Beyond the Asylum: *Colonies agricoles* and the History of Psychiatry in French Indochina, 1918-1945

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In 1905, Dr. Edouard Jeanselme, a professor of medicine in Paris and expert in tropical diseases, took a study trip to the Far East, traveling to Thailand, Java, Burma and Singapore. He sought inspiration for a model of psychiatric care that could be successfully introduced in French Indochina, which at the time possessed no mental health system of its own. Jeanselme joined a growing chorus of voices who criticized the rudimentary state of mental health care in the French empire as compared to other colonial powers whose own programs were thought to be “growing more and more refined everyday.”¹ During his trip, Jeanselme made special note of the asylum system in Java, at Buitenzorg, where in 1881 the Dutch had converted the entire asylum into a massive agricultural colony. Writing in the _Presse Médicale_ on his return home, Jeanselme marveled that despite the absence of any restraint or coercion, there had been “no suicide, murder, or even escape, meanwhile the asylum is not enclosed by walls.”²

Buitenzorg represented the first systematic application of this kind of care, premised on the idea of labor as therapy, to a colonial setting. For French psychiatrists in Indochina who saw in neighboring Java fundamental ethnological and geographical similarities, it signified the prospect of incorporating many of the same elements within the colony's first asylum, Bien Hoa, which finally opened in 1919.

The Dutch experiment at Buitenzorg was part of an international flourishing of agricultural colonies and other forms of “open door” care that spread throughout France, England, Belgium and Germany, as well as to the United States, Canada, Argentina, Japan and Norway in the late nineteenth and

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¹ Edouard Jeanselme, “La Condition des Aliénés dans les Colonies Françaises, Anglaises et Néerlandaises d’Extrême-Orient,” _La Presse Médicale_, 9 August 1905. In 1912, this article was presented to the Conference of French and Francophone Alienists and Neurologists in Tunis. All translations from the French are by the author.

² Ibid.
early twentieth centuries. The establishment of these colonies agricoles, or small farms attached to psychiatric hospitals, first emerged in Europe as a response to broader calls for psychiatric reform dating from the mid-nineteenth century. With mounting concerns over asylum overcrowding and accusations of patient negligence, psychiatrists began to experiment with alternative forms of patient care that relied on new uses of space and the environment; instead of chaining or isolation cells, psychiatric reformers argued that putting people to work in the fields, in the open air, would be more humane and therapeutically effective.

At the heart of discussions about the uses of labor as therapy was actually a much older idea rooted in anti-urban discourses and a vogue for experimental farms dating from the early 19th century. The first colonies agricoles were introduced in France as rural outlets for a revolutionary urban underclass and as penal colonies for orphans and juvenile delinquents, including the famous colony of Mettray. Early discussions about the colonies were marked by a condemnation of urban, industrial society and a countervailing valorization of the countryside as a site for the restoration of authority, order and social discipline. Reformers embraced these agrarian utopias but for reasons that went beyond an appreciation of their aesthetic or romantic qualities. As the French historian Ceri Crossley writes, “Rurality was not so much emblematic of an earlier, simpler world as constitutive of a passive citizenry. This was not the countryside as escapism: agricultural work – with religion in support – was understood as a process of socialization.”

As a model of “socialization,” the agricultural colony was premised on a set of distinctions between urban and rural life that guided psychiatric reformers in their efforts to rehabilitate abnormal populations. In contrast to the disorienting effects of city life, the agricultural colony would instead provide patients with a “life out of doors” and a daily routine structured around principles of regular exercise and discipline, a reorganization of the external social world would produce a reordering of the interior private one.

