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Before Addiction:

The Medical History of Alcoholism in Nineteenth-Century France

By

Lauren Elizabeth Saxton

A Dissertation submitted to the Graduate Faculty in History in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The Graduate Center, City University of New York

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This manuscript has been read and accepted by the Graduate Faculty in History in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Dr. Clifford Rosenberg

Chair of Examining Committee

Dr. Helena Rosenblatt

Executive Officer

Dr. Megan Vaughan

Dr. Dagmar Herzog

Dr. Mary Gibson

Dr. Elizabeth Heath

Supervisor Committee

The City University of New York

## Abstract

Before Addiction: The Medical History of Alcoholism in Nineteenth-Century France

By

Lauren Elizabeth Saxton

Adviser: Professor Clifford Rosenberg

In 1849 a Swedish physician coined the term “alcoholism,” but it was not until the advent of the Third Republic that French physicians began to give shape to this new disease. This work explores the medical facts physicians presented concerning alcohol consumption from the disease’s inception up until the outbreak of World War I, when regulation of alcohol consumption changed dramatically. It works to uncover the links between social anxieties and medical thought, and argues that physicians created a complex relationship between alcoholism and personal responsibility over these years. This relationship privileged bourgeois styles of consumption, undermined the cultural preferences of the working class, and perpetuated pre-existing medical and social beliefs concerning women. Critically, these physicians did not formulate a theory of addiction, which significantly changed the ways in which they understood the motives of drinkers, and the ways in which they evaluated a drinker’s personal responsibility in a variety of spheres, both criminal and civil.

## Acknowledgements

I would not have been able to complete this project without the generous support and guidance of my adviser, Clifford Rosenberg, who pushed me to think larger and harder. I'm also indebted to Megan Vaughan, particularly for her comments on the fifth chapter of this work, and Dagmar Herzog, who helped me to see the larger story that I was telling. Elizabeth Heath and Mary Gibson have also provided invaluable insights, even when it was impossible to be physically present. Evelyn Ackerman oversaw the initial stages of this project, for which I am deeply grateful. Any flaws that remain in this work are of course a reflection of my imperfections, not those of these thoughtful scholars.

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## Introduction

How did physicians decide what alcoholism meant when the term was first invented? Overconsumption of alcohol remains one of the most common and one of the least well-understood life-threatening social problems that troubles nearly every civilization. If all diseases and medical maladies are evaluated against cultural norms, surely some, such as a broken bone or Huntington's disorder, are diagnosed as a result of clear evidence. Others, like autism or alcoholism, exist at the opposite end of that spectrum and their diagnoses rely in large part on the judgment of a medical practitioner.<sup>1</sup> The only way to determine if someone suffers from alcoholism is to evaluate whether his or her relationship to alcohol is disordered compared to those around them.<sup>2</sup> This work is intended to historicize the medical understanding of alcoholism, a phenomenon that has been largely viewed as unchanging over time, and common across spatial and cultural contexts.<sup>3</sup>

In the second half of the nineteenth century, physicians throughout the industrialized world grabbed hold of a new term, "alcoholism," which they used as an axis around which to group observations concerning a variety of behaviors, physical changes, social concerns, and cultural transformations. Although the physical effects of alcohol consumption were the foundation of these discussions, individual contexts incorporated unique sets of anxieties and preferences with contemporary developments, all of which came to influence both the medical and popular

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<sup>1</sup> For a discussion of how the judgment and views of the treating physician, as well as social and cultural beliefs, are so important to the diagnosis of diseases on this end of the spectrum, see Steven Novella on February 23<sup>rd</sup>, "ADHD is Real," *NeuroLogica Blog*, <http://theness.com/neurologicablog/index.php/adhd-is-real/>.

<sup>2</sup> There are, of course, a number of scientific studies that try to make sense out of why some people develop alcoholism. These have pointed to, among other factors, heredity, gender, religion, upbringing, and certain electrical activity tendencies in the brain in order to explain why some people become alcoholics and others don't. None of this, however, has identified as litmus test or causal agent for alcoholism. For more on diagnosis of disease through social behaviors, and social components of medical evaluation, see Rayna Rapp, *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis* (NY: Routledge, 2000).

<sup>3</sup> Gina Hames, *Alcohol in World History* (London: Routledge, 2012), Jean-Charles Sournia, *A History of Alcoholism* (NY: Blackwell, 1990).



understandings of what it meant to suffer from alcoholism.<sup>4</sup> A close study of the information that physicians in France constructed in these years can help us to uncover the prejudices and assumptions that helped to shape the production of knowledge concerning alcoholism.

A prodigious number of medical school theses, journal articles, and monographs were written on the medical definition of alcoholism between 1871 and 1915. Although the term alcoholism was invented in 1849, few physicians showed interest in it until after the loss of the Franco-Prussian war and the violent end of the Commune. Many then began to argue that alcoholism could induce irrational and violent behavior, and that it posed a significant threat to the survival of the young Third Republic. In these same years, social commentators throughout Europe instigated a number of influential discourses on social organization, which Christian Topalov has labeled a “reformist nebula.”<sup>5</sup> Medical concern over alcohol consumption fits into these conversations well, particularly as it was directed specifically at the working-class, where most of the reformist impulses found vent in these years. Concern over housing and nutrition, abortion and pre-natal health grew rapidly at the end of the nineteenth century. The future of the French nation was very much tied up in both anxiety over potential disasters and hope that these interventions could produce a bright, healthy future. In the case of alcoholism, reformist discourses and medical interest in alcoholism dropped precipitously following the 1915 military order outlawing the

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<sup>4</sup> For more on alcohol consumption in non-French nineteenth-century contexts, see An Vleugels, *Narratives of Drunkenness* (NY: Pickering and Chatto, 2013), Patricia Herlihy, *Alcoholic Empire: Vodka and Politics in Late Imperial Russia* (Oxford: Oxford University Press, 2002), Charles Ludington, *The Politics of Wine in Britain: A New Cultural History* (NY: Palgrave MacMillan, 2013), Gerry Johnstone, “From Vice to Disease? The Concepts of Dipsomania and Inebriety, 1860-1908” *Social and Legal Studies*, 5, no. 1, (1996): 37-56, Leo A. Loubère, *The Red and the White: The History of Wine in France and Italy in the Nineteenth Century* (NY: State University of New York Press, 1978), Marian Valverde, *Diseases of the Will* (Cambridge: Cambridge University Press, 1998), B. Lucas, “Reducing Discursive Complexity: The Case of Alcohol Policies in Europe (1850-2000),” in *From Science to Action*, eds. Richard Müller, Harald Klingemann (NY: Springer, 2004): 71-100.

<sup>5</sup> Christian Topalov, *Laboratoires de nouveau siècle: la nébuleuse de réformatrice et ses réseaux en France* (Paris: Éditions de l’Ecole de Hautes de Études en Sciences Sociale, 1999).

production of absinth. Before 1915, however, and particularly after 1871, physicians developed a complex syndrome that explored the far-reaching effects of the new disease.

The history of alcoholism in France also highlights the failures and losing strategies that marked the struggles of French physicians to become recognized both socially and politically as professionals with a unique body of knowledge that they portrayed as critical to the continued survival of the nation. Finally, studying the history of alcoholism in France reveals that physicians constructed a unique understanding of alcoholism, significantly different from today's medical understanding. This profile did not include the concepts of desire and craving, or the emotional connection that are both integral parts of addictive disorders today, including alcoholism.<sup>6</sup> The medical world of nineteenth-century France did not develop the concept of addiction in their discussions of alcoholism, although physicians did exhaustively discuss the ways in which alcohol consumption changed the brains of habitual drinkers.

I originally intended this project to be a study of French socialists prior to World War I. Looking to understand how socialist factions had merged their messages when they created a single party in 1905, I was soon frustrated by what my sources kept talking about. Socialists, it appeared, were obsessed by the dangers of alcoholism, if the amount they wrote on the subject was any indication. These men and women, I realized, felt that one of the greatest dangers to their cause was either alcohol consumption, or the perception that alcoholic degenerates were overrunning the working class. How could a disease that been invented only fifty years earlier already exercise so much influence over the political process? Everywhere I looked, I was struck the contradictory

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<sup>6</sup> For an example of a first-person discussion of this, see Caroline Knapp, *Drinking: A Love Story* (NY: Dial Press, 1997). There is evidence that American physicians did discuss an addictive component to alcoholism much earlier than their French counterparts. For more on this, see Harry Levine, "The Discovery of Addiction," in *Journal of Studies on Alcohol* 39, no. 1 (1978): 143-174, Jessica Warner, "Resolv'd to Drink No More: Addiction as a pre-Industrial Concept," *Journal of Studies on Alcohol and Drugs* 55, no. 6 (1994): 685-691.

suggestions of both sociability and danger, maturity and irresponsibility tied up in alcohol consumption. These themes carried over into complex arguments concerning who should drink what when. Social commentators of all allegiances – conservatives, socialists, liberals, priests, Protestants, anti-Semites, feminists – worked themselves up into a frenzy over alcoholism, and argued that their partisans needed to be careful, because the disease was a particularly potent danger to their interests. I soon came to realize that alcohol consumption and physicians' attempts to discuss and pathologize that consumption were more relevant to the daily lives of the French, particularly the urban French, than the answer to my relatively limited question regarding socialist theory.

New medical works on alcoholism considered the effects of alcohol consumption on the nervous system, digestion, kidney, liver, heart, lungs, spleen, reproductive functions (both male and female), musculature, bones, eyes, and brain, essentially inscribing every part of the alcoholic's body with potential meaning. Connections between the brain, body, and alcohol consumption were theorized and charted, transforming certain social activities into evidence of a disease. These conversations also reflected both particular French sensibilities concerning the nature of ideal social relations, and the unique patterns of consumption that low-cost alcohol had produced in new industrial settings. For example, according to physicians, drinking absinth in working-class cafés was not merely a sociable way to pass time. It was evidence of alcoholism. Women drinking alone in a home were not relaxing, they were violating the rule that alcohol should only be consumed in the company of others, thereby displaying signs of alcoholism. It is clear that medical interest in alcohol consumption was on the rise in the fin-de-siècle, and that through that interest, physicians were able to comment on and potentially restructure the definition of acceptable behaviors.

Reading through physicians' writings on alcoholism at first seemed to confirm the basic effects of the disease as we know it today. But there were also significant differences. Some of them immediately stood out, and clearly shaped the basic understanding of the disease. For example, physicians believed that alcoholism differed significantly between men and women, so much so that its progress varied distinctly between the two groups. They also believed that alcohol stimulated the nervous system, increasing blood flow and raising body temperature, whereas today consuming alcohol is understood to slow down blood flow and lower core body temperature, while briefly raising temperature at the skin's surface. The damages of alcoholism were long-term, and physicians believed that they were hereditary, that if a man suffered from alcoholism he would pass the stain of the disease on to his children.

These points all stood out to me immediately. What took more time, and more prodding, to realize, was that this idea of alcoholism did not include discussions of the mind or the ways that alcohol consumption could change the mentality of the drinker. Instead, they were focused on a physicalist understanding of the brain and the ways that drinking damaged the tissues of this organ. This emphasis on the brain, rather than the mind, did not prevent physicians from discussing madness, which they argued resulted from tangible damage to the brain, but it did make it difficult to consider how patterns of thought could contribute to growing or sustaining alcoholism. This relative disinterest in the mind of the alcoholic, in favor of the brain, left little space for physicians to develop the role of craving and desire that are critical to modern-day definitions of addiction.<sup>7</sup>

There was no sense that alcoholics drank because they couldn't help themselves, that they drank against their own wishes, or that they drank because of their emotional ties to alcohol. Rather, physicians believed that alcoholics drank to excess because they were the type of people who

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<sup>7</sup> For a full discussion of addiction today, see the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Washington, D.C: American Psychiatric Publishing, 2013): 483 (Criterion 4).

wanted to drink more. For this reason, there was no danger in the limited consumption of alcohol by all. There was, after all, no slippery slope that the truly French, truly bourgeois man or woman could slide down, no way to develop alcoholism. The responsible French citizen could not become an alcoholic. Alcoholism was evidence of anti-social, irrational, irresponsible natures that existed whether or not one drank. There was no discussion of “high-functioning” alcoholics, no alcoholics who worked in high-pressure situations, no one who drank in both the ideal social situations and was an alcoholic. According to these physicians, alcoholism was a sign of a fundamental problem with the drinker, a sign that s/he was dysfunctional.

Physicians did assert that excessive alcohol consumption could result in transformations of the brain, but that damage resulted in tremors, monomaniacal behavior, paranoid behaviors and insanity, not addiction to alcohol. Furthermore, physicians remained stubbornly focused on the brain of the alcoholic and its physical damages, rather than the mind or the psyche of the drinker. The lack of attention to the mentality of alcoholism and the heavy interest in the physicality of the disease meant that there was no room for the concept of addiction. Given this physicalist understanding of alcoholism, there was no reason for physicians to believe that alcoholics drank in spite of themselves, that they drank despite internal conflict over the act and its consequences.

Some physicians did believe that alcoholics felt called or impelled to drink, but none attempted to pathologize that feeling, or suggested that it was a significant part of the disease. At most, they asserted that this was evidence of the hereditary nature of alcoholism, saying it was in the nature of hereditary alcoholics to feel most comfortable drinking. This left the “why” of alcoholism awkwardly unexplained, simply moving the question back a generation. In an impressively unending circle, it seemed that alcoholics drank to excess because who they were was the type of person who wanted to drink to excess. A small number of psychologists suggested

that alcoholics lacked the sufficient strength of will to prevent themselves from drinking to excess, but even this formulation (never meaningfully pursued or employed by physicians treating alcoholics) was different from addiction.<sup>8</sup> An alcoholic could not stop himself from drinking because something was wrong with him before he ever picked up a bottle, according to the weakened will theory. The non-alcoholic did not want to drink to excess, so he did not. The fundamental point of this theory remained that alcoholics drank because their will was damaged, not because alcohol had addictive properties or exerted control over their mind. Essentially, addiction to alcohol was not the problem. Rather, it was the weak will of the drinker. Drinking just happened to be the particular troublesome behavior s/he had fallen into.

Of course, French physicians were confronting the abuse of other substances at the same time that they began to produce this large body of scholarship on alcoholism. While *morphinomania* did become a topic of concern, it did not create nearly as much anxiety among physicians or generate as much written material. The government did begin to control the abuse of opiates in 1908, but it seems that these drugs were used by a comparatively small proportion of the population, primarily those in the navy. A far larger number of French men and women suffered from alcoholism. It seems that a physicalist understanding of the brain was important to the pathology of *morphinomania*, but the two conditions were not typically discussed together, as two sides of the same “drug-use” coin. This disinterest in contemplating the two disorders together perhaps reflects physicians’ disinterest in calling the healthfulness of moderate alcohol consumption into question. Doctors asserted that unlike opiates, alcohol could be used safely

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<sup>8</sup> For more on this, see Marianne Valverde, *Diseases of the Will* (NY: Cambridge University Press, 1998).

without a doctor's supervision, and if physicians did develop a theory of addiction that they employed to make sense out of *morphinomania*, they did not apply it to alcoholism.<sup>9</sup>

The meaning of addiction is difficult to pin down, even when looking for a medical definition. Addiction no longer appears in the Diagnostic and Statistical Manual (DSM-V), having been replaced by the phrase "addictive disorder." What exactly it means to be addicted is tricky to define with a great deal of precision, particularly if one chooses to look for physiological evidence of addiction (commonly done today via brain scans, albeit without much success). If, however, we rely on a combination of the DSM's definition of addictive disorder and the testimony of self-identified addicts, we see that addiction is characterized by an intensely personal and emotional connection between addict and addictive substance.<sup>10</sup> This component was entirely absent from the concept of alcoholism that French physicians constructed in the nineteenth century. The emotional pull that addicts typically associate with their substance, the yearning and the love that today plays such a large role in our understanding of alcoholism, was simply not a part of the disease in France at this time. Without the idea that alcoholics drank in spite of themselves and their own wishes, or because they felt compelled to by emotion, there was no space for compulsion. Put most simply, the world of alcoholism that this dissertation investigates did not include addiction. The absence of that concept dramatically changed the way that physicians understood the cause of the disease, the ability of alcoholics to overcome the disease, and the implications of alcoholism for the alcoholic's general character.

