Chapter 2
Discovering Deviance: The Criminalisation of Patients

2.1 Case Study on Alternative Modes of Admission

In an article published in 1896, the French psychiatrist Abel-Joseph Meilhon presented a collection of case studies on the 83 Muslim patients treated in the asylum in Aix-en-Provence during the year 1880. Among these patients were ten women, and Meilhon specified their disorders, descriptions of their behaviour and also the manner of their admission into psychiatric care. The admission of these female Muslim patients mostly followed the voluntary, administrative and judicial routes detailed in the chapter below. However, one of Meilhon’s female Muslim patients was admitted in an uncommon way. The patient, a 40-year-old, single Arab woman, was admitted in November 1874, and Meilhon noted that “charged with arson, she comes from prison, where she was violent towards her fellow inmates; she knows the charge against her; but she denies it and assigns it to a cigarette, discarded by [some] Spaniards.”

Before being transferred to the mental asylum of Montperrin in Aix-en-Provence, this particular patient was admitted to another form of colonial “care” – the prison. This shows that her responsibility for the crime she had committed had not been questioned either by the police or in court. She had not been examined by a psychiatrist before being sent to prison. Instead, it was the physical threat she posed to her fellow inmates which made her psychiatric problems apparent to the French observers and which prompted her admission to psychiatric care. In Aix-en-Provence, however, the patient showed signs of confusion, agitation and megalomania, on which Meilhon specifically focused in his description. He described that she “takes the nurses for the sons of God, says that her daughter has had children, but that she herself has never had any. During her long stay in the asylum, we find reports of an intense, almost continuous, manic agitation, with incoherence, aggressive tendencies and hallucinations of sight and hearing. When we observed her [in 1880], we found her in a state of senile dementia; she rips [things] and becomes nasty at times; she answers us that she is 80 years old, [that she has] 80 children, that she has been designated by the Arabs to light fires; she says she is the daughter of God, but only on paper; she is very rich; at night, when she sleeps with closed eyes, eight women come to open them and to prevent her from sleeping.”

1 Meilhon, Aliénation mentale, part 2, 203.
2 Ibid., part 2, 203 f.
The confusion and distress of the patient is palpable in Meilhon’s study. The initial reason for her arrest – the act of arson (which was not further elaborated on) that she claimed had been committed by some “Spaniards” – was of only secondary importance when Meilhon observed her after she had already been in Aix-en-Provence for six years. In 1880, at the age of only 46, she allegedly suffered from an aggressive form of senile dementia, which explained and justified her placement in colonial care. It is uncertain whether she suffered from this disorder when she was transferred to Aix-en-Provence from prison in 1874, or whether it developed during her stay in psychiatric care. It is also unclear whether her aggressive behaviour towards her fellow inmates, or, indeed, the crime itself, had been caused by an early onset of dementia or some other disorder, or whether this had instead been a display of protest, disobedience or fear.

This case study, detailing an exceptional mode of admission into colonial psychiatric care, was chosen as an introduction to this chapter because it illustrates a diversity in patient experiences that could easily, but should not, be neglected in an overview comprising almost 80 years of institutionalisation of North African women. Not all patients followed the same route through the colonial institutions, as shown in Chapter 2.6.4. Additionally, this case study allows for an initial critical look at the diagnosing process, which will be taken up again in Chapters 3 and 5.

2.2 Fascination with Criminality

French colonial psychiatrists, especially those belonging to the École d’Alger, frequently described male North Africans, including patients, as either dangerous or outright criminals in both their theories and their case studies, but insisted the same could not be said for Muslim women because of the supposedly innate opposition of everything feminine to crime and brutality. Women, even if mad, were seen as docile and gentle, their behaviour perceived as having more in common with the idealised female normality discussed in Chapter 1 than with the actions of male Muslim patients. The argument that only the most dangerous insane were admitted into mental asylums, and that this basic criterion of admission – which, psychiatrists pointed out, did not come from them but from the “unreasonable traditions” of the local populations – excluded women, was one of the explanations used by French psychiatrists for the low numbers of female patients in the psychiatric hospitals. One of the first psychiatrists focusing on North African patients at a time when they were still treated in France,

3 Keller, Colonial Madness, 208.
4 Even though it was entirely comparable to the situation in France, where the same focus on the danger posed by the patients dominated the processes of institutionalisation. See, for example: Guignard, Prémices de dangerosité, 35.
the aforementioned Abel-Joseph Meilhon, wrote on the low number of female Muslim patients in Aix-en-Provence in 1896: “One could perhaps say with some reason that the indigenous mostly sequestrate the dangerous insane, and that these rigorous measures become much rarer with regard to women, who, through their temperament, are less given to violence, and who can also be more easily mastered [...].”

Even though, on a theoretical level, colonial psychiatrists propagated the dogma of the violent male and the gentle female, there was, in reality, a strong criminalisation of female Muslim patients, the evidence for which can be found in the descriptions of the actions and the behaviour of these women in the case studies, as well as in the ways in which they were admitted to colonial psychiatric care.

Three “premises” will be analysed in order to introduce the main arguments of this chapter: a) definitions of criminality in a colonial context; b) French laws concerning asylums and the manners of internment these laws favoured; and c) the picture of the “violent Muslim man” and the “passive Muslim woman” in French colonial sources. In a second section, the three possible manners of internment in the colonial Maghreb – “voluntary placement”, “administrative placement” and “judicial placement” – will be examined. Descriptions of female patients – especially those defined as “prostitutes”, “addicts” and “vagrants” – in published case studies will also be analysed in order to gain an insight into admission processes through the social classification of patients. It is important to note that most case studies did not feature extensive descriptions of the pre-institutional life of the patients, either because of the significant problems of communication between psychiatrist and patient or because of a mutual absence of interest. Very often one can only find the most basic patient descriptions: name, often shortened in order to grant anonymity in publications, age, profession and ethnic group. These descriptions follow a strict format, specified according to what was deemed important by the hospital administration, in which the manner of admission was either so obvious that it need not be stated or so unimportant that it need not be recorded.

5 Meilhon, Aliénation mentale, part 1, 25. This was repeated, word for word, but without acknowledgment to Meilhon, in a 1908 dissertation on Senegalese patients shipped to France. Borreil, Considérations, 13.

6 While “placement volontaire” and “placement administrative” are colonial terms, the term “judicial placement” was chosen as an extension of the colonial vocabulary. It should be pointed out that traditional Islamic law was in fact very tolerant towards the insane and did not hold them responsible for their acts – judicial internment was therefore extraneous to Islamic law. See for example: Khiat, Essai, 128; Luccioni, Habous ou wakf, 48 f.; Chaley, Forensic Psychiatry, 19; Pridmore/Pasha, Psychiatry and Islam, 383; Arabi, Regimentation of the Subject, 264; Dols, Insanity in Islamic Law, 81. Similarly, the popular interpretation of insanity as demonic possession meant that the insane were not believed to be answerable for their behaviour. See: Fanon/Sanchez, Attitude, 25.

7 The problems of communication will be looked at in Chapter 4 on the treatment of Muslim female patients. See p. 170.
The descriptions of female patients in the case studies were not static throughout the colonial period: psychiatrists more strongly “condemned” aggressive or immoral behaviour in their female patients in the early case studies, for example Meilhon in 1896, but much less so later on. During the period of these early publications, Muslim patients were still shipped to France from Algeria, and the only contact with “Islam” these psychiatrists had was with the Muslim insane. The high costs of transport and treatment in France meant that only the worst cases of mental problems were ever brought to the attention of French psychiatrists before the establishment of asylums on North African soil.

Changes in broader psychiatric theories (for example, the rise and fall of degeneracy), which one can find mirrored in the diagnoses and treatments administered to North African women, seem not to have been influential when it came to the admission processes of female patients. The manner of admission into psychiatric care – that is, the selection of patients through admission processes – did not evolve significantly in North Africa during colonial times. The only notable change was the instalment of a “two line” psychiatric service under the École d’Alger in Algeria and, to a lesser degree, in Tunisia and Morocco. A “first line” of small psychiatric wards in the departmental hospitals (première ligne) looked after everyday cases, “curing” as many of them as possible and only sending severe cases on to the “second line” hospitals (deuxième ligne). It was hoped that the installation of a “two line” system would allow for more “voluntary placements” by having the “first line” look after less severe cases, thus attenuating the association with the unpleasant aspects of chronic insanity. Despite the high hopes invested in the installation of this system, no change was made to the admission processes themselves.

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8 See Chapter 3.2.1 “Transported to France” for an in-depth analysis of these transfers.
9 The costs of the whole process – shipping the patients to France, their upkeep, and, in successful cases, their return journey to North Africa – was heavily criticised in colonial times. For example, by Meilhon in 1896: Meilhon, Aliénation mentale, part 6, 357.
10 Even though there was no major change in the types of admission during colonial times, many psychiatrists variously claimed that a change from “administrative” and “judicial placements” to “voluntary placements” had either already happened, like Gervais in 1907, or was surely about to happen, as asserted by Porot in 1943. Gervais, Contribution, 70; Porot, Œuvre psychiatrique, 362.
11 Ibid., Services hospitaliers, 794 f.
12 Ibid., Œuvre psychiatrique, 366 f.
13 Ibid., Services hospitaliers, 793.
14 Ibid., 794. See also: Rappel historique de l’assistance psychiatrique en Algérie, 815. Schwarz mentioned in his 1976 article that a third line for chronically ill and incurable patients was initially planned. Schwarz, Psychiatrie in Algerien, 88.
15 Desruelles/Bersot, Assistance aux aliénés en Algérie, 589.
2.3 Definitions of Criminality in a Colonial Context

Before looking at the administrative modes of admission into colonial psychiatric care, one must examine the colonial definition of indigenous criminality. Many French psychiatrists working on North Africa focused on the effects of criminality and criminal insanity on the general population. The first important work on Muslim criminality and its relation to insanity is the 1883 dissertation by the French psychiatrist Adolphe Kocher, “Criminality in Arabs from the Point of View of the Medico-Legal Practice in Algeria”, which forms the starting point for this historical analysis of colonial psychiatry in the Maghreb. Even though Kocher had already researched “Arab criminality”, the psychiatric obsession with North African criminality started under the influence of the École d’Alger. One of the first dissertations of the École d’Alger, dealing with the “Criminal Impulsivity in the Indigenous Algerian”, was written in 1926 by Don Côme Arrii, who also published, together with his teacher Antoine Porot, an article under the same name in the Annales Médico-Psychologiques in 1932. Another of Porot’s students, Charles Bardenat, wrote an important article about “Criminality and Delinquency in the Mental Alienation of Indigenous Algerians” in 1948, also published in the Annales Médico-Psychologiques.

Parallel to metropolitan interest in crimes committed by the “raving mad”, as documented by countless sensationalist columns under the heading of “Aliénés en liberté” in the Annales Médico-Psychologiques, one can find reports about crimes committed by North Africans, both in North Africa and as immigrants in France. Many colonial psychiatrists regretted that, mainly due to budgetary reasons, the systems of admission into colonial care were incomplete and allowed for potentially dangerous Muslim madmen to slip through the net. Charles Bardenat, for example, exclaimed in 1948: “And how many psychopaths or abnormal natives still escape the control of the doctor!”