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This paper examines how French psychiatrists in Indochina reimagined the relationship between rural spaces, inner character and productive work in the everyday life of the colonial asylum. Drawing on a rich psychiatric discourse in the metropole about the virtues of patient employment, and lessons learned from their study trips to Java, experts in Indochina designed the colony’s two asylums as large *colonies agricoles* where patients could work the land on the path to healing and eventual liberation. In spite of its early origins, the agricultural colony seemed to offer colonial psychiatrists a modern conception of psychiatric care that promised not only “cerebral hygiene” and discipline through physical labor but also, in simulating the appearance of freedom and normal life, a kind of moral re-education. Agricultural colonies could also yield significant financial and administrative benefits to the asylums themselves. Annual asylum reports reveal the ways in which colonial psychiatrists framed the therapeutic and economic imperatives for labor, and how they came to articulate a vision of psychiatric rehabilitation that blurred the distinctions between patients and laborers, between spaces of confinement and release. In simulating real life outside the walls of the asylum, the agricultural colony was designed to create a kind of continuity between the discipline of institutional order and social life in the community. In so doing, it provided patients with a path to rehabilitation and colonial psychiatrists with the challenge of articulating a vision of what the aims and forms of this kind of rehabilitation should look like.

In 1918, French officials constructed Indochina’s first asylum, Bien Hoa, thirty-four kilometers outside Saigon. Deliberately situated on a small river that traversed its grounds and provided irrigation to gardens and crops, the asylum occupied sixty-five acres of land: forty-three acres dedicated to agricultural exploitation surrounded a compound of thirty-four buildings including patient lodgings or “pavilions” segregated according to race (including both Vietnamese and European patients), gender and severity of diagnosis. Each pavilion at Bien Hoa was arranged on its own large plot, surrounded by plants, flower beds and some trees. Iron rails masked by live hedges separated the pavilions one from the other, with the entire group of asylum buildings also enclosed in the same way. Psychiatrists organized asylum life around these open spaces so as to simulate the social world and provide patients with a kind of “semi-liberty” and “comfort in freedom previously unknown.” Not only did this reflect a more modern and more humanitarian conception of care than earlier methods of confinement – one that proved useful in improving the poor public image of the asylum – but the “appearance of freedom” itself was seen as curative. Yet patients laboring in

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6 Peyre, 1934.
the open air also exacerbated the practical challenges of maintaining order and discipline in the asylum, both inside and out.

As soon as they had “sufficiently improved,” patients were sent to work. The fact that the majority of patients in Indochina were already farmers lent optimism to colonial psychiatrists who insisted on the special therapeutic value of agricultural labor.\(^8\) It was seen as an important factor of “cerebral hygiene” on account of its physical, outdoor qualities and for the impact of repeated movements on the motor skills of the brain. The act of gardening, in particular, was thought to yield valuable results, demanding constant and meticulous attention. Left idle, as one psychiatrist warned, patients’ physical degradation would only accelerate their psychiatric degradation. Instead, labor would “channel” the unutilized energy of the insane for more productive ends.\(^9\) One asylum report from 1931 thus framed patient labor as “indispensable for the organism, a method of physical education which is to be valued above all others. The distraction it creates works against ideas that are obsessive, melancholic or depressive. It withdraws the patient from a delirious world and restores him to a sane reality.”\(^10\)

In terms of who would provide the labor, it was up to the discretion of the asylum director to assign patients to any one of several labor activities based on their “professional and physical aptitudes, as well as their type of psychosis.”\(^11\) In making their assignments, asylum directors adhered to a typology of work choice, developed in the metropole, in which patients, depending on their diagnosis, were thought to derive a certain kind of benefit from certain kinds of work. Labor in this way was transformed into a kind of therapeutic agent that asylum directors prescribed and whose effects they were able to observe and measure. Indeed the language used by one asylum director in 1933 displays a medicalization and rationalization of work choice that stands in sharp contrast to former methods of treatment, “From a medical point of view, work constitutes a powerful distraction and an excellent method of treatment that is easily implemented. Methodically organized, bien dosé (“well dosed”), and judiciously applied to able-bodied patients, it avoids the sad spectacle of those who are idle,

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\(^8\) The belief that most patients were previously employed farmers was not based on vague impressions. Rather psychiatrists kept detailed records on every patient that entered the asylum that included their race, age, gender, home province and criminal background as well as their profession prior to entry. These records were compiled and analyzed in annual asylum reports. The occupation of “farmer” was, by far, the most consistently cited. See, for example, “Repartition par Profession,” Rapport annuel de Bienhoa, 1926, Goucoch, IA.8/2912(1), TTL2.