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<sup>9</sup> For more on *morphinomania* see Howard Padwa's *Social Poison: The Culture and Politics of Opiate Control in Britain and France, 1821-1926* (Baltimore, MD: The Johns Hopkins University Press, 2012). Padwa uses the term addiction and addict throughout his work to refer to those suffering from the condition, but it seems likely that because he was less concerned with the medical understanding of *morphinomania*, and instead writing on efforts to control the drug's use, he projected the term addiction into his work. Not having read physicians texts on morphine, however, this is rather speculative.

<sup>10</sup> See especially *Diagnostic and Statistical Manual V*: 485.

This is not to say that French doctors did not generate a body of medical knowledge concerning alcoholism that was compelling and influential. Physicians published an astonishing amount on the subject, and these documents coalesced around several points of agreement, and other areas of interest. The first and most fundamental was that two types of alcoholism existed: acute and chronic. Doctors also agreed that alcohol stimulated the nervous system, raising body temperature and speeding the circulation of blood. As a result, alcoholism killed far more often than most people realized. It was also difficult to treat, requiring a stay of several months in some sort of medical facility. They were further in agreement that alcoholism in women was a separate phenomenon, and almost always a secondary symptom of a man's alcoholism. At the turn of the century, a sizeable shift took place in the medical understanding of the relationship between alcohol consumption and heredity, driven by laboratory testing of various hypotheses. This shift had the potential fundamentally to alter the understanding of how alcohol consumption during pregnancy could affect a fetus, but, as we will see, physicians manipulated their findings to avoid those conclusions and maintain the status-quo understanding of male and female contributions to reproduction.

Despite these points of agreement, an ever-growing level of interest was the primary characteristic of medical discussions of alcoholism. There were few debates that resolved, and disagreements could stretch for decades. Instead of coalescing around a well-developed nosology and widely agreed-upon pathological characteristics, physicians disagreed with colleagues of their own specialties, and members of every specialty argued with one another over what amounted to minutiae. Would all chronic alcoholics experience uncontrollable trembling? Would their eyes become bright and shining in an acute crisis, or dull and flat? How much did a woman need to drink, on average, before she became drunk? Could only two drinks prompt a crisis? Did



alcoholism lead to hereditary degeneration? Physicians could not agree on these points, which made it difficult for them to utilize the political capital the new concept of alcoholism potentially offered. In other words, discussions of alcoholism routinely became so fractious that physicians could not gain much from them professionally.

A number of studies of France over this same period have discussed alcoholism as one of a panoply of dangers driving a rapidly growing concern over the future of the French nation.<sup>11</sup> Medical concern over alcoholism is often presented as evidence of a more generalized anxiety that characterized politics in France at the time.<sup>12</sup> While alcoholism was in fact one of several medical dangers that doctors and social commentators pointed to as threatening the continued survival of the nation, it nonetheless necessitates sustained historical research. After all, despite its continued diagnosis today, alcoholism is not an ahistorical physical state. It is, like other diseases, an object of knowledge that requires deconstruction and careful study.<sup>13</sup>

Several investigators have made alcoholism central to critical studies that look to understand the social consequences of its discursive trajectory, particularly as it related to crime and incarceration.<sup>14</sup> These texts trace the explosion of interest in alcoholism, and have done an admirable job of demonstrating alcoholism's relevance to a variety of social debates, as well as the disease's political uses.<sup>15</sup> The earliest of these works was done by a group of historians who focused on the meanings of the social behaviors that surrounded the increasing alcohol

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<sup>11</sup> Jean-Charles Sournia, *A History of Alcoholism* (NY: Blackwell, 1990)

<sup>12</sup> I understand politics as suffusing all power relations. For more on this, see Joan Scott, *Gender and the Politics of History* (NY: Columbia University Press, revised edition 1999).

<sup>13</sup> Michel Foucault, *Archaeology of Knowledge* (NY: Vintage Books, 1982), Michel Foucault, *The Birth of the Clinic*, trans. Alan Sheridan (NY: Vintage Books, 1994).

<sup>14</sup> Robert A. Nye, *Crime, Madness, and Politics: The Medical Concept of National Decline* (Princeton, NJ: Princeton University Press, 1984), Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the fin-de-siècle* (NY: Oxford University Press, 1991).

<sup>15</sup> For examples of how this anxiety played out and where it could lead, see Patricia Prestwich, *Drink and the Politics of Social Reform: Anti-Alcoholism in France since 1870* (Palo Alto, CA: SPOSS, 1988),

consumption of nineteenth-century France. Michael Marrus's work demonstrated the centrality of drinking to sociable activities in the second half of the century.<sup>16</sup> W. Scott Haine's 1996 work, *The World of the Paris Café*, made clear through its dissection of the working-class' social lives that the café was one of the only leisure spaces available to all in urban settings.<sup>17</sup> Patricia Prestwich's *Drink and the Politics of Social Reform* underlines that while consumption was rising, so too was social anxiety over alcoholism, yet the French National Assembly did little to combat drinking until the post-World War II era.<sup>18</sup> Looking at alcoholism, these authors contend, helps them to better understand the cultural world of fin-de-siècle France.<sup>19</sup>

The next thread of studies focused on how the growing body of medical knowledge concerning a variety of disorders with criminological tendencies were instrumentalized, most importantly in courts of law. Robert Nye, Susannah Barrows, and Ruth Harris in particular produced works on the history of deviance, its prosecution, and its punishment that demonstrated how the diagnosis of alcoholism often reduced the individual responsibility of criminals, making little more than marionettes out of criminal drinkers.<sup>20</sup> This work, done largely in the mid-to-late 1980s, was also largely influenced by the growing interest in the history of professionalization, laid out most influentially by Jan Goldstein's *Console and Classify*.<sup>21</sup> Studying alcoholism in this way has helped to reveal various social fault lines, and studies of criminality in particular have

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<sup>16</sup> Michael Marrus, "Social Drinking in the Belle Epoque," in *Journal of Social History* 7, no.2 (1974): 115-141.

<sup>17</sup> W. Scott Haine, *The World of the Paris Café: Sociability among the French Working Class, 1789-1914* (Baltimore, MD: The Johns Hopkins University Press, 1998).

<sup>18</sup> Patricia Prestwich, *Drink and the Politics of Social Reform: Anti-Alcoholism in France since 1870* (Palo Alto, CA: SPOSS, 1988).

<sup>19</sup> For more on this transformation, see Mary Gibson, *Born to Crime: Cesare Lombroso and the Origins of Biological Crime* (NY: Praeger, 2002), Peter Becker, *Criminals and Their Scientists: The History of Criminology in International Perspective* (NY: Cambridge University Press, 2006), especially 105-133, 207-229, and 301-316.

<sup>20</sup> Robert A. Nye, *Crime, Madness, and Politics: The Medical Concept of National Decline* (Princeton, NJ: Princeton University Press, 1984), Susannah Barrows, *Distorting Mirrors: Visions of the Crowd in Late Nineteenth-Century France* (New Haven, CT: Yale University Press, 1981), Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the fin-de-siècle* (NY: Oxford University Press, 1991).

<sup>21</sup> Jan Goldstein, *Console and Classify* (NY: Cambridge University Press, 1987).

benefited from thoroughly considering this as one of many nineteenth-century medicalizations of social behaviors, which were critical to the transition from morality-based explanations of crime to biological ones.

The third thread of historiography examines the failures of the anti-alcoholism movement, which, given the newly recognized relevance of the discourse outside of medicine, read as surprising. Didier Nourrisson's 1988 formulation, which cast the second half of the nineteenth century as a period of "germination" for the anti-alcoholism movement that was simply too immature to bloom, argued that physicians were too interested in other pathologies to advocate sufficiently against alcoholism.<sup>22</sup> While Bertrand Dargelos' 2008 text did not employ the same botanical terms, his tracing of the anti-alcoholism movement in the nineteenth century reached similar conclusions.<sup>23</sup> Prestwich's work also discussed this phenomenon, but concluded that the state only took up anti-alcoholism when it became an economic imperative, and that physicians' arguments had little effect even after 1945. All these works begin from the premise that what alcoholism meant was determined by physicians, but they move quickly from there to the heart of their stories: the political struggles and entrenchments that prevented government reforms intended to curb alcoholism.

While this work does interact with many of the issues raised by these investigations, my evidentiary basis creates a new set of questions that help to inform these works. My project begins from the premise that alcoholism had to be constructed, and that physicians were responsible for a great deal of that work. As a result, this project focuses exclusively on documents written by physicians, for physicians. This approach, which excludes the social commentaries and courtroom

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<sup>22</sup> Nourrisson, Didier. "Aux origines de l'antialcoolisme." In *Histoire, économie et société* 7, no. 4 (1988): 491-506.

<sup>23</sup> Dargelos, Bertrand. *La lutte antialcoolique en France depuis le XIXe siècle* (Paris: Dalloz, 2008).

testimonies that form the backbone of most other works on the same topic, creates a new set of questions that revolve around the original ontology and epistemology of alcoholism.

Starting from the premise that physicians failed or succeeded in disseminating their thinking has not encouraged a close investigation of medical logic. As a result, “alcoholism” often seems to be a timeless disease, one that is essentially understood the same today as it was in 1870. Yet a close examination reveals that this is far from the case. Looking closely at the medical knowledge offers an opportunity to understand the foundation of these influential discourses, as well as their evolution. This approach can also help to ground works that have looked at the evolution of anti-alcoholism efforts, and the general perception of alcohol.<sup>24</sup>

If they had established a simple, well-defined disease concept, alcoholism could have offered physicians a significant level of social and political utility. Medical discussions of the disease gave physicians an opportunity to underline that their body of knowledge was invaluable to a nation where the birth rate remained low and the mortality rate high.<sup>25</sup> Furthermore, because alcohol consumption was a key component of most social and many solitary moments in France, physicians also gained unprecedented access to daily life by making themselves the authorities on how it should and should not be consumed. Finally, these discussions provided doctors space to grapple with concerns over citizenship and responsibility, belonging and the very nature of Frenchness.<sup>26</sup> By discussing alcoholism, physicians were creating an opportunity to comment on and modify essentially all the social, cultural, political, and gender codes in their society.

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<sup>24</sup> For examples of this scholarship, see Sarah Howard, *Les images de l'alcool en France 1915-1942* (Paris: CNRS Éditions, 2006).

<sup>25</sup> Elisa Camiscioli, *Reproducing the French Race: Immigration, Intimacy, and Embodiment in the Early Twentieth Century* (Durham, NC: Duke University Press, 2009), Karen Offen, “Depopulation, Nationalism, and Feminism in fin-de-siècle France,” in *The American Historical Review*, 89, no.3 (1984): 648-676.

<sup>26</sup> Kolleen M. Guy, *When Champagne Became French: Wine and the Making of a National Identity* (Baltimore, MD: The Johns Hopkins University Press, 2003).

Only two laws specifically addressed alcoholism and its potential consequences in these years: The Law of 1873, which criminalized public drunkenness, and Article 64, section 10, of the penal code, which stipulated that if an individual was intoxicated at the time s/he committed a crime, s/he was not entirely responsible for his/her acts. Although the Law of 1873 was unevenly applied, and never to more than a relatively small number of Parisians, the ever-more severe punishments for repeat offenders (the first-timer was fined at most five francs, while a fourth arrest for intoxication removed all the rights and privileges that male citizens enjoyed) revealed the popular belief that alcoholics were irresponsible, untrustworthy, and largely incapable of escaping their disease. Article 64, section 10 of the penal code offered a way out of criminal responsibility, which made it appealing to those who faced conviction, but physicians were wary of those who claimed intoxication. The members of the medical establishment typically viewed the impulse to claim the label “alcoholic” as evidence against the diagnosis, demonstrating an initiative that alcoholics were not supposed to possess.

Aside from these two laws there was very little legislation undertaken to curb the consumption of alcohol. The lack of tangible consequences that accompanied the medical publishing on alcoholism, however, does not indicate that the discourse was insignificant, or irrelevant. Rather, the failures and limits of the discourse on alcoholism demonstrates that attempts to deploy medical and scientific knowledge to structure social behavior often failed to accomplish the intended goals. Not all exercises of power are effective, or overwhelm the groups they flow towards, or play out in expected, predictable interactions. Most are more accurately understood as part of a web of various other relationships that structure and define a social world, that are influenced by other portions of that web, and that almost never play out according to the script they were originally written into. No transfers of power relations are unopposed, and those

oppositions often produce surprises through discursive transformations. These failures and unintended consequences, however, are an integral part of biopower and all the more realistic, as they take into account the opposing forces, the preexisting logics, that physicians discussing alcoholism encountered.

Close study of the medical evidence demonstrates that physicians used alcoholism to mark boundaries and to try to shore up lines of inclusion and exclusion. Through discussions of the relationship between fertility and alcohol consumption, physicians could address and stigmatize women who failed to have children, as well as women who had too many. In talking through the anti-social impulses that low quality wines and absinths encouraged, they could stigmatize the sociability of working-class men.<sup>27</sup> As we will see, there were not many social costs that physicians believed alcoholism was incapable of inflicting, even though it made little sense to argue that alcoholics were simultaneously responsible for the nation's low birth rate and the supposedly increasing proportion of "low quality" children born each year. The contradictions of the medical discourse on alcoholism, however, did not prevent it from helping to effect real marginalizations and privileged positions.<sup>28</sup> The instability of the discourse was useful, rather than damaging, as it allowed for a great deal of elasticity.<sup>29</sup>

Chapter 1 offers a contextualization of the professional conflicts physicians were working through as they engaged in discussions of alcoholism in the period from 1870 to 1914, when publishing was at its peak. I underline the internal struggles for status and financial stability that

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<sup>27</sup> For more on this see Chapters 2 and 5.

<sup>28</sup> For discussions of how a discourse sustains itself and exercises a great deal of influence despite contradictions, see Stuart Hall, "Signification, Representation, Ideology: Althusser and the Post-Structuralist Debates," in *Critical Studies in Mass Communication* 2, no.2 (1985): 90-114, Ann Stoler, *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule* (Berkeley, CA: University of California Press, 2010 new preface edition).

<sup>29</sup> For more on how instability and elasticity in a discourse does not limit its applicability, see Judith Surkis, *Sexing the Citizen: Morality and Masculinity in Third Republic France* (Ithaca, NY: Cornell University Press, 2011). Ann Stoler, *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule* (Berkeley, CA: University of California Press, 2010), Homi Bhabha, *The Location of Culture* (NY: Routledge, 2<sup>nd</sup> Edition 2004).

different specialties engaged in with one another. New research in bacteriology had encouraged a proliferation of opinions on how diseases spread, and how to best combat them, just as the number of trained medical practitioners was similarly blossoming.<sup>30</sup> I suggest that, given this state of professional affairs, it made sense for physicians to focus their attention on a pastime that essentially all men, women, and many children took part in. It was just at this moment that industrialization and urbanization, among other factors, were growing the amount of alcohol produced and consumed within France, and the Paris Commune had ignited fears about the dangers posed by irrational mobs. The medical discourse on alcoholism tapped into these fears and fed them, as they increased the popular salience of physicians' knowledge. At the same time, the discourse on alcoholism also drew on and agreed with pre-existing as well as newly emerging medical information concerning the functions of the brain, which served to legitimate it.

Chapter 2 investigates the state of medical knowledge surrounding alcoholism, and attempts to pull on and straighten out some of the most intertwined threads of that conversation. As all physicians agreed that alcoholism came in two types, acute and chronic, the chapter begins by discussing these two states and the differences physicians attempted to outline between the two. Many other variations on these two states were discussed, such as sub-acute alcoholism, or absinthisme, but these terms failed to catch on or they became obsolete and were discarded, demonstrating that physicians were engaged in a process of trial and error. Throughout the chapter, my evidence underlines that despite the presence of social assumptions that influenced their research, physicians nonetheless relied on investigative methods that were, by the standards of their day, sophisticated and entirely scientific. The theoretical medical interplay between heredity and alcoholism also became important in these conversations. Taken altogether, these

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<sup>30</sup> Historiographical debates over what viewpoint gained ascendancy in these years are covered in detail in Chapter 1.

developments underline that physicians highlighted certain themes with more salience to significant contemporary debates, while they abandoned others.