Solomon Lwoff and Paul Sérieux encapsulated the colonial fear of the “unrecognised” indigenous mad in 1913 by stating that “thousands of unrecognised insane, these half-madmen, these degenerates of all sorts, [...] live in freedom, committing offences, committing crimes...”

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16 See, for example: Les aliénés en liberté, 173 f. On the crimes committed by uninstitutionalised “madmen”, see also: Livet, Aliénés algériens, 43; Maréchal, Réflexions, 70. Don Côme Arrii summarised these fears in his 1926 dissertation on “Criminal Impulsivity in the Indigenous Algerian”: “Too many madmen still roam free in the ‘bled’ [the countryside, from the Arabic word balad, which means country], free to indulge in all the deadly consequences of their impulsivity. In the absence of other means of assistance, families still sometimes impede them by chains on their feet, which are not always enough, however, to avert the danger of murder.” Arrii, Impulsivité criminelle, 51.
17 See, for example: Susini, Quelques considérations, 27 f.
18 Bardenat, Criminalité, 318.
crimes, attacks of all sorts, participating in riots or even causing them, and from among whom many of the alleged fanatics, mystics and xenophobes are recruited.” French psychiatrists wanted to place the Muslim insane in asylums precisely because they feared that they all posed a hidden danger, and it greatly upset them to think that this total control was not possible. It was this fear of the half-mad, of the hidden, of the seemingly normal which dominated the colonial treatment of the North African insane, and the idea that such crimes could also happen in France only made it all the more tangible. Porot and Arrii stated in their 1932 article on “Criminal Impulsivity” that one could find reports in France “every day” about the “crimes of these ‘sidis’ [here a derogatory designation for North African men, it is usually a respectful form of addressing someone; from Arabic sayyid, which means lord], newcomers in French criminality, who have rapidly found themselves playing a major role”.

The duty of psychiatrists therefore lay not only in recognising and diagnosing “danger” in the indigenous population, they also had to be able to contain it. This aspect of their duties gave considerable responsibility to colonial psychiatrists as, effectively, they had to protect the population. In 1936, Porot quoted instructions from the then Governor-General of Algeria, Jules Gaston Henri Carde, about asylum regulations: a psychiatrist had the right to prohibit the release of any patient that he deemed dangerous – those who could “compromise the public order or the security of people” – even if the patient and his/her family demanded it.

In 1883 Kocher studied the different medico-legal categories of indigenous criminality based on his experience of working at the Civil Hospital of Mustapha in Algiers.

19 Lwoff/Sérieux, Note, 695. Henry Reboul and Emmanuel Régis even claimed in their 1912 Congress report that “one could not exaggerate the role of the insane, in Muslim lands, as disruptors of the public order.” Reboul/Régis, Assistance, 78.
20 Bardenat, Criminalité, 318.
21 Porot/Arrii, Impulsivité criminelle, 588. The same phrase can be found in Arrii’s 1926 dissertation. Arrii, Impulsivité criminelle, 13. One of these authors, Antoine Porot, had written in 1912 that criminal acts committed by North African lunatics were “rare enough”, basing this statement on “testimonials by the police […].” This startling change in his opinion mirrors his deeper involvement in Algeria, slowly adapting to the mentality of French settlers, which is also shown in the scientific and biological racism of the École d’Alger. Porot, Tunisie, 71.
22 In 1911, for example, the psychiatrist Livet described the responsibility of psychiatrists in estimating the potential threats of patients. He recounted how a Muslim patient, released too early, had murdered a doctor in Algiers: “The assassin had stayed in Aix, had left unhealed, still deluded and hallucinating. On his return to Algiers, being denied entrance to the hospital, he waited, armed with an axe, at its door, for Dr Moutet and split his skull. It is obvious that this individual should not have left the asylum in Aix as early, or at least [that he should] have been carefully monitored after his release.” Livet, Aliénés algériens, 43.
His definition of criminality included offences that we would no longer classify as criminal, such as addictions and various forms of sexuality, such as prostitution or homosexuality. Through this broad definition of criminality, Kocher showed that he was part of the very popular movement of degeneration theorists, who saw, in the words of the historian Daniel Pick, “crime, suicide, alcoholism and prostitution” to be part of “social pathologies” that “endangered the European races.” In Kocher’s categories, the “criminal” could be either sane or mad, and it was extremely difficult to authoritatively and scientifically differentiate between pure criminality and actual insanity. The distinction between criminality and criminal insanity was most often defined by the extreme violence of the act or by the breaking of unbreakable social norms. Kocher’s dissertation portrayed the general fear of an intricate hidden relationship between criminality and insanity, which was also shown through one of the main duties of psychiatry being the identification of the “dangerous insane” before they had actually committed a crime – intercepting insanity to prevent it from evolving into criminality.

2.4 French Laws on Placements in Asylums

A French law created on the 30th of June 1838 made it clear that the insane could only be kept in psychiatric asylums, gradually eliminating all other forms of care that existed before and in parallel. All mentally ill people, and also all those who disturbed the public order, could, under this law, be legally interned. The reason for this decision was not so much a genuine desire for better treatment of the insane than a deep-felt wish to protect the population from the perceived threat that the insane posed. Soon after the passing of this law – that is, from the 1840s onwards –

24 Addictions were suspected to lead to violent forms of insanity in indigenous populations. Kocher, Criminalité, 135.
25 For example: Ibid., 161.
26 Pick, Faces of Degeneration, 21.
27 As late as 1961, L. Couderc explained that “the most distressing consequence of this state of affairs is the near impossibility, in most cases, of hospitalising and treating a mentally ill person before his condition has worsened to the point of making him dangerous, before he has come to the serious anti-social act, duly and officially recorded.” Couderc, Conséquences, 253.
28 Keller, Colonial Madness, 25.
29 The French historian Hervé Guillemain wrote that prior to 1838, the three places where the “insane” were institutionalised in France were hospices, prisons and prison infirmaries. Guillemain, Malheur, 25.
30 Keller, Colonial Madness, 52 f.
only dangerous patients were admitted into psychiatric care in France due to serious overcrowding in existing asylums.\textsuperscript{31}

It was not until 1876 that a new system of “voluntary admission”, placement volontaire, was introduced in France as a reaction to protests against the existing preference of the system for the criminally insane.\textsuperscript{32} “Voluntary” did not mean that the patient could or would bring himself to the attention of a psychiatrist through their own volition; rather, this new system allowed family members, friends or neighbours to place a person in a psychiatric asylum.\textsuperscript{33} In France, most patients placed through “voluntary admission” were brought to the asylums by their husbands or wives: Patricia Prestwich’s 1994 research showed that almost 40 percent of “voluntary admissions” in France in the late 19th and early 20th century were demanded by spouses.\textsuperscript{34}

Even after the introduction of this law, the strong focus of institutional psychiatry on criminal patients remained. The fact that only the dangerous insane were admitted to mental hospitals while all other patients, because they posed less of a danger to society, were sent away, was also the case in the colonies.\textsuperscript{35} French colonial psychiatrists complained that this focus on “criminals” left non-threatening cases without treatment, cases that could be more easily cured than the “criminally insane”. Antoine Porot, for example, wrote in 1936 that this focus of psychiatric treatment on criminality meant that in Algeria patients with “light psychoses” were left without care or medical help because there was only enough space in the psychiatric institutions for the most dangerous patients.\textsuperscript{36}

These laws focusing on the internment of the “criminally insane” brought new legal problems. How could one decide whether somebody was truly insane or merely pretending in order not to be put into prison? How could insanity be defined and deduced, especially in persons who committed truly horrific crimes? The people who took it upon themselves to act as judges of this important subject with absolute authority were psychiatrists. In the 19th century psychiatrists became the specialists in Europe for determining responsibility in criminals. They defined themselves as the only ones capable of drawing the line between the “criminally insane” and the “common criminal”, between prisoner and patient, and they were increasingly asked to do so in court. They deplored less developed countries like their colonies, where

\textsuperscript{31} Prestwich, Family Strategies, 800, FN 13.

\textsuperscript{32} Dowbiggin, Back to the Future, 386, FN 11.

\textsuperscript{33} A person placed through “voluntary admission” could also be withdrawn from the asylum at any point. Prestwich, Family Strategies, 800.

\textsuperscript{34} Ibid., 803.

\textsuperscript{35} The same happened in non-French colonies, for example in Indonesia and India. Ernst, Idioms of Madness, 174; Pols, Development, 363 f.

\textsuperscript{36} Porot, Services hospitaliers, 796.
“criminally insane people” were still placed in prisons. The psychiatrists Lwoff and Sérieux, for example, disapprovingly described in their 1911 report that in Morocco the criminally insane were often confused with common criminals.\(^{37}\)

In Muslim colonies, the expertise of psychiatrists was contested due to differing notions of insanity. In Islamic law, nobody could be held responsible while insane and was, therefore, not punishable – a criminally insane person had to be delivered to the care of their families, and only if their families could not take them back were they transferred to Islamic hospitals.\(^{38}\) The experts responsible for determining whether somebody was sane, insane or in a lucid moment of his insanity were traditionally judges with a completely different set of ideas about the causes, scope and definition of insanity.\(^{39}\) The Muslim process of admission into “medical care” was purely legal, based on witness testimonials – no medical expert was involved, as recorded by Henry Bouquet in his 1909 dissertation on the “Alienated in Tunisia”. Having heard the witnesses brought before him by the family of the potential patient, the judge would decide on whether the accused was sane or insane. If insane, he could either be immediately arrested and brought to a mental asylum or stay in the care of the family responsible for his upkeep.\(^{40}\)

Another problem psychiatrists were faced with was the separation of the “dangerous insane” from the “harmless insane” within their institutions. While this separation was introduced in most of Europe in the late 19th century as well as in the British colonies in India\(^{41}\) and Egypt\(^{42}\), this was not the case in France, which only instituted its first asylum for criminal cases in 1910 with the establishment of the Villejuif \textit{Quartier de Sûreté}.\(^ {43}\) Unsurprisingly, there was no segregation of the “dangerous insane” and the “harmless insane” in the Maghreb either,\(^ {44}\) despite French psychiatrists repeatedly

\(^{37}\) Lwoff/Sérieux, \textit{Aliénés au Maroc}, 472 f. The same regret – about the traditional confusion of the “criminally insane” with criminals in Muslim societies, caused by the absence of psychiatric expertise – is also stated by Henri Soumeire in his 1932 dissertation on “Murder in the Indigenous Alienated in Algeria”. Soumeire, \textit{Meurtre}, 23.

\(^{38}\) Chaleby, \textit{Forensic Psychiatry}, 21; Pridmore/Pasha, \textit{Psychiatry and Islam}, 383.

\(^{39}\) As the Islamic scientist Michael Dols pointed out, the Maliki School of Law is the only one of the four Islamic Schools which does not have the idea of “lucid moments” in insanity. Dols, \textit{Insanity in Islamic Law}, 84.

\(^{40}\) Bouquet, \textit{Aliénés en Tunisie}, 75 f.

\(^{41}\) Ernst, \textit{Idioms of Madness}, 153.

\(^{42}\) Abbasîya and Khanka, 794. In Egypt, this architectural separation only concerned male patients. Warnock, \textit{Twenty-Eight Years}, 244.

\(^{43}\) Fau-Vincenti, \textit{Vers les UMD}, 69.

