal residence in Saint Dizier on 26 August 2007 19.00h.

6.7 The meteorological situation and effects on mortality

One significant difference in annual hospital reporting during the Occupation is the inclusion of climatic effects on mortality; not present before 1940 in any hospital. France Météo data and seasonal figures record the winter months of 1940-41 and 1941-42: snow covered most of France for many weeks, severe frosts and flooding brought further problems unexperienced since before 1878.[889] In addition, summers brought drought and high temperatures affecting not only agriculture, crop harvests, animal fodder, but the vulnerable and physically ill in society.[890] (As a current example, in France in 2003, deaths from adverse meteorological conditions affected the most vulnerable in society and rose to 15,000 above the habitual mortality for the same period in 2002.)[891]

In all four target hospitals MCs reported deaths as seasonal events. Whether this was to explain or justify the phenomenon of such high mortality in factual terms which would to some extent exonerate them from a certain allegation of professional incompetency is possible. Seasonal extremes are implicated in increased mortality in the two winter periods seen in Saint-Jean-de-Dieu, figure 20.

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[889] J. Sanson, *Mémorial de la météorologie Nationale : Recueil de données statistiques relatives à la climatologie de la France*, (Paris: Imp. Nationale, 1953).
[890] M. Aubenque, P. Damiani, and H. Masse,'Variations saisonnières et séries chronologiques des causes de décès en France de 1900 à 1972', *Cahiers de sociologie et de démographie médicales,* 19, (1979), 17-22.
[891] Denis Hémon and Eric Jougla, Rapport remis au Ministre de la Santé et de la Protection Sociale: Surmortalité liée à la canicule d'août 2003, 2004.

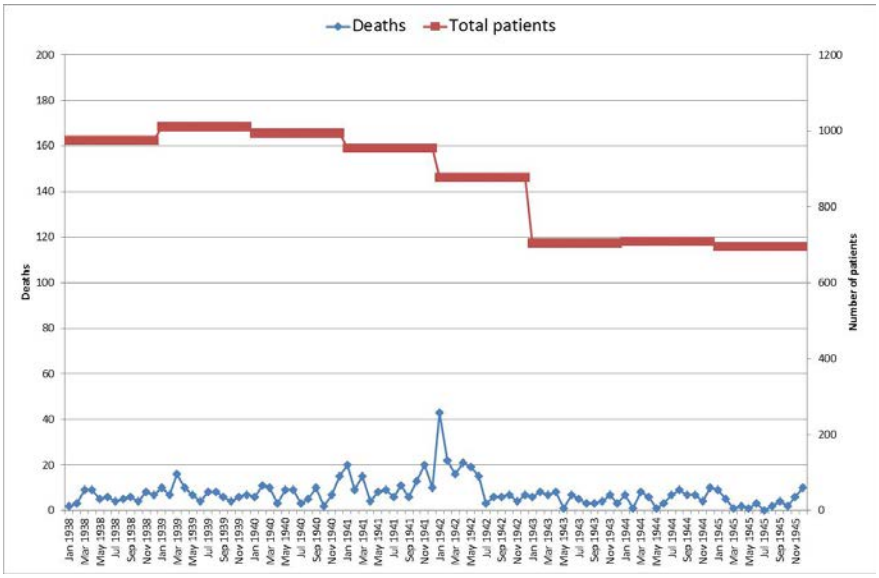

Figure 21 Saint-Jean de Dieu: seasonal mortality for the years 1938 to 1945
Source: UHASJDD Death registers

6.8 The German effect: proximity of the German military

As we have learned, the German effect was very real for Saint-Jean-de-Dieu, with German troops encamped in the hospital grounds from June 1940-44.[892] This proximity was detrimental to the health of patients with critical consequences due to the profligate manner with which troops used water and electricity (both valuable resources for major services and patient treatment) but the extent to which this intrusion on daily life exacerbated mortality is unclear and unconvincing as other hospitals had a serious lack of both resources. In departmental documentation and hospital reports there is no evidence of the military displaying aggression or behaving in a negative manner reflecting eugenic values towards patients, such as the Nazi Euthanasia programmes for the mentally ill and

[892] UHASJDD, Compte moral 1938 à 1945.

physically disabled established in Germany.[893] Possibly this was due to the mentality of locally based troops and the remoteness from political ideologies of their leaders. Scholarship suggests that German attitudes to the French was a complex issue ranging from dislike and revenge to sympathy to Francophilia, as in the case of the German Ambassador Otto Abetz an admirer of French culture, and General Dietrich von Choltitz.[894] It is reported that cordiality existed between the Prior and local military officials, and the mayor of Saint-Brieuc, the local town to Saint-Jean-de-Dieu, noted in his reports that most troops in the area were well–behaved.[895] To test the theory that for Saint-Jean-de-Dieu, Dinan-Léhon the German effect was minimal on mortality we can compare the hospital with Marchant which was in the non-occupied zone until November 1942.

From figure 12 we see mortality for Saint-Jean-de-Dieu had a similar pattern to the other three hospitals. However, Marchant was state-run and a better comparative is the brother establishment of Saint-Jean-de-Dieu in Lyon in the non-occupied zone. In Lyon, as seen in figure 10, (mortality for both Saint-Jean-de-Dieu hospitals) for the period 1939-42 deaths rose vertiginously to 19% whereas in Saint-Jean-de-Dieu Dinan-Léhon the figure was 11%. By the end of 1942 when all of France came under German rule, deaths in Saint-Jean-de-Dieu Lyon rose even more to 21.1% whereas in Dinan-Léhon, the mortality curve was returning slowly to its pre-war average.

Although the German effect cannot expressly be blamed for the early increase in mortality in Lyon as it was in the non-occupied zone until November 1942, from

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[893] Bronwyn Rebekah McFarland-Icke, *Nurses in Nazi Germany: Moral Choices in History*, (Princeton: Princeton University Press, 1999); Burleigh, *Death and Deliverance*.
[894] Craig F. Morris, 'German Occupation of France 1940-42. Between Armistice and Capitulation?', (master's dissertation, Air Command and Staff College, Maxwell Air Force Base, Alabama 2006), p. 7; Samuel W. Mitcham, *Retreat to the Reich: The German Defeat in France, 1944* (Mechanicsburg Pennsylvania: Stackpole, 2007), pp. 199,98.
[895] ADCA, Série 1W 30, Visits to the communes by sous-prefect 1943.The sous-prefect comments on the good behaviour of the German troops in and around Saint Brieuc.

this date the increase to 21.1% might be accounted for by the German effect. Lyon was the heart of the Resistance and the headquarters for the Schutzstaffel (SS) and Gestapo. If the Germans were not in close proximity from May 1940 until November 1942 another element in increased mortality must be considered. Despite von Bueltzingsloewen's assertion that Vichy held no covert eugenic policy and that she found no evidence of an official attempt to starve psychiatric hospital inpatients, in Lyon, individual officials held sway over the fate of the patients in HPs Vinatier and Saint-Jean-de-Dieu, Lyon. The latter hospital highlights that even within clerical establishments there were dissimilarities in experiences of mortality. The dissimilarities were not dependant on locality or proximity to the occupiers but on a palpable negative attitude in the aid of the mentally ill by the local authorities and individual officials.

However, in Saint-Dizier, one advantage of the German effect, if it can be called such, was a demand for laundering troops' clothing and bedding which involved improvements to the dilapidated laundry services, and paid for by the authorities, which may in some small way have helped to improve hygienic conditions for patients and staff who worked in the laundry.[896] It is not recorded as to whether the health-conscious disease-concerned Germans considered the possibility of contamination from patients' laundry.

For most patients in Ainay life was very little disrupted by German troops despite being just 50 kilometres away in Moulins, one of only four 'crossing points' through which all returning exodus refugees were funnelled across the demarcation line.[897] But in the early days of the invasion patients at Ainay were caught up even so when their large supply of warm clothing and shoes was lost in

[896] UHASD, Registre des délibérations de la Commission de Surveillance. 22 juin 1935 à 20 février 1944.Séance 22 dec 1940 visit of the Feldkommandantur to the HP.
[897] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. p. 18.

the chaos of the exodus.[898] Moreover, German troops assassinated two of the colony's patients, but this was not because they were mental patients but because they were discovered in the vicinity of a search operation for the Maquis.[899] From the beginning of the Occupation, the hospital had been involved in hiding fleeing POWs, relatives of civil servants and other officials from the Paris prefecture, and officials of certain Seine hospitals.[900] Perhaps rumours of such activity reached the ears of the German commanders and that might be the reason why they were shot. Apart from the confirmation of these two deaths, there is no written evidence that inpatients died because of the German effect in Ainay.

6.9 The German effect: hospital patient evacuation and transfers

One further cause of mortality related to the German effect is patient transfers. Many deaths in the target hospitals are quantifiable and incontestably associated with the German military and its occupation policies. The transfer of patients from one hospital to another is a dynamic intrinsically linked to disruption and dislocation in daily life and markedly influenced mortality. Conventionally, transfers were implemented, especially from Paris hospitals to reduce overcrowding and for the state this had financial advantages as tariffs in the Provinces were well below Paris.[901] As has been shown, patients by reason of their diagnosis were susceptible to psychological distress when their normal daily pattern was altered: depression

[898] UHAALC, Rapport Administratif et Rapport Médical (1938-1945) Hôpital Psychiatrique la Colonie familale d'Ainay le Château Département d'Allier.
[899] UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. p. 29.
[900] Ibid. p. 2.
[901] M. Bénézech and C. Lièvre,'Le triste sort des aliénés de Sarreguemines transférés à l'asile de Cadillac pendant la Seconde Guerre mondiale', *Revue de la société français d'histoire des hôpitaux,* 141, (2011), 3-7 pp. 3-4).

paranoia, mania and anorexia were exacerbated. Deterioration in mental and physical health ensued for existing patients and those transferred.[902]

Marchant was heavily involved in transfers, predominantly out of necessity. In June 1940, 251 patients from HP Hoerdt Alsace (Bas-Rhin) were transferred.[903] Patient numbers increased from 1572, to 1802. In early 1942, 65 patients arrived from the *colonie familiale* Dun-sur-Auron, (the female equivalent establishment to Ainay), and, following the closure of HP Montauban (Midi-Pyrénées) a further 305 patients arrived. From hospital death registers and patient dossiers, collated with reports, it is clear that many transferees died within a short time of arrival.[904] To some extent this clouds mortality figures in the receiving hospitals as the deaths of many transfers would not have happened if there had been no invasion.[905]

Much as the exodus refugees disturbed host communities that were expected to receive them, transferees in hospitals elicited a similar attitude.[906] For many in the hospitals, transfers were perceived as taking already-depleted and restricted food supplies, space, bedding, and nursing time. They also added to the atmosphere of desperation, to the noise factor – existing patients' noise was acceptable but transferees' noise was sufficient to heighten instability in an already fragile mental state. In addition, many transferees were German speaking, a communication problem for them and something that for others would be a hostile situation.