Chapter 3 analyzes how the medical body of knowledge concerning alcoholism shaped treatment proposals, as well as the actual treatment facilities and practices that were available. Many of the treatment options, I explain, were based on contradictory understandings of alcohol's actions on the body. The limited efficacy of these treatments might have discouraged some from calling on physicians to treat alcoholism, but the length of stay that physicians advocated for – at least six months, and ideally an entire year – in order to cure alcoholism was also a significant deterrent. The state's limited support of alcohol treatment also significantly narrowed the number of alcoholic patients physicians could treat. This in turn significantly circumscribed alcoholism's most immediate impacts as a way through which to manage the national population's health, as well as physicians' abilities to make a living off alcoholism alone. These failures, however, did not stop physicians from drawing conclusions regarding alcoholism that clearly and easily lent themselves to the vocabulary of social reformers.

Chapter 4 explores the body of medical knowledge concerning alcoholism among women. Although ideally this discussion would be included in Chapter 1, the way in which physicians believed the phenomenon differed between the sexes ultimately made this impossible. In another point of agreement, nearly all doctors asserted that alcoholism was pathologically distinct between men and women, that women's alcoholism was secondary to either a husband's or a father's alcoholism, and that it could not be understood or approached in the same way as alcoholism in a man. Physicians could try to treat a woman's alcoholism, but that would be the equivalent of pruning a branch, rather than pulling up a diseased root. Nonetheless, alcoholism among women remained concerning, particularly for its potential consequences on reproduction, which



physicians were constantly grappling with given the low birthrate of the Third Republic. There was little agreement on exactly how alcohol consumption affected women (physicians would often contradict themselves within their own texts), but considered on the whole, these arguments successfully reinforced the perception that women's actions were secondary to men's, that women were physically weak, and that they succumbed more easily to the irrational behavior and the unreasonableness of alcoholism.

Finally, Chapter 5 turns to the attempts of physicians to apply their knowledge regarding alcoholism to questions of responsibility, both socially and legally. Several laws had created a legal space in which alcoholism became critical and intoxication could lessen or even potentially negate criminal responsibility, if not guilt. When physicians tried to take advantage of these opportunities to emphasize their professionalism and the critical nature of their knowledge, however, it became difficult to avoid the malleability, opportunism, and contradictions that marked their knowledge of alcoholism. The amount of talk that they had created on the subject and the flexibility of their interpretive framework render many of their conclusions questionable when examined closely. Nonetheless, they were effective at upholding previously established social stigmas against certain behaviors.

This research is based almost exclusively on medical texts published between 1849 and 1914. These texts include monographs, medico-legal reports, textbooks, conference proceedings, theses, and journal articles, as well as the occasional speech and public comment. In cases that judges ordered physicians to evaluate criminals for alcoholic insanity do figure in this work, but only when they were published and read by colleagues. These sources were collected largely from the Bibliothèque Nationale de France, which in addition to the complete collection of medical texts contains printed copies of every medical dissertation written in these years, as well as a

comprehensive corpus of journal articles. Additionally, a number of texts produced by hygienists were found within the archives of the New York Academy of Medicine.

The vast majority of the authors studied here were medical students who wrote theses on alcoholism, instructors at medical faculties, or physicians associated with public hospitals and asylums, although the work of medical practitioners who defy these categorizations is also at times considered. Across these identities were physicians with a variety of specialties, beliefs, and allegiances. Although it is likely that physicians moderated themselves somewhat in these formal writings, and did not speak as forthrightly as they would have in personal interactions, these sources nonetheless provide an accurate representation of the state of medical knowledge concerning alcoholism in these years. The potentially moderated tone of these writings is, after all, a part of the medical knowledge itself, and was the basis of reformers' and commentators' concerns.

The arguments of social commentators do not play a significant role in this work, as those individuals took the existence of alcoholism for granted. They were primarily interested in "solving" alcoholism (or, in some cases, perpetuating stereotypes about it), rather than developing its medical definition. While the writings of these commentators are a rich source base, they are not what I was concerned with in this investigation. Additionally, I do not consider whether physicians' claims concerning alcohol's action on the body were accurate. Rather, what those claims were and how their creation and communication played out is the object of this work.

## Chapter 1 – Only in France: Drinking Practices and Medical Rivalries

In 1849 a Swedish physician named Magnus Huss published a text titled *Chronic Alcohol Illness. A Contribution to the Study of Dyscrasias Based on my Personal Experience and the Experience of Others*. Although several of Huss' contemporaries had previously produced medical treatises on the dangers of alcohol consumption (in 1819 Dr. C. von Brühl-Cramer had written in Russian on the hereditary consequences of chronic alcohol consumption, using the term *Trunksucht*, which a German physician subsequently translated as *dipsomania*), none had gone into such depth or were so widely read as Huss.<sup>31</sup> Doctors throughout Europe and America proclaimed the importance of his work. The idea that excessive alcohol consumption was a disease requiring individual medical treatment caught on quickly, and “alcoholism” spread throughout Europe and the United States via a flood of publishing on the subject. Although physicians and social reformers had long discussed the negative consequences of excessive drinking, they had never before had a single, universally recognized term to employ. In America, Great Britain, Germany, and even Russia, physicians and anti-alcohol organizations latched onto “alcoholism” almost instantaneously, recognizing the concept's potential for systematizing and consolidating their concerns.<sup>32</sup>

Physicians in France, however, were initially hesitant to take up the term. Between 1849 and 1864 no more than fifteen monographs were published on alcoholism, and only rarely did two

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<sup>31</sup> Dr. Foville, *Du Delirium Tremens, de la Dipsomanie, et de l'Alcoolisme* (Paris: A. Parent, 1867).

<sup>32</sup> For more on alcohol consumption and alcoholism in different nineteenth-century European and North American contexts, see An Vleugels, *Narratives of Drunkenness* (NY: Pickering and Chatto, 2013), Patricia Herlihy, *Alcoholic Empire: Vodka and Politics in Late Imperial Russia* (Oxford: Oxford University Press, 2002), Charles Ludington, *The Politics of Wine in Britain: A New Cultural History* (NY: Palgrave MacMillan, 2013), Gerry Johnstone, “From Vice to Disease? The Concepts of Dipsomania and Inebriety, 1860-1908” *Social and Legal Studies* Vol. 5, No. 1, 37-56, Leo A. Loubère, *The Red and the White: The History of Wine in France and Italy in the Nineteenth Century* (NY: State University of New York Press, 1978), Marian Valverde, *Diseases of the Will* (Cambridge: Cambridge University Press, 1998), B. Lucas, “Reducing Discursive Complexity: The Case of Alcohol Policies in Europe (1850-2000),” *From Science to Action*, eds. Richard Müller, Harald Klingemann (NY: Springer, 2004): 71-100.

appear in the same year. In 1853, while honoring Huss' work at the *Académie française*, a spokesman proclaimed "France has many drunkards, but, fortunately, no alcoholics."<sup>33</sup> Yet twenty-two years later, just following the establishment of the Third Republic, writing and publishing on alcoholism exploded in France. Physicians pointed to excessive alcohol consumption as one of the three great dangers menacing society. They debated the topic at length, elaborated considerably on Huss' initial findings, and asserted that they could improve on his work.<sup>34</sup> Seeing the original text as insufficient, one physician argued that, "In order to understand his goal fully and the way he limits himself, it is necessary to remember that Dr. Magnus Huss is a Swede and writes for Sweden with aqua vitae in mind... If he had also considered fermented drinks, his understanding of this interesting subject would have been even greater."<sup>35</sup> In other words, because Huss was not French, he could not understand the ways the French drank, or the ideal mental state of a healthy French drinker.

Obviously, dangerous alcohol consumption in France could only be understood and recognized by French doctors. Alcoholism offered physicians a unique opportunity to address a variety of professional challenges. Additionally, it provided a useful vantage point from which to address a number of anxieties that structured life in pre-World War I France. In the complex discourse they developed on alcoholism physicians were able to tackle a variety of critical topics, ranging from their concerns over the rapid social changes of the Third Republic to their desire to

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<sup>33</sup> Joseph Reinach, *Contre l'alcoolisme* (Paris: E. Fasquelle, 1910): 18. This quote has been reproduced in nearly every text discussing alcoholism in France, in large part, it seems, because it so neatly encapsulates the dominant French attitude towards alcohol consumption. There have been some debates over whether these words were in fact spoken (they were reproduced in an account of the event).

<sup>34</sup> See, for example, René Lavollée, *Fléaux Nationaux: Dépopulation, Pornographie, Alcoolisme, Affaïsement Moral* (Paris, Félix Alcan et Guillaumin Rèunies: 1909).

<sup>35</sup> Renaudin, *Mémoires de l'Académie des Sciences* (1853): 208. In the nineteenth century "aqua vitae" referred to any distilled alcohol that was not mixed with other substances. Renaudin's critique of Huss rests on the widespread popularity of beverages such as vermouth (wine fortified with distilled alcohol) and absinth in France, and their relatively low consumption rate elsewhere.

underline their own medical expertise. In doing so, physicians fashioned the meaning of the disease entity “alcoholism,” which began to accrue reality as their conversations expanded to include a host of related social and medical anxieties.<sup>36</sup>

In their discussions of alcoholism, medical professionals were creating a conceptual space that they could utilize to address the rapid social changes taking place in both the middle and working classes. Established in 1871 after the fall of the brief-lived Paris Commune, whose end was so brutal that it became known as Bloody Week, the Third Republic had attempted to paper over striking social and economic divisions upon its establishment with varying levels of success.<sup>37</sup> Anarchist attacks targeted middle-class pedestrians as well as the Chamber of Deputies from 1892 to 1894. It seemed at certain points in 1889 that a military *coup d'état* was imminent, and the Dreyfus Affair split the nation across a variety of axes, which threatened to shine light on fundamental ideological differences that were perhaps best left unremarked upon.<sup>38</sup> The Catholic Church struggled to retain its relevance and influence in the face of an uninterested and hostile political establishment.<sup>39</sup>

After 1890, when the Long Depression began to lift, France enjoyed relative economic prosperity and cautious optimism began to bloom. The constant innovations of the Second Industrial Revolution eased many tasks of daily life, particularly for the middle classes. The

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<sup>36</sup> For more on the ways in which categories such as “alcoholism” or “medical” take on meaning, see Ian Hacking, “Making Up People,” in T. Heller, M. Sosna, and D. Wellberry, eds, *Reconstructing Individualism* (Palo Alto, CA: Stanford University Press, 1986), Ian Hacking, “The Looping Effects of Human Kinds” in D. Sperber, D. Premack and A.J. Premack, eds., *Causal Cognition: A Multidisciplinary Approach* (Oxford: Clarendon Press, 1994), and Michel Foucault, *The History of Sexuality* (NY: Random House Books, 1978). It’s important to note here that there is a critical difference between alcoholism and the identity of the alcoholic. In these years, as we will see, individuals never labeled themselves as alcoholics, or expressed a sense of understanding, relief, or self-recognition based off of the disease. Alcoholism was a disease physicians diagnosed, not a part of an individual’s identity.

<sup>37</sup> Gary Gullickson, *Unruly Women of Paris: Images of the Commune* (Ithaca, NY: Cornell University Press, 1996).

<sup>38</sup> Ruth Harris, *Dreyfus: Politics, Emotion, and the Scandal of the Century* (NY: Picador, 2011)

<sup>39</sup> Frederick Brown, *For the Soul of France: Culture Wars in the Age of Dreyfus* (Norwell, MA: Anchor Press, 2011).

Empire continued to expand, confirming for the French that they remained a world power, and staged exhibitions and spectacles such as the World's Fair (held in Paris in both 1889 and 1900) emphasized that, by their own standards, France stood at the pinnacle of world civilizations. Employment rates were relatively high by 1890, following the recession of the 1880s. After World War I, the French would come to call these years the *Belle Époque*.<sup>40</sup> The instabilities of the Third Republic, which resulted from its unique mixture of success and crisis, created a curious optimism in the nation's ability to overcome seemingly certain disaster that coexisted uneasily with a resigned acceptance that disaster would continue to lurk behind every turn.

Industrialization and the concomitant growth in the size of cities had encouraged significant changes in urban planning that in turn led to dramatic demographic shifts, best illustrated by the case of Paris. During the rule of Napoleon III (1851-1870), George Haussmann, Prefect of the Seine, had overseen a dramatic structural reorganization of Paris. Wide, tree-lined boulevards and public parks replaced the narrow, winding streets that had previously characterized the city, and with the construction of larger apartments came bourgeois families. Central Parisian neighborhoods, which the working class had previously occupied, transformed in order to appeal to their new middle-class residents, and fashionable cafés soon filled these streets.<sup>41</sup>

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<sup>40</sup> For more work discussing the debate over interpretations of Third Republic France, see Philip Nord, *The Republican Moment: Struggles for Democracy in Nineteenth-Century France* (Cambridge, MA: Harvard University Press, 1995). For work that discusses changes in science and medicine that were particular to France in these years, see Fox and Weisz, eds., *The Organization of Science and Technology in France, 1880-1914* (Cambridge, 1980), Robert Fox, *The Savant and the State: Science and Cultural Politics in Nineteenth-Century France* (Baltimore, 2012).

<sup>41</sup> For more on Haussmanization, see David H. Pinkney, *Napoleon III and the Rebuilding of Paris* (Princeton, NJ: Princeton University Press, 1958), Louis Chevalier, *La formation de la population parisienne au XIX<sup>e</sup> siècle* (Paris: Institut national d'études démographique, 1949), Adéline Daumard, *Maisons de Paris et propriétaires parisiennes au XIX<sup>e</sup> siècle, 1809-1880* (Paris: Éditions Cujas, 1965), Philippe Ariès, "La population parisienne," in *Histoire des populations françaises et de leurs attitudes devant la vie depuis le XVIII<sup>e</sup> siècle* (Paris: Éditions de Seuil, 1971), 119-198, Jeanne Gaillard, *Paris: La ville, 1852-1870* (Lille and Paris: Honoré Champion, 1976), Roger Gould, *Insurgent Identities: Class, Community, and Protest in Paris from 1848 to the Commune* (Chicago: Chicago University Press, 1995), 65-95. On the changing nature of consumption and sociability, see Charles Rearick, *Pleasures of the Belle Époque: Entertainment and Festivity in Turn-of-the-Century France* (New Haven, Conn.,

With small tables outside, the cafés that lined these new grand boulevards quickly became popular among bourgeois men and women eager to take in the sights of their changing city. Perceiving limited sociable consumption of alcohol as a sign of good breeding, the middle class continued to drink, but more of this consumption took place in public, and it became common for groups of only one gender to drink together, particularly early in the evening. Alcohol consumption in these cafés came to indicate sophistication and the best, most “French” type of sociability.<sup>42</sup> Moderate levels of intoxication were acceptable and even encouraged. Many argued that this low level of impairment allowed their thoughts and wit to flow more freely, and that so long as they were drinking wine, champagne, or heavily watered down absinth, they became the best versions of themselves in these moments.

Drinking patterns in France were not so dissimilar from those of other industrialized Western nations, most notably Germany and America, that they do not invite comparison.<sup>43</sup> The French medical establishment’s reaction, however, was notably idiosyncratic from that of their neighbors. The vast majority of French physicians discouraged complete temperance, and instead counseled their patients and encouraged the general public to abstain from pure vermouth or absinth (when sufficiently watered down, even these drinks were acceptable, so long as they were consumed socially), and to instead drink “healthful” beverages such as wine or cognac in moderate amounts. Indeed, many physicians encouraged their colleagues to prescribe wine to recovering alcoholics for its ability to soothe stomachs and anxieties alike.