\(^{44}\) French colonial psychiatrists often claimed that this confusion of criminals with the criminally insane was due to pre-colonial Islamic conceptions and treatment of insanity. The colonial administrator Joseph Luccioni, who wrote a report on the situation of traditional Muslim
requesting this in their publications.\textsuperscript{45} Consequently, they felt that, in this respect, they were behind other colonial powers in their treatment of the colonial mad.\textsuperscript{46} The lack of segregation throughout French colonialism in the Maghreb is partly explained by the aforementioned differences in implementing theories about committing the mentally ill in France and Britain. Further, the first European-built and -run mental hospitals for Muslims in the Maghreb were only founded in the 1930s, while those in India and Egypt were built in the 19th century, a period when France still sent its colonial “mad” to asylums in France.

2.5 The Violent Muslim Man and the Passive Muslim Woman

Another explanation for the lack of segregation of the “criminally insane” concerns a specific, “race-related” quality of North African patients. Frantz Fanon wrote in 1961 that French colonial psychiatry was one of the cornerstones in reinforcing and validating the settler notion of the North African as a “born criminal”,\textsuperscript{47} a “hereditary” and “congenital criminal”.\textsuperscript{48} In Fanon’s eyes, colonial psychiatry, especially the theories propagated by the École d’Alger, was the scientific foundation of these notions.\textsuperscript{49} Porot and Arrii, for example, wrote in their 1932 article on “Criminal Impulsivity” that “the frequency of criminal impulsivity” was a “phenomenon especially particular to this race”;\textsuperscript{50} while Charles Bardenat suggested in 1948 that the low intelligence

\textsuperscript{45} For example at the time of the instalment of the first hospital for the criminally insane in France, in 1911. Livet, Aliénés algériens, 42. As late as 1948, Charles Bardenat still demanded institutions for criminally insane Muslim men. Bardenat, Criminalité, 480.

\textsuperscript{46} This regret was also palpable with respect to other aspects of colonial psychiatry’s duties. Bouquet, for example, professed his shame in his 1909 dissertation about the state of French colonial psychiatry, regretting that, unlike Holland and Great Britain, France had not yet developed a psychiatric assistance for the colonial mad. Bouquet, Aliénés en Tunisie, 83.

\textsuperscript{47} Fanon wrote that colonial psychiatry solidified the idea of the North African as “born slackers, born liars, born thieves, born criminals”. Fanon, Damnés, 285.

\textsuperscript{48} Ibid., 287.

\textsuperscript{49} Ibid. This idea is taken up by the secondary literature, for example in: Macey, Algerian with the Knife, 162; McCulloch, Empire’s New Clothes, 38 f. As noted above, the notion of the criminal North African already existed before the heyday of the École d’Alger and Fanon’s criticism of it – Lemanski, for example, described male Arabs as a “race of bold and violent men” in 1913. Lemanski, Mœurs arabes, 136.

\textsuperscript{50} Porot/Arrii, Impulsivité criminelle, 589. Emphasis in the original.
of Muslims, their “mental insufficiency”, made them intrinsically more delinquent than Europeans.\footnote{Bardenat, Criminalité, 468 f. Even postcolonial North African writers support this theory. In 1965, the Tunisian sociologist Abdelwahab Bouhdiba wrote: “These data [i.e. repeat offenders] are disturbing, because they seem to question the perfectibility of man, and the reform of criminals proves to be at the very least illusory. Without going as far as to talk about ‘professional criminals’, it seems that we are dealing with something very deeply rooted in the mentality of the Tunisian Muslim.” Bouhdiba, Criminalité, 59.} This psychiatric theory of male North Africans as “born criminals” had wide-reaching implications. It meant that no money needed to be invested in the education or assimilation of North Africans because criminality was too deeply ingrained in their inherited “racial” characteristics, and the money saved on education should instead be invested in the police and psychiatric hospitals to ensure the protection of the settler population against an innate criminality that made Muslims inaccessible to the French ideals of the \textit{mission civilisatrice}.'\footnote{Keller, Colonial Madness, 16.}

From the point of view of colonial psychiatrists, criminality was not a sign of insanity – because male North Africans were dangerous and violent even in their normality\footnote{In Fanon’s eyes, the danger posed by North Africans was not a purely colonial construct, as violent protest was one of the only forms of dissent open to the colonised. In his interpretation, North Africans were forced, by colonial oppression, into violent reactions. See for example: Fanon, Damnés, 83. Though Fanon used the word “Algerian”, which nominally included women, it is clear from his examples and from the quotes of French psychiatrists that he reproduced in his texts that he was actually referring to men. This has been noted by Anne McClintock, for example, in her 1995 book “Imperial Leather”. “Potentially generic terms like ‘the Negro’ or ‘the Native’ – syntactically unmarked for gender – are almost everywhere immediately contextually marked as male […]”. McClintock, Imperial Leather, 362.} –, and if this definition held true for normal North African men then, naturally, male North African mental patients who had lost their reason were dangerous and violent as well. Because of this alleged penchant for violence, the separation of the “dangerous insane” from the “harmless insane” in North African hospitals was not necessary since other mechanisms of separation were already operating: a “racial” separation of Muslim patients from European patients as well as gender segregation.\footnote{For example in: Desruelles/Bersot, Assistance aux aliénés en Algérie, 591. See also: Schwarz, Psychiatrie in Algerien, 88.}

Female wards for the “dangerous insane” were deemed unnecessary because the theories of French psychiatrists mirrored popular conceptions of normal femininity. Female Muslims were not only seen as set apart from the “born criminal” class discussed by Fanon but viewed as almost genetically incapable of being violent and dangerous\footnote{For example: Lemanski, Mœurs arabes, 117. This notion is still widespread. The aforementioned Tunisian sociologist Bouhdiba wrote in 1965: “Crime in Tunisia remains, as elsewhere in the world, an essentially male manifestation. Women, and Muslim women in particular, remain}
and, instead, were traditionally portrayed as the victims of male aggression. Women were seen as being too passive to be the perpetrators of criminality, a notion that fitted in with Muslim concepts of gender segregation and patriarchy, or at least the French interpretations of these concepts.

The reason for the widespread male violence against women was believed to be jealousy, which Kocher defined in 1883 as the moral basis of the Algerian male psyche. In Kocher’s opinion, there were multiple causes for this jealousy: “polygamy, divorce, and marriage, which is often, with Arabs, only a shameful commerce – the young girl is allocated to the highest bidder, and jealousy and hatred awake between rivals.” The basis for Muslim women’s suffering was therefore seen to be part of Muslim family law, which, in the eyes of the French, permitted and tolerated excessive sexuality and all the vices that came with it, such as violent jealousy.

The repetition of quotes about the Muslim woman’s status as an eternal victim, discussed in Chapter 1, enabled the French to criticise societies in the Maghreb. France did not actively interfere in Muslim civil law and Muslim traditions because they feared uprisings would ensue if they did. Having allegedly no opportunity to change Muslim civil law or traditions, but still wishing to voice their outrage, many colonial authors instead focused on the miserable life Muslim women led, which they attributed to Muslim civil law and Islamic traditions as much as to male Muslim normality, as discussed in the previous chapter. Presenting Muslim women as victims of male Muslim despotism soon became a trope yet never sparked any real urgency

The psychiatrist Sextius Arène wrote in his 1913 dissertation on “Criminality in Arabs”: “The crimes of Muslims are mostly crimes of passion, motivated by adultery or jealousy. The lack of loving emotions between men and women should be emphasised here; Arabs are male and female [animals]: an Arab man cannot see a woman without desiring her and an Arab woman cannot see a man without wanting him for her personal pleasure; from this comes the jealousy of men and the explanation of the confinement of women.” Emphasis in the original. Arène, Criminalité, 105 f. See also: Porot/Arri, Impulsivité criminelle, 589.

This notion was taken up by many later psychiatric authors. See for example: Lemanski, Mœurs arabes, 141; Bardenat, Criminalité, 325 f.; Aubin, Indigènes Nord-Africains, 292.

Kocher, Criminalité, 98. Emphasis in the original.

Clancy-Smith, Islam, Gender, and Identities, 155 f.

For a discussion of this “refusal to intervene” in other French colonies, see: Conklin, Mission to Civilize, 87 f., especially FN 43.
to tackle the deplorable – but perceived as unchangeable – misery of female Muslims. Even though Muslim women were depicted as passive victims, they were, due to their exotic sex drive, also seen as responsible for the crimes committed against them. In 1883 Kocher wrote about the presumed sexuality of young Arab girls who were dressed provocatively by their mothers: “An accusation of rape, produced under these conditions, would evidently lose a great part of its gravity.”

The theory that indigenous women were incapable of crime was a colonial construct, showing the notable gap between psychiatric theory and practice, as the case studies show numerous examples of female patients being very violent and destructive. However, there was no question of women not being victims of “criminally insane” men. Muslim women were assaulted by confused or demented male family members, just as they were in Europe at that time, and as it still happens to this day. One can find allusions to women suffering from the hereditary criminality of Muslim men, often in the summaries that psychiatrists gave in court when judging whether a murderer was responsible for his crimes. One can also find female victims of male aggression and violence in case studies of female mental patients – the background information, used by colonial psychiatrists to explain the emergence of diseases, often depicted Muslim women as victims. Jean Sutter, for example, studied cases of “Mental Epilepsy in the Native Algerian” for his 1937 dissertation. One female patient, first married at 17 and mother, widow and remarried by the age of 24 when Sutter wrote about her, was so badly mistreated by her second husband that she miscarried and suffered a traumatic brain injury, which seems to have triggered her first epileptic shock. In Sutter’s view of the case, she was completely innocent and fulfilled the criteria of ideal Muslim femininity by being brought to a mental asylum as a victim rather than a dangerous or criminal perpetrator.

Female Muslim perpetrators were extremely rare over the entire colonial period, as some psychiatrists tried to prove through numerical evidence. Porot and his student Arrii described in 1932 40 cases of “criminal impulsivity” in Algerian Muslims, only two of them concerning female criminals. In the same year, only one woman in 14 case studies was documented as being criminal in a psychiatric dissertation on “Murder in the Indigenous Algerian Population”, which is, according to Henri Soumeire, in “accordance with the conclusions of all psychiatrists.” In Suzanne Taïeb’s 1939

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61 Kocher, Criminalité, 185 f.
62 It coincided with Muslim notions that, while women were maybe untrustworthy and immoral, they were not physically dangerous. In Muslim societies, the danger of women was seen to lie in their association with magic.
63 Sutter, Épilepsie mentale, 181 f.
64 Porot/Arrii, Impulsivité criminelle, 607.
65 Soumeire, Meurtre, 78.
dissertation, she found that none of the criminal cases she looked at were committed by women, which led her to the general conclusion that deliriums and psychoses made Muslim men more violent and dangerous but, interestingly, not to the corresponding theory that Muslim women were somehow incapable of criminality. Finally, Assicot et al. stated in 1961 that among 66 Muslim admissions into Blida Psychiatric Hospital for medico-legal reasons in 1958 and 1959 only one concerned a Muslim woman.