\(^9\) Rapport annuel de Bienhoa, 1926, Goucoch, IA.8/2912(1), TTL2.


crammed into rooms or wandering in the corridors.”\textsuperscript{12} This categorization of work choice represented a natural addition to asylum life organized around the principles of division and separation. For patients already classified into different pavilions based on their race, gender and form of psychosis, work assignments easily followed.

In their annual reports, asylum directors quoted widely from international conferences and studies that heralded labor practices as the universal standard of psychiatric treatment. However, these findings only went so far as to support the uses of labor for the indigenous populations of Cochin China on account of the perceived special vulnerabilities of Europeans to the local climate. As a result, asylum directors complained about the European patients who, segregated in their own pavilions, “currently do nothing and pass the days smoking, resting sprawled out, it is necessary to create for them some sort of occupation.”\textsuperscript{13} Instead physical education took the form of outdoor leisure activities in the practice of sports like tennis, swimming and other games “in the open air.”\textsuperscript{14}

Patient employment was considered as much a form of “cerebral hygiene” as it was a kind of moral re-education, which, psychiatrists hoped, by approximating the habits of ordinary life, would better prepare patients for life outside the asylum. For asylum directors, outdoor work proved useful in preventing the patient from becoming “absorbed in false ideas” and experiencing mental degeneration but also in warding against those “habits of laziness which, in the case of cure, would be deplorable for him and for society.”\textsuperscript{15} This notion of “inactivity” formed a major preoccupation that bled concerns over psychiatric treatment into broader anxieties about the social organization of indigenous life and the development of a productive local labor force. A 1931 study on mental illness in Indochina, for example, reported that men between the ages of twenty-six and thirty, in the prime of their working years, experienced the highest rates mental illness in the colony. The psychiatrist who authored the report, a former director of the Bien Hoa asylum, worried in particular over the high rates of alcohol and opium consumption among youth men, observing that “the native lives life in the fast lane.”\textsuperscript{16} He lauded the agricultural colony, which promoted the inculcation of rigid bodily discipline and values of hard work, as a powerful model for behavior by way of contrast.

\textsuperscript{12} Rapport Annuel de l’Asile d’Aliénés de Bienhoa, 1934, Inspection Generale de l’Hygiène et Santé Publique, 50-03, TTL1.
\textsuperscript{13} Rapport Annuel de Bienhoa, 1925, Goucoch, IA.8/281(2), TTL2.
\textsuperscript{14} Rapport Annuel de Bienhoa, 1927, Goucoch, IA.8/2912(3), TTL2.
\textsuperscript{15} Rapport Annuel de Bienhoa, 1925, Goucoch, IA.8/281(2), TTL2.
\textsuperscript{16} Etiologie des psychopathes par Dr. Augagneur, 1931, BIB AOM, 12391, Achives Nationales d’Outre Mer (ANOM), Aix-en-Provence, France.
Even for those with no hope of cure, psychiatrists believed that approximating the habits of ordinary life would serve a kind of harmonizing function. Part of the ambiguity around the use of therapeutic labor derived from the fact that a cure was not the only or even necessarily the primary goal, indeed for some chronic patients a full recovery was considered impossible. Rather psychiatrists believed that the sense of accomplishment and confidence a patient derived from finishing a task, no matter how minor, represented a “precious moral benefit” which fought against the more harmful and destructive symptoms of mental illness. Earlier beliefs about the uses of labor to occupy and distract thus became re-framed in the 1930s as no longer the most important outcomes of therapy. Instead asylum care increasingly concerned itself with the “attempt to readapt the patient. This re-education must interest the patient and awaken his initiative. For this goal we must do what we can to guide him, and reward him when he is finished.”

Agricultural labor, as well as work in ateliers or workshops, therefore not only helped to promote a kind of psychiatric rebalance but also to arm patients with those professional skills that would allow them to secure work after their release. Psychiatrists recognized that patients who left the asylum often needed special guidance during the first period of transition back to normal life. They therefore recommended the creation of a special form of social assistance specifically designed to help patients once they left the asylum. One proposal even suggested the creation of a kind of “village of transition” adjacent to the asylum where a number of patients could live in simulated families and learn how to live independently on the path to full emancipation.