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University of Connecticut Press: 1985), Vanessa Schwartz, *Spectacular Realities: Early Mass Culture in Fin-de-Siècle Paris* (Berkeley, CA: University of California Press, 1999).

<sup>42</sup> For more on this sociable style of drinking, see Michael R. Marrus, “Social Drinking in the Belle Époque,” *Journal of Social History* 7 (1974): 115-141, Thomas Brennan “Towards the Cultural History of Alcohol in France,” *Journal of Social History* Vo. 23, No. 1, 71-92.

<sup>43</sup> Valverde book

There is also likely a difference between Protestant and Catholic countries approaches to temperance. In general terms, it seems that in nations where Catholicism dominated, temperance gained little success, whereas England and America, which were primarily Protestant, boasted popular temperance organizations, so much so that the United States federal government outlawed the sale of alcohol between 1920 and 1933. British and American physicians appear to have incorporated thinking that privileged the individual and his/her ability to resist the pleasures associated with alcohol consumption much earlier than their French and Italian counterparts, perhaps reflecting the different emphases each context placed on the individual.<sup>44</sup> Italian physicians, however, did not concern themselves nearly as much with alcoholism in comparison to their French counterparts.<sup>45</sup> It seems likely that this is a result of the limited production of industrial alcohols, such as grappa, that characterized Italy until the post-World War II era. Consumption of alcohol continued to take place primarily through wine drinking, which in Italy as in France provoked little concern, socially or medically speaking. Taken altogether, these various conditions created a unique framework within France that shaped the medical response to alcoholism. It is clear that alcohol occupied a central role in enough portions of daily life in France that abstention was a laughable idea, both socially and medically. This was the case in Italy as well, but new styles of consumption and the increased production of distilled alcohols that were sweeping France generated a great deal of anxiety, whereas the absence of these trends kept Italian concern over alcoholism much lower in comparison.

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<sup>44</sup> Harry Levine, "The Discovery of Addiction," in *Journal of Studies on Alcohol* 39, no. 1 (1978): 143-174, Jessica Warner, "Resolv'd to Drink No More: Addiction as a pre-Industrial Concept," *Journal of Studies on Alcohol and Drugs* 55, no. 6 (1994): 685-691.

<sup>45</sup> Leo A. Loubère, *The Red and the White: The History of Wine in France and Italy in the Nineteenth Century* (NY: State University of New York Press, 1978).



A variety of social commentators argued that alcohol consumption was much more dangerous among the working class, however, and that following the Commune it was on the rise. While their escalating estimates of the amount these men and women drank are impossible to verify, their assertions that the working class drank more frequently in public establishments were very likely correct. A number of transformations had brought this about. Firstly, the same neighborhood changes that drew the bourgeoisie into central Paris exiled the working class, who could no longer afford the rent in their old lodgings.<sup>46</sup> Pushed to the margins of the city, Parisian workers no longer saw as much appeal in the suburban cabarets, which in the past had presented themselves as charmingly rural, offering a holiday-like atmosphere as a change of pace. Instead, these men and women began to investigate the growing number of small, relatively low-cost café options that sprang up in their new neighborhoods.<sup>47</sup>

Secondly, rising minimum wages made it possible for the working class to spend more on non-necessities and entertainment, particularly wine.<sup>48</sup> Until the advent of the Second Industrial Revolution, most of the French working class had been unable to afford more than a small bit of the worst of French vineyards, which cemented wine's status as an aspirational good – to be able

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<sup>46</sup> Ann-Louise Shapiro, *Housing the Poor of Paris* (Madison, WI: University of Wisconsin Press, 1985), Gérard Jacquemet, *Belleville au XIXe Siècle: du faubourg à la ville* (Paris: EHESS, 1984), Jean Bastié, *La croissance de la banlieue parisienne* (Paris: PUF, 1964), Alain Faure, “Les racines de la mobilité populaire à Paris au XIXe siècle in O. Benoît-Guilbot, ed., *Changer de région, de métier, changer de quartier* (Paris: Université de Paris X-Nanterre, 1982), 103-119, Alain Faure, “Transfuges et colons: Le rôle des Parisiens dans le peuplement des banlieues (1880-1914), in Jean-Paul Brunet, ed., *Immigration, vie politique et populisme en banlieue parisienne, fin XIXe-XXe siècles* (Paris: Harmattan, 1995): 29-48.

<sup>47</sup> W. Scott Haine, *The World of the Paris Café: Sociability among the French Working Class, 1789-1914* (Baltimore, MD: The Johns Hopkins University Press, 1998), Marie-Claude Blanc-Chaléard, *Les italiens dans l'est parisien: Une histoire d'intégration (1880-1960)* (Rome: École française de Rome, 2000), especially chapters 1-3.

<sup>48</sup> Roland Barthes, *Mythologies*, (NY: Hill and Wang, 1972): 58-61. Barthes accepts that national identity in France has always been associated with alcohol consumption. I am much more in agreement with Kolleen Guy that these qualities were initially articulated and attached to wine consumption during the industrial era. See Kolleen Guy, *When Champagne Became French: Wine and the Making of a National Identity* (Baltimore, MD: The Johns Hopkins University Press, 2007). Roger Price, “The Transformation of Agriculture,” in *The European Economy, 1750-1914: A Thematic Approach*, ed. D. Alcroft and S. Ville (Manchester: Manchester University Press, 1994), 72-109.

to drink wine was to be comfortably middle class.<sup>49</sup> This perception did not change, even as wine prices dropped in the late nineteenth century and the working class began to drink it on a daily basis. Further driving up the rate of consumption was the falling price of other alcohol. Distilled alcohol was so inexpensive by 1900 that nearly all could afford it, which forced some wine prices to fall in tandem, in order to remain competitive. Finally, the continued dangers of impure water, particularly in industrialized cities where alcohol consumption rates were highest, encouraged many workers to drink wine rather than water while on the job (it wasn't until 1969 that alcohol consumption was made illegal in the industrial French workplace). While statistics on working-class consumption from the end of the nineteenth century are suspect, they were not so inflated that political representatives of the working-class ignored the question.<sup>50</sup>

Urban and economic changes alone did not attract workers to the cafés, however. As industrialization rapidly increased the number of workers in larger French cities, political parties and unions meant to appeal to the working class also grew. Not allowed to organize within the city of Paris until 1884 (when trade unions were legalized under the Waldeck-Rousseau laws), politically-minded workers often gathered in cafés, where they could plausibly claim they were spending time together socially. The Parisian police, far from disliking the practice, actually preferred it, as it enabled their monitoring of cafés and thus made it easier to keep an eye on potential disruptions.<sup>51</sup> Workers also used these spaces to find employment, meet with prostitutes,

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<sup>49</sup> Jean-Paul Sournia, *A History of Alcoholism* (NY: Blackwell Publishing, 1990), Barthes, *Mythologies*.

<sup>50</sup> These statistics are suspect for a number of reasons: two statisticians virtually never reproduced the same numbers, statisticians would often exclude women and children when calculating consumption, but only occasionally mentioned that they were doing so, and were similarly vague about what beverages they considered alcoholic (many figures likely did not include wine, but once again rarely explained whether or not that was the case). Patricia Prestwich and W. Scott Haine have both estimated that there was one establishment selling alcohol every 31 meters in Paris, and that in the entirety of France there was one café or cabaret for every 82 people. Jacqueline Lalouette demonstrated definitively in "Le Débit de boissons urbain entre 1880-1914," *Ethnologie française*, 12 (1982), 131-136 that the number of establishments serving alcohol was growing over these years.

<sup>51</sup> See W. Scott Haine, *The World of the Paris Café: Sociability among the French Working Class, 1789-1914* (Baltimore, MD: The Johns Hopkins University Press, 1996): 1-32 and W. Scott Haine, "I go to the café to create

socialize before and after work, and consume food.<sup>52</sup> The café became a hub for a wide variety of social and economic activities that were critical to the continued survival of the working class.

While the middle and working classes were settling into their respective cafés, young artists were identifying their own, particularly in Paris, where they encouraged high rates of consumption and experimentation with new alcoholic beverages, including absinth. Just as political groups would often come to see one café as their unofficial headquarters, groups of artists would similarly congregate around one establishment, many of which were in Montmartre. The neighborhood, situated on a hill overlooking Paris, was technically outside the city and thus escaped a significant share of taxation. Just as importantly, the local nuns made a relatively high-quality, inexpensive wine.<sup>53</sup> In the final years of the nineteenth century, these cafés overflowed with aspiring painters, actors, writers, and artists. Soon, it became fashionable for middle-class men and women to visit these bohemian cafés on occasion, thrilling themselves by temporarily transgressing self-imposed social norms.<sup>54</sup> The transgressions themselves, however, seem to have served in part to reaffirm the superiority of bourgeois patterns of consumption, as it helped to reveal the permissibility of other forms of sociability. Taken altogether, the rapid urbanization and accompanying social changes in urban France encouraged a greater share of alcohol consumption to take place in the public sphere, where it was sure to be commented on.

In addition to these social components, economic factors shaped consumption patterns, particularly among the working class, who had never previously had access to alcohol that was so

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my relations': Sociability and Strategy in Parisian working-Class Cafés, 1870-1890," Ph.D. thesis (Madison, WI: University of Wisconsin-Madison, 1984)

<sup>52</sup> W. Scott Haine, "'Café Friend': Friendship and Fraternity in the Parisian Working-Class Cafés, 1850-1914," *Journal of Contemporary History*, Vol. 27, No. 4, pgs. 607-626. For more on socialist responses and attitudes towards working-class responses to alcoholism, see Jeanette Lalouette, *Le Débit de boisson en France, 1871-1919*, Ph.D. thesis (Paris: University of Paris, 1979).

<sup>53</sup> Jad Adams, *History of the Devil in a Bottle* (London, Tauris Park, 2003).

<sup>54</sup> Gabriel P. Weisberg, *The Making of Mass Culture in Montmartre* (New Brunswick, NJ: Rutgers University Press, 2001), Alain Corbin, *Les filles de noces* (Paris: Flammarion, 2010).

cheap relative to their average income. The expansion of the railroad had decreased transportation costs, as had the increased efficiency of production aided by industrial innovations, which made distilled alcohols cheaper than many wines. At the same time, the rapid spread of phylloxera (a sap-sucking insect that attacked the roots of French vines, which had never developed an immunity to the pest), decimated French vineyards in the 1880s and 1890s, driving down profits and jeopardizing vintners throughout the country. These crises forced the French to rely temporarily on Algerian, Spanish, and Italian wines (despite their constant complaints about their low quality). “Fortifying” wine by adding distilled alcohol, in an attempt both to mask their low quality and to stretch them further, also became more popular in these years, as did the practice of *chaptalisation*, in which makers added sugar to wines to increase their alcohol content.<sup>55</sup> French vineyards only recovered at the end of the century with the grafting of French vines onto American roots, which were not susceptible to the insects.<sup>56</sup> During these years the vineyards avoided insolvency and ruin partially through the National Assembly’s decision to maintain a low tax rate on wine makers. When French wineries recovered, they encountered a market with a greater demand for inexpensive wines. The recovery thus increased the amount of wine available, and the growth of the national railway system eased distribution. As a result, prices remained low and occasionally dropped lower after 1891, partially because of the growing imbalance between supply and demand, partially because of the overall power of this new bottom-shelf market.<sup>57</sup>

The common belief that consumption of wine reaffirmed French national identity and belonging originated in these years as a result of new challenges facing wineries. While wine had

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<sup>55</sup> Elizabeth Heath, *Wine, Sugar, and the Making of Modern France* (NY: Cambridge University Press, 2014): 95.

<sup>56</sup> For more on this, see George Gale, *Dying on the Vine: How Phylloxera Transformed Wine* (Berkeley, CA: University of California Press, 2011).

<sup>57</sup> Elizabeth Heath, *Wine, Sugar, and the Making of Modern France: Global Economic Crisis and the Racialization of French Citizenship, 1870-1910* (NY: Cambridge University Press, 2014).

long been popular in France, in the early years of the Third Republic agricultural lobbyists endowed it with a new, almost mythical meaning in a successful attempt to promote the drink at the expense of its new competitors.<sup>58</sup> According to this new narrative, those who did not drink were not only socially incompetent; they were, in the words of one alcohol salesman “bad Frenchmen!”<sup>59</sup> Wine, unlike absinth or other distilled alcohols, produced a particular type of sociability that reaffirmed friendship, good humor, and health, enthusiasts and physicians argued.<sup>60</sup> The only type of acceptable consumption, given these constraints, took place in public, ideally in cafés. When members of the middle class encountered the cafés of the working poor, they expressed “disgust, provoked by horror, or visceral intolerance,”<sup>61</sup> a feeling that physicians legitimated on medical grounds. Medical discussions, as we will see, reinforced the bourgeois monopoly of good taste and cultural capital, while simultaneously casting those preferences as evidence of good health. Low prices, this emerging discourse tying the proper consumption of alcohol to propriety and legitimacy in the nation, and the recovery of French vineyards in the 1900’s came together to spur total alcohol consumption to new heights. Government statistics (which likely underestimated how much alcohol was produced) indicate that between 1820 and 1869 consumption of alcohol climbed by at least fifty percent. The amount of pure alcohol consumed in France over these years rose from 350,000 to 978,000 hectoliters.<sup>62</sup>

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<sup>58</sup> For a discussion of new marketing strategies in alcohol sales that incorporated quasi-mythological, timeless qualities, see Kolleen Guy, *When Champagne Became French* (Baltimore, MD: The Johns Hopkins University Press, 2007).

<sup>59</sup> AN: F12:6868, Henri Turpin, “La Loi des boissons,” 30.

<sup>60</sup> Sournia, *A History of Alcoholism*, 35.

<sup>61</sup> Pierre Bourdieu, *Distinction* (NY: Routledge, 1984 edition): 55.

<sup>62</sup> Susanna Barrows, “After the Commune: Alcoholism, Temperance, and Literature in the Early Third Republic,” in *Consciousness and Class Experience in Nineteenth-Century Europe* (NY: Holmes & Meier, 1979): 207. For more on efforts to control alcoholism in France prior to World War I, see Patricia Prestwich, *Drink and the Politics of Social Reform* (Palo Alto, CA: Society for the Promotion of Science and Scholarship, 1988). A good example of the continued relationship between wine and nationalism in France is found in Donald and Petie Kladstrup’s *Wine and War*, an account of French vintners’ attempts to prevent German soldiers from gaining control of the highest quality wines and champagnes during the Vichy period. The text relies on oral accounts, which collectively argue that vintners who kept back these vintages were refusing to give the Nazis an invaluable part of French identity and thus

Further encouraging consumption, but also frightening doctors, was the rise in the popularity of absinth. Although the first French absinth distillery was opened in 1805, the drink did not begin to grow in popularity until 1830, following the invasion of Algeria undertaken by Bourbon Restoration monarch Charles X. The drink, which many physicians initially believed had medicinal qualities, was prescribed to soldiers in Algeria in order to prevent both dysentery and malaria. Demanding it in the chic cafés of the *grands boulevards* while on medical leave, these soldiers simultaneously popularized the drink and continued to perpetuate the belief that absinth could aid in healing, and perhaps even stave off disease. It also appears that many French men and women associated it with the exoticism that they believed characterized life in Algeria.<sup>63</sup> Absinth became so popular that it figured prominently in the work of several well-known nineteenth-century French artists, further increasing its notoriety. One of the most famous images of absinth comes from Edgar Degas' 1876 work, *Dans un café ou L'Absinthe* (in a café or Absinth), but Degas, was far from the only artist to make absinth a central character in his work – Jean Béraud's *Le buveur d'absinthe*, (the drinker of absinth) Vincent van Gogh's *L'Absinthe*, and Henri de Toulouse-Lautrec's *Monsieur Boileau au café*, all featured glasses of the green liquid. There was, it appeared, little stigma surrounding absinth. Instead, the drink was associated with mystery, creativity, and urban life.