In another statistic covering the admission numbers to Blida Psychiatric Hospital in Algeria from 1933 to 1940, the psychiatrist Charles Bardenat found that out of 1,324 female patients (795 European Christians, 412 Muslims, and 117 Jews), only three were condemned criminals – and all three were Muslim women. He argued that Muslim women were indeed very unlikely to commit crimes, but still more likely than their more civilised European or Jewish sisters. Bardenat concluded: “Without wanting to draw definite conclusions from this fact, we have to admit that the indigenous woman – noisier and more destructive in the hospital than her kind in the other ethnic groups – does not reach the harmfulness of the male native, because of her condition as a minor, in which she is kept in her society, living under a narrow and quasi-slavish dependence.”

2.6 Mechanisms of Admission

As has been shown, crimes in general and violent crimes in particular were regarded as a male domain by French colonial psychiatrists, regardless of the reality encountered in their daily lives. Even when they were confronted with criminal female Muslim patients, it was argued that the numbers were so small that they could be neglected. The facts therefore seemed congruent with their theories of gendered aggression and criminality in both normality and abnormality.

However, an examination of the ways in which women were admitted to psychiatric care in the Maghreb reveals a strong criminalisation of female patients. As mentioned above, these mechanisms of admission can be roughly divided into three groups: “voluntary placements”, “administrative placements” and “judicial placements”, each with their own manner of criminalisation. As neither the case studies nor the statistics state how many patients were interned via each of these possible placements, some of the cases mentioned below could be subsumed under more than one category.

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66 Taïeb, Idées d’influence, 78.
67 During the same period, only six European patients were admitted in that way, among them also one woman. Assicot et al., Causes principales, 263.
68 Bardenat, Criminalité, 318.
69 Ibid., 320.
2.6.1 Voluntary Placement

One might reasonably presume that “voluntary placement” of mentally ill people by family members and neighbours should have been the most common mode of admission of Muslim patients to colonial psychiatric hospitals. However, placement for health reasons seems to have been quite rare, as people with mental illnesses were traditionally looked after by their families, brought to local healers or placed in purpose-built Islamic hospitals (māristāns) next to the tombs of saints. Only under extreme circumstances did Muslim families contact colonial psychiatrists. Livet explained this in 1911 through the distances between Muslim families in rural Algeria and the general hospitals in Algiers or even the mental institutions in France. He stated: “As to the families, given that the asylum is two days travel [away], they resolve with much difficulty to [agree with] the separation from the sufferer who, despite everything, is dear to them. For this, it is necessary that the insane has shown some dangerous or offensive symptoms.”

In a 1936 article on the “Psychiatric Hospital Services in North Africa”, Antoine Porot quoted instructions from the Governor-General of Algeria at the time, Jules Gaston Henri Carde, from the 10th of August 1934. Article 5 of these instructions stated that people with “light or inoffensive” mental problems could be admitted by either their own request or that of their families. Carde, Jules Gaston Henri, Instruction, article 5. As quoted in: Porot, Services hospitaliers, 798.

Franz Fanon and François Sanchez even mentioned in 1956 that they knew of patients who had been interned against the express wishes of their families. Fanon/Sanchez, Attitude, 27. This was also observed in postcolonial psychiatric texts. The British psychiatrist John Racy wrote in 1970 that female patients in Arab countries were still mostly brought to the attention of the authorities by their male family members, or through official forms of placement. Racy, Psychiatry in the Arab East, 40.

The French colonial administration in Tunisia and Morocco tolerated these māristāns, as a means of institutionalising the indigenous insane, but only when the patient had not committed a crime. In Algeria, the French disbanded all traditional hospitals or reorganised them under European rule at the beginning of the French conquest. Desruelles/Bersot, Assistance aux aliénés en Algérie, 594. One of these traditional māristāns became, for example, the Civil Hospital of Mustapha. Livet, Aliénés algériens, 13 f. These traditional asylums will be discussed in detail in Chapters 3 and 4.

Ibid., 35.

Ibid., 53. See also: Susini, Quelques considérations, 27 f. The Iraqi psychiatrist Ihsan Al-Issa and his Finnish wife Brigitta Al-Issa wrote in a 1970 article on psychiatric problems in Iraq that Muslims were very tolerant towards people with mental issues, “as long as it is not expressed in unprovoked violence, sexually shameful behaviour, or uncontrollable motor overactivity […].” In their opinion “the mental content of a patient is seldom enough to bring him to the healer
Due to a too literal and rigid incorporation of Muslim ideals about gender segregation into their simplistic interpretation of Islam, it was a widespread colonial belief that Muslim families would never voluntarily bring their ill female family members to a male doctor and that this accounted for the reluctance to admit patients to psychiatric care. While Muslim ideals of gender segregation might have hindered some women from contacting male European specialists, and while others might have been stopped by jealous husbands or worried families, just as many might have had completely different reasons for preferring other cures. Many patients, especially at the time when they were still shipped to France, did not survive their placement in colonial care – the death rates were shockingly high. Families that could afford to look after their patients without involving colonial care would do so at almost any cost. While Muslim women who were treated by local healers or in a traditional māristān for mental disorders were readily accepted back into society once healed, those who spent time in colonial asylums, and were lucky enough to survive, usually suffered stigmatisation. The reluctance to bring female patients to psychiatric

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76 For example: Matignon, Art médical, 91. Unsurprisingly, this belief can also be found in the texts of French female doctors, as for example in the 1905 dissertation by Hélène Abadie-Feyguine about “Medical Assistance of Indigenous Women in Algeria”. Abadie-Feyguine, Assistance médicale, 65.

77 This explanation, for example, was given in an article published in the journal Hygiène Mentale in 1955 – one of the authors was Frantz Fanon. Dequeker et al., Aspects actuels, 1112.

78 See Chapter 3.3.1 “Chances of Death”.

79 This tradition of keeping people with mental problems with their families was repeatedly criticised by French psychiatrists. Reboul and Régis, for example, felt in 1912 that the Muslim insane were mistreated by their families, because of their lack of psychiatric knowledge. Reboul/Régis, Assistance, 76.

80 This tolerance was caused by traditional notions of insanity being caused by “Jinn”, who might attack anybody, regardless of their actions or behaviour. Especially among women, possession by a “Jinn” was seen as normal and was therefore socially tolerated. Aouattah, Ethnopsychiatrie maghrébine, 242 f.

81 Lemanski, for instance, wrote that because of a stigma connected to all kinds of European hospitals, only the poorest population of North Africa brought their female mental patients to the French doctors and psychiatrists. Lemanski, Mœurs arabes, 122. This stigma attached to former patients of psychiatry in Arab countries is still observed in postcolonial and even contemporary research. See for example: Katchadourian, Survey, 24; Al-Krenawi/Graham, Gender and Biomedical/Traditional Mental Health Utilization, 226; El-Islam, Mental Illness, 133; Okasha, Mental Health Services in the Arab World, 45; Mejda et al., Histoire, 691.
hospitals therefore might have had less to do with Muslim gender segregation and clinging to traditional healing than with negative connotations of colonial care, of which the psychiatrists had little awareness.

Still, some patients were admitted through “voluntary placement” by their families. In his 1907 dissertation “Diet and Treatment of the Indigenous Insane in Algeria”, Camille-Charles Gervais mentioned a woman who was brought to psychiatric care and his personal attention by her husband, who seemed to have been earnestly worried about her health. At a time when patients from Algeria were shipped to Aix-en-Provence, this could have easily meant the end of the contact between husband and wife, but the husband, who apparently had eight other wives – so that “one more or less did not really change anything”82, as Gervais noted patronisingly and clearly against the evidence of his own case study –, was a retired military man with money. Shocked at how much the asylum in Aix-en-Provence made him pay for the upkeep of his wife, he decided to get her back, but on his arrival at the hospital, he was denied permission to see his wife, despite the long journey he had expressly made to meet her. He returned to Algeria, only to turn up again in Aix-en-Provence, this time demanding to talk to someone in authority. He spoke to the director of the asylum and allegedly told him: “Your doctors cannot cure, do you want to try my remedy? Give me back my wife; in Algiers, in my village, I will take charge of her cure.”83 Unsurprisingly, they did not give him the chance to cure his wife with traditional medicine, and Gervais mentioned no more about either husband or wife.

This case seems to have been unique: no similar stories about families worrying about the health of an interned family member and trying to be actively involved in the treatment are to be found in published case studies.84 However, in her 1941 dissertation Eliane Demassieux mentioned Muslim mothers and wives visiting the psychiatric services in Algeria to inquire about institutionalising a male family member, whose violent reactions they feared.85 More often, however, voluntary placement took the form of formal complaints by neighbours or family members to local magistrates in order to protect themselves from the violence of a mentally ill person rather than seeking treatment for their mental health problems per se. When these magistrates thought the claim of insanity was justified by the unreasonable actions of the patient

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82 Gervais, Contribution, 72.
83 Ibid.
84 This is also shown through a passage in a 1954 article, in which the French doctor Pierre Charbonneau explicitly stated that “[...] some requests of voluntary placement are sometimes made by Moroccans to the hospital in Fes [...].” Had voluntary placements of Muslim psychiatric patients occurred regularly, this remark would have been unnecessary. Charbonneau, Assistance, part 2, 792.
85 Demassieux, Service social, 41 f.
and verified by witnesses, they transferred the case to a māristān. As already men-
tioned, in Islamic Law it was the qāḍī, the local judge, who determined whether the
accused was sane or insane. Under colonial rule, a doctor’s statement was added as an
extra step between magistrate and asylum, and the final decision about whether a per-
son was deemed sane or insane lay with the “true experts”, the colonial psychiatrists.

This more common manifestation of the “voluntary placement” mainly concerned
women who were, for some reason, unbearable to their families, who usually looked
after their “insane” female relations until their death, although this line of action was
only taken under extreme circumstances, most often when patients uttered wild threats
or became too violent for the makeshift restraints at home. The psychiatrist Jean Sutter
described in his 1937 dissertation cases of “voluntary placement” and the threat that
violent “madwomen” posed to their families. One was the aforementioned case of a
woman whose mental epilepsy was triggered by the physical abuse she suffered at the
hands of her second husband. Her violent epileptic crises disturbed her neighbours,
who finally contacted the police. A second case study concerned a 37-year-old Kabyle
woman with another heart-breaking life story of young marriage (first wedding at the
age of 12), young widowhood (at 18), another marriage, then a divorce, after which
the woman was “always sad”, “fleeing all society”, “often crying”, and “speaking to her-
self in a low voice […].” Six months before her internment in Algiers, she underwent
a “crisis”, in which she tried to “hit her mother”, whom she later threatened to kill.

Another psychiatrist who described cases of Muslim women becoming a danger to
their families was Suzanne Taïeb in 1939. One female epileptic “had quickly become
‘malicious’, hitting her mother, hitting her brothers”, running away into the coun-
tryside, and “slapping children she encountered […].” Her parents reacted to these crises
by “locking her up in a room, hoping that she would calm down, but seeing that she
became more and more violent, they ultimately had to hospitalise her.” In another
of her case studies, Taïeb wrote about a schizophrenic, who, in phases of “general
over-excitement”, threatened “to kill everybody, her mother included, who wants to
approach her. In her anger, she breaks everything within her reach. She is furious.”
After those phases, the patient became calmer, sadder, and refused to speak or let other
people look after her. In cases like these, it is probable, though often not specifically
mentioned, that either families or neighbours contacted the local magistrates, who

86 Bouquet, Aliénés en Tunisie, 75.
87 Bouquet also mentioned that families sometimes sidestepped local magistrates and contacted
the asylum directly to get help with their violent family members. Ibid., 75 f.
88 Sutter, Épilepsie mentale, 181 f.
89 Ibid., 156 f.
90 Taïeb, Idées d’influence, 95 f.
91 Ibid., 104 f.
then interned them. It is also important to understand that these patients were taken from their family homes and brought to psychiatric asylums because of the perceived danger they posed due to their violence and threatening manner and not because they were seen as being ill.