The events caused Marchant's already severely depleted staff to be even more stretched: admitting, classifying, pacifying, medicating, accommodating, all adding

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[902] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943; Xavier Bonnefoy,'Inadequte Housing and Health: An Overview', *International Journal of Environnement and Pollution,* 30, (2007), 411-29 (p. 419); Cherry, *Mental Health Care in Modern England,* pp. 209, 14.
[903] Bueltzingsloewen, *L'hécatombe des fous,* p. 413.
[904] Also see Caire, A propos de l'hécatombe.
[905] UHAGM, Séance 24 juillet 1941.
[906] Dombrowski Risser, *France under Fire: German Invasion, Civilian Flight and Family Survival*; Fogg, *Politics of everyday life, 2009*.

to existing problems, the most serious of which was maintaining health, hygiene, and providing an adequate diet.

However, in comparison, in four years Saint-Jean-de-Dieu received only 126 patients, in one group. Patients and staff walked the 49 kilometres in two stages from HP Pontorson but their fate was less severe than at Marchant.[907] In the nine months they were there, ten died, one on admission and the others later in the period. From numbers of transfers elsewhere it would appear Saint-Jean-de-Dieu had fewer transfers, but there is no documentation as to why. It was not simply because it was managed by a religious order. HP Sainte-Marie (Clermont Ferrand) was also clerically run, and received large numbers of transfers. Of 334 transfers from HP Rouffach, (Haut Rhin), only 90 returned.[908] It might have been that Saint-Jean-de-Dieu's location on the far west had a bearing on such a small number of transfers, whereas Saint-Dizier was on a main route from the north eastern borders receiving many transfers from the Haut- and Bas-Rhin and Sainte-Marie was central, on the main route to the south.

Other hospitals in diverse geographical locations relate similar experiences. In September 1939, HP Cadillac-sur-Garonne (Gironde) received 374 male patients from HP Sarreguemines (Moselle): 268 had died by 1945.[909] HP Vinatier received more than 1,000 transfers.[910] But then again, HP Leyme (Lot), which had the same status as Saint-Jean-de-Dieu, and on the main route to the south, received only small numbers: 77 in four years.[911] Transfers to Ainay were only minimal. The significance of transfers during the Occupation lies in the high numbers of deaths recorded in the receiving hospitals. Although some transfers were for patient safety like HP Hoerdt, many were at the demands of the German occupiers

[907] ADCDN, Série 94W 1; UHASJDD, Compte moral 1938 à 1945.
[908] Bonnet, De l'Assistance aux malades mentaux, p. 188.
[909] Bénézech and Lièvre, Le triste sort des aliénés, p. 4.
[910] Bueltzingsloewen, Morts d'inanition, 2005, pp. 59-60.
[911] Vedié, Moser, and Paulin, Surmortalité dans un hôpital psychiatrique, p. 513.

requisitioning buildings with no thought of the consequences on patient health. However, this was not focused specifically on mental patients as general hospitals like the one is Saint-Dizier town were also evacuated to accommodate troops. It is more likely that size dictated the choice of hospital and that in evacuation procedures the mentally ill were grouped with 'la totalité de la population'.[912] If this is so it is a significant sign, illustrating an official attitude of consideration for the mentally ill in such an action plan.[913]

However, albeit minor, two valuable assets arose from Marchant's 1940 transfer procedure. The accompanying MC remained at Marchant until its evacuation and the group brought a large supply of clothing, blankets and bed linen, enough, with Marchant's stock, to cover the war years, although 'hand-me-downs' became common-place and a lack of textiles, mending materials and washing detergents, gave patients and staff a shabbiness which MCs noted strained morale. In Ainay such attire drew adverse reactions from the townsfolk with patients giving 'des allures de clochards, spectacle pénible'.[914] However, it should be pointed out that although transferees brought clothing and bedding with them, it was only the equivalent of hospital issue and would not have been a great help in the severe winters of 40-41 and 41-42.

As the Occupation progressed, an indirect German effect regarding location became a serious disadvantage for Marchant. Close proximity to the large conglomeration of Toulouse and *La Pouderie,* a major chemical works and suspected target for allied bombing, turned Marchant's inpatients into transferees.

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[912] Bénézech and Lièvre, Le triste sort des aliénés, p. 4 fn.
[913] According to the instruction générale de sauvegarde 1 July 1938 citizens from Moselle were destined to be accommodated in the Charente and Vienne departments, but perhaps some hospital transferees went to hospital considered less overcrowded or better adapted to receive them.
[914] UHAGM, Report from the director to the prefect 15 august 1941 p. 2; UHAALC, Remarques sur l'évolution de l'Assistance psychiatrique Maurice Leconte. p. 16.

In 1943, all patients were evacuated to various surrounding hospitals or discharged to relatives as seen in Figure 21.[915] There is no data on the total number of mental patient-transfers from all psychiatric hospitals during the Occupation but with the experiences of hospitals such as Marchant, Sarreguemines, Vinatier, and Cadillac, the German effect was significant for transferees.

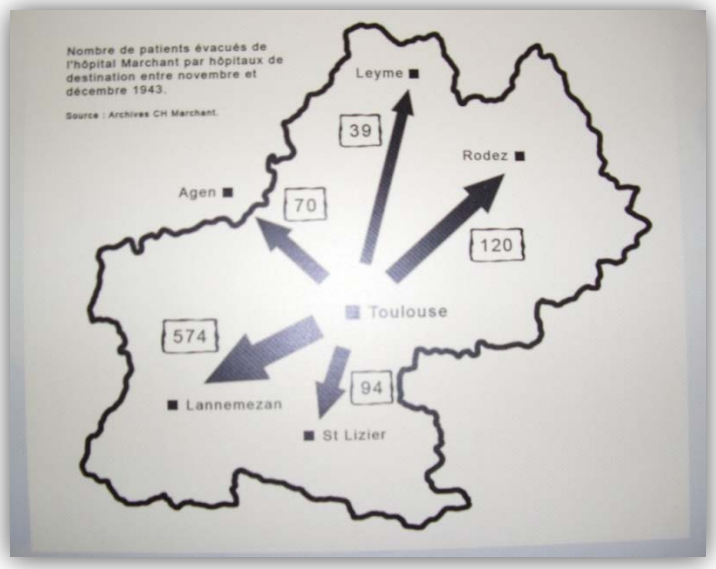

Figure 22 Evacuation destination hospitals from HP Marchant November/December 1943
Source: UHAGM Séance du comité de surveillance 12 octobre 1943

Motivation for transfers is an important aspect in the belief systems of psychiatry of the day. In the case of HP Hoerdt the worth of the individual was displayed by both administrators and psychiatrists. That these patients were under threat of death from Nazi-influenced policies is indisputable: 50 patients from HPs Stephansfeld and Hoerdt, in the annexed Alsace region, were sent to the German

[915] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 6; ibid.; UHAGM, Rapport sur la Commission de Surveillance (1937-1943).

HP Hadamar-en-Hesse where all but one perished in the extermination centre.[916] If the inference by certain theorists is that directors and MCs were indifferent to the fate of patients or that a mentality of the *élimination des bouches inutiles*, or as German jurist Karl Binding stated, 'not merely worthless, but actually existences of negative value', hovered not only over French psychiatry, but in the culture of many French people, why transfer patients, why not see the invasion as a quick fix to the solution of overcrowding? [917] This theory is at variance with the actions of MCs in Hoerdt and other hospitals, although there were grave repercussions for their patients in transferring them.

Although explanation is given for many transfer procedures, the question presents itself as to whether the receiving MDs or hospital committees encouraged transfers in an attempt to shore up dwindling income: a method of balancing the books. The economic crisis and cost of daily living rose well above all hospitals' annual budgets and allowances, driving administrative concerns of closure with the ever-decreasing patient numbers that in turn reflected a down-turn in the total daily tariff.[918] This is unequivocal in the words of Dr Chatagnon, Maison Blanche, in 1944, regarding psychiatrists' concerns during the Occupation : 'Une conséquence de la diminution de la population dans les hôpitaux psychiatriques [...] font qu'il est envisagé la fermeture ou plutôt la transformation des hôpitaux psychiatriques en établissements destinés aux malades tuberculeux'.[919] Furthermore, private patient

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[916] Bueltzingsloewen, Les « aliénés » morts de faim, p. 107; Jost, Les malades mentaux dans la tourmente 1939-1945; Vedié, Moser, and Paulin, Surmortalité dans un hôpital psychiatrique, p. 516; Quétel, *Histoire de la folie de l'Antiquité à nos jours,* p. 476.

[917] Pédron, *La prison*; Burleigh, *Death and Deliverance,* p. 17; Denis Peschanski, *Vichy 1940-1944: controle et exclusion*, (Brussels: Complexe, 1997); Also see Karl Binding and Alfred Hoche, *Allowing the Destruction of Life Unworthy of Life: Its Measure and Form*, (Greenwood WI: Suzeto Enterprises, 2015).

[918] UHASJDD, Compte moral 1938 à 1945. pp. 1-2. Caire, A propos de l'hécatombe; Bonnet and Quétel, La surmortalité asilaire, p. 32; Le Guillant and Bonnafe, La condition du malade à l'hôpital psychiatrique, p. 835.