The consumption of absinth came with its own rituals and patterns of behavior, which defined the beverage just as much as its anise flavor did. Waiters served absinth in a large, elaborately decorated chalice, with a serving spoon laid across the top. A sugar cube would be placed on top of the spoon, which had an elaborate patterns cut into it, and the drinker would pour

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resisting (despite the fact that many of these men and women collaborated in other ways). For more on the economics of French wine, see Leo A Loubère, *The Red and the White* (Albany, NY: State University of New York Press, 1978), especially 119-153, and that work on Vichy, discussing the return to the land section.

<sup>63</sup> Marie-Claude Delahaye, *L'Absinthe: Les Affiches* (Auvers-sur-Oise, France: Musée de l'Absinthe, 2001).

water over the cube and into the chalice until the sugar was dissolved, sweetening and watering down the drink. This process would be repeated several times over the course of multiple hours, stretching the drink out as far as the drinker wanted, in order to prolong conversation.

While many artists claimed that heavy consumption of absinth inspired them, physicians argued that it resulted in madness, rapid physical degeneration, and death. It quickly became apparent that absinth was capable of intoxicating its drinker far more rapidly than any other alcoholic beverage.<sup>64</sup> Physicians became so alarmed that they coined a new disorder, *absinthisme*, to refer to the both the physical and psychoactive consequences of rapid consumption of the beverage. Nonetheless, by 1870 absinth was available in bourgeois, working-class, and bohemian cafés alike, and was often the most popular drink among both men and women.<sup>65</sup> The primary difference was that middle-class drinkers were likely to water absinth down far more than the working-class or the bohemians.

As these dramatic social and economic changes were taking place, medicine was also transforming, both in its professional organization and its approaches to treating and eradicating diseases. A number of developments in the middle and latter half of the nineteenth century spurred intra-professional conflicts among physicians over status, authority, and prestige. First among

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<sup>64</sup> Beginning in the late nineteenth century, physicians, social commentators, and artists alike claimed that the wormwood in absinth commonly induced hallucinations. While wormwood does contain thujone, which impairs chemical receptors in the brain and thus can create psychedelic states, the amount of thujone in absinth was never large enough to affect brain chemistry. Instead, it is likely that the 35-75% alcohol by volume (ABV) of nineteenth-century absinth, when most wines were 4-6% ABV, which was responsible for the beverage's perceived effects.

<sup>65</sup> The beverage spread throughout Europe, most notably to the Czech Republic (then a part of the Austro-Hungarian Empire), Great Britain, Spain, and the United States in the years before World War I. Well-known authors such as Oscar Wilde and Mark Twain enjoyed the Sazerac, perhaps the first mixed cocktail to incorporate the beverage, at *The Absinthe Room* in New Orleans, and many who wished to assert their membership in artistic circles or underline their own cosmopolitanism consumed absinth outside of France. The international bourgeoisie never developed a taste for absinth, however, and the cost coupled with the exoticism of absinth prevented it from becoming a staple for the non-French working class. Consumption remained highest by far in France prior to 1915, when production was outlawed. This popularity, too, was significant in shaping the unique consumption patterns that in turn influenced French medical understandings of alcoholism. For more on the history of absinth in France, see Delahaye, Marie-Cluade. *L'Absinthe: Son Histoire*. Auvers-sur-Oise, France: Musée de l'Absinthe, 2001.

these was the continued debate over how to understand and combat the spread of disease most effectively.<sup>66</sup> On one side of this discussion were Quarantinists, who argued that the only way to stop disease was to give government authorities the power to impose travel limitations on entire neighborhoods. On the other side were the Sanitationists, who argued that social measures were much more effective at addressing issues such as sewage disposal and the minimum quality of housing. These were the factors that Sanitationists believed were primarily responsible for the spread of diseases. For example, when confronted with an outbreak of cholera in an urban area, Quarantinists advocated for measures that cut off interactions between affected neighborhoods and the rest of the population, whereas Sanitationists urged an immediate purification of the city's drinking water. While Sanitationist interventions invited more critical examinations of how economic inequalities created disease, they simultaneously encouraged the perception that

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<sup>66</sup> Historians have developed a number of explanations for why some nations prefer certain approaches to the control of disease over others. Erwin Ackerknecht's works (see in particular *Medicine at the Paris Hospital* (Baltimore, MD: The Johns Hopkins University Press, 1967) argues that more authoritarian or absolutist regimes preferred measures that restrict personal choices, required forcible quarantine, and generally privileged the health of the community over the liberty of the individual. More democratic systems of government were in their turn more likely either to not become involved in public health measures, or to focus on environmental ways of combatting them, reflecting their commitment to free trade and the rights of the individual. Ackerknecht's formulation therefore rests heavily on the idea that scientific evidence did not favor either approach as more effective and that social and political considerations proved the deciding factor. This interpretation has been popular among investigators of medical and scientific history as it provides a framework through which to relate these fields to political, economic, and social contexts without surrendering their field's intellectual autonomy. For an example of this interpretation, see Stuart Woolf, "The *Société de Charité Maternelle*, 1788-1815," in Jonathan Barry and Colin Jones, eds., *Medicine and Charity Before the Welfare State* (NY: Routledge, 1991). Peter Baldwin offers a different explanation in his *Contagion and the State* (Cambridge, UK: Cambridge University Press, 1999). According to Baldwin, "quarantinism applied to cholera, vaccination applied to smallpox, the regulation of prostitution in hopes of stemming syphilis all were... involving violations of the bodily freedom and integrity of those feared as infectious..." (18) Yet all these measures were taken in non-authoritarian contexts. Baldwin argues that rather than political and social contexts structuring public health interventions (or a lack thereof), different experiences with diseases, both chronic (syphilis) and epidemic (cholera) determined the types of interventions different states (Baldwin studies France, Germany/Prussia, Sweden, and Great Britain) were willing to take. Those decisions then shaped the long-term structures and policies that each state developed. Geography, Baldwin argues, was also key – Great Britain did not have to contend with regular epidemics, unlike Prussia, which made it less likely to develop strict quarantine measures. For more examples of scholarship that favors this line of interpretation, see Andrew Robert Aisenberg's *Contagion: Disease, Government, and the "Social Question" in Nineteenth-Century France* (Stanford, CA: Stanford University Press, 1999), Ann-Louise Shapiro, *Housing the Poor of Paris, 1850-1902* (Madison, WI: The University of Wisconsin Press, 1985).



morality, intelligence, and health were tied to one another through hygiene.<sup>67</sup> As a result, those who suffered from disease regularly were often assumed to be dim-witted and debauched. The recommendations of these Sanitationists grew more popular in France after the cholera outbreak of 1832 and had become the basis of public health efforts in most of Western Europe by 1880.<sup>68</sup>

At the same time, a number of physicians and scientists were producing work that offered explanations concerning the spread of disease that were dramatically different from their forebears. In France, no name was larger in this conversation than Louis Pasteur's. His first well-known experiment, completed in 1862, demonstrated that mold could only grow on broth when it was exposed to microorganisms. Shortly thereafter he created a method by which these organisms could be eliminated from cow milk (today known as Pasteurization), effectively disproving the thesis that disease spores spontaneously generated in the right conditions. Although Pasteur was not the first to posit that bacteria and microorganisms caused disease, his work signaled the beginning of a new phase in scientific research, driven by a bacteriological explanation of disease. Pasteur's subsequent research into anthrax brought another dramatic paradigm shift, which resulted in a new approach to vaccination. His work demonstrated that a weakened form of a virus was both an effective vaccination agent, and safer for the patient than a healthy, thriving virus.<sup>69</sup> Robert Koch, a German physician also closely associated with microbiology, drew on many of the same principles as Pasteur in his own explorations of microbiology, and across the Channel, Joseph Lister applied Pasteur's logic to surgery, pioneering the sterile setting and dramatically increasing a patient's chances of surviving an operation. Overall, the work of Pasteur and his colleagues

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<sup>67</sup> William Coleman, *Death is a Social Disease* (Madison, WI: University of Wisconsin Press, 1982).

<sup>68</sup> Peter Baldwin, *Contagion and the State*.

<sup>69</sup> Pasteur's work on anthrax, it turns out, was a bit of a sham – although he publicly claimed that he had produced the weakened anthrax virus by exposing the bacillus to air, his laboratory notebooks show that he had actually employed the strategies of a rival scientist.

prompted physicians to look for bacteriological vectors of diseases in order to stop their spread. This in turn encouraged those interested in public health to turn their attention towards either eliminating the elements spreading disease (for example, fleas) or isolating contagious patients.<sup>70</sup>

Before bacteriological theory became popular, many physicians had relied on a miasmatic understanding to explain the spread of disease. Miasma theory held that particles from decomposing materials polluted air, changing its basic chemical makeup and enabling disease to spread. These particles were not spread *by* air; rather, they fundamentally changed the structural composition of the air itself. Individuals could, as a result, supposedly contract diseases from clouds and fogs, which were often called miasmas. Put simply, in this theoretical configuration, smell was disease.<sup>71</sup> This understanding had instilled a greater fear of the air than of the germs that people could pass along to one another through physical contact, and physicians throughout industrialized Europe made use of miasmatic theory until the turn of the century. As a result of this concentration on odor pollution, miasma theory encouraged public health efforts to focus on urban settings where overcrowding and insufficient waste removal systems created odors that would affect the air.

It is important to note that these different understandings of how diseases spread and could be stopped shared a number of common assumptions, and were not entirely opposed to one another. Quarantinists and Sanitationists were at different points on a spectrum, but they were not so removed from one another that conversation and common ground was impossible. The vast majority of medical practitioners in France did not hold steady to a single ideology, but rather used bits and pieces of each line of reasoning to make sense out of different problems. Disagreements,

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<sup>70</sup> Bruno Latour, *The Pasteurization of France*, trans. Alan Sheridan (Cambridge, MA: Harvard University Press, 1993).

<sup>71</sup> David S. Barnes, *The Great Stink of Paris and the Nineteenth Century Struggle Against Filth and Germs* (Baltimore, MD: The Johns Hopkins University Press, 2006).

whether over how to best combat alcoholism or what measures needed to be taken so that newly recruited soldiers would be stronger, split both groups in unexpected cross sections, depending on their various priorities. The clear common ground between these views tended to promote collaboration and discussion, rather than blood feuds. As a result, physicians who placed themselves at either end of the spectrum, or fell in the middle of it, worked together and discussed a variety of diseases, including alcoholism.

Although the work of Louis Pasteur, Robert Koch, and their numerous students had begun to provide more precise answers to important questions concerning how and why disease travelled, miasma theory was by no means immediately discarded in a “bacteriological revolution” – instead, new thinking regarding germs and the methods by which they were transmitted (or spontaneously generated, depending on the author) were combined with contemporary theories regarding, for example, the medical significance odors.<sup>72</sup> When most physicians wrote on the relationship between sewage (commonly pointed to as the origin of germs in large cities) and disease, it was unclear if they believed that disease spread through germs released into the air via the sewage, or through a contamination of the air itself. Pasteur himself once claimed to have encountered sheep which, after sniffing dirt other anthrax-infected sheep had been buried in, contracted the virus, demonstrating the continuing reliance on old understandings of disease, even among the most

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<sup>72</sup> There are three main trends in the scholarship on the spread of laboratory-based, bacteriological thinking in France. The first is identified most closely with Bruno Latour, *The Pasteurization of France* (Cambridge, MA: Harvard University Press, 1987). While Latour does not deny the general thesis of the “Pasteurian Revolution” (by 1895 essentially all French physicians had accepted the superiority of hygienic thinking and the bacteriology that backed it up, given the field’s greater rate of success in patient care), he does reorient his focus as historian to underline that Pasteur’s ideas were successful because he was encountering an audience that was already familiar with his ideas. The ground had been softened for Pasteur, allowing his success. In short, ideas are spread by many actors, not just one, as Pasteur’s champions had previously argued. This Pasteurian Revolution model was more forcefully challenged by Patrick Zylberman and Lion Murard, *L’Hygiène dans la République : La santé publique en France ou l’utopie contrariée, 1870-1914* (1996). Zylberman and Murard argued that hygienic thinking did not take over in France until 1920, when the Rockefeller Foundation offered help to stop the spread of tuberculosis. In this account, we see far more of the squabbling, the inefficient bureaucracy, and the general piecemeal concessions that typically characterize accounts of the Third Republic.

passionate champions of the new ones.<sup>73</sup> By 1895, a sort of common ground had been found between the bacteriological and miasmatic points of view, which David S. Barnes has termed the Sanitary-Bacteriological Synthesis.<sup>74</sup> This common ground was further reinforced by the general social and cultural disgust that came to be associated with some practices and odors (spitting and the external excretion of bodily fluids in general) in the nineteenth century.<sup>75</sup>

The growing interest in considering new approaches to the control of disease encouraged a wide variety of educated, primarily middle-class men to involve themselves in questions of environmental health in the late Enlightenment. These men were also heavily influenced by the principles of the Sanitationist movement, the growth of which significantly changed the movement around 1820s.<sup>76</sup> Known in France as hygienists, these physicians, scientists, engineers, and reforming administrators believed that public health could and should be turned into a scientific discipline based on bacteriological principles. The movement began to grow with the increased interest of Napoleon III's regime, which established a number of committees with public health responsibilities, but took little action on their recommendations. It was under the Third Republic with its bureaucratic interest in discussions of public health that hygienists exercised the most influence, and their numbers swelled rapidly. Private physicians, however, came to resent these intrusions into the doctor-patient relationship, seeing state mandates regarding the health of individuals as overly paternalistic.

Hygienists argued that their reliance on statistics and the quantitative analysis that this enabled made their interventions more effective than those of traditional physicians. Intent on

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<sup>73</sup> David S. Barnes, *The Great Stink of Paris and the Nineteenth-Century Struggle against Filth and Germs* (Baltimore, MD: The Johns Hopkins University Press, 2006): 1.

<sup>74</sup> Also see David S. Barnes, *The Making of a Social Disease* (Cambridge, MA: Harvard University Press, 1995).

<sup>75</sup> See Norbert Elias, *The Civilizing Process*, trans. Edmund Jephcott (NY: Urizen Books, 1978).

<sup>76</sup> See Ann LaBerge, *Mission and Method*, 11-18.

establishing a formal presence, in 1829 a group of hygienists primarily associated with the Paris health council launched a journal, the *Annales d'hygiène publique et de médecine légale*, which acted as the movement's unofficial mouthpiece. The quickening pace of industrialization was magnifying the public health dangers of cities, and hygienists proved particularly good at organizing and communicating with one another in these urban settings, which helped to grow both their numbers and their influence in the mid-century. At the same time, municipal health councils became common in larger cities after 1848. Hygienists joined these councils in large numbers, and in this way came to exercise a great deal of influence in citywide approaches to controlling disease. These developments, which took place before Pasteur ever set his eye to a microscope, were central to the rapid communication of bacteriology's message in the final quarter of the century. The *Annales* in particular aided in creating networks of like-minded individuals, and sharing successful strategies and proposals that could be taken up by other councils.

In order to implement their recommendations more effectively, hygienically inclined reformers sought greater governmental support for their authority under the Third Republic. Hygienists who had become members of departmental public health boards began to call for the authority to enforce their recommendations, not only across their entire *department*, but also within individual neighborhoods, particularly in large urban centers. Led by the suggestions of the Consultative Committee on Public Hygiene (CCPH), which was established in 1848 and was responsible for the nation's public health, departmental councils argued that physicians and midwives should be required to report outbreaks to health councils, thereby enabling hygienists to institute combative measures when necessary.<sup>77</sup> They also recommended that dispensaries (which

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<sup>77</sup> The Committee was established as one of several public health reforms in 1848, and operated under the authority of the Ministry of Agriculture and Commerce. Although the committee initially fulfilled the same role as the one it replaced, which was very limited, by the end of the nineteenth century its recommendations concerning national health policy carried considerable weight. For more on the CCPH, see Ann LaBerge, *Mission and Method*,

physicians who were not quite so hygienically-inclined argued often encroached on their diagnostic territory) should be more widely available, particularly to the poorest sections of the population, and that communes should be required to ensure clean streets, healthful disposal of human waste, and untainted water.<sup>78</sup> The popularity of Pasteur and of the institute founded in his name in 1887 helped hygienists to publicize their ideas, and in 1902 the National Assembly passed legislation initially proposed by the CCPH. This legislation mandated vaccination against smallpox in the general population, the establishment of health offices and committees in every city, and placed greater emphasis on the importance of gathering and reporting statistics regarding a city's health.<sup>79</sup> All of these measures, it should be clear, were not only intended to address the concerns of hygienists, but also privileged hygienists' procedures.