There were also women deemed dangerous not to others but to themselves. Jean Sutter, for instance, summarised the danger that Muslim women posed in 1937 as follows: “In women [...] one notes fewer dangerous or criminal reactions, but [instead] a disorderly agitation which leads sometimes to auto-mutilation.”92 French psychiatrists held the theory that suicide, prohibited through Islamic law, had been unknown in North Africa before France started its mission civilisatrice.93 To them, it was only with the civilising project that suicide started in the Maghreb. Kocher wrote in 1883 that, “especially in women”, suicide, formerly infrequent, seemed to increase with the contact with France.94 Kocher went on to say that, unlike in Europeans, where single men and women killed themselves, suicide in the Maghreb concerned married Muslims in two thirds of all cases. In his opinion, “this number should not astonish us, if we think of the cruel suffering which brings with it, for women, the state of abjection in which they are kept by their husbands.”95

2.6.2 Administrative Placement

“Administrative placement” is the name the French gave to the admission of patients who were picked up by the police because they behaved in a way that was unacceptable to local and French social customs or, often, morals.96 Antoine Porot, quoting again from the instructions of the general governor of Algeria concerning mental hospitals,

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92 Sutter, Épilepsie mentale, 215.
93 Kocher, Criminalité, 143 f.
94 Ibid., 233. Suzanne Taïeb also described several cases of Muslim women who tried to commit suicide, often in very violent ways, both prior to their internment and during their psychiatric treatment. These Muslim women often had to be physically restrained in the hospitals in fear of self-harm. Taïeb, Idées d’influence, 89 f.
95 Kocher, Criminalité, 148 f. Apart from the general malaise regarding the low status of Muslim women, Kocher also blamed, in another part of his dissertation, the alcoholism that France’s mission civilisatrice brought with it for the rise in both suicide rates and “insanity”. This reason for the rise of suicides, however, seems to be applied mainly to Muslim men. Ibid., 28.
96 Henri Bouquet described Islamic “administrative placements” in his 1909 dissertation, translating article 629 of the pre-colonial Tunisian Civil Code from the year 1861: “Each individual, in a state of drunkenness or dementia, will be hindered from circulating in the streets... The police will arrest the madman and will bring him to his parents or, in the absence of those, to the house of the alienated.” Bouquet, Aliénés en Tunisie, 76, FN 1.
wrote in 1936 that “administrative placements” took place when a subject was disturbing the public order or menacing the security of people.97 As with “voluntary placements”, these cases were brought before a local magistrate who determined whether the patient should be deemed sane or insane. Next, a local doctor was contacted, who might again send them on to a psychiatric hospital where psychiatric experts decided whether the person was merely difficult or truly insane.98 Porot went on to say that the normal rules (necessitating an official statement, a medical certificate and personal papers) could be bypassed “in case of urgency or of imminent danger, at the request of the patient, or of his family, or of authorities [...]”.

In such cases, the manner of admittance itself, reinforced by the involvement of the police, stressed the potential danger of these patients to society. Police involvement was, surprisingly, almost never mentioned in the published case studies, but it is reasonable to assume that patients described in ways that pointed to this idea of “disrupting the public order” were admitted to psychiatric hospitals by “administrative placements”. These disruptions could take various forms. Adolphe Kocher, for example, mentioned in 1883 that many Muslim patients were institutionalised after having committed “public crimes against decency”,100 while Reboul and Régis explained almost thirty years later that “only those who reveal publicly their excessive extravagance” came to the attention of colonial psychiatrists.101 Charles Bardenat regretted in 1948 that “an act of violence, impossible to hide” was needed “to trigger the intervention by the authorities” and to initiate psychiatric treatment,102 while in 1955 a group of French psychiatrists – among them Frantz Fanon – further elaborated on this unease about “administrative placement” by explaining that Muslim patients only arrived at Blida Psychiatric Hospital after having passed through “stages of scandal and public danger [...]”.

These disruptions of the public order, with regard to Muslim women, can be divided into three possible categories: a) women classified as prostitutes, b) women with alcohol problems, and c) vagrant women, who behaved in a socially, morally or even legally unacceptable way. However, the lines between these categories were

97 Carde, Jules Gaston Henri, Instruction, Article 7. As quoted in: Porot, Services hospitaliers, 798.
98 Bennani, Psychanalyse, 111; Keller, Colonial Madness, 90.
99 Carde, Jules Gaston Henri, Instruction, Article 8. As quoted in: Porot, Services hospitaliers, 798.
100 Kocher, Criminalité, 160.
101 Reboul/Régis, Assistance, 11. Similarly, Jude and Assad Hakim stated in 1927 that, in Damascus, patients were only brought to the psychiatric institutions after they had caused a scandal. Jude/Assad Hakim, Troubles mentaux, 126. See also: Bullard, Truth in Madness, 120.
102 Bardenat, Criminalité, 319.
103 Dequeker et al., Aspects actuels, 1112.
blurred, for instance women classed as prostitutes were likely to be described as alcoholics or vagrants as well.

Prostitutes

Police, magistrates and psychiatrists could define women as prostitutes just because they behaved in an unaccepted way, but, while technically legal, prostitution was seen to be closely connected to criminal offences and was, both in France and in the North African colonies, frequently cited as a symptom of insanity, as a lifestyle finally leading to insanity or as only undertaken by women already insane. The psychiatrist Camille-Charles Gervais proposed in his 1907 dissertation that, among Muslim women, “[…] those who come to Aix are mainly those who trade in prostitution.” However, colonial observers understood that not all prostitutes were classified as insane and that most of them ended in prison rather than in a psychiatric institution, as a visit to a Moroccan female prison in 1923 showed, where “almost all [the inmates] were thieves or women with light morals.”

Meilhon, a doctor at the mental asylum in Aix-en-Provence, wrote in 1896 that one of his case studies concerned a Muslim prostitute, whom he called “une fille galante”. This woman had been brought to Aix-en-Provence after having been treated at the Civil Hospital of Mustapha in Algiers for syphilis. She initially showed no signs of mental alienation but became agitated in the hospital. Once transferred to Aix-en-Provence, she was kept in the asylum, even though, interestingly, Meilhon never could confirm that she was suffering from any sort of syphilis-induced mental illness. A second of Meilhon’s case studies described the history of a hysterical “fille soumise”, who

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104 Kocher implied that there was a relationship between female homosexuality and prostitution. He wrote that female homosexuality was only observed in prostitutes and was generally not widespread in Arab societies because “it seems that this vice demands a certain degree of civilisation to flower”. Kocher, Criminalité, 168.

105 Lazreg, Eloquence of Silence, 23.

106 Sérieux, Recherches cliniques, 26. Jules Comby even hinted in 1923 that psychiatrically normal Muslim women were brought to traditional Moroccan asylums “by the pasha” because “of their light conduct” – a practice he claimed to have witnessed himself in Meknes. Comby, Voyage médical, 1203. On the other hand, prostitution was imagined to be an acceptable alternative for Muslim women to life in the two “cages” discussed in Chapter 1. See for example: Lazreg, Eloquence of Silence, 56.

107 Gervais, Contribution, 48.

108 Celarié, Un mois au Maroc, 213.

109 Meilhon, Aliénation mentale, part 2, 195 f. Similar to the case study discussed at the beginning of this chapter, the story of this allegedly syphilitic prostitute shows an alternate possibility of psychiatric internment: admission by passing through a prison or, in this case, through the
was brought to the asylum in Aix-en-Provence because she was “alcoholic, addicted to venereal excesses” with both violent and “erotic” tendencies. Based on this vivid description, it is easy to imagine that this patient had been arrested by the police for indecent behaviour, although Meilhon did not think it necessary to explain the reason for his patient’s admission.

Interestingly, the only psychiatrist openly classifying patients as “prostitutes” after Meilhon, using the same colourful euphemisms, was one of the few women working in colonial North Africa, Suzanne Tâieb. One might ask whether this was due to a stricter moral high ground that Tâieb took, as was described for many European women living in colonies, or a mechanism of self-defence in a profession still dominated by male authority. A Tunisian Jew, speaking fluent Arabic, and with a Maghrebi surname, she might have felt a stronger need to differentiate between herself and the women she treated. Tâieb mentioned, for example, cases of patients who were “filles soumises” or who had been forced to work in brothels. One case study, for example, concerned a 40-year-old Muslim woman, who came to Blida Psychiatric Hospital suffering from deliriums. This woman told Tâieb that she left her husband, whom she had married at the age of 13, and her three children to be with another man, who treated her very badly. One day, after a violent dispute with her abusive partner, her landlady brought her to the police. “They” – presumably the police – brought her to a “house of tolerance”, where she was said to be highly unhappy. This happened years before her admission to Blida, but it was still perceived to have been relevant with regards to her present illness in the eyes of Tâieb.

Both Meilhon and Tâieb, even though they wrote with 40 years of colonial experiences separating them, described their patients using strikingly similar terms – “filles légères”, “filles galantes”, “filles soumises” –, though it is not always certain whether they really meant to imply that the described patients had been working prostitutes.

100 Ibid., part 4, 40.
111 This theory that European women were the cause of a heightened racism in the colonies has been criticised by the historian Ann Laura Stoler. Stoler, Carnal Knowledge, 56. It is not implied that Tâieb was “more racist” than her male colleagues, but that, as a woman, she was seen to embody French colonial morals and was probably conscious of that. Ibid., 57.
112 Tâieb, Idées d’influence, 15.
113 Keller, Madness and Colonization, 315.
114 Tâieb, Idées d’influence, 85; 92; 105.
115 “Maison de tolérance” is a French euphemism for a brothel, and used in colonial sources quite often. For example: Nicole, Prostitution, 211.
116 Tâieb, Idées d’influence, 120 f.
117 Meilhon, Aliénation mentale, part 2, 195; part 4, 40; Tâieb, Idées d’influence, 85; 92.
Arguably, by that time an automatic connection between the “Oriental woman” and prostitution had already become a colonial trope.\textsuperscript{118} It was often stated that, perhaps due to the (one-sided) facility of divorce in Islamic family law,\textsuperscript{119} sex work was always a possibility for North African women. This notion had been present from almost the beginning of French colonial medicine in North Africa. In 1855 the doctor Émile-Louis Bertherand, for example, suggested a strong link between the normal life of Muslim women and their will to prostitute themselves. “One can say with reason that the Arab woman willingly trades her body. Habituated from a very early age to see herself lowered to the role of slave or a simple instrument of pleasure, prematurely delivered to despotic men who treat her like a commodity, having no principles of moral education which could support her in this series of distressing tests which could inculcate aversion to vice, she gives in promptly and easily to her whims, to her instincts, to the possibility of fleeing an existence of bad treatment and of having some distractions in compensation. Also prostitution is widespread with Arabs; it [prostitution] is recruited generally from among repudiated women.”\textsuperscript{120} This quote from 1855 was, in a way, still valid a century later as the colonial medical and psychiatric understanding of how the world of Muslim women worked had not changed much. It was still supposed that normal Muslim women could very easily be forced to become prostitutes by certain circumstances. In 1959, for example, Sutter et al. mirrored Bertherand by stating that “prostitution is essentially the result of girls married too young and repudiated long before they come of age.”\textsuperscript{121}

This classification of normal women as prostitutes seemed to occur regularly with “vagrant women”: Alice Bullard thus wrote in her 2001 article “The Truth in Madness” that only destitute prostitutes, having been repudiated not only by their husbands but also by their extended families, could no longer rely on their care in cases of insanity and therefore had to become insane vagrants.\textsuperscript{122} Even if there was no other sign of insanity or prostitution in a vagrant woman, it was often assumed that all three things must go together.