[919] G. Massé and D. Ginestet,'Une lecture des 'Annales' de l'Occupation: La vie dans les hôpitaux psychiatriques de 1939 à 1945', *Actualités Psychiatriques,* 3, (1977), 53-57 (p. 55).

income diminished as families were forced to request declassification of their relative, as has been evidenced and others could not pay at all and many patients passed to indigent status, dependant on the state.[920] This blow to the hospital budget was offset in some cases by transfers from other departmental hospitals. For many patients, it was two edged. In Marchant the state of the hospital's finances were such from the reduction of patients the committee reported to the director that at government level it was muted that psychiatric hospitals could be converted into much needed santoria for TB patients.[921]

Whilst there were hospital committees attuned to patient needs such as HP Montdevergues-les-Roses (Vaucluse) where members actually sanctioned the illegal activity of sourcing foods from local farmers to supplement diminishing supplies, attitudes of other hospital committees raise the question as to whether there was a collective or individual undercurrent of *laisser mourrir* in the asylum system administration linked to mental hygiene beliefs that saw the mentally ill as a financial burden and of no value.[922] Did finances or political pressure or the official line take precedence over the welfare of patients? It undoubtedly did at Saint-Dizier, where MCs Déffuant complained bitterly of the adverse outcomes for both patients and transferees. They brought considerable pressure and even danger for staff and resident patients. Overcrowding grew to such an extent that patients slept in corridors.[923] Cases of lice and contagious diseases accompanied the transferees requiring isolation rooms, clean nightwear and bed linen; none of which were available. Patients were failed due to inadequate medical experience

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[920] UHAGM, Rapport administratif et rapport médical pour la période du 31 décembre 1937 au 31 décembre 1943 p. 11.

[921] UHASD, Projet de budget des recettes et des dépenses de l'exercice 1943.This reduction of population has a serious repercussion for the finances of HP. The Centre regionale d'hygiène mentale has put forward options for HPs and collectivities in the fight against TB.

[922] Colin Gordon, 'History of Madness', in *A Companion to Foucault,* ed. by Christopher Falzon Timothy O'Leary and Jana Sawicki (Chichester West Sussex: John Wiley & Sons, 2013), pp. 84-103 (p. 95).

[923] UHASD, Registre des délibérations Séance de 18 septembre 1943.

and nursing care, along with a paucity of medication for acute and chronic cardio-respiratory conditions. Moreover, many transferees only spoke Mosellan or German which led to serious communication problems.[924] Nevertheless, in certain hospitals, records show that there were transferees who not only survived the journey but lived for many years after the Liberation. Such was the case of Madame L-M., admitted aged 39, a transferee from Sainte-Anne, Paris, on 12 March 1942, and died aged 69 on 7 October 1972.[925]

[924] Bénézech and Lièvre, Le triste sort des aliénés, p. 4.
[925] Bueltzingsloewen, *L'hécatombe des fous,* p. 381; UHAGM, Patient dossier, Madame L-M., age 39 admitted 12 March 1942 died 7 October 1972 age 69.

6.10 Conclusion

A culmination of the analysis of research evidence in the four target hospitals has been set out in this chapter and concludes that during the years 1940-44 the consequences of the German Occupation brought about the deaths of over 40% of inpatients. In order to understand the deaths of such a large swathe of the hospital population a time line of the mortality curve is valuable. In September 1939 France had mobilised some five million men, many were agricultural workers and the harvests would all but perish for lack of manpower and by the following spring grain and seeds were unsown. In December 1939 psychiatric hospitals fell in line with the government's 'invitation' rationing certain products. In October 1940 Vichy introduced *Ravitiallement général*. The winters of 1940-41 and 1941-42 were the hardest since 1878 and the summers brought drought and high temperatures. However, in December 1942 Vichy enacted a directive to increase rations for psychiatric hospital inpatients.

It is unequivocal that mortality in the three closed target hospitals rose vertiginously in the first two years of the Occupation with a slow downward trend from the beginning of 1943. Ainay's mortality increased but not to the degree of the other three hospitals. Numerous predisposing factors embracing both internal and external triggers gave rise to this mortality. Each of the target hospitals whether state- or clerical-run display some or all of these influences.

What principally separates the target hospitals is the non-carceral aspect of Ainay, although this did not completely protect patients from an uncharacteristic rise in mortality during the Occupation. For patients in Ainay this *liberté* is reflected in the smallest proportion of deaths with a downward trend earlier than the other three hospitals indicating that the directive of December 1942 was of less influence on mortality in Ainay and that nutritionally patients fared much better than the other three hospitals.

Saint-Jean-de-Dieu with its clerical management had fewer deaths than the other two closed hospitals. This was due chiefly to its particularity of personnel and networking systems. Marchant, with the largest inpatient population, had the highest mortality followed by Saint-Dizier, both were state-run. The German effect was not reported as implicated in mortality and more pertinent there was no obvious imposition of Nazi ideology on inpatients.

The emotional and mental state of the mentally ill was inherently friable, making them an established 'at risk' group; stress and disruption to normalcy of daily life brought about a chain of reactions to extraordinary external factors. The German quota system on industrial and agricultural resources forced Vichy to implement a rationing system which was incompetently and unfairly administered and nutritionally deficient leading to serious health issues for citizens who were considered to be in 'normal' health. For those already compromised by ill-health the consequences were often fatal. Vichy's discrimination policies and persistent inertia towards a disenfranchised group in society added to the misery.[926]

Profiling inpatients has generated an image of who died. The curve of upward mortality moved from male patients and the young and elderly. These groups were among the first to succumb followed by the unmarried and those without relatives or friends. They were obvious victims of a lack of family contact and little or no food parcels and lower levels of morale.

However, although studies have shown that single or widowed male patients were the first to succumb, mortality in the all-male *colonie* of Ainay gives a different picture. This is rests on three factors. Firstly, moral may have been higher as patients had some socialisation and were not deprived of social interaction as they were in closed hospitals and they may also have been protected due to less

[926] Masson and Azorin, La surmortalité des malades mentaux, p. 471.

disruption to daily life in the quiet villages of the Tronçais. Thirdly, they were in better physical health than patients incarcerated in the other target hospitals who were deemed less fit, especially the long-term patients with chronic physical conditions. Male patients in Saint-Jean-de-Dieu may also have been protected by their private status as when they were admitted they might have been in better health, and nursed in less densely packed dormitories where TB as cause of death would have been limited. However, the mortality curve of indigents and private patients was similar.

Furthermore, those who were transferred from other hospitals due to the German effect are also implicated in the high level of deaths from 1940 to early 1943. Added to these dynamics were the unprecedented and brutal weather conditions of the winters and summers of 1940-41 and 1941-42. This factor alone underlines the unpreparedness of the hospitals in their duty of care towards patients. There were extant weaknesses of the FMHS: institutional inadequacies and bureaucratic hospital frameworks did not allow for autonomous action in a time of crisis unprecedented in mental hospital history, and a lack of acute nursing beds in infirmaries and no emergency procedures hampered action and care. There were professional shortcomings too. Psychiatrists were powerless to cope with such medical emergencies, with little experience or training. This is part was due, as von Bueltzingsloewen argues, that even in the northern area of France which was occupied in the First World War, such a crisis was unseen in psychiatric hospitals.[927]

However, what is observed predominantly in the target hospitals is the effect of the extra rationing allocated to mental patients in Vichy's directive of December 1942. Even such minimal increase in rations: a daily average of roughly 200 calories, saw the rapid rise in deaths from late 1939 to the end of 1942 reduced, albeit

[927] Bueltzingsloewen and Horassius-Jarrié, La famine dans les hôpitaux psychiatriques.

slowly.[928] The phenomenon of the diminishing mortality in the target hospitals in early 1943 substantiates the claim that the increase in rations was sufficient and the difference between life and death in the target hospitals. Moreover, it occurred despite intensifying daily hardships *extra muros* for the general population: real wages had fallen by 37% and from 1940 prices increased on average 17% per year.[929] In addition, incessant food shortages and the return to power of Pierre Laval as Vichy's head of government led to food riots.[930]

Although specific causes of death in the target hospitals are problematic due to errata and non-conformity, official causes were classified under tuberculosis, debilitation and 'other'. Together they demonstrate how 45000 patients died. However, in their individualistic manner of certifying deaths, it is possible that MCs used the opportunity to vent their concerns about Vichy's restricted rationing and repression policies and the pitiful facilities and conditions for their patients. Nevertheless, from all evidence examined there is no indication that MCs clouded the issue of the cause of increased mortality for their own means or in a professional closing of ranks. Indeed, evidence offered demonstrates that many MCs did much to bring their patients' plight to the authorities' attention and to alleviate the problems associated with restricted rations and the consequences evidenced in their lobbying and in Vichy's directive. Despite the many mantles of exclusionism, racial discrimination, and repression with which Vichy has been cloaked, the directive establishes that Vichy participated to some degree in the reduction of hospital deaths, and importantly claims of any covert policy to deliberately starve the mentally ill are unproven.

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[928] Caire, A propos de l'hécatombe, pp. Caire quotes Circulaire No. 186 du décembre 1942, allocating: 250g pasta, 50g dried legumes, and 1kilo potatoes weekly, 90g meat every eight days, 15g lipids every four days, 20ml wine daily.
[929] Taylor, The Black Market.
[930] Paula Schwartz,'The Politics of Food and Gender in Occupied Paris', *Modern and Contemporary France,* 7, (1999), 35-45 (p. 42).

Main conclusion

The histories of the four target hospitals have acted as exemplars to the divergent provision of facilities and care for the mentally ill from state-run establishments, as in the case of Braqueville/Gérard Marchant and Saint-Dizier, to the clerically run Saint-Jean-de-Dieu, to the innovative *colonie familiale* in Ainay. They illuminate dynamics at play from their foundational philosophies of care and their progress from asylums to psychiatric hospitals driven by those who managed and worked in them. Each asylum was a legal and medical institution developed within the framework and role of the 1838 asylum law, regulated by the dual dynamics of a custodial and therapeutic approach to care for the mentally ill, although it was not many decades before the law was incompatible with early alienists' ideals of therapy and cure. The state's view of the asylum as a prime apparatus for the control of social deviance, whether mildly so as in the case of a confused vagrant or alcoholic or an elderly noisy neighbour, was apparent, seen in overcrowding therapeutic stagnation.