Private practitioners and primary-care physicians saw this new enthusiasm for public health and preventative measures as an attack on their sphere of influence, one which would increase the visibility and prestige of asylum physicians and the hygienically-inclined at their own expense.<sup>80</sup> Eventually, these doctors feared, the proposed hygienic boards and growing centralization would degrade their professional status, making them little more than government lackeys subject to the whims of the elite asylum physicians and hygienists, whose authority private practitioners, especially those who worked in family practices, both resented and rejected. Doctors therefore viewed not only these reformers, but also nearly all government regulations with suspicion.

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(Cambridge, MA: Cambridge University Press, 1992), 89-94, and Martha Hildreth, *Doctors, Bureaucrats, and Public Health in France, 1888-1902* (NY: Garland, 1987).

<sup>78</sup> La Berge, *Mission and Method*.

<sup>79</sup> For more on public health developments in nineteenth-century France, see George Rosen, *A History of Public Health* (Baltimore, MD: The Johns Hopkins University Press, 1958, 1993 expanded edition).

<sup>80</sup> Technically all physicians were *docteurs* (doctors), but in an attempt to differentiate between asylum physicians and private practitioners, in this dissertation I have termed all private practitioners as doctors. Asylum physicians would use the "Dr." prefix, but followed their name with a list of the hospitals and boards they were associated with, which private practitioners of course could not do.

In an attempt to combat the possibility that as a result of these developments their prestige, and even more alarmingly, their incomes, might diminish, private practitioners began to establish their own professional associations and launched a journal, *Le Concours médical*, in 1879. Two years later Dr. Auguste Cézilly founded the Union of Medical Syndicates, which was intended to protect the rights and advance the professional privileges of average physicians. Martha Hildreth estimates that up to 10,000 doctors, or 71% of the profession, belonged to local syndicates by 1892, but that only about 19% of the syndicates were affiliated with Cézilly's national organization.<sup>81</sup> Although these syndicates protected their professional rights, physicians were uncomfortable with the similarities between their unions and those of uneducated workers. Indeed, the 1864 annulment of the Loi le Chapelier, which had precluded unions from organizing, had opened the door for such an association, but there was so little enthusiasm among doctors for such an organization that it took seventeen years for one to materialize.

Despite their initial unease, private practitioners unaffiliated with asylums eventually contributed to these efforts to unite, which became known as the Physicians Union Movement (PUM), and used it to discourage the rise of government management and the growth of a state-run bureaucratic system overseeing their work. Focusing on the intra-professional rivalries between doctors and asylum physicians, once created, the Union directed their energies towards shaping legislation intended to diminish their professional competition and to create a bureaucratic and financial preference in favor of doctors while marginalizing the primacy of public asylums and the elite physicians who staffed them, *officiers de santé*, and the wide variety of traditional healers throughout the countryside. For these practitioners, their professional concerns were political, rather than ideological. They were less concerned over how to understand or halt the

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<sup>81</sup> Martha Hildreth, "Medical Rivalries and Medical Politics in France," *Journal of the History of Medicine and Allied Sciences* (1987) 42, 1: 5-29.

spread of disease, and instead interested in rejecting hygienists' incursions on their patients. Fundamentally, this was a battle over the best way to organize the relationship between private doctors and public health.

Frustrating the average private practitioner first and foremost was the attention heaped upon a small minority of elite physicians. This widely published, well-known group was employed primarily by (and therefore in favor of a system built around) state-funded asylums and faculties of medicine. They also often held side posts in state bureaucracies, where they could both experiment with hygienic measures and accumulate not-insignificant sums of money. Many of the earliest and most well-known hygienic thinkers came from these institutions, including Alexandre Parent du Châtelet, whose 1832 study of Parisian prostitutes was deemed a landmark work for its use of statistical thinking and well-ordered categorization of patients. Observation and work in these asylums was also a fundamental part of a medical student's education. When students wrote theses in support of their degrees, they often relied on the observations they made in asylums as their primary evidence. This meant that these theses reflected regional variations in both common diseases and asylum populations. The fact that a vast majority of the works produced on alcoholism came from either authors associated with asylums adjacent to urban areas (particularly Paris and Lyon) underlined that in the eyes of physicians, alcoholism was largely a result of urbanization and its attendant stresses.

Writing a thesis on alcoholism while living in an urban center would have made a new graduate a strong candidate for employment in an urban, rather than rural, setting, which was very much desired among these young professionals.<sup>82</sup> There were typically more opportunities for

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<sup>82</sup> Hildreth, "Rivalries and Politics in France," 11. In reality, as Hildreth explains, the ratio of physicians to patients grew in the late nineteenth century, with the result that many rural areas were underserved, and likely continued to rely on a variety of traditional healers out of necessity as well as preference.



employment in urban settings due to the presence of more patients who were less likely to consult unlicensed practitioners. These physicians preferred to live in sophisticated urban environments, and hoped to find positions on public health boards, or administrative roles in the state's various hygienic projects (for example, inspection of schools, management of epidemics), which were prestigious as well as paid. Writing on alcoholism would also have made it difficult for a student to become a private family practitioner, as that was the speciality that had the least interest in the subject.<sup>83</sup>

This is not to say that alcoholism and the countryside were incompatible with one another. For example, it also seems that a number of former *officiers de santé*, who had to complete medical degrees after 1892 in order to continue practicing, focused on alcoholism. These men typically wrote their medical theses on to they had encountered repeatedly over the course of their careers. Despite the fact that they practiced in the countryside, where physicians and hygienists asserted there were few, if any, cases of alcoholism, several former *officiers* used numerous experiences with alcoholics to support their conclusions regarding the disease's progression. Alcoholism existed in the countryside, such works make clear, despite the fact that physicians discussed it almost exclusively in urban settings.

Regardless of these exceptions, it was this group of elite, asylum-employed, primarily male practitioners and their medical school students who wrote nearly all the medical works produced on alcoholism in France prior to World War I. They were the most likely to see patients suffering from the consequences of short-term, large-scale alcohol consumption, as these patients were likely to seek treatment at public institutions (which physicians today would term alcohol poisoning). Many students also relied on the case studies of practitioners in other asylums to fill

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<sup>83</sup> The reasons for this are more fully laid out in the following chapter on treatment of alcoholics.

out their primary evidence sections. These students, whose theses are a significant portion of this work's primary evidence, were clearly influenced by their advisers, several of whom headed up multiple projects on alcoholism and advised multiple dissertations on different aspects of alcoholism.

Private practitioners were largely uninterested in the topic. Alcoholism was, in their eyes, little more than another one of the pseudo-scientific topics that professional journals and sensationalist writers adored.<sup>84</sup> For the asylum physicians, there appears to have been a simple, two-tiered explanation for the interest in alcoholism. Firstly, there were huge numbers of patients presenting with symptoms arising from excessive alcohol consumption. Making oneself an expert in alcoholism could translate into a higher demand for services, particularly given the long timeline they estimated for effective treatment. Secondly, discussions of alcoholism, as we will see, provided an entrance point to a number of other political, social, and cultural debates. By discussing alcoholism, physicians could make themselves relevant to concerns over population growth, employment, and citizenship rights. This, in turn, could hopefully grow the professional status, protections, and concessions physicians received from the state.

Nearly as troubling to the private practitioners as the asylum elite were the *officiers de santé*, who had become a sore point by 1871.<sup>85</sup> Required to complete their training at departmental medical schools (which lacked the prestige of the physicians' faculties of medicine) and free from writing theses, these men were state-employed and practiced primarily in the countryside. They

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<sup>84</sup> For more on these frustrations and tensions, as well as private practitioners' disdain of hygienists and asylum physicians, see Jacques Léonard, *La France médicale au XIX<sup>e</sup> siècle* (Paris: Gallimard, 1978), Martha Hildreth, *Doctors, Bureaucrats, and Public Health in France* (NY: Garland Publishing, 1987), and Claudine Herzlich, "The Evolution of Relations between French Physicians and the State from 1880 to 1980," *Sociology of Health and Illness*, Vol. 4, No. 3: 241-253.

<sup>85</sup> For more on the rivalries between physicians and *officiers*, and general information regarding the *officiers*, see Matthew Ramsey, *Professional and Popular Medicine in France, 1770-1830* (NY: Cambridge University Press, 1988).

were not allowed to perform surgery without a physician's supervision, but otherwise the *officiers* fulfilled the same functions as doctors. Despite the difference in education and pay, it seems that patients in the countryside rarely distinguished between *officiers* and *docteurs*.<sup>86</sup> This threatened to undermine the elite status of physicians – if the *officiers* corps continued to grow, as it had for the first half of the nineteenth century, they might end up vying with the much more thoroughly educated physicians for patients and income. The loi Chevandier, passed in 1892, did abolish the position of *officier*, but this ultimately served to shift the competition, rather than to eliminate it, as the number of medical students graduating each year continued to increase.<sup>87</sup> In reality, the French population was growing faster than the number of medical practitioners, but the perception that a potential surplus threatened their employment and prestige structured the professional anxieties of doctors.

Finally, doctors faced a surprising challenge in the countryside, one that came from beyond their professional borders. Outside large urban centers, where a wide variety of traditional healers were available, doctor's and asylum's methods of treatment in the nineteenth century were only slowly and partially accepted. The first line of defense in the countryside against infectious diseases remained home remedies, most of which were based in folklore. If these failed, empirics, unlicensed midwives, "inspired" healers, *maiges*, and even witches could be consulted. These options were by no means discarded or made irrelevant by the arrival of physicians; attitudes were slow to change, and the addition of physicians to the menu of medical options did not obviate the desire for other practitioners. The eventual acceptance of doctors in the countryside by the end of

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<sup>86</sup> Evelyn Ackerman, *Healthcare in the Parisian Countryside* (Newark, NJ: Rutgers University Press, 1990).

<sup>87</sup> The *officiers* were given the option of completing supplementary work in order to become *docteurs* when the law was passed. It is likely that many did this. I have not found statistics attesting to the percentage that made the switch, but I have come across several theses that were written by former *officiers*.

World War I was likely tied as much to their decreasing cost and the increasing disposable income of French peasantry as it was to the efficacy of their treatments.<sup>88</sup>

Ultimately, the PUM reflected back these tensions and rivalries, which structured the medical profession in nineteenth-century France. The legislation passed by both the upper and lower chambers of the National Assembly in 1892, the loi Chevandier or Medical Practice Act (MPA), supported by the PUM, is an apt example of how those tensions played out. Concerned first and foremost with securing enough financial guarantees to ensure the middle-class status of private practitioners, the MPA granted union doctors access to state money set aside for the general population's medical expenses, one of the many public assistance programs offered by the French state.<sup>89</sup> Known as the Landais system, this measure was theoretically meant to provide increased medical services to the poor. Its supporters, however, were more interested that the new system paid physicians for the services they rendered. In this way, practitioners who were not associated with state-run asylums or health councils could ensure a constant flow of income, unfettered by the economic concerns of rural or working-class patients. At its most basic level, the Landais system would help to channel more money to private practitioners.

Prior to 1892, both the urban and rural poor in France had utilized asylums and hospitals frequently for their medical needs. The Landais system changed this state of affairs, as it required patients to have a written order to enter asylums.<sup>90</sup> Ultimately, this served “to break the power of

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<sup>88</sup> For more on changes in health care preferences, see Ann La Berge, *Mission and Method* (NY: Cambridge University Press, 1992), and Evelyn Ackerman, *Health Care in the Parisian Countryside* (Newark, NJ: Rutgers University Press, 1990).

<sup>89</sup> For more on the class status of physicians, see Ramsey, *Professional and Popular Medicine*, especially 110-112. Ramsey makes clear that physicians could not assume that they would make enough money to be comfortably within the middle class prior to the passing of the MPA.

<sup>90</sup> The French had mandated that every *departement* establish a public asylum to treat both mental and physical patients in 1838. This initiative did speed the construction of these institutions and made available a much more comprehensive system of care in rural areas, but several *departements* still lacked asylums in 1914.

the local elites over clientele and to keep clients out of dispensaries and hospitals.”<sup>91</sup> The new law also struck a blow against the panoply of unlicensed practitioners who had so long competed against private physicians, as it did not make state monies similarly available for patients to draw upon when consulting those who were not registered practitioners. Approval of the Landais system was eased slightly by the large numbers of physicians in both legislative houses of the Third Republic, which ensured a high level of interest and a preexisting basis of support for the lobby.<sup>92</sup> Despite all this support, French physicians continued to contend that they were under-supported and that their economic existences did not reflect their high level of specialized training.<sup>93</sup> As a result, efforts to underline their professional status remained common among physicians.

Following World War I, the increasing status of private medical practitioners, who had little interest in discussing or treating alcoholism, at the expense of state-asylum physicians seems to have discouraged most physicians and medical students from writing on alcoholism. Further driving the drop in interest, the professional borders that physicians had needed to defend were much more secure by 1919 than they had been in 1880, and the social issues that discussions of alcoholism had allowed them to address were no longer as live. As a result, research on, and indeed most medical conversations concerning alcoholism stalled after World War I. Between 1864 and 1914 there were well over five hundred fifty medical texts published on the topic, whereas in the interwar years there were hardly more than a hundred, reflecting the waning interest in alcoholism.<sup>94</sup> Furthermore, Belgian, not French, authors and publishing houses, produced a large

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<sup>91</sup> Hildreth, “Rivalries and Politics in France,” 26.

<sup>92</sup> For more on this, see Jack Ellis, *The Physician Legislators of France* (NY: Cambridge University Press, 1990).

<sup>93</sup> For more on professionalization of physicians in Europe, see Michael H. Kater, “Professionalization and Socialization of Physicians in Wilhelmine and Weimar Germany,” *Journal of Contemporary History*, Vol. 20, No. 4, 677-701.

<sup>94</sup> The continued influence of nineteenth-century medical opinions regarding alcoholism is apparent in modern-day French attitudes to drinking, particularly regarding the healthfulness of wine consumption. In 2005, the World Health Organization’s survey of national drinking patterns reported that, on average, French citizens above the age of fifteen consumed 8.14 liters of wine every year. The only western European nation with a higher level of wine

number of the French-language texts published between 1919 and 1939. These shifts in publishing underline the interwar dominance of private physicians within the French medical community, who remained uninterested in studying, discussing, and treating alcoholism. Medical interest in the subject would not pick up until after 1950, when the French state began to put money towards the treatment of alcoholism.<sup>95</sup>

Medical practitioners were not the only group emphasizing their professionalism and expertise in medicine over these years. Psychiatry was also in the process of becoming one of the most prestigious specialties in nineteenth-century French medicine. The spread of asylums following the Law of June 30, 1838, which established a nation-wide network of these institutions, had created an enormous demand for psychiatrists in addition to providing employment for medical practitioners. In creating their professional status, psychiatrists had come into conflict with a number of other groups, most particularly the judiciary and the clergy.<sup>96</sup> The 1838 legislation had done a great deal to resolve discrepancies regarding which group had legitimate claims to an insane individual, by ending the legal requirement that a judge had to declare a person insane in order to keep him or her in an asylum. Instead, a physician practicing in an asylum (this could be a medical practitioner, or a psychiatrist) merely needed to attest to the patient's insanity in order to require his or her confinement. Replacing legal judgment with medical authority not only gave the physician a greater ability to enforce his/her treatment plan, it also served to legitimize physicians, via the state's investment of confidence and authority in the field's practitioners. Although there had been debates in the Chamber of Deputies over whether "mixed establishments,"

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consumption was Luxembourg, at 8.16, and among those same nations only Ireland and Portugal had higher averages of total amount of alcohol consumed per capita.