Embedded in the discourse on re-education was a colonial vision of what normal social life should look like. The internal organization of the asylum – from the segregation of pavilions along racial criteria to the strict schedule of daily labor, even the meals provided to different classes of patients – reflected a particular vision of colonial order aimed at patients on their journey from confinement to release. This order reflected not only assumptions about the racial hierarchy of colonial life but also came to be inflected with class-based notions about the distribution of labor. Europeans did not labor but neither did the members of the Vietnamese bourgeoisie who came to occupy the old European wing when a “paying service” for indigenous populations was

18 Rapport Annuel de Bienhoa, 1926, Goucoch, IA.8/2912(1), TTL2.
20 Rapport au sujet de la création d’un asile colonie sur le terrain de l’Asile de Voi par Dr. Grinsard, 5 June 1937, Résidence Supérieur du Tonkin Nouveau Fonds, ANOM.
inaugurated at Bien Hoa in 1934.\textsuperscript{21} The ways in which the agricultural colony obscured the distinction between life inside and outside the asylum held the key to the therapeutic promise, and rehabilitative potential, of this model of care. At the same time, its capacity to blur boundaries between spaces of freedom and spaces of surveillance, between patients and laborers, introduced fundamental ambiguities into the meaning of “freedom” and treatment in the everyday practices of the colonial asylum.

Economic productivity, meanwhile, was not an incidental but desired outcome of this kind of therapy. Concerned over how best to finance the asylum’s expansion as patient numbers grew at an alarming pace, colonial officials proposed the asylum generate its own revenue given the “abundant labor force put at its disposition.”\textsuperscript{22} In order to offset the mounting costs of confinement, asylum directors decided to transform the scale of agricultural labor from simple self-sufficiency into a genuinely expansive revenue generating operation that targeted urban markets. Following asylum directors in France who had come to favor more intensive forms of cultivation, ensuring year-round harvests, colonial psychiatrists in the mid-1920s also called for the diversification and escalation of crop production,

Until now, we have cultivated rice, tobacco, cassava root and potatoes. These are crops that demand little time and little care because once seeds are planted there is nothing to do but wait. On the other hand, gardening fresh vegetables for market requires many cares, the preparation of the land, planting of seeds, watering twice a day, weeding out of harmful herbs, putting into place protective foils, garden stakes, etc. It is in this sense that we plan the extension of future works.\textsuperscript{23}

Preliminary attempts to expand the annual harvest yielded promising results. Seeds imported from France – including varieties of lettuce, cabbage, carrots, celery and watercress, as well as green beans from Dalat – were tested in order to prove which would provide a “sure output.” In addition, “thanks to the dam installed during the dry season on the Suoi river which traverses the asylum, we have at our disposal an abundance of very clear and pure water which allows us to grow vegetables without any danger to the consumer.” Asylum directors proposed the sale of vegetables on a subscription basis to colonial settlers and bureaucrats, as well as to shopkeepers in Saigon, in order to establish an “easy

\textsuperscript{22} L’Inspecteur Général de l’Hygiène et de la Santé Publiques à Monsieur le Gouverneur Général de l’Indochine (Direction des Affaires Économiques et Administratives), 30 June 1936, Résidence Supérieur du Tonkin Nouveau Fonds, 3678, ANOM.
\textsuperscript{23} Asylum Report de Bienhoa, 1925, Goucoch, IA.8/281(2), TTL2.
flow of all quantities of vegetables.” The sale of fresh vegetables at the Saigon markets, estimated at 600 piastres per year, would join with the proceeds from the sale of rice and tobacco, rubber, pork, basket making and weaving, projected to total an additional 3100 piastres. Patients would not only receive more fresh vegetables above the normal ration but the expansion would also create a critical revenue stream for the asylum that could be used to purchase machines for the ateliers, improve agricultural tools, increase the indemnity given to patients upon release and assure supplementary funds for special holidays. As one French psychiatrist remarked, “Happily the labor force of the asylum works well. Without it, the upkeep and repairs would represent an important loss.”