However, during the late-nineteenth century opinions of causes and treatment of insanity became increasingly more scientific and alienists became psychiatrists, and in 1937 asylums became hospitals. Nevertheless, as this study demonstrates, neither the advancement of divergent theories nor name-changes was of much use in practical terms concerning facilities and management of the mentally ill. The target hospitals are a potent symbol of the origins and evolution of the FMHS and in the early-twentieth century were a defining character of facilities for patients whilst highlighting the system's weaknesses and failures and offering comparison of state- and clerical-run hospitals. Yet the medical and nursing care and patient well-being, whether of good, bad, or mediocre measure, was a constant in the existence of each hospital and its patients. Regimentation, a sense of stability, and regular meals were of significant importance to patient care and part of the principal ideas advocated in psychiatric practice.

However, all aspects of hospital life were to change beyond any recognition. In 1939, when France entered the Second World War, the FMHS had just reached its centenary. By the Liberation from German occupation in August 1944, the total population of hospitalised mentally ill patients had been almost halved due to conditions beyond the control of the main care providers. The primary factors at play, disruption and dislocation were *extra muros* and decisive to the deaths of more than 45,000 inpatients. The scale of experiences in the target hospitals during the Occupation and Vichy is extensive and multifaceted but contextualised with those of the general population this study has revealed inpatient experiences were magnified disproportionately for a disadvantaged societal group.

In analysing the German occupation in terms of change to daily life in the target hospitals and what brought about such high mortality it is imperative that the picture of hospital life and death before the Occupation is clear. During the 1930s, in the four target hospitals, there had been various modernising projects: upgrading to electrical supplies and basic central heating, catering, laundry, and farm and agricultural building and equipment improvements. Patient welfare had also benefited from additional leisure facilities such as cinema, board-games, newspapers, magazines, and music. Such efforts demonstrate willingness by hospital psychiatrists and certain state authorities to develop facilities and improve material conditions. Nevertheless such minor efforts within enormous antiquated asylums demonstrate systemic failings in institutional practice and critical under-investment by the state, although during the interwar years, like most European countries, France faced economic depression and deflation.

If facilities and material conditions had been of a better standard would this have protected patients? It must be considered that with the extant facilities, insufficiently trained staff and parsimonious officials during the 1930s the target hospitals' average annual mortality ran from 3.5% for Ainay to 10% for Marchant, within the national average. With this in mind, it is unlikely outcomes would have been different because mortality rose to such proportions predominantly due to

extra muros factors that were principally related to increasingly diminishing foodstuffs and commodities and subsequent ill-health rather than poor sanitation and hygiene, although rationing had severe consequences.

In addition, even with the modernisation of Marchant's patient quarters, laundries, kitchens, and installation of additional electricity supplies mortality rose enormously. Modernisation did not protect patients in light of elevated prices for fuel and raw resources, electricity restrictions and frequent cuts as catering services were severely restricted, patients' menus were minimal and often half-cooked, if cooked at all. Furthermore, and not considered sufficiently in causes of mortality, lack of resources in laundries led not only to unsatisfactory laundering and sterilisation of bedlinen, bandages and uniforms, but increased risk of cross-infection for staff and patients.

Between the outbreak of war in 1939 and the invasion of May 1940, disruption and dislocation to normal life for the whole nation took on many guises. Firstly, there was the loss of working men affecting the main national resources of industry and agriculture. In the three closed institutions large numbers of men in nursing, hospital services, and overseers in farming and agriculture were mobilised. By default this loss of men had an effect on women working in the hospitals too. With their men away many stayed at home running family small-holdings, or providing for large families. In the target hospitals, mobilisation laid the foundation for hardships and difficulties in security, food provisioning, general upkeep of the fabric of the hospital, and nursing for patients as well as lowered morale.[931]

The defeat of France and the Armistice in June 1940 established the presence of the German military and the collapse of France's economy. Embargos of external

[931] UHAGM, Letter 18 November 1941 from the director to the prefect. In discussing mobilisation, the director notes, 'L'absence, dans un établissement de cette importance, d'un personnel infirmier spécialisé consitute, une grave lacune.

trade and resources destabilized the French nation and amputation of raw material caused a heavy toll on industry and business affecting many citizens' spending power. With this came the harsh imposition on the French people of a daily maximum consumption of foodstuffs, to the benefit of the German people, and unreasonable and crippling demands for a large proportion of industrial resources, for the German war effort. Thus France was in a stranglehold and Vichy's attempt at a rationing system, which covered items from foodstuffs to household goods, even before self-interested farmers, suppliers, shopkeepers, certain citizens and the occupiers encouraged a black market parallel system. Wartime shortages in France led to vast changes in the dynamics of daily life, whether affected by Vichy's increasing deficiencies and inequalities of the food provisioning system or fragmentary and divergent refugee welfare programmes, or its discriminatory measures.

One year into the German Occupation saw signs of severe ill health for many citizens. The problematic of food was associated with an inadequate and nutritionally imbalanced diet leading to serious outcomes such as increased respiratory, cardiac and renal disease. The rationing system was undoubtedly a contributory factor in increasing mortality. In questioning the reasons as to why there was such high mortality in the target hospitals, it is possible to map the experiences of citizens and their struggle for existence during the Occupation with those of the target hospital inpatients.

Firstly, a large proportion of the general population were able to *se débrouiller* or barter, or visit country cousins, or made time to spend half a day or more queuing for a loaf of bread. These options were not open to bursars responsible for hospital provisioning. Even for civilians mobility was difficult, fuel regulated and expensive, spare parts scarce and even bicycle-tyres rare. Such experiences reduced patients' visits and food parcels and loss of contact with family and friends played on morale. As the Occupation continued, economic crises deepened; for a family of ten or a hospital of a thousand, a franc did not buy what it had bought before the

Occupation. The Occupation was the catalyst changing the rhythm and pattern of established life imposing great hardships for all of France: with the gravest consequences for hospitalised mentally ill people.

Each of the four target hospitals has both similarities and dissimilarities in the experiences of mortality during the Occupation. The experiences lived through by patients and staff are interconnected to the individual features of the hospitals, institutional framework driven by psychiatric and religious practice, leadership, the character of the nursing and medical care, and geographical location. The consequences of the German Occupation are reflected in the distinctiveness of mortality in each of the hospitals.

Saint-Jean-de-Dieu's foundational philosophy of care for the needy and insane was an important and defining factor in life and death for patients. Care for them was enhanced by Saint-Jean-de-Dieu's clerical status, solidarity and the Order's networking systems along with the character of its personnel. Compared with the other target hospitals, the staff were mainly trained, long-standing and, true to their calling, they were unmaterialistic and received no salary. They were more patient-aware due to their strict training as nurses and although the two MCs were in charge on a medico-psychiatric level, as all MCs, they relied heavily on the expertise and practical skills of the Brothers who were steeped in the Order's tradition of responsibility and charity.

The collective identity of the Brothers demonstrates there was less friction between management and nursing which only highlights a lack of cohesion and professional unity seen in the other hospitals. Problems encountered in the state hospitals with lack of staff supervision especially at mealtimes appears absent in clerically-run institutions. In addition, Saint-Jean-de-Dieu was run by a Prior whose training in nursing and management sets him aside from a more medically oriented director employed by the state. Saint-Jean-de-Dieu also benefited from fewer transfers which had a bearing on mortality, as did its high volume of private

patients, although the curve of mortality for both *pensionnaires* and *indigents* was similar and the daily tariff was lower than state hospitals.

Staffing characteristics were much the same in Marchant and Saint-Dizier but neither had such stable and motivated staff as Saint-Jean-de-Dieu. This indicates a gulf between state and clerically-run institutions. Although there was a presence of clerical Sisters in both Marchant and Saint-Dizier, they essentially looked after female patients and did not drive either hospital management or philosophy of care. This difference was significant in patients' experiences during the Occupation.

Events in Marchant demonstrate how patients were failed by those who worked there. Omissions in patient care are obvious. The unexpected and uncommon deaths during December 1940 and March 1941 and the reaction and investigation by Marchant's MCs equally demonstrate professional shortcomings in a lack of medical supervision and expertise as well as institutional inadequacies in terms of the state's inability or unwillingness to understand or cater for the needs of the mentally ill, along with its persistent parsimony. However, Marchant's MCs were proactive, if tardy adapting and prioritising: increasing material warmth for patients, increased control at mealtimes, increased staff discipline, all aspects of management that should have been in place but were not. It cannot be taken for granted that had the MCs been more vigilant or more in tune with patient and staff needs in the extreme weather conditions of the winter of 1940-41 and 1941-42 they might have prevented some deaths. It is unlikely given institutional and legislative regulations which made autonomous action almost impossible.

Furthermore, Saint-Jean-de-Dieu acts as a barometer on the notion of the effects of the proximity of occupiers on mortality. The hospital had troops on its doorstep for the whole Occupation period. Mortality rose in the first two years, but not to the extent of the other target hospitals, indicating that the closeness of troops had no direct effect on mortality. Had there been any discriminatory action against patients a different pattern would have been revealed. In academic work, these facts make it imperative that experiences of the Occupation are taken on a micro-

scale, and not by whether hospitals were clerical or state-run or by location or by size.

The trauma of patient transfers caused by German requisition of buildings for German troops was experienced in the target hospitals, excluding Ainay, although most severely affecting Marchant. Correlating dates of transfers and the deaths of transferees demonstrates that for Marchant the admission of hundreds of patients, often in a single day, caused severe disruption to existing patients and staff and added to problems of shortages of foodstuffs and resources. Marchant is illustrative of the fact that differences in mortality cannot be reduced to whether a hospital was in the occupied or non-occupied zones.

Saint-Dizier was similar in institutional and management structure to Marchant although in a much more rural area and a much smaller town than Toulouse. However, it had similar experiences to Saint-Jean-de-Dieu in its close proximity to German troops. It also encountered indirect hazards of war in terms of bomb damage to the town's main water supplies, which led to the deaths of citizens and patients from contamination and water-borne diseases.