<sup>95</sup> See Patricia Prestwich, *Drink and the Politics of Social Reform* (Palo Alto, CA: SPOSS, 1988) and Bertrand Dargelos, *La lutte antialcoolique en France depuis le XIXe siècle* (Paris: Dalloz, 2008).

<sup>96</sup> For more on the professionalization of psychiatrists in nineteenth century France, see Jan Goldstein, *Console and Classify* (Cambridge University Press: NY, 1987). For more on psychiatry and the professions relations to the working class, see Hilary Marland, "Disappointment and Desolation," *History of Psychiatry*, Sept. 2003, 303-320.

which treated the mentally as well as the physically ill, ought to be allowed to continue operating, a family's right to privacy (essentially their right to conceal a family member's mental illness by plausibly claiming that a relative was being treated for physical illness) had prevailed, and comprehensive asylums had grown in the second half of the century. This meant that psychiatrists as well as general medical practitioners routinely saw alcoholics.

Further enhancing the psychiatrists' ability to influence power relations within the medical profession was the dramatic increase in diagnoses and general interest in hysteria in the late nineteenth century. Led by the pioneering Jean-Martin Charcot of the Salpêtrière in Paris, psychiatrists turned hysteria, which had previously been a rather vaguely defined disease with few diagnoses into a sophisticated nosological entity that they perceived more and more commonly in female patients as the century progressed. Although nearly all physicians, regardless of their specialty, had initially discussed hysteria, by the 1880s psychiatrists claimed that non-specialists were prone to mistaken diagnoses. Further expanding their authority, these psychiatrists also argued that mental disturbances of any type, even if they defied classification, were warning signs of disease. Jan Goldstein in particular has defined this move as "expansionist," and deemed it a wildly successful strategy to gain more patients on the part of the psychiatrists.<sup>97</sup>

As profitable as this strategy was, it was by no means unopposed by more general practitioners, as it constituted a tangible threat to their professional prestige and their access to patients. By asserting that most physicians were not qualified to treat diseases that affected the brain, psychiatrists threatened to exclude them from a great deal of business. As we will see, when physicians who did not label themselves psychiatrists wrote on alcoholism, they were laying claim

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<sup>97</sup> See in particular pages 331-338 in Goldstein, *Console and Classify*.

to conceptual space that psychiatry threatened to overrun.<sup>98</sup> The argument that the health of the brain was based largely in somatic (that is to say, physical) changes then constituted an attempt on the part of the physicians to assert their expertise in the face of the psychiatrists' encroachments and pretensions to exclusion.

This interpretation, that alcoholism was a medical problem resulting from physical changes to the brain that caused mental deficiencies, jibed well with the medical orthodoxy of the day. Ethical flaws and skewed patterns of reasoning had physical origins, physicians typically argued, which only they could treat. This argument was itself a movement away from the "moral" understanding of disease that had previously dominated. According to the "moral" explanation, often employed by members of the Catholic clergy, dangerous alcohol consumption was the consequence of a troubled spirit. In their expositions on the disease model of alcoholism, however, physicians asserted that high-volume alcohol consumption caused physical changes to the brain, which then resulted in irrational and criminal behavior. In this physicalist understanding of the disease, it was alcohol's ability to cause tangible changes in the brain that caused all the ensuing problems.<sup>99</sup> Concerns over alcoholism also fit nicely into the larger theme of degeneration that characterized much of French medical thinking prior to World War I. Fear of a perceived national decline became pervasive in these years, driving up interest in theories of biological criminality and hereditary degeneration. As Robert Nye has shown, physicians lavished medical attention on

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<sup>98</sup> For more on psychiatry's interest in treating alcoholism, see Patricia Prestwich, "Female Alcoholism in Paris, 1870-1920," *History of Psychiatry* Vol. 14, no. 3 (2003): 321-336. Prestwich argues that psychiatrists were not unsympathetic to alcoholism among women, and that in asylums women could expect to receive a measure of comfort, and also perhaps relief from the grind of their daily responsibilities. Prestwich, however, asserts that alcoholism in women was not discussed until the postwar era. While she is correct that female alcoholics were not typically included in works concerning male alcoholism, it is incorrect to say that physicians turned a blind eye to drinking women. Rather, the problem was considered unique, and therefore discussed independently of alcoholic men.

<sup>99</sup> Jan Goldstein, *Console and Classify: The French Psychiatric Profession in the Nineteenth Century* (University of Chicago Press, second edition 2002).



the working class in these conversations, which served to pathologize their economic status, as well as their social behaviors.<sup>100</sup> This discourse on degeneration extended into other debates, and loaded medical metaphors that stigmatized economic, political, and social statuses became common.<sup>101</sup> Working from a “deterministic” model of humanity, in which nature superseded desire and intention, the vast majority of French physicians argued that together heredity and milieu created a small number of biological possibilities, which could not be escaped or overcome.<sup>102</sup> Seeing an unending, mutually influential relationship between biological and social factors, French theorists of these interactions justified a complex stigmatization of not just criminals, but of their homes, social circles, and places of employment as well. Over time, French physicians also began to argue that evolution could move backwards as well as forwards, or that a group could “degenerate.”

Valentin Magnan’s discussions of degeneration are illustrative of the dominant logic concerning degeneration in these years. Magnan was employed as a psychiatrist at the Hôpital Sainte-Anne, where he developed a well-known model of degeneration. He based his theories in a dynamic, biologically and socially-induced hereditary degeneration, which physicians cited back to routinely. Physical structures played the primary role in creating mental maladies, Magnan and his students contended, but this did not nullify the role that other factors could play. In particular, Magnan went on to clarify, heavy consumption of absinth induced especially large and sensitive lesions in the brain that other alcoholic beverages did not typically create. The conclusion of this work on high-volume absinth consumption was that those who drank the beverage quickly and did

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<sup>100</sup> Robert Nye, *Crime, Madness and Politics in France* (NJ: Princeton University Press, 1984).

<sup>101</sup> For more on the complex workings of these discourses on degeneration, see Daniel Pick, *Faces of Degeneration: A European Disorder, 1848-1918* (NY: Cambridge University Press, 1989).

<sup>102</sup> For more on the concept of biological criminality and its Italian origins, see Mary Gibson, *Born to Crime: Cesare Lombroso and the Origins of Biological Crime* (NY: Praeger, 2002).

not dilute it sufficiently with water suffered from a particularly aggressive form of degeneration.<sup>103</sup> These two signposts were also two common critiques of working-class absinth consumption. Clearly, these discourses were transforming social behaviors into physical pathologies.

Panics over increasing rates of hysteria, a low birthrate, pathological and hereditary criminality, and the dangers of a mob mentality animated nineteenth-century French medicine and popular society alike.<sup>104</sup> These anxieties stemmed from multiple sources, including the French military defeat to the Prussians in 1871 and the subsequent unification of the German nation, along with Germany's much higher birthrate and more rapid industrialization. The continued dangers of infectious diseases in France called their national progress into question. While tuberculosis rates declined in both England and Germany in the 1880s, they appear to have reached their peak in France only in 1890.<sup>105</sup> Although typhoid had become less common in Germany and Austria, it remained the largest killer in France.<sup>106</sup> Diseases that their neighbors had managed to corral could still send the French into a panic. In other words, French medical investigations during the Third Republic consistently returned results that created a scientific narrative of decline, degeneration, and impending doom.

Beginning in the 1860's the research of Paul Broca rose to prominence, which further encouraged the perception that the brain's control of the personality and the body would be

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<sup>103</sup> For examples of this discussion, see Valentin Magnan, *De l'alcoolisme, des diverses formes de délire alcoolique at de leur traitement* (Paris: A Delahey, 1874) and Valentin Magnan, *Étude expérimentale et clinique sur l'alcoolisme, alcool et absinthe; épilepsie absinthique*, (Paris: Imprimerie de Renou et Maulde, 1871).

<sup>104</sup> For more on the falling birth rate and the complex discourse on that topic, see Elinor Accampo, *Blessed Motherhood, Bitter Fruit: Nelly Roussel and the Political of Female Pain in Third Republic France* (Baltimore, MD: The Johns Hopkins University Press, 2006), Angus McLaren, *Sexuality and Social Order* (NY: Holmes & Meier Publishers, 1983). For in-depth discussions of social anxiety and how that became medicalized in France, see Susanna Barrows, *Distorting Mirrors: Visions of the Crowd in Late Nineteenth-Century France* (New Haven, CT: Yale University Press, 1981), Ruth Harris, *Murders and Madness: Medicine, Law, and Society in the Fin de Siècle* (Oxford: Clarendon Press, 1989), Robert Nye, *Crime, Madness, and Politics in Modern France: The Medical Concept of National Decline* (Princeton, NJ: Princeton University Press, 1984).

<sup>105</sup> *The Making of a Social Disease*, 7-8.

<sup>106</sup> Hildreth, *Physicians*, 121.

changed if the physical structure of the brain altered. Broca's work focused on the relationship between changes in the brain and the ability to speak, but had far-reaching implications for the practice of medicine generally, and neuroscience in particular. Beginning with the case of a young man in Paris, who had lost the ability to speak but showed no other mental or physical impairments, Broca demonstrated via a post-mortem dissection of the man's brain that lesions on the frontal lobe (today referred to as Broca's Area) were responsible for these speech-related deficits. His theory, that physical changes in the brain could be responsible for changes in behavior, when combined with the dynamic relationship between heredity and environment that the French medical community favored, provided the theoretical foundation for discussions of alcoholism in France, and justified the perception that alcoholism had far-reaching consequences that could be systematized. Every time physicians referenced lesions on the brain (which, we will see, were fundamental in discussions of alcoholism's pathology) they were drawing on the work of Broca and his disciples, who were revolutionizing the relationship between brains and behavior in these same years.<sup>107</sup>

When considered together, it is clear that the conditions of their professional life created an atmosphere in which physicians felt it was necessary to underline their own expertise and relevance to a shifting social order while protecting themselves from the encroachments of other medical practitioners. Alcoholism was uniquely capable of creating space to do both. Only physicians had the requisite level of knowledge regarding the functions of the human body to diagnose and treat alcoholism. According to these doctors, the *officiers de santé* and the traditional healers that still proliferated in the countryside lacked the training to treat such a complex disease. The diagnosis and treatment of alcoholism, which was a complex disease involving both mental

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<sup>107</sup> For more on Paul Broca, see Leonard LaPointe, *Paul Broca and the Origins of Language in the Brain* (San Diego, CA: Plural Publishing, 2012).

and physical function, required a particular skill set that no other practitioners or healers in France possessed, thus underlining the training and the elite nature of those who graduated from a faculty of medicine. Not all physicians were equally interested in alcoholism, however. The topic had little utility to private practitioners, while asylum physicians clearly felt alcoholism offered them access to make a number of truth-claims and involve themselves in a variety of debates. As we will see, however, alcoholism in many ways failed to grow the professional status of physicians.

The idiosyncrasies of the culture surrounding alcohol consumption in France, of course, did little to discourage the average French man or woman from drinking in the late nineteenth century, while a variety of changes de-stigmatized public consumption. At the same time, a variety of meanings came attached to different styles of consumption, many of which were negative and lowered the social capital of the drinker. As we will see, physicians, who were attempting to solidify their professional status and simultaneously exclude traditional healers and *officiers de santé*, tapped into these widespread social anxieties in their discussions of alcoholism.

In short, in the second half of the nineteenth century, a variety of professional challenges made it valuable for physicians to identify a common, dangerous disease that they alone were qualified to control and treat. Medical texts outlined socially acceptable, limited forms of consumption, which encouraged patterns of consumption already common among the middle class. Middle-class drinking had become more visible, and the distinctions between middle- and working-class tastes had begun to erode as alcohol costs continued to drop. Bohemians who subverted and critiqued these norms imbibed the same beverages, occasionally in the same establishments. It would be no exaggeration to say that given these developments, middle-class moral superiority was becoming suspect. Despite this, no robust temperance movement stepped forward to form a bulwark between the classes, a state of affairs unique to France. Instead, medical

texts outlined socially acceptable, limited forms of consumption, which encouraged patterns of consumption already common among the middle class. As we will see, attempts to shore up the acceptability of middle-class drinking while stigmatizing the patterns of others were no small part of French physicians' writing on alcoholism. This would in turn influence the creation of an often convoluted logic surrounding just who should drink how much of what, according to the medical experts of the nineteenth century. In these varied and wide-ranging medical discussions regarding alcoholism we can observe the progression of the disease's process-of-becoming that revolved around the anxieties and subjective observations of the authors.

## Chapter 2 - Alcoholism in Men

When the police brought a thirty-six year old man into the Parisian hospital of Saint-Anne on the recommendation of his family, who had become worried about his sanity following a drinking binge, the initial order of diagnostic operations Dr. Auguste Motet needed to follow were very clear.<sup>108</sup> The first critical point to determine, whether the patient was male or female, was already clear.<sup>109</sup> The second, did s/he suffer from chronic or acute alcoholism, was more difficult to answer.<sup>110</sup> Although doctors took these terms from Huss, the definitions of each expanded considerably during the nineteenth century.<sup>111</sup> As the medical consequences of chronic and acute alcoholism evolved, the growing rate of alcohol consumption became increasingly dangerous.<sup>112</sup> Neither of these states, however, included a discussion of the idea that alcoholics might feel compelled to drink, that they drank despite feeling conflicted over their consumption, or that they had developed close emotional relationships to alcohol. There was no concept of addiction in this understanding of alcoholism, which would bear significantly on the treatment options available to alcoholics, as well as the way physicians made sense out excessive drinking and what it revealed about the alcoholic's personality. While these fundamentals remained relatively stable, other ideas, such as alcoholism's influence on heredity, evolved considerably, or were, like the stage "subacute alcoholism," discarded completely. Taken altogether, exploring the basic tenets of alcoholism's

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<sup>108</sup> Dr. Auguste Motet, *Considérations Générale sur l'Alcoolisme* (Paris: Rignoux, 1859): 31-34.

<sup>109</sup> Physicians argued from the start that alcoholism varied significantly between men and women, and therefore rarely discussed both sexes when writing on the disease. For a complete discussion of alcoholism among women, see chapter 4 of this work.

<sup>110</sup> Terms aside from acute and chronic were used on occasion, but acute and chronic were employed most regularly. Dr. Valentin Magnan used the term "delirious" and "dipsomania" to refer to acute crises, but also used Huss' acute when both of those terms failed to catch on. While "dipsomania" remained in circulation throughout the nineteenth century, "alcoholism" was more frequently and consistently used. Valentin Magnan, *De l'Alcoolisme, des diverses forms du délire alcoolique et de leur traitement* (Paris: A. Delahaye, 1874), Valentin Magnan, *Leçons Cliniques sur la Dipsomanie* (Paris: A. Delahaye & E. Lecroisner, 1884).

<sup>111</sup> See Jean-Charles Sournia, *Histoire de l'alcoolisme* (Paris: Flammarion, 1986).

<sup>112</sup> Dr. E. Decaisne, *La Statistique de l'Alcoolisme, ou l'éloquence de la chiffres* (Paris: Imprimerie de E. Donnaud, 1873).

pathology (how it affected the nervous system, individual organs, the flow of blood) reveals the physicalist bent that characterized these discussions, as well as the basic medical logic that would justify more complex assertions regarding alcohol's ability to change and pervert the mental functions of the alcoholic.