By 1934, nearly a third of all patients were kept busy performing tasks associated with every aspect of the daily running of the asylum: from the harvesting of rice and vegetables for meals, to the construction and painting of new pavilions, laundry and the sewing of patient clothing, making baskets, husking rice, manufacturing bricks and the production of latex. To give a sense of the massive scale of the work, the annual rice harvest grew from 1,800 kilograms in 1924 to almost 7,000 a decade later. Crops were also diversified to include 12,000 tobacco plants, nearly 1000 rubber trees, 50 lemon trees, evergreens, and coffee plants, covering two acres of forest.

The organization of patient labor also proved remarkably efficient. For example, in order to remedy the persistent problem of patients sleeping on the floor, in 1932 it was decided that patient-laborers would construct a number of new beds out of wood. Teams were formed under the direction of the guards and a carpenter and the work was divided into specialized tasks with some sawing the boards to size and others charged with planing the wood for a smooth and even finish. The planks were then passed to assembly teams who would adjust the size of the feet and the frame. In a matter of days, they had managed to build two hundred beds. If purchased locally, the price of the beds (including transport costs) would have come to 5 piastres each. Using their own labor force, asylum directors were therefore happy to learn that they had procured more sturdy beds for half the cost.

24 Ibid.
25 The piastre de commerce was the silver-standard unit used by the French in Indochina between 1885 and 1952. In 1930, the piastre was pegged to the French franc at a rate of 1 piastre to 10 francs.
In their annual reports to the colonial government, asylum directors attributed their therapeutic successes in overwhelming measure to the *colonies agricoles* and requested funds for continued land acquisition in order to provide expanded employment opportunities for patients.\(^{29}\) While acknowledging the financial benefits of the practice, asylum directors also routinely insisted that the organization of patient labor was for medical purposes first and foremost and that in no circumstances were patients coerced into working. Throughout the 1920s and 1930s, colonial psychiatrists stressed that only those “able bodied and voluntary lunatics” who requested to participate were eligible for work outdoors. They even framed work as something that was actively pursued by the patients themselves who had come to appreciate its medical value. One psychiatrist, for example, noted that when therapeutic labor produced an improvement, no matter how slight, the patient would “demand to know the kind of work with which he was to be entrusted.”\(^{30}\)

This insistence by directors on the entirely voluntary nature of asylum labor, however, belied the actual use of a range of persuasive and coercive measures to encourage patients to work. In 1921 a decree mandated that those interned at the asylum would receive a *pécule* or two cents a day in compensation for their labor. One half would be given to the patients directly each Sunday to purchase cakes, sugar, cigarettes, and other goods that were subject to official approval. The other half would be noted in individual registers and returned to the patient following their release from the asylum. Three cents would also be reserved from weekly wages in order to cover the costs of food.\(^{31}\)

As a source of “precious encouragement,” the *pécule* clearly succeeded: “As soon as they are able, improved patients are submitted to work therapy. No difficulty here; on the contrary, work is solicited because it is compensated.”\(^{32}\) Asylum directors would also encourage patients to work in teams by giving those with the best results supplementary rations of tobacco, fruits and cakes.\(^{33}\) Asylum administrators did not shy away from using a range of techniques to encourage patients to work. In a 1926 report the director of Bien Hoa noted that,

Labor is, moreover optional, any patient who does not want to work is left at the pavilion. While they are laboring if the patient stops himself and does not work anymore the guards have been ordered to not force him to

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\(^{29}\) Rapport annuel de 1934 sur le fonctionnement du Service de l’Assistance Médicale de Bien Hoa, Sai Gon, Bac Lieu, Inspection Général de l’Hygiène et de la Santé Publique, 51-07, TTL1.

\(^{30}\) Rapport Annuel de Bienhoa, 1926, Goucoch, IA.8/2912(1), TTL2.

\(^{31}\) Indemnité allouée aux internés de l’Asile ‘Alienes de Bien Hoa, 1934, Goucoch, 3731, TTL2.