Unlike Saint-Jean-de-Dieu, during the Occupation Marchant and Saint-Dizier were paralysed by state legislation, unable to rely on outside help or resources, with no scope to react to crises. They could neither pay elevated prices, even if goods were available which they were not, nor could they increase or modify official rationing policies on the total daily calories allocated for inpatients. As a result, shortages of both food and raw materials triggered a physical deterioration in inpatients' health much sooner and to a greater degree than that of the general population. However despite hidebound bureaucracy, increased mortality in some hospitals persuaded MDs to bend institutional and psychiatric practice, as in the case of Dr Ferdière who risked his livelihood acquiring rations for his patients on the black-market.

However, such actions indicate that psychiatrists were concerned enough to react in the interests of patients. What stands out in the experiences in Saint-Dizier is the MD's action in June 1940. He ignored institutional legalities in releasing patients in what was probably a humane and practical action. Such consideration for patients' welfare is seen in the evacuation of all Marchant's patients in December 1943. Officials had been planning the event for six months due to concerns of Allied bombing - Marchant was across the road from a large chemical factory. It was not an action of cloaked indifference by hospital officials.

The colonie of Ainay reflects two major factors in the history of the four target hospitals, the development of the French mental health system and psychiatric theories in the early twentieth century. Firstly, it was innovotive in its era, the accomplishment of psychiatrists who sought alternatives to incarceration. It is an example of the reassessment of the role of the asylum and of future programmes such as the 'Open-Door' services founded by Edouard Toulouse. Furthermore it emphasises that patients in closed institutions were more likely to die during the Occupation than patient–lodgers in *demi-liberté* Ainay. Secondly, Ainay was a significant exercise in reducing overcrowding but was not repeated, revealing the state's inertia and lack of commitment in providing suitable facilties for the mentally ill. It was Ainay's character as a non-carceral establishment that protected patient-lodgers, demonstrating the lowest mortality of the four target hospitals. However, patients were still casualties of a restricted rations system imposed by the Vichy regime and the German occupiers, but mortality was more in line with that of the general population as opposed to the closed system of the other three target hospitals.

A major element of increased mortality was one that was inherent before the war with mentally ill patients being 'at risk' compared with those without mental problems. The substantial rise in mortality for the years 1940, 1941, and to the end of 1942 is shown in the mortality curve as it applied to Ainay with its patient-lodgers and that of the three closed target hospitals. Moreover, it also reveals the

intra muros determinants of why there was such a rise and who were involved in this tragedy.

The answer to why patients died is unquestionably time-linked demonstrated in the gradual but persistent decrease in mortality from the beginning of 1943, a short while after Vichy's directive of increased rations for patients in psychiatric hospitals. This increase of almost 20% on the average daily calorie value, which were about 1000 calories, was sufficient to allow inpatients to have enough calories to maintain some form of 'normal' health. This event is of major importance when placed beside key changes in the nature of the Occupation for the same period: a response to Anglo-American landings in North Africa. By 1943 the whole of France came under German command and food supplies became even more restricted for all citizens.

The phenomenon of the mortality curve is also explained principally by the profile of who died and when. Those who died in the early years of the Occupation were the most vulnerable, the least resistant to adverse changes: the frail and elderly, the young, epileptics, long-term residents and those with concomitant medical problems. By the beginning of 1943, for the remaining patients having survived well into 1942, life-chances improved, even with such a small increase in rations, mainly because they had already withstood psychological traumas and had sufficient resistance to survive. This was the survival of the fittest, not in Darwinian terms but more in a Weberian concept of the least 'at risk', had a better chance of survival when the initial crisis had become more of a 'new way of life', however pitiful.[932]

[932] Henderson, et al, Psychiatric disorder in early adulthood and risk of premature mortality in the 1946 British Birth Cohort; Abas, Hotopf, and Prince, Depression and mortality in a high-risk population II-Year follow-up of the Medical Research Council Elderly Hypertension Trial; John W. Newcomer and Charles H. Hennekens,'Severe Mental Illness and Risk of Cardiovascular Disease', *American Medical Association,* 298, (2007), 1794-96.

Main conclusion

That mortality returned to normal in the four target hospitals after the Liberation and remained so for a decade despite many foodstuffs remaining rationed until nearly 1950 is similarly significant. The removal of the common denominator, the German occupiers, explains that most deaths in the target hospitals can be accountable to the Occupation years and their corollaries: restriction on all forms of raw materials, insufficient quantity and quality of daily rations for adequate healthy living, and forced transfers of large numbers of patients caused great hardship and lowered moral.

Was mortality inevitable in the mental hospital system as it stood on the eve of the Second World War? Would mortality have risen to such high levels if there had been a different governing regime other than Vichy? The study concludes that rationing was unrealistic and totally impracticable due to the demands of the German military and was a major factor in ill-health, malnutrition and death, although some citizens were responsible for restriction of foodstuffs and raw materials by their selfish and illegal actions, namely black-marketeering. Vichy's rationing services were mal-administered, insufficient and discriminatory against those who could not manage to provide for themselves. However, the existing state of French mental hospitals and Vichy's unrealistic rationing services do not indicate that patients' welfare was neglected deliberately or that there was any selectivity, or covert beliefs similar to those in Nazi Germany, of killing the unworthy in society.

Were Vichy's discriminatory measures more severe in the non-occupied zone; did officials apply a policy of negative eugenics for the mentally ill and enforce deliberately strict rationing for psychiatric hospitals? Evidence from HP Vinatier in Lyon point to a harsh attitude to the mentally ill but this is not evidenced to the same degree by officials connected to Marchant.

Although evidence supports the argument that psychiatrists in the target hospitals demonstrated compassion for their patients and protested about neglect there were other groups less empathetic such as Vichy officials in the Isère, Toulouse,

and Lyon. Indeed, even before the Occupation belief in the *non-valeur* of the mentally ill was implied by Mayor Edouard Herriot, implying patients were an economic burden on the state, an attitude echoed in the beliefs and actions of German psychiatrists and their euthanasia programmes.[933] Certain members of the Académie de médecine had a similar view: M. H. Martel felt there were others in society more worthy of extra rations. Saint-Dizier and Marchant's hospital committee members were not quite as openly ruthless, but they were less than sympathetic in the face of diminishing rations, malnutrition and inadequate material conditions. They applied rules rather than practical solutions; although this attitude was not necessarily derived from negative eugenicism it was harmful to patients. Staff in Marchant and Saint-Dizier were unconcerned for patients, stealing their precious resources of food or bedding. In other HPs, staff blatantly took foodstuffs condoned by other hospital staff. All these people exhibited an attitude that patients were of less worth than other members of society, characteristic of a culpable neglect that was widespread throught France.

This study has highlighted a need to contribute more towards an understanding of the narrative of the Occupation and its consequences at a local level and position the target hospitals in the *lieux de mémoire*.There has been a conscious attempt to move away from the traditional, often theory-laden literature constructed around the Vichy period and history of psychiatry and hospitals in order to negotiate an understanding of relationships, conduct and the consequences of the German Occupation in the target hospitals.

Reflecting on the future prompts the questions: will it happen again to such a disadvantaged group? After the Liberation, there was a 'grand gathering of ideas on the need to rebuild France', but despite reform, debate and movements led by

[933] Bueltzingsloewen, Réalités et perspectives de la médicalisation de la folie dans la France de l'entre-deux-guerres, pp. 55-6.

Main conclusion

MCs. who were practising during the Occupation, there remained persistent inequalities in facilities and care for many mentally ill and difficulties of admission to mental hospitals for others.[934] Today, as health care costs climb sharply, without due attention there is a strong possibility of an acceptance of human life by a bottom-line in cost-benefit analysis. Understanding the past can add perspective to institutional and educational practices as well as to social perceptions of mental illness and stigmatisation.

The loss of so many lives in psychiatric hospitals in France during the Occupation should have affected politicians and society in a meaningful way. It did not - it took decades after the Liberation before the 1838 law was changed and sectorisation of psychiatric services became the new method of mental health facilities. The timing of this reform is illustrative of state inertia and parsimony and society's business with other issues, but even with sectorisation, there are critics who point out inadequacies of a system which takes people out of an institutional setting and places them in the community. The system often fails patients and relatives due of insufficiently trained staff, high work-load, too few housing schemes and a society that should value the disadvantaged and disabled.

[934] Magali Coldefy, Philippe Le Fur, Véronique Luca-Gabrielli, and Julien Mousquès, Questions d'économie de la Santé. Cinquante ans de sectorisation psychiatrique en France; des inégalités persistantes de moyens et d'organisation, 145, 2009; Henckes, Narratives of change and reform processes; Michael Kelly,'War and culture: The lessons of post-war France', *Synergies Royaume-Uni et Irlande,* 1, (2008), 91-100.