\textsuperscript{118} Lazreg, Eloquence of Silence, 56.
\textsuperscript{119} Divorced women from the poorer classes were seen to be the most likely to become prostitutes in the eyes of French psychiatrists, as stated in an article in 1959. Sutter et al., Quelques observations, 908.
\textsuperscript{120} Bertherand, Médecine et hygiène, 198.
\textsuperscript{121} Sutter et al., Aspects algériens, 895.
\textsuperscript{122} Bullard, Truth in Madness, 120.
Drug addicts

Addicts were often regarded as potential criminals by colonial psychiatrists, but deciding whether the addiction was also a sign of insanity was more difficult, especially considering the often very large amounts of alcohol the French population of North Africa drank on a daily basis. 123 Most Muslim men were described as suffering from addictions (mainly to alcohol or hashish, and often to both), 124 but it is difficult to tell in these cases whether drug addiction was the cause, a symptom or actually its own form of insanity. With women, this differentiation was easier. Female drug addicts needed no other symptoms of insanity apart from their addiction itself – their obvious breaking of social norms was sign enough. Not only did they break their own religious laws, they also behaved in a way that was distinctly unwomanly to French observers. 125

French colonial psychiatrists often mentioned that before the start of colonialism in North Africa in 1830, alcohol, alcoholism and alcohol-related mental diseases were unknown. Kocher wrote in 1883 that North African men – Muslim women were mostly seen as abstinent – had managed to “assimilate the vices” of French civilisation and quickly became addicted to alcohol. 126 Many deplored the advent of alcohol in the indigenous population, who seemed unable to control themselves under its influence, and the psychiatric experts blamed alcohol not only for the strong rise in certain specific organic diseases but also for the rise in both mental problems and general violence. In 1926 Military doctor S. Abbatucci, for example, stated about the situation in all French colonies that “the boost of a toxic, such as alcohol, on a primitive brain, triggers immediately sudden and violent impulsive crises.” 127 Alcoholism was therefore not only a “trigger” for mental disorders but also for the much-feared innate violence of Muslim men.

123 See, for example, Armand, Algérie médicale, 474; Lemanski, Hygiène du colon, 80. On this topic, see also: Studer, Green Fairy in the Maghreb.
124 The propensity of Muslim men towards addictions became a colonial trope. Writing about psychiatry and North Africans without mentioning them was soon impossible, as the psychiatrist Raoul Vadon mentioned humorously in his 1935 dissertation “Medical Assistance of Psychopaths in Tunisia”: “Not to speak about kiff or mint tea, in an essay about psychoses in Tunisia, would be a gap that I ought not to leave.” Vadon, Assistance, 49. See also: Matignon, Art médical, 88; Reboul/Régis, Assistance, 51; Maréchal, Héroïnomanie, 255. This notion persisted during colonial times and is still present today. See for example Al-Issa’s chapter on “Culture and Mental Illness” from the year 1990, republished in 2000: Al-Issa, Culture and Mental Illness, 112.
125 See also: Faradj Khan, Hygiène et islamisme, 57.
126 Kocher, Criminalité, 72.
127 Abbatucci, Assistance, 653. Emphasis in the original.
While there were a number of case studies dedicated to female Muslim alcoholics, none specifically dealt with other addictions. Drug addictions were seen to be so closely connected to Muslim men, so inherently unfeminine, that female Muslim patients were normally excluded from the French psychiatric investigations.\textsuperscript{128} Those who did remark upon addictions in Muslim women usually emphasised their rarity.\textsuperscript{129} In 1955, for example, Manceaux et al. presented a paper on heroin addiction in Algeria at the Congress in Nice. In it, they stated: “All our patients are men. There is, to our knowledge, only a very small number of prostitutes indulging in heroin in Algiers [...].”\textsuperscript{130} This automatic equation of a marginalised group of society with a form of socially unacceptable and potentially morbid behaviour occurred regularly. The first case study of a female Muslim alcoholic to be found in the published source material was the aforementioned “fille soumise” in Meilhon’s 1896 article.\textsuperscript{131} Whether the woman was really both an alcoholic and a prostitute or whether one was assumed because the other was “found” is impossible to say. The same problem occurs when evaluating another, aforementioned, case study by Taïeb: a former vagrant “fille soumise” had been treated at Blida Psychiatric Hospital after suffering terrifying visions, brought on by the patient’s alcoholism.\textsuperscript{132} Assicot et al.’s research on the patients at Blida Psychiatric Hospital between 1958 and 1959 also only described one case of female Muslim alcoholism – in a prostitute.\textsuperscript{133}

Other case studies on addictions were not concerned with women labelled as prostitutes. Chronologically, the next case study about female patients with alcohol problems after Meilhon’s was written by the psychiatrist Levet in 1909 and published in the \textit{Annales Médico-Psychologiques}. A 35-year-old woman from Algiers, who had

\textsuperscript{128} For example, in the 1941 article on “Alcoholism and Mental Troubles in the Indigenous Muslim Algerian” by Maurice Porot and J. Gentile, where they wrote: “The extreme rarity of alcoholism in Muslim women (apart from prostitutes) has made us limit this investigation to only men.” Porot, M./Gentile, Alcoolisme et troubles mentaux, 126 f. In 1957 the Moroccan psychiatrist Ahmed Benabud analysed the frequency of hashish addiction in Morocco and justified the neglect of female patients by stating that “the number of observations of female hashish addiction – 15 – is negligible”. Benabud, Aspects psychopathologiques, 4.

\textsuperscript{129} The same was described for the Muslim populations in Egypt. In 1903, for instance, John Warnock stressed the rarity of female Muslim hashish addictions in Egypt. Warnock, Insanity from Hasheesh, 109. See also: Parant, Review of Warnock, 455. Gervais, however, claimed in 1907 that many Muslim women at the asylum in Aix-en-Provence suffered from a “passion for tobacco” and the consequences of tobacco withdrawal once interned in French asylums. Gervais, Contribution, 56 f.

\textsuperscript{130} Manceaux et al., Héroïnomanie, 294.

\textsuperscript{131} Meilhon, Aliénation mentale, part 4, 40.

\textsuperscript{132} Taïeb, Idées d’influence, 92.

\textsuperscript{133} Assicot et al., Causes principales, 272.
been brought to the asylum in Aix-en-Provence in 1905, was described as an “alcoholic” with “excited periods and hallucinations”. Louis Livet wrote in his 1911 dissertation on “Algerian Mad and their Hospitalisation” that out of 21 female mental patients at the Civil Hospital of Mustapha in Algiers only one was an alcoholic – but because of the overall low numbers of female patients, this still amounted to 5%. In his 1940 dissertation on “General Paralysis in Muslim Natives of Tunisia”, Jean Olry wrote about his experiences while working at the Manouba Psychiatric Hospital in Tunis. He described a 40-year-old widow, “a proven alcoholic (wine, spirits, eau de Cologne)” also suffering from “eroticism” and “claiming men [...].” A second female patient he described had been moved to the Manouba Psychiatric Hospital from the French Civil Hospital in 1936. Her family said that “in her history, one can find ‘teaism’, but no alcoholism”. In a third case study, Olry described another widow, whom he categorised with one word: “alcoholic”. She was brought to Manouba Hospital and her “neighbours were unanimous in asserting her habits of alcoholism”.

The connection between alcoholism and prostitution seemed to have been clear to colonial psychiatrists. Quoting Scherb’s 1905 article on “The Rarity of Nervous Accidents in the Muslim Indigenous Algerian”, the psychiatrist Georges Sicard wrote in his 1907 dissertation that syphilis was widespread among people living in cities, port workers and prostitutes, all of whom were seen as heavy consumers of alcohol. Louis Livet wrote in his 1911 dissertation that “in Arab women, it [alcoholism] is a vice of almost all prostitutes [...].” The same connection was made as late as 1940 by the psychiatrist André Donnadieu, working at the Berrechid Hospital in Morocco.

134 Levet, Assistance, 53.
135 Livet, Aliénés algériens, 66 f.
136 Olry, Paralysie générale, 53.
137 Ibid., 54. “Teaism” was one of the specifically North African diseases that French psychiatrists liked to name and describe. It was thought to be a dangerous addiction, as it affected the work force of the North African populations. On the topic of the colonial medical and psychiatric construct of the particularly Tunisian “addiction to tea”, see: Studer, ‘Was trinkt der zivilisierte Mensch?’.
138 Olry, Paralysie générale, 55.
139 For example: Donnadieu, Alcoolisme mental, 164; Porot, M./Gentile, Alcoolisme et troubles mentaux, 126 f.
140 Sicard, Etude, 12 f. The same quote is mentioned in the 1919 dissertation by Étienne-Paul Laurens about “Nervous Syphilis in Algeria”. Laurens, Contribution, 14.
141 Livet, Aliénés algériens, 66.
142 André Donnadieu suspected in his 1940 article “Mental Alcoholism in the Indigenous Population of Morocco” that “contact with French civilisation” was the reason behind the few cases of female Muslim alcoholics that French psychiatrists observed: “Moroccan women also provide their share [in numbers of alcoholics at the Berrechid hospital], but almost exclusively in the category of prostitutes or domestic servants.” Donnadieu, Alcoolisme mental, 164.
Even in postcolonial times, this connection between addictions and prostitution was regularly made. The Moroccan psychiatrist Ahmed Benabud, for example, wrote in a 1957 article in the *Annales Médico-Psychologiques* about the Muslim hashish addicts he treated at the Berrechid Hospital in 1956. He concluded that of 15 female Muslim cases – compared to 1,252 male cases in the same period –, five were prostitutes while three came from the middle classes.¹⁴³

**Vagrants**

Descriptions of “vagrants”¹⁴⁴ took many different forms and it is difficult to determine what kind of women warranted this classification and for what reasons. One explanation for the low numbers of North African patients in colonial hospitals was that North African families traditionally either kept their insane at home or let them roam the streets as harmless vagrants, who did not need to be interned in the opinion of the Muslim population.¹⁴⁵ Those vagrant females selected to be categorised by the expert opinions of the psychiatrists were the aggressive, the demented and those who behaved in a socially unacceptable way. Consequently, an automatic linking of vagrancy with prostitution and drug addiction occurred very often.

One might also ask whether these women were truly vagrants, homeless and begging in order to survive, or whether there was a cultural misunderstanding behind the French concept of Muslim vagrancy. One can easily imagine women on local pilgrimages, or perhaps Sufi women, who might have been viewed as “holly fools” because of their unorthodox lifestyle, being judged to be home- and friendless by the French colonial authorities, taught that all respectable Muslim women were kept from the view of those who did not belong to their families.