\(^{33}\) Rapport Annuel de Bienhoa, 1926, IA.8/2912(1), TTL2.
work. They should find out if he is tired, in which case he is brought back to the pavilion, if not they are to wait to see if he would like to take up his task again. Ordinarily this pause does not last for long, the patient being encouraged by the other companions of his team.\(^{34}\)

How to balance the directives for labor, framed at once as an important benefit to the individual and to the institution, with the ostensibly voluntary nature of patient employment presented a challenge to colonial psychiatrists. In many ways, the art of convincing rather than forcing the patient to work emerged as the most suitable strategy. The asylum personnel were charged with this important yet "delicate" task of navigating the different impulses of patient care around both a firm discipline and compassion. As one asylum director explained, “To win the confidence of the patient in order to then direct him, to order him in such a way as to think that the direction and order are in his interest, is an often difficult task that requires much patience and devotion.”\(^{35}\) However the fact that the guards themselves often participated in the manual labor of the asylum alongside their charges and benefited from its revenues complicated their use of authority to encourage patients to work. Asylums also often hired back a number of patients as coolies who were deemed “cured” and ready for release but did not have families to return home to. Such an arrangement allowed these patients to continue to be an object of surveillance yet in their new role as “coolies” they were also entrusted with the supervision of labor and the exercise of the surveillance of other patients at night.\(^{36}\) The fluidity of these hierarchies within the asylum's walls worked to disrupt ideas about what it meant to be a patient and what it meant to be an employee, as well as the notion of labor itself as a therapeutic strategy reserved for the sick.

While some patients required encouragement to work, psychiatrists wondered at those patients who “work with an activity and conscientiousness truly astonishing in a country where work at a slow pace is the norm” and often remarked on their “punctuality, tranquility and silence.”\(^{37}\) In one instance, the labor of ten patients was thought to have resulted in an output superior to that of the work of twenty coolies.\(^{38}\) A 1925 report admitted, “It would seem paradoxical to claim that we find less difficulties with the patients than we would with another labor force” for “certain patients work with a real care and enjoyment.” The ability to work also emerged as a major prerequisite for release and constituted critical evidence of improvement of the patient's condition. Those who were viewed as uncooperative were much less likely to be considered cured.

\(^{34}\) Rapport Annuel de Bienhoa, 1926, Goucoch, IA.8/2912(1), TTL2.

\(^{35}\) Rapport Annuel de Bienhoa, 1927, Goucoch, IA.8/2912(3), TTL2.

\(^{36}\) Rapport Annuel de Bienhoa, 1923, Goucoch, IA.8/281(2), TTL2.


\(^{38}\) Rapport Annuel de Bienhoa, 1926, IA.8/2912(1), TTL2.
and ready for a return to normal social life. Indeed the inability or unwillingness to work was often cited as a reason to reject requests for release initiated by family members or by the patients themselves.\textsuperscript{39}

Located on the margins of asylum grounds, the agricultural colony signified the last step in patient recovery and re-entry into normal society. By drawing our attention to those liminal spaces between confinement and release, the history of the agricultural colony demonstrates the fluidity of abnormality as an object of medical knowledge – a state that could be cured or at least improved through rational treatment – and as part of broader French debates over what kind of subjects the colonial state sought to mold. Colonial scholars have written extensively on the proliferation of the ‘agricultural colony’ model throughout Southeast Asia as penal colonies for political prisoners, reformatories for paupers and juvenile delinquents, and as sites for the occupational training of poor white settlers.\textsuperscript{40} Yet the use of labor as a kind of medical intervention, as a way not only to discipline the body but also to recalibrate the mind, has been largely overlooked in the historiography. This paper argues that agricultural colonies for the “psychiatric re-education” of the insane both intersected with, and departed from, these imperial visions for social reform in important ways, most crucially by introducing an explicitly therapeutic element into the justifications for state organized labor. Yet the discourse of patient freedom and work therapy, premised on modern and humanitarian notions of care, clashed with the practical everyday realities of surveillance and economic profit that governed the administration of the colonial asylum. The ways in which psychiatrists in Indochina addressed and managed these tensions in the public presentation of their work, and in their daily practices, offers a new perspective on how a Western model of psychiatric care and social reform, premised on distinctions between rural and urban life, became reimagined in the colonial setting.

\textsuperscript{39} For example: Lettre de Gouverneur Général à Médecin-Directeur de l’Asile de Bienhoa au sujet de [....] Vinh, April 1, 1920, Goucoch, IA.8/274(3), TTL2.