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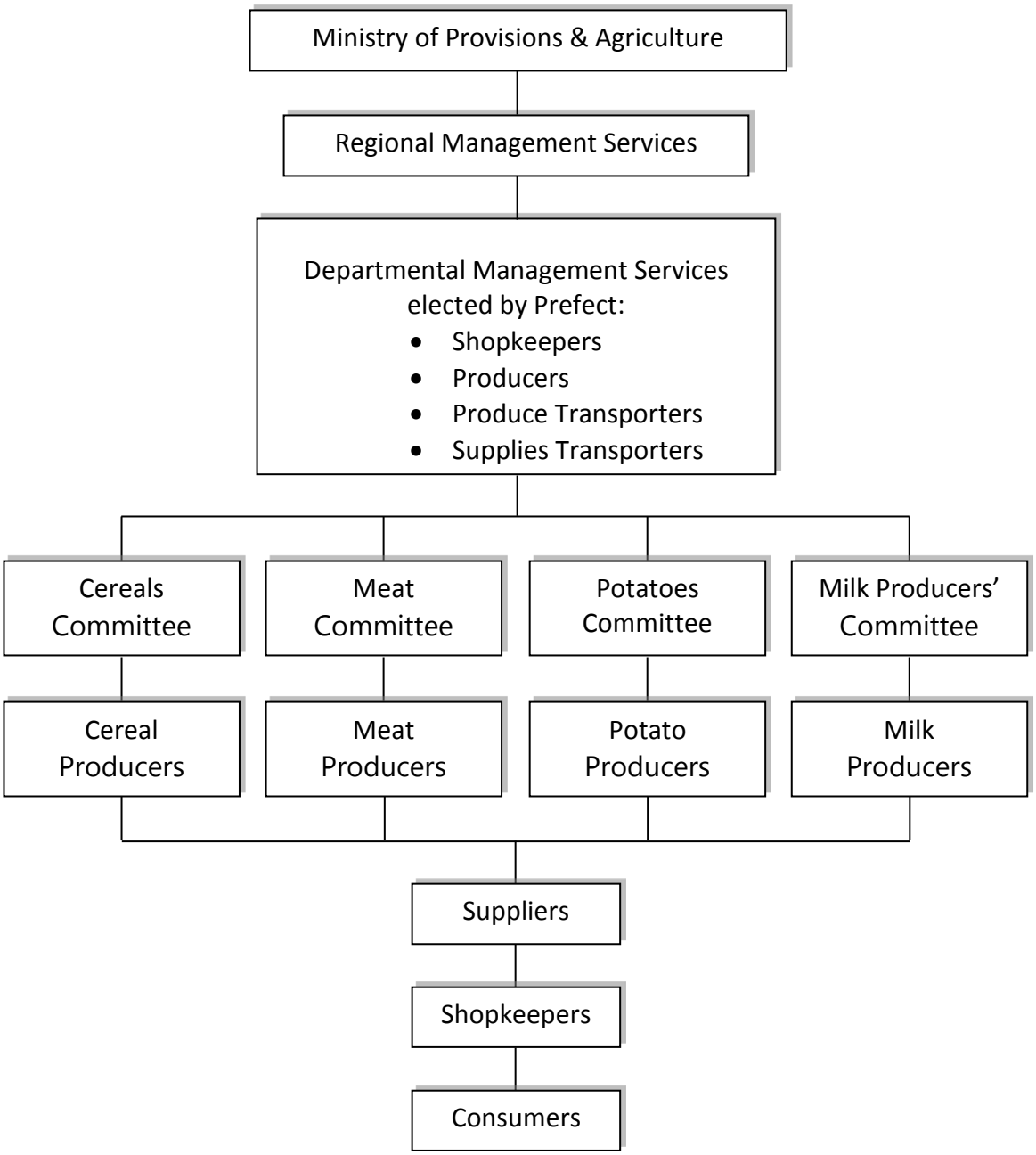
Appendix A Vichy rationing services



Appendix B Data-collecting system

Patient dossier data gathered and formulated for the four target hospitals

Data gathered	Hospital			
	ALC	GM	SD	SJDD
Sex	✓	✓	✓	✓
Marital status	✓	✓	✓	✓
Profession	N/A	✓	✓	✓
Year of birth	Formula	Formula	Formula	✓
Age on admission	✓	✓	Formula	Formula
Diagnosis	✓	N/A	N/A	N/A
Date of admission	✓	✓	✓	✓
Date of death	✓	✓	✓	✓
Age on death	Formula	Formula	Formula	Formula
Duration of stay (full years where 0 = <1 year)	Formula	Formula	Formula	Formula
Cause of death	✓	✓	✓	✓
Category of death	Formula	Formula	Formula	Formula
Patient dossiers	N/A	✓	N/A	✓
Date of discharge	N/A	✓	N/A	N/A
Total patients (3435)	247	1923	619	646
All above data was then correlated and given a study specific:- Hospital patient number Hospital name Database patient number Case study number				

Appendix C Archives Series and call numbers

ARCHIVES NATIONALES: Bibliothèque interuniversitaire de Santé Paris

Series	No.	Description
110603	110603	préfecture du département de la Seine Conseil général

ARCHIVES NATIONALES: Fontainebleau (AN)

Series	No.	Description
SAN	70846	Documents statistiques anciens et divers (1835-1961). Travail de l'Institut National d'Hygiène présentée par H. Duchêne. Les Statistiques des HPs. Evolution de la population et mouvement dans les HPs depuis 1939.
SAN	770621 9	Centre d'études hygiéniques de Marseille Etude sur l'état de nutrition de la population de Marseille
SAN	19950093	Les articles 2,8,13, 21, concernant les hôpitaux psychiatriques de Gérard Marchant de Toulouse, St Dizier à Saint Dizier en Haute Marne, St Jean de Dieu à Dinan Léhon, Cotes d'Armor et Ainey-le-Château en Allier.
SAN	200 50593 ART 2	Fonds de Chevallier

ARCHIVES NATIONALES: Paris (AN)

Series	No.	Description
F1a	4514-4598	Inspection générale des services administratifs devenue Inspection générale de l'administration 1916-1944
F1a	4520	Inspection générale des services administratifs. Rapport: Armand, Inspecteur général des services administratifs 20 novembre 1919.
F1a	4533	Inspection générale des services administratifs. Rapport: Roger Capart, Inspecteur général des services administratifs 11 mars 1929.
F1a	4538	Inspection générale des services administratifs (devenue Inspection générale de l'administration. Mission spéciale de l'Inspecteur général R. Lacaisse (25 novembre 1935).
F1a	4550	Inspection générale des services administratifs. Rapport: M. Winter, Inspecteur général des services administratifs 16 décembre 1938.
F1a	4570	Inspection générale des services administratifs. Rapport: M. Sarraz-Bournet Inspecteur général des services administratifs au ministère de l'Intérieur 22 April 1930.
W	200W 127	Ordre de médecins
W	729W 6	Liste des hôpitaux en Allier

Appendix C

ARCHIVES DEPARTMENTALES: Allier (ADA)

Series	No.	Description
W	673W 1,2,3	Statistiques hospitalière de la France 1942-1946
W	727W 9	Colonie familiale d'Ainay-le-Château Dossier individuel de personne, placé, d'office, placé, volontairement, transférée, ou décédé 1940-1948
W	729W 6	Prix de journée des hôpitaux et hospices comptes administratifs 1943-1946
W	729W 10	Mouvement de la population d'Ainay et dossiers des malades et Rapports
W	729W 11	Ainay-le-Château colonie familiale
W	957W 6	Prix des produits
W	958W 2	Ravitaillement, Rapports sur le fonctionnement du Ravitaillement 1940-1945
W	958W 7	Ravitaillement, Rapports sur le fonctionnement du Ravitaillement (1940-1945) Service du contrôle mobile. Enquêtes sur des personnes soupçonnées de marché noir. Rapport au sous-préfet 4 April 1942
W	959W 1	Ravitaillement 1943-1946
W	959W 2	Ravitaillement instructions sur les titres et cartes d'alimentation 1940-1949 Letter from Direction département Ravitaillement général de l'Allier départemental du ravitaillement général 29 juin 1941
W	959W 4	Organisation de la production laitière: - décrets, lois, textes législatifs, circulaires, instruction générale Prix des produits laitiers; Fabrication, vente, circulation Organisation du bureau national de la viande; arrêtés Fixation du prix du bétail sur pied et de la viande à l'étal. Instruction générale sur les attributions des groupements d'achat et de répartition des viandes (GARV): statuts 1939-1942
W	960W 1	Organisation général notices instructions
W	960W 2	Direction du ravitaillement générale 1942-1946
W	960W 3	Commission consultative départementale du Ravitaillement: arrêtés. Rapports mensuels sur le fonctionnement du ravitaillement dans l'Allier 1941-1946
W	960W 4	Rapport mensuels sur le fonctionnement du ravitaillement dans l'Allier 1944-1946
W	960W 7	Rapport Mensuel sur le fonctionnement du ravitaillement dans le département de l'Allier sept 1941
W	970W 8	Synthèse des rapports des préfets nov 1941 mai 1943
W	970W 9	Rapports mensuels des préfets 1944-1945
W	970W 17	Rapports mensuels des préfets + pièces annexés + synthèses Rapport mensuel sur le fonctionnement du ravitaillement 1942
W	970W 20	Rapport mensuel du département d'Allier sur le foncionnement du ravitaillement général pendant le mois de janvier 1942
W	970W 22	Rapports sur la situation économique démographique et l'esprit de la population des communes 1941

ARCHIVES DEPARTMENTALES: Côtes d'Armor (ADCA)

Series	No.	Description
M	1M 248	Bureau des affaires communales. Correspondance (1930-1941). Répertoire des affaires communales.
M	1M 249	Rapports du préfet et des sous-préfet s. Instructions et correspondance (1806-1934)
V	4067	Le régime des congrégations (an VIII-1940). Congrégations d'hommes: Frères hospitaliers de Saint-Jean-de-Dieu. Établissement de Saint-Aubin: lettre, 1834
V	4068	Le régime des congrégations (an VIII-1940). Congrégations d'hommes: Frères hospitaliers de Saint-Jean-de-Dieu. Établissement de Léhon: arrêté, procès-verbaux, correspondance, 1851-1922
W	1W	
W	1W 14	Rapports sur la situation des communes de l'arrondissement 1941, 1942
W	1W 29-30	Service du ravitaillement: Rapports et statistiques 1943-1944; ravitaillement: plan, circulaires, correspondance et notes, 1941-1945
W	2W 1	Finances et économie (travaux publics, combustibles, postes, agriculture, ravitaillement, industrie), 1940-1942
W	2W 9-10	Services préfectoraux (ravitaillement, cabinet, combustibles liquides, affaires sociales): circulaires adressées aux maires ou aux autorités, civiles et militaires, 1940-1941
W	2W 160-161	Vie économique. Ravitaillement, 1940-1945
W	5W 2	Correspondance des autorités allemandes et de la Préfecture des Côtes-du-Nord, 1940-1944: Service du ravitaillement général (1943-1944), service agricole (1941-1944)
W	5W 330-411	Ravitaillement, 1924-1958
W	40W 76	Administration hospitalière. Hôpital psychiatrique de Léhon: rapports, commissions de surveillance (procès-verbaux de réunions), 1943-1966
W	43W 43	Administrations diverses, ravitaillement général, 1940-1946
W	45W 70	Instructions divers concernant les HPs
W	45W 79	Personnel. Instructions et correspondances diverses (économiques, politiques, sociales, militaires), 1940-1968
W	51W 1 – 11	Registres comptables et répertoires nominatifs: Bégard, Léhon, Plouguernével (1912-1959)
W	51W 250	Convois, transferts de malades mentaux; états des mouvements des psychopathes (1945-1959)
W	79W 1	Décret du 29 juillet 1939 et décrets relatifs aux hôpitaux et hospices
W	94W 1	Hôpitaux psychiatriques, généralités, rapports annuels, personnel (1930-1955), secours aux aliénés inoffensifs : dossiers spécimens (1891-1947); statistiques annuelles des hôpitaux psychiatriques, gestion du personnel, mouvements des malades (1941-1956)
W	94W 8	Hôpitaux psychiatriques de Plouguernével, Bégard et Léhon : convois de malades évacues ou amenés : rapports, correspondance (plus un plan) (1940-1962)
W	109W 69	Asile de Léhon personnel 1906-1946 Aliénés instructions 1912-1946
W	117W 28	Victimes civiles de guerre : liste, instructions, correspondance (1941-1956)