In his 1891 article “General Paralysis in Algeria”, Meilhon quoted patient records from E. Battarel, which were sent to Aix-en-Provence with a patient, a 50-year-old woman “without profession [...].” She was “found in a state of vagrancy by the police service” in Algeria and brought to the Asylum in Aix-en-Provence because of her “mania”, where she was classified as “dangerous to herself and the people around her”.¹⁴⁶ Meilhon also described several cases of female vagrancy in his article on “Mental Alienation in Arabs”: one woman was placed under his observation after having been sent to Aix-en-Provence from a city in Kabylia, where she had been arrested by the police in a “state of vagrancy [...].” In the asylum, she was violent, destroying everything she laid her hands on and hitting other patients and the religious sisters who looked after

¹⁴³ Benabud, Aspects psychopathologiques, 8.
¹⁴⁴ The French terms range from “mendiante” to “vagabonde”.
¹⁴⁵ Desruelles/Bersot, Assistance aux aliénés en Algérie, 581; 593.
¹⁴⁶ Meilhon, Contribution, 391.
them. Another case study was concerned with a woman, described by Meilhon as a 30-year-old “beggar”, who was admitted to the asylum in Aix-en-Provence in 1887. Even though he described her as “docile” in her state of vagrancy, he reported that she suffered from aggressive moments in France: “Agitated, she is malicious, angry, hits her neighbours, rips apart and breaks everything she can reach [...]”.

Jean Sutter wrote about the case of a 20-year-old vagrant, suffering from epilepsy, who had thrown a stone at a child “without motive” and attacked the passers-by who had wished to intervene. “A policeman arrived at this moment and took her with him to the Commissariat, where they found out that she was a woman who had formerly worked as a domestic servant, but who, without employment for several months, had been begging in the quarter where she had been arrested and where she was considered as simple minded.”

Suzanne Taïeb wrote about the case of a 36-year-old vagrant – an “ancienne fille soumise” (former prostitute) – who was arrested in Bel-Abbès, “where she looked for trouble with passers-by in the street, causing a scandal in public; she became menacing and she exposed herself.” She also suffered from “terrifying visions” because of her alcohol addiction. Asked about her “mode of existence”, she admitted to having lived off begging but denied ever having been an alcoholic. Another vagrancy case Taïeb described concerned a female general paralytic. She was “found on the public street” and brought to a general hospital, where she “became agitated, took her clothes off, scratched her face, and became dangerous to other patients.” Taïeb also wrote about a 40-year-old Moroccan woman at Blida Psychiatric Hospital, who seemed to have been a vagrant and was picked up by the police because she tried to dig up bodies, saying “she was happy to see the corpses discovered by digging in the cemeteries [...].”

Demented vagrants were often interned for indecency because they took their clothes off in public. The naked female lunatic, freely roaming the streets of North African cities, seems to have been a colonial anecdote, almost from the very beginning of French colonialism. The military doctor Adolphe Armand, for instance, wrote in his 1854 book “Medical Algeria”: “[...] it is not uncommon to find in the cities or in the ksours [settlements in the countryside] the insane in the most absolute poverty, and sometimes without any clothing. At Constantine, ‘madmen and idiots met in the streets, among other things, I saw two women, said Mr Deleau, one of sixteen to

147 Ibid., Aliénation mentale, part 2, 198 f.
148 Ibid., part 3, 370 f.
149 Sutter, Épilepsie mentale, 151 f. Emphasis in the original.
150 Taïeb, Idées d’influence, 92.
151 Ibid., 122.
152 Ibid., 117 f.
seventeen years, walking absolutely naked.” Armand further claimed to have personally seen one of these naked madwomen in Taouila, a small town in the Algerian Sahara. In his 1926 book on “Ritual and Belief in Morocco”, the Finnish ethnologist Edward Westermarck also mentioned having personally witnessed a naked madwoman: “The saintly lunatic is not held responsible for any absurdity he commits. During my first stay in Fez there was an insane woman who used to walk about in a state of perfect nudity; and when I visited the same town again, after an interval of nearly twelve years, she was still alive and continued her old habit.” Other such cases of Muslim women being brought to the psychiatric attention by their willingness to shed their clothes can be found in the psychiatric texts themselves. Jean Sutter, for example, writing about the cases brought to the University Hospital in Algiers in 1937, mentioned a 28-year-old woman, interned for public indecency. The police “arrested in the street a Moorish woman completely naked, who gesticulated, cried and hit passers-by”. They brought her to the commissariat of police, where it was decided to have her interned.

This nakedness was shocking to the colonial observers, not only because it hurt their own social sensibilities but also because it did not correspond to their notions of how the North African societies worked. One of the most repeated and well-known facts about Muslim female normality in French texts was the veil; therefore, these women broke one of the most important rules among the perceived Muslim customs – the hiding of femininity.

Often mentioned were cases of women not arrested for running naked in the streets, but who insisted on being naked in the asylums. Meilhon wrote in 1896 that a female patient “absolutely wanted to stay naked” and “ripped apart all clothing, no matter whether European or indigenous [...].” Sutter wrote in his 1937 dissertation about four female epileptic patients, whose nakedness seemed to be part of their disease. In the first case, Sutter described a woman brought to the hospital because she attacked a passer-by. She was described as “ripping apart her clothing” and sitting “all naked in her cell [...].” The second patient, openly described as a vagrant, was “probably found ‘ill on a public street’” – and one might ask whether Sutter’s term “voie publique” was a euphemism for a brothel. This woman tried to flee the hospital “all naked [...]”. The third case study concerned a Moorish woman who tried to run

153 Armand, Algérie Médicale, 445.
154 Ibid., 446.
156 Sutter, Épilepsie mentale, 148.
157 Meilhon, Aliénation mentale, part 3, 367.
158 Sutter, Épilepsie mentale, 153 f.
159 Ibid., 155.
away from her parents “entirely naked”, and when they tried to bring her back, she tried to scratch and hit everybody, so that they had to tie her down.160 The fourth case occurred in Oran and was treated by a Dr Camatte – a murder case, in which the perpetrator was a young girl who, for seven months before her crime, had suffered from epileptic crises, in which she stripped naked and ripped her clothes apart.161

2.6.3 Judicial Placement

Psychiatrists were, as already mentioned, the officially accepted experts in judging the responsibility of criminals and were mostly asked for their official reports in murder cases. In 1932 Antoine Porot and Don Côme Arrii claimed that murder and attempted murder cases made up 90% of medico-legal reports: “At first sight, the considerable proportion of attacks [...] is striking, in the judicial statistics, and we can say that nine-tenths of [cases of] expertise [on] natives assigned to overseas psychiatrists relate to murders or attempted murders. The native plays with the baton, the knife or with guns with an ease, a quickness and savagery, which most often cause death. These are, very often, close relatives, father, mother, brother, and especially wife, who are beaten and, in a certain number of cases, there are several victims of the impulsive fury of the murderer.”162 In this passage, Porot and Arrii established the frequency of these violent crimes and repeated the clearly gendered imagery belonging to the roles of perpetrator and victim.

Regarding female Muslim perpetrators, their responsibility was usually questioned in cases of the suspected murder of husbands or of illegitimate newborn children.163 Most often, a verdict of “responsibility”, i. e. of psychiatric “normality”, was given, but the psychiatrists argued that the hard life Muslim women led, as nothing more than “beasts of burden” and “instruments of pleasure”, limited their responsibility, and even normal Muslim women could not be held completely responsible for their actions. One illustration of this can be found in 1883, when Kocher looked at seven cases of murder by poison, all of them committed by women. While the women were all deemed responsible for their actions, i. e. not insane, the sense of them not being completely responsible is tangible in Kocher’s dissertation: “All of these poisonings have been committed by women, against a single person, their husband, be it through jealousy,

160 Ibid., 198 f.
161 Ibid., 206.
162 Porot/Arrii, Impulsivité criminelle, §89.
163 In Islamic law, there was no place for illegitimate children – they had no status, they did not exist. Unmarried women therefore often felt they had no choice but to take drastic measures in order to prevent repudiation by their families. Bousquet, Morale, 62.
or to save themselves from ill treatment, or through the instigation of a lover.” For all three motives, Kocher diagnosed a certain lack of responsibility in female poisoners, arguing that female jealousy was only natural in an environment dominated by polygamy and by the simplicity of getting a divorce; that Muslim women, since they were continually suppressed by their husbands, were prone to take drastic action; and that, though it was morally reprehensible to have a lover, the responsibility for the murder surely rested with the instigator, not with the woman who had been pushed to extremes.

One of the most detailed case studies about a female Muslim patient concerned a woman accused of infanticide, as reported by Don Côme Arrii in his 1926 dissertation, which he based on notes taken by Antoine Porot. He stated that on the 15th of January 1925 “the cadaver of an infant, born at term” was found, “who had been breathing and who carried clear signs of strangulation”. The inquest found a 20-year-old woman, living just 200 metres from where the body was found, who had given birth two or three days before. She confessed, but accused a neighbour, “an old man”, of having raped her and said that his wife, who had helped her with the birth, had taken the child with her. In prison, she showed signs of “rather tumultuous nervous disorders” and a “mental assessment” was ordered, which Antoine Porot gave in court. Once in prison, overwhelmed by the internment, she had what Porot called a “crisis of maniac excitation”, with manifestations of hysteria, where she hit and “even bit” other inmates. “She screamed, sang […] ; she demanded men be brought to her, she took her clothes off, threw herself on the floor, writhed, with haggard eyes, or indulged in obscene gestures […]. At other times she fell into a lethargic attack, pretended to be dead, threw the people around her into a panic, and, at the moment when they approached her, jumped at the throats of her neighbours.”

She only calmed down once her parents had been to see her, bringing Porot to the conclusion: “Still, she does not seem unintelligent to us, she does not have the facial expression of an idiot. There is, in her silence, more reluctance than incapacity to answer and we do not think that her intellectual level is much lower than that of the subjects of her race, her age and her condition.” But she was not insane, for Porot concluded that “she was not in a state of dementia at the moment she committed the crime of infanticide, [which] she is accused of. But she presents a light

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164 Kocher, Criminalité, 126.
165 Arrii, Impulsivité criminelle, 84.
166 Biting people was, as Meilhon assured his readers in his 1896 article, a widespread characteristic of alienated Arabs. Meilhon, Aliénation mentale, part 2, 196.
167 Arrii, Impulsivité criminelle, 85.
168 Ibid., 86.
degree of mental debility and of hysteric imbalance, likely to attenuate her responsibility slightly.”\textsuperscript{169}

Another medico-legal court report was written by Jean Sutter in 1937, concerning an epileptic woman accused of having murdered another woman by cutting her throat.\textsuperscript{170} The victim died in hospital a few days after the attack, having told a judge who had attacked her.\textsuperscript{171} Accused of homicide, the woman accused her mother of having been the perpetrator before finally confessing,\textsuperscript{172} but she demanded “indulgence” for herself, saying “she did not know what she was doing [...].”\textsuperscript{173} The girl was finally brought to the University Hospital in Algiers, where Sutter himself examined her. He concluded that she was an epileptic with strong epileptic impulsions, characterised partly by her violent attacks on people around her. The young woman “did not always fully enjoy her mental faculties; her responsibility is inexistent regarding the crime she is charged with, because, in the absence of witnesses, it [the crime] seems to have been committed after a crisis or the equivalent of an epileptic attack [...].”\textsuperscript{174} In his opinion, the murder had been committed while the young woman was in either an epileptic crisis or following a post-epileptic impulsion – which seems bizarre, considering she probably took the murder weapon, a razor, with her while showing the victim around. However, Sutter also said that the accused, “through her violent actions, is capable of compromising public security; she is therefore dangerous. We estimate that it would be best to place her in an establishment for the alienated and to leave her there, locked up until the day her mental state appears sufficiently healed to suppress the dangers which she poses at the moment.”\textsuperscript{175}