Appendix C

W	1135W 1	Service de la Répartition, 1941-1948
W	1377W	Versement de l'Administration générale. D.D.A.S.S. des Côtes-d'Armor (1865-1986)
W	1377W 33	Occupation par l'ennemi allemande hôpital Léhon
W	1377W 36	Règlements intérieurs des hôpitaux psychiatriques
W	1377W 37	Maladies mentales: Bégard, Léhon : opérations (lobotomies), capacités d'hospitalisation, dépenses, organisation des services d'hygiène mentale, recrutement (personnel médical et secondaire) (1940-1950)
W	1377W 39	Hôpital de Bégard - dossiers individuels de malades, dossiers de placements, entrées, sorties (1939-1968)
W	1377W 40	Hôpital de Bégard - administration des biens des malades (1939-1960)
W	1377W 41	Hôpital de Léhon. Prix de journée, correspondance, commissions de surveillance, traités, 1940-1950
X	1X	Administration hospitalière
X	1X 97	Généralités, Aliénés, Circulaires, arrêtés (1813-1939): rapports sur les asiles du département (1841-1911)
X	1X 99	Comptabilité : prix de journée, subventions, contingent des familles, dispenses à la charge des communes, du département, budget (1841-1934); statistique des aliénés (1835-1849)
X	1X 101-111	Répertoires alphabétiques des aliénés internés dans les asiles du département
X	1X 114	Asile de Saint-Aubin. Établissement dans l'ancienne abbaye des Frères de Saint-Jean-De-Dieu d'un hospice pour aliénés (1830-1936)
X	1X 115	Asile de Léhon; Transfert de l'établissement de Saint-Aubin, règlements, fonctionnement, affaires diverses (1840-1937) Rapports annuels des Médecins et de la Commission de surveille (1840-1932)
X	1X 116	Personnel (y compris membres de la commission de surveillance) (1841-1940)

ARCHIVES DEPARTEMENTALES: Haute Garonne (ADHG)

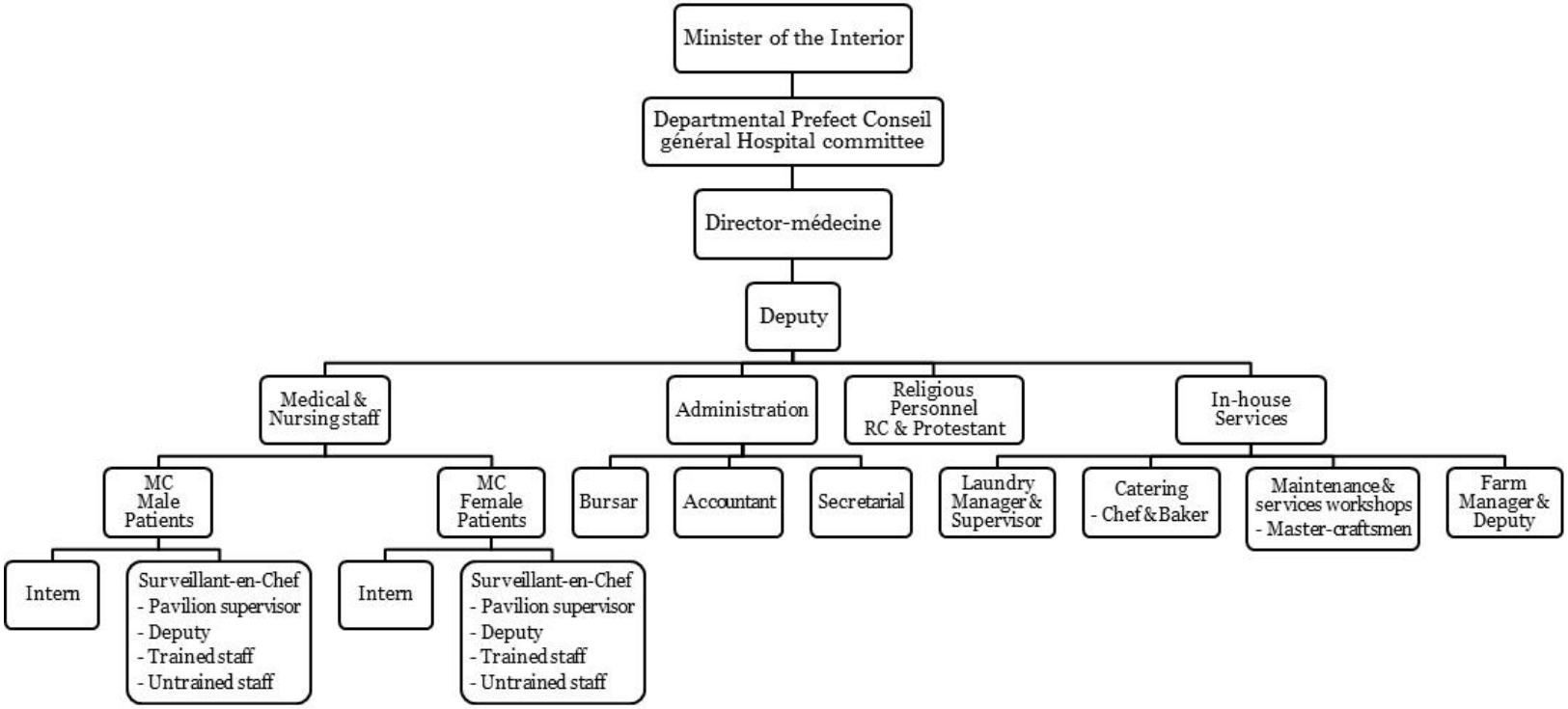
Series	No.	Description
M	1098M	Dossier du docteur Dide, directeur (1909-1936)
M	1447M	Dossiers individuals d'anciens fonctionnaires
M	1514M 4	Rapport mensuel de la Direction régionale de la santé et de l'Assistance sur évolution de la mortalité dans les hôpitaux psychiatriques, avec graphiques (juillet 1942)
M	1541M	Rapport concernant le ravitaillement des hospices 1937-1943
M	1831M 38	Corresponds with 10 Mi 60. Rapport au ministre de l'agriculture (décembre 1941)
W	1325W 3-4	Dossiers du personnel (1910-1943)
W	1831W 38	Fiches individuelles d'internés étrangers transférés du camp de Noé dans les hôpitaux et les asiles (1941-1944)
W	1896W 184	Mise à la retraite du docteur Dide, directeur (1936-1937)
W	2205W 7	Registre des internements entrées-sorties dont décès, frais 1935-1945
W	2740W 25	Rapports semestriels sur l'état des aliénés, la nature de leur maladie et les résultats du traitement (1907-1918, 1930)
W	2848W 8	Fermeture temporaire et évacuation des malades sur différents hôpitaux: Lannemezan, Saint-Lizier, Montauban, Rodez, Naugeat, Agen, Lyme etc.
W	2848W 9	Nouveau projet de règlement intérieur élaboré par la commission de surveillance et soumis à l'approbation du préfet et du ministre de la santé publique (1938-1941)
		Réglement intérieur Gérard Marchant
W	5203W 322	Commission de surveillance de l'hôpital Marchant 1945-1971
X	205X	Rapport manuel par le docteur Dide (1912)
X	271X	Aménagement des cuisines; réorganisation d'une buanderie; installation du chauffage central; acquisition d'un appareil <<Thermaux>> pour le traitement des malades per électro-pyrexie. (1927-1934)
X	272X	Comptabilité: comptes administratifs, moraux et médicaux (1839-1944)
X	272X	Projet de budget Rapport du Budget 1932. Séance de la Commission de surveillance (10 mai 1910)
X	272X	Statut du personnel et modifications. Concours 1937-1936
X	308X	Rapport de Dide sur le budget primitif de l'exercice 1935
X	361X	Rapport Administratif et médical du docteur Perret (1941)
X	364X	Administration hospitalière, bureaux de bienfaisance et d'assistance, hospices, assistance et prévoyance sociales, assurances sociales, pupilles de la nation (1937-1943)
X	365X	Prix de journée Jura HP Oct 1943

Appendix C

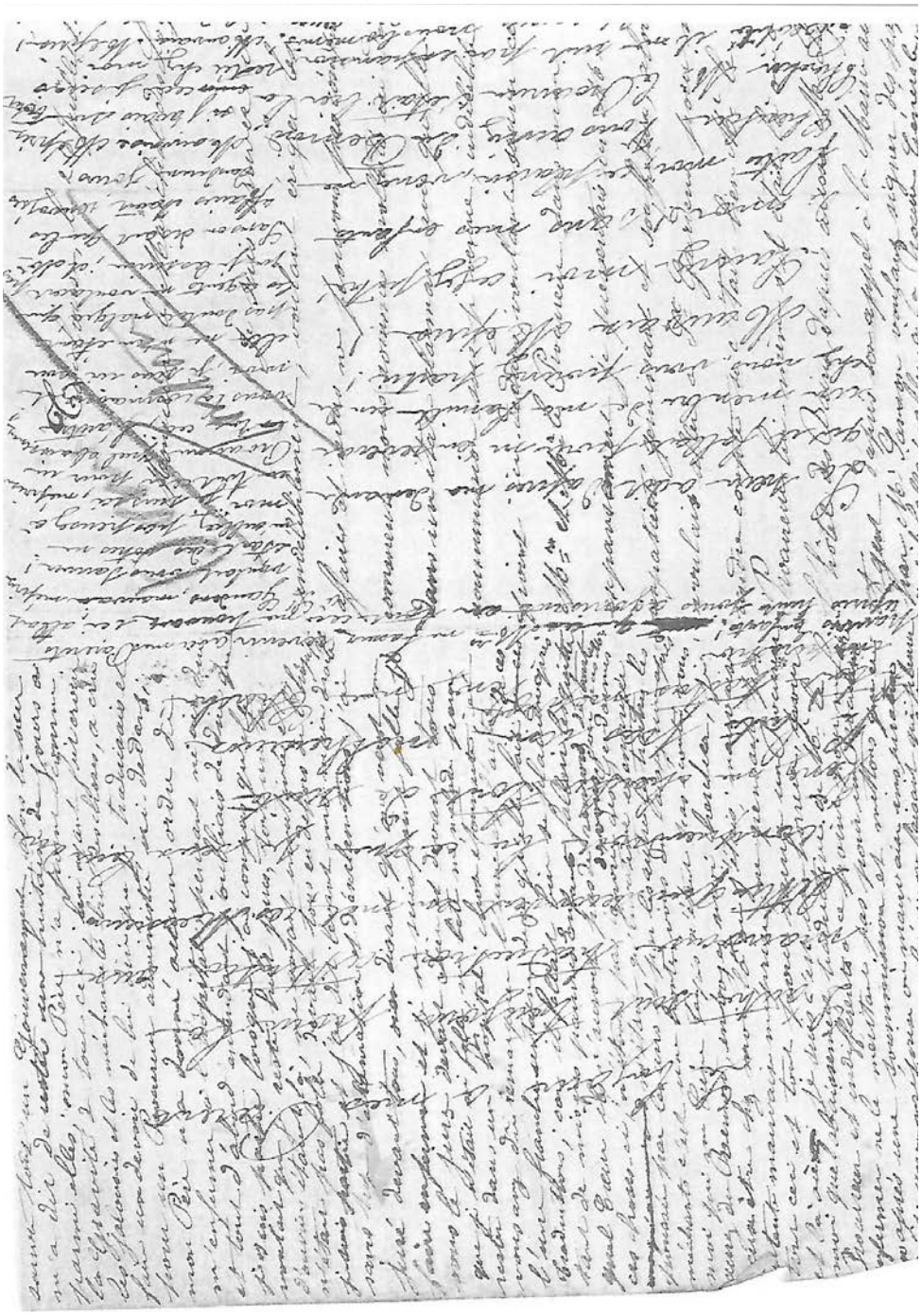
ARCHIVES DEPARTEMENTALES: Haute Marne (ADHM)

Series	No.	Description
H	6H 12	Rapport administratif novembre 1940
W	342W 265	Situation politique et économique du département
X	1X 154	Administration: circulaires et règlement intérieur 1833-1947
X	1X 157	Administration: commission de surveillance 1903-1950
X	1X 161	Administration: rapports généraux du service médical 1918-1940
X	1X 164-167	Administration: rapports semestriels du médecin sur l'état 1932-1937, 1937-1938, 1939-1941, 1942-1945
X	1X 172	Administration: dossiers disciplinaires 1935-1942
X	1X 174	Administration: surveillants en chef 1880-1930
X	1X 175	Administration: directeurs administratifs 1938-1945
X	1X 184	Administration: médecins chefs de service 1815-1940
X	1X 185	Administration: revendications du syndicat du personnel 1920-1936
X	1X 188	Administration: malades, dossiers individuels 1936-1942
X	1X 189	Administration: malades individuels 1943-1947
X	1X 207-258	Administration: dossiers individuels 1936-1942
X	1X 278 -280	Administration: comptabilité, comptes administratifs, moraux et médicaux, 1911-1918, 1919-1926, 1927-1944
X	1X 292	Administration: prix de journée 1929-1948.
X	1X 302	Administration: adjudications et marches 1937-1944
X	3U SUP 3/121	Mouvements de la population et rapports de visites 1930, 1931, 1934, 1948 – 1953

Appendix D Psychiatric Hospital Organisation Structure



Appendix E Patient's letter: a mind in turmoil or paper shortage



Source : UHAGM Patient dossier

Appendix F Major articles concerning the 1838 law

Article 1: Each department must provide a specific establishment for the receiving and care of the insane, or make provisions with another department.

Article 2: Public establishments taking the insane are placed under the direction of the public authorities.

Article 3: Private establishments taking the insane are place under the surveillance of the public authorities.

Article 3: In the interests of the patients it is prohibited for directors to admit more than the allocated number of patients.

Article 5: According to the terms of the *Ordonnance* 18 December 1839 the *Commission de surveillance* must meet every month when it is given the minutes of the weekly meetings of the administration of the HP in order for the Administrative Committee to have full control of proceedings. The Director and *Médecin-chef* must be present.

Article 8: A member of the Administrative Committee must be allocated to look after the possessions of *placement volontaire* patients (*non-interdits*).

Article 21: All control of the HP is governed by the prefect and Minister of the Interior. In a dispute, either medical or administrative, the Administrative Committee must intervene.

Article 25: Requests for holidays: The Director must be covered by a SP or member of the Administrative Committee or member of the prefect's bureau.

Article 33: Finances must only be dealt with by the *Receveur* (finance officer).

Article 51: Each evening the Concierge must hand all keys of all exterior doors to the Director. This is to prevent the keys being handed over to those people not qualified to have them.

Article 53: Legislation forbids any mixing of the sexes of patients, even the staff must be the same sex.

Article 54: Interns can only be employed if they have completed the necessary courses and distinguished themselves in their practical skills.

Article 65: Medical and administrative reports must always be available.

Article 68: The SP must not practice or have any medical interests outside of the HP.

Articles 73-75: A Surgeon and surgical facilities must be available in the HP and the SP must visit the infirmary daily. All observations regarding the surgical condition of patients must be reported to the SP.

Articles 95-104: Refers to the discipline, responsibilities and standards of care expected from *infirmiers* and staff of Religious Orders and their rapport with the SP or the officials with whom they work.

Article 131-137: Dietary regimes are formulated in each HP according to local and seasonal variations. Wine is allowed to each patient and food must not be utilised as remuneration for work. Regimes are to be modified only by the SP and with the agreement of the minister. All staff are to take all meals in the refectory with the patients. The only exception to this rule are married staff who live-in and this must be agreed by the director. It is forbidden to take food from the refectory to be consumed by others elsewhere and any selling of food is strictly forbidden, either in or outside the HP.

Articles 146-149: Personal cleanliness of all patients is imperative and washing facilities must be provided in each division.

Article 150-154: Work, as the most efficient manner to combat mental illness must not be performed in the interest of the HP but for the benefit of the patient. The SP must designate those patients who are fit for work. Each patient has the right to remuneration for a 10 hour day from 10 centimes to 15 francs per day.

Article 164: Work is not the only method to influence the morale of mental illness, reading, individually or in groups, singing, lessons in drawing and writing are efficacious. Daily walks and billiards and dances also are helpful**.** All these distractions can be organised at certain hours twice a day, after meals and before work.

Article **165:** Tobacco is essential to certain individuals and for humanitarian reasons this must be supplied**.**

Article 184: Patients are only to be looked after by same sex staff. Establishments found not conforming would be closed.

Loi sur les aliénés n° 7443 du 30 juin 1838

Au palais de Neuilly, le 30 juin 1838.

Louis-Philippe, Roi des Français

Source : Michel Caire web pages (see Bibliography)

Appendix G Cited medical journals

A brief background to the psychiatric medical press researched for the thesis is presented to help with greater understanding of the following review:

Les Annales Médico-psychologiques (*AMP*), is over a hundred and fifty years old, very scientific in content and with automatic subscription to one of the largest psychiatric societies, *La Société Medico-Psychologique* (SMP). The *AMP* was the only medical journal permitted to publish during the Occupation. (Three studies give accounts of the medical journals and the reporting of the Occupation and increased mortality: Bourgeois (1993), Noel (1996) and Massé and Ginestet (1977). In 1961 Henri Ey was General Secretary of AMP and Paul Sivadon, Treasurer.[935]

L'*Evolution Pychiatrique*, with similar focus, was founded in 1925.[936]

La Revue Aliéniste français, which in 1946 became *l'Information Psychiatrique,* was the official review for the *Bulletin du syndicat des médecins des hôpitaux* psychiatriques and was specifically orientated professional reviews for HPs.

Perspectives Psychiatriques was similar to *Information Psychiatrie* covering issues for junior doctors in psychiatry in Paris and La Seine hospitals.[937]

Synapse and *Nervure* offer topical issues, theoretical, clinical and biological reviews and information for the general public with a widespread circulation and readership.[938]

Esprit, founded in 1932 by Catholic non-conformist philosopher, Emmanuel Mounier, not medical in substance but an ideological review defending human dignity.[939]

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[935] Donna Evleth, *The authorized press in Vichy and German-occupied France, 1940-1944 : a bibliography*, (Westport, Conn. ; London: Greenwood Press, 1999).

[936] This journal was supported by Ey, Lacan, Male, Minkowski, Sivadon, Le Guillant, Bonnafé and Follin among many others.

[937] Daumézon was the General Secretary of Information Psychiatrique and Chief editor, Pierre Noel. *Syndicat* members included, Drs Sivadon, secretary, Damézon, Bonnafé, Le Guillant, Follin, Ey, Tosquelles and Bernard.

[938] Gérard Massé was Publication Director of *Nervure* with François Caroli as Chief editor. These two journals are the equivalent for the psychiatric profession to *Figaro* and *L'Express* in French daily newspaper terms.

[939] Hellman (1997) discusses Mounier who was suspected of participating in the Resistance, imprisoned in Lyon during the war but released after an acquittal. See also Jackson (2001).