\textbf{2.6.4 Exceptions}

In addition to these three official mechanisms of admission, for which the patients’ consent was not needed, there were also other ways and reasons for women to be treated by French psychiatrists. One of them was the aforementioned concept of “voluntary admission” or “free entrances”, requested not by the family but by the patient. This only happened from the 1940s onwards and only seems to have occurred with middle

\textsuperscript{169} Ibid., 87.
\textsuperscript{170} The medico-legal report upon which he based this case study was by a Dr Camatte from the psychiatric service of the Civil Hospital in Oran.
\textsuperscript{171} Sutter, Épilepsie mentale, 204.
\textsuperscript{172} Ibid., 205.
\textsuperscript{173} Ibid., 206.
\textsuperscript{174} Ibid., 208.
\textsuperscript{175} Ibid., 208 f.
class women. Another means of entrance entailed some patients being brought to mental hospitals from other hospitals, to which they had previously been admitted for physical problems only. Once in the hospital, doctors sometimes detected mental problems, which made their relegation to a psychiatric asylum necessary. Antoine Porot, quoting article 6 of the instructions from the Governor-General of Algeria at the time, Carde, from the 10th of August 1934, mentioned that all sick people who “accidentally presented mental troubles” should be brought to the psychiatric hospitals.

There were also individual cases which did not fit into any of the sanctioned patterns of admission. One example concerned a young Muslim woman that Antoine Porot had met in 1912 in Tunis, and whom he brought to his hospital, which at that time was reserved for European patients, the French Civil Hospital. This woman was the only Muslim patient there, and would remain the only Muslim patient in a French psychiatric hospital in North Africa until the building of the first asylum on North African soil some 20 years later. In this case, the motive for the impromptu institutionalisation was pity for an individual who was seen as a victim, without any criminalisation implied – if anything, Muslim society was criticised for not offering other possibilities for compassionate care in such cases.

2.7 Criticisms of Admissions

In the processes of institutionalising Muslim psychiatric patients, the focus clearly lay on security and order. Those patients interned were perceived to threaten both the safety and the decorum of the French settler societies in North Africa. This resulted in a selection that, administratively speaking, excluded more easily controlled, more easily “mastered” potential patients, like the allegedly meek Muslim women. L. Couderc, for example, lamented in 1961 that “there is a paradoxical selection of admission: calm patients, women, who are often easier to keep at home, rarely benefit from priority of admission; relatively older patients, who seem less dangerous, are often systematically dismissed from the mental hospitals.” Instead of admitting governable and curable

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176 It seems that this rise coincided with the establishment of asylums on North African soil. The fact that the patients were no longer brought to another country, away from their friends and families, seems to have attracted a certain clientele of voluntary patients. However, among the published case studies, no voluntary admissions of female Muslim patients can be found.
177 Carde, Jules Gaston Henri, Instruction, Article 6. As quoted in: Porot, Services hospitaliers, 798.
178 Ibid., Tunisie, 58.
179 See also: Meilhon, Aliénation mentale, part 1, 25.
180 Couderc, Conséquences, 254.
patients, the mechanisms of admission favoured the most challenging group among
the colonised populations – dangerous young men, who were seen to pose difficulties
to both the budget and the security of the psychiatric institutions.

While all male North Africans were frequently criminalised in the psychiatric
writings of the time, the same theories stressed that Muslim women, with their passive
femininity and lack of agency, could not be criminals. Nominally, therefore, nothing
pointed to a definition or classification of female Muslim mental patients as criminals,
but, as shown, the selection of female patients – which was not based on medical
criteria but on those of public order and prevention of crime – caused exactly such a
criminalisation, which explains why so few women were voluntarily brought to the
attention of French psychiatrists. Paradoxically, French psychiatrists were convinced
that Muslim women could not be de facto criminals, but the end result of the patient
selection was that most of their institutionalised female patients were criminalised to
some degree. Through their lack of awareness, colonial psychiatrists failed to notice
that this criminalisation deterred Muslim women and their families from contacting
them and requesting their help in cases of mental disorders.

However, colonial psychiatrists criticised these different mechanisms of admission
on several levels. The most general complaint, voiced by Antoine Porot in 1943 for
example, was that voluntary admissions were rare and that “administrative placements”
were “applied often with excessive rigour [...]”\textsuperscript{181} Others claimed that the neglect of
voluntary treatment, in favour of internment by official institutions, falsified their
colonial accounts. The abundance of violent Muslim patients, for instance, noticed by
so many of the psychiatrists responsible for colonial patients in France, was explained
by Abel-Joseph Meilhon in 1896 in terms of this skewed selection mechanism, as the
administration was only contacted after potential patients had already committed
a violent act. Meilhon concluded that this specific selection, caused by the focus on
security, made “the alienated Arab in general seem so dangerous to us [...]”\textsuperscript{182}
Though emphasised by Meilhon in his important text for French colonial psychiatry, the
selection of Muslim patients remained highly problematic during the colonial period.
Almost 50 years later, Charles Bardenat still insisted that “in hospital statistics, the
proportion of dangerous patients tends to seem stronger, relatively, among the natives.”\textsuperscript{183}

However, by far the biggest criticism of the admission mechanisms was the ques-
tion of who possessed the authority to decide on admission into colonial psychiatric
care. Meilhon, for instance, claimed in 1896 that Muslim patients could be admitted
to a psychiatric institution after “scenes of violence” “on the grounds of a simple

\textsuperscript{181} Porot, Œuvre psychiatrique, 362.
\textsuperscript{182} Meilhon, Alienation mentale, part 2, 178.
\textsuperscript{183} Bardenat, Criminalité, 319.
police report” – without the involvement of a psychiatric expert. This outrage at their profession being sidestepped by other groups endowed with colonial authority can be found in many other texts. Bouquet, for example, wrote in 1909 that “the arbitrariness of the police, the goodwill of a doctor who possessed no special power alone regulated the question of admissions and releases.” While Bouquet’s concern was generally directed at the wellbeing of patients and the involvement of non-experts in the processes of psychiatric selection, other psychiatrists were more specific in their attacks. In the same year, Levet stressed that the general nature of the terminology of disorders in the patient records, delivered with the patients shipped to Aix-en-Provence from the Civil Hospital of Mustapha in Algiers, proved that the initial diagnosis could not have been conducted by specialists. He smugly stated that “this formulation indicates clearly a doctor foreign to mental pathology.” Clearly, in the eyes of many colonial psychiatrists, this involvement of non-experts was to blame for the one-sided selection of patients.

Finally, a third, more general cluster of criticism focused on the idea that the system of admission in North Africa was hopelessly outdated and that French colonial psychiatrists were therefore prevented from working to the best of their abilities by unprofessional regulations. This criticism is expressed in the following quote by Henri Aubin, taken from his paper on the “Native Psychiatric Assistance in the Colonies” at the 1938 Algiers Congress: “Thus, in Algeria, an outdated text demands, for the internment of a patient in Blida [...], a report by the Police Commissioner, supported by the written statements of witnesses; practically, these [witnesses] are the nurses of the Service... who thus control their own head of service.” Aubin therefore objected to the “outdated” restriction on psychiatric authority in the mechanisms of institutionalisation by those most directly involved in the everyday treatment of patients.

Psychiatrists strongly disagreed with the system of admission in place in colonial North Africa, mainly because it interfered with their efforts to compile objective statistics and because their professional expertise and authority was seemingly not valued enough. The stigmatisation of institutionalised female Muslim patients, however, remained unnoticed.

If Muslim women were admitted because of complaints from their families or neighbours, they were classified as dangerous. They had usually physically attacked family members or neighbours and often uttered death threats, which the colonial authorities took very seriously, not least because this contrasted so deeply with their picture of normal Muslim femininity. If they were questioned by the police and

184 Meilhon, Aliénation mentale, part 1, 28 f. See also: Woytt-Gisclard, Assistance, 165 f.
185 Bouquet, Aliénés en Tunisie, 46.
186 Levet, Assistance, 55.
escorted to a hospital, they were almost always defined as vagrants, addicts or prostitutes. This over-zealous reaction to prescribe a criminalising classification to women in asylums compounded the stigma of the involvement of the police, who were often called in because of physical violence committed on the streets. Due to the criminalisation of the “administrative placement” – which meant being arrested for violence or indecency in a public place, picked up by the police and classified as immoral –, the stigmatisation caused by colonial psychiatry could hardly have been greater. Finally, if Muslim women came to the attention of French psychiatrists through court cases, it was mostly as soon-to-be-condemned murderers.

The mechanisms for admission into colonial psychiatric care did not reflect an unaugmented desire to care for patients or to cure a mental disease, but rather official condemnation. Muslim families had realised that only women recognised as too dangerous or immoral for the supervision of their own families would be admitted into colonial care. Indeed, the admission processes seemed to almost eliminate all placements for purely medical reasons, while those women who were admitted were stigmatised for life, even if they had been admitted for other reasons, as shown by the criminalisation of possibly harmless vagrants. No family, if they could help it, would therefore seek to have their female family members admitted to the charge of colonial psychiatry. With male patients, the situation was slightly different; North African men were already criminalised as a whole and could not be stigmatised much further by the additional criminalisation of admission processes. Men also had other ways of being admitted to colonial care, for example because of the complaints of employers.

Arguably, French psychiatrists used this criminalisation of Muslim female patients through the admission processes as a means of determining which of the Muslim women they encountered were sane or insane. As discussed in Chapter 1, it was difficult for French psychiatrists to differentiate between normality and abnormality due to the strangeness that normal Muslim women embodied for them. The conclusions drawn from their experiences with female Muslim patients did not change their picture of female normality – they still maintained the idea that no Muslim woman was violent or criminal. Even without acknowledging it, their experiences with often

188 This contrasted not only with colonial notions of femininity but also with Muslim ideals of what women should or should not be.
189 The psychiatrist Pierre Maréschal wrote in 1956, summarising his twenty years of practical experience in Tunisia: “Afraid of what people would say, for fear of the stigma that plagues the insane and prevents girls of the family from marrying […], the insane are not directed to our consultations at the beginning of their illness.” Maréschal, Réflexions, 69. As already mentioned, this stigmatisation by psychiatry has also been noted in Arab countries in postcolonial contexts, especially in ruining marriage prospects for Muslim women. For example: Al-Issa/Al-Issa, Psychiatric Problems, 21; Al-Krenawi et al., Ethnic and Gender Differences, 48.
very violent Muslim women in the psychiatric asylums and institutions reinforced those differences between normality and abnormality. With only the female Muslim “insane” being able to react in an aggressive, immoral or even criminal way, it was much easier to determine who was insane and who was not. “Normal” Muslim women were, as described above, “de-criminalised” as far as possible. Consequently, the contrast between this construct of “normality” and the institutionalised patients must have been overwhelming.