### **I. Acute Alcoholism**

Acute alcoholic crises could present in an almost infinite variety, but several symptoms were generally present, which made it possible for physicians to differentiate between what was often referred to as normal drunkenness, and the pathological state of the disease. While acute crises could manifest more rapidly or intensely in those who were hereditarily predisposed to alcoholism, any individual, young or old, was susceptible to them whenever they consumed alcohol. Patients were more likely to fall into these manias when drinking large amounts of distilled alcohol, or if they drank excessive amounts of alcohol regularly, but even small quantities could prompt a crisis, given the right confluence of events (one physician claimed to have seen a patient who had consumed no more than two drinks in one hour go into a multi-day crisis).<sup>113</sup> Additionally, some patients, due to their parents' history with alcohol, were likely to suffer from acute crises whenever they drank, regardless of the amount.<sup>114</sup> It should be stressed that drunkenness was not the defining symptom of an alcoholic crisis, – all drunks did not suffer acute crises, and occasionally those suffering acute crises did not appear drunk.<sup>115</sup> Acute crises could present with a wide variety of symptoms, making the nosology, which physicians did not entirely agree on to

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<sup>113</sup> Georges Desforges, *De l'alcoolisme aigu et chronique dans ses rapports avec l'épilepsie* (Paris: Imprimerie de la Faculté de la Médecine Henri Jouve, 1887), J Lagarosse, *Essai sur la folie alcoolique aiguë* (Paris: A. Parent, Imprimerie de la Faculté de la Médecine, 1864).

<sup>114</sup> B Loussert, *de l'Alcoolisme Aigu et Chronique et de son Influence sur la Progéniture* (Montpellier: Publiquement soutenue à la Faculté de Médecine de Montpellier, 1881), esp. Pgs 2-7.

<sup>115</sup> This sheds light on why physicians kept patients in hospitals long after they stopped exhibiting signs of intoxication – because they continued to show reasoning patterns associated with an acute crisis, they must still be intoxicated. This also helps to explain why physicians produced studies intended to demonstrate that it could take days for alcohol to stop affecting the brain.

begin with, extremely complex. The result was that physicians began to point to an increasingly wide variety of behaviors and symptoms as evidence of acute crises. While this might have been correct, it also served to grow the dizzying complexity of medical perceptions of acute alcoholic crises.

The most common symptom reported in acute crises was a mania characterized by excessive energy and an absence of rationality. Often the transition from calm to the state of excitation that constituted mania occurred rapidly, taking no longer than five minutes. The transition out of this state could be similarly rapid, although most cases required several days of detoxification. Nervousness, irritability, uncontrollable excesses of physical energy, and anxiety were all pointed to as symptoms of a nervous system ramping itself up towards the manic state that characterized crises.<sup>116</sup> Additionally, alcoholics might experience secondary symptoms including increased nasal congestion, reddening of the face, headache, tightening of the chest, quickened heartbeat, breathlessness, and a certain shining, glossy light in the eyes.<sup>117</sup> If a physician was unsure whether an individual exhibited these symptoms (they might have already been in the grips of a manic energy, be naturally nervous, or have a particularly pink face), observing the patient in the midst of a potential crisis would likely enable one to make a diagnosis. Exuberance, incoherence, bizarre mood swings, and irresponsible, violent urges (including the creation of plans to kill loved ones, public figures, start fires, or incite political revolution) were all pointed to as indicative of an acute alcoholic crisis.<sup>118</sup>

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<sup>116</sup> Pierre Broussain, *Les Manifestations Nerveuses de l'Alcoolisme* (Paris: Vigot Frères, Éditeurs, 1899), 7-19 especially.

<sup>117</sup> Gaston-René Colombe, *Contribution à l'étude de l'Alcoolisme en Normandie* (Paris: Imprimerie de la Faculté de la Médecine Henri Jouve, 1896), 22-24.

<sup>118</sup> Dr. Cullerre, Médecin adjoint de l'asile d'Auxerre, *Alcoolisme et Delire de la Persecutions* (Paris: Imprimerie de E. Donnaud, 1875), Dr. A. Pauchon, *étude sur quelques conditions du Développement de l'Albuminerie et en particulier sur l'Alcoolisme* (Marseille: Barlatier-Feissat père et fils, 1873). It is notable that only one symptom today commonly pointed to as evidence of extreme intoxication was almost entirely excluded from discussions of alcoholism: vomiting.



Those suffering simply from an acute attack were not particularly likely to hallucinate, most physicians agreed.<sup>119</sup> It was much more likely that a patient's senses would continue to work perfectly, but that his reasoning faculties would be so encumbered that he would misinterpret reality, often with fatal consequences. While the results were not significantly different from those of a hallucination, the pathological distinction was critical. It indicted the patient's ability to discern reality from fiction, and thus his ability to reason. Fear, anger, and violence were the most common mental states of the acute crisis.<sup>120</sup> There is no discussion of alcohol being used to calm nervous patients on the edges of "crises" or anxiety attacks; in fact, there are several accounts from these physicians of alcohol consumption exacerbating feelings of unease.<sup>121</sup> The smallest disagreements could lead to deadly arguments during acute crises, and doctors occasionally reported that under the influence of alcohol, feelings of rage lasted for days.<sup>122</sup> Additionally, although patients exhibited extreme emotions during crises, they would often have no memory of either their emotions or their actions once they had passed through the crisis.<sup>123</sup>

These crises were entirely explained through somatic causes, physicians explained, and they could predict the course of the disease accurately so long as they knew everything the alcoholic had ingested. Alcohol, they argued, was a stimulant, one which dramatically raised both blood pressure and brain and body temperature.<sup>124</sup> This accounted for the mania, the rise in skin

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<sup>119</sup> It is notable that there are very few reports of patients experiencing spinning sensations, which are commonly reported among drinkers in the twenty-first century. It seems unlikely, given the thoroughness of physicians in documenting every other symptom that they would have failed to relate this if it were observed.

<sup>120</sup> Auguste Voisin, *De l'État mental dans l'alcoolisme aigu et chronique et dans l'absinthisme* (Paris: J.-B. Baillière et fils, 1864), Anonymous, *Extrait des 'Annales médico-psychologiques,'* janvier et juillet 1864.

<sup>121</sup> Justin Cassagnau, *Quelques Réflexions sur les diverses forms de délire alcoolique et particulièrement sur le forme aigu* (Paris: Typographie A. Viollet, 1878). As will be discussed in Chapter 2, physicians did occasionally prescribe wine to calm patients' minds and stomachs. It is important to keep in mind, however, that these doctors did not perceive wine as a form of alcohol when compared to gin, vodka, or absinth.

<sup>122</sup> Dr. Henri Bonnet, *Rapport Médico-Légale sur l'état Mental de François-Paul B...* (Paris: Imprimerie de E. Donnaud, 1874).

<sup>123</sup> Dr. Lagardelle, *Affaire Caillot: Rapport Médico-Légale* (Paris: J. Bazire, Libraire, 1877).

<sup>124</sup> Beginning in the seventeenth century mental illness paradigms had begun to focus more attention on the nervous system, shifting away from explanations that relied on displacements of humors and organs. This shift is both

temperature, the increased sweating, the lowered urine output, and the extreme thirst that doctors observed in their patients. The alcohol-as-stimulant theory also helped to explain why alcoholic crises terminated suddenly, without warning – the body could not maintain the heightened conditions that created the crisis indefinitely, and its demands were so extreme that the body needed significant rest to recover. Many patients would end their crises by almost instantaneously falling into deep sleeps, lasting between twelve and twenty-four hours, but sometimes extending to two or three days.<sup>125</sup> The vast majority of patients reported amnesia or only vague, disagreeable memories following these crises, and few symptoms that seem to correlate to the modern-day “hangover.” Patients who failed to awake from their sleep were termed comatose, but these cases were relatively uncommon, unless the patient injured him or herself while intoxicated, according to the physicians who reported their experiences with alcoholics. The emotional highs and lows that physicians diagnosed were similarly short-lived, and could not influence patients once they exited the acute crisis.

When attempting to explain the pathology of either acute or chronic alcoholism, physicians most commonly used case studies as evidence, rather than statistics. These accounts, typically no longer than three pages, often read less as medical studies, and more as tragic vignettes, particularly when written on acute crises. The case of Napoléon Ferdinand, 47 years old, a married father and a café waiter, illustrates this tendency.<sup>126</sup> Ferdinand had always enjoyed a small dose of alcohol in

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reflected and furthered in the medical model of alcoholism. For more on this, see Mark S. Micale, “Charcot and the Idea of Hysteria in the Male: Gender, Mental Science, and Medical Diagnosis in Late Nineteenth-Century France,” in *Medical History*, 34, no. 4 (1990): 363-411. Most physicians today agree with their nineteenth-century colleagues that more than moderate consumption of alcohol raises blood pressure. However, more recent studies show that alcohol consumption causes blood vessels to dilate, moving them to the surface of the skin. This results in a temporary warming sensation, which physicians monitoring temperature on the skin would note. However, they would not be able to observe the blood vessel migration, and therefore would not be able to conclude that the core body temperature was simultaneously going down.

<sup>125</sup> Olga Barjnikoff, *Remarques sur quelques cas de délire alcoolique aigu* (Paris: Imprimerie de la thèses de la Faculté de Médecine de Paris Ollier-Henry, 1900): 8-22.

<sup>126</sup> Brajnikoff, *de délire alcoolique aigu*, 35-39.

the morning (this was referred to as a *goutte*, which technically translates as a spot or drop, but was considerably larger than that), but when he had been promoted to head waiter, he began to drink more, particularly rum, absinth, and cognac (this was, the reporting physician indicated, a sign that Ferdinand was too irresponsible to manage the larger wage that came with his promotion). He began to drink throughout the day more regularly, and in larger servings as a result of his increased access to alcohol. Although Ferdinand did not suffer from nightmares, he did begin to complain of pains in his arms and legs. After two months of this, he informed his family that robbers had attempted to break in the previous night. They became worried when he began brandishing a hammer and assuring his wife that if the robbers returned, he would protect the family with a hammer. After this, he suffered persistently from a variety of nonsensical nightmares.

Five days after these nightmares began, Ferdinand had deteriorated notably – he was morose, he stabbed his own feet constantly, and he had started to carry a pile of rags around, saying they were his children. At this point, on February 7<sup>th</sup>, 1900, his family, who Ferdinand could not recognize, had him taken to the Sainte-Anne hospital in Paris. The initial exam, in which he was speaking coherently, belied the serious nature of his condition. After three days in the asylum, Ferdinand could not recognize his wife, and accused her of selling their furniture in order to marry off their daughter. His paranoia grew, and soon Ferdinand was convinced that his wife had put him in the hospital because she was in cahoots with the thieves he had worried about at the beginning of his decline. Ferdinand continued to suffer from a wide variety of hallucinations and waking nightmares that involved robbers and a wide variety of exotic animals. Over the next several days he let go of most of the ideas concerning his wife scheming against him to sell or help to steal the family's furniture, but he could not let go of his belief in the existence of robbers, who he shouted were at that moment concocting elaborate plans. Ferdinand argued that he would believe the

robbers were not real only if the physicians could prove why lying would be in his own self-interest, which they were both unable and unwilling to do. The physicians seem rather frustrated by Ferdinand's demands at this point. Perhaps as a result, he was transferred to Ville Evrard, the only French hospital was an alcoholic ward, for treatment, at which point his case study ends.

Similarly typical of the presented pathology of acute crises was the account of Auguste, an eighteen year-old grocer who began drinking alcohol at age two.<sup>127</sup> Sixteen years later, having never stopped consuming alcohol for more than a day or two in his entire life, Auguste generally started the day with a small glass of brandy, and continued to drink several more throughout the day in addition to an unspecified amount of wine. He suffered from a great deal of trembling and nervousness, as well as nightmares. Prior to entering Sainte Anne hospital in January of 1900, Auguste had been visiting family in Paris. Walking along one of the grand boulevards, he came upon a garden containing several empty animal cages, which he began shaking and banging in an attempt to get a worker's attention, as he was convinced that lions were roaming the garden freely. Two men seized him and threw him out of the garden, at which point he was admitted to the local hospital. In addition to basic misunderstandings concerning reality, Auguste was certain that his fellow patients were soldiers in training, his hands trembled, and nightmares continued to disrupt his nights. He ate with gusto and slept a great deal, but refused to speak with staff at the hospital regarding his crisis. When, three days after he was admitted, there was no sign of remaining delirium, the patient was transferred to Ville Evrard, at which point his case study also ended.

The largest difference between these two accounts is that, in the terms of nineteenth-century French physicians, Ferdinand suffered from an acute crisis only, whereas when Auguste regained sobriety he was still suffering from chronic alcoholism, due to his much longer history

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<sup>127</sup> Ibid., 49-50.

of heavy drinking. While physicians believed that it took as long as three to four days for the alcohol that caused an acute crisis to leave the body, they insisted in chronic cases it took around three months for the alcoholic's body to completely eliminate alcohol from its system, and several more months for him to readjust to sobriety. As a result, he should be treated for the entirety of this time, at minimum six months, ideally one year.

## II. Chronic Alcoholism

Chronic alcoholism was not associated with the dramatic, almost instantaneous loss of control physicians observed in acute cases. In fact, chronic alcoholism was diagnosed less by observing one or two particular symptoms (the primary indicator of an acute alcoholic crisis), and more through making sense out of patterns of behavior. While physicians associated a breathtaking array of health problems with chronic alcoholism, as we will see, they struggled to pinpoint the disease's pathological nature. As one priest writing for the general public put it, "the phenomenon of alcoholism is easier to describe than to define."<sup>128</sup> Put in more modern terms, French physicians would likely have agreed that while it was difficult to define, they knew chronic alcoholism when they saw it.

Chronic alcoholics were, according to physicians, generally found in states of profound indolence and lethargy, with overly relaxed muscles. Their eyes lacked spark and vivacity, their speech was low and quiet, and they were more aggressive than their sober counterparts and less violent than those suffering from acute crises. In political terms, acute alcoholics were those who would incite a revolution; chronic alcoholics were the ones who would follow them, happy to engage in general senseless mayhem. Drunkenness, however, was not an indicator of chronic

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<sup>128</sup> Les Frères des Écoles Chrétiennes, *Alcoolisme, sa nature, ses effets, ses remèdes* (Tours, Paris: Collections des Écoles Chrétiennes, 1898): 1. Although the author does not specify in this quote, he is referring specifically to chronic alcoholism. This text does not have a credited author.

alcoholism. In fact, chronic alcoholics were likely to appear less drunk than individuals who only consumed large amounts of alcohol on an irregular basis, many physicians argued.<sup>129</sup> Repeated drunkenness could eventually lead to chronic alcoholism, but many chronic alcoholics never experienced an acute crisis. Instead, most chronic alcoholics developed their disease by indulging in a large number of small drinks of distilled alcohol throughout the day that were unlikely to result in the emotional outbursts associated with acute alcoholism.<sup>130</sup> Men who worked in manual labor were particularly likely to drink *petits verres*, small glasses of vermouth, absinth, and other bitter alcohols that they consumed every few hours. Physicians often pointed to these as responsible for instigating chronic alcoholism. The small glasses were consumed with the intent to refresh and to stimulate, not to intoxicate, reflecting the widespread nature of the belief that alcohol energized drinkers. These drinks were staples of pre-work sociability, midday breaks, and post-work café trips, and were often exchanged to indicate friendship. Refusing these drinks would have been considered an unpardonable social slight.<sup>131</sup>

It is interesting to note that the spaces where working-class consumption took place were off-limits to the almost exclusively middle-class male population of physicians writing on the subjects. While working-class cafés were of course public, physicians could never *belong* in those contexts, and even when they slumped in bohemian cafés, their attendance was motivated by the setting's novelty, not its comfort or stability. Their presence in the cafés of working-class Parisians

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<sup>129</sup> Pierre Broussain, *Les Manifestations Nerveuses de l'Alcoolisme* (Paris: Vigot Frères, Éditeurs, 1899), Élysée Leclère, *Étude sur quelques Accidents nerveux aigus et de l'Alcoolisme chronique* (Paris: A. Parent, Imprimeur de la Faculté de Médecine, 1868).

<sup>130</sup> Lucien Gambus, *De l'alcoolisme chronique terminé par paralysie générale* (Paris: Imprimerie de E. Donnaud, 1873).

<sup>131</sup> The exact volume of these drinks is hard to gauge, both because they were not standardized and because I have yet to find multiple references corroborating the same number. It seems likely that these drinks were roughly the equivalent of today's 1.5 ounces, aka "shots."

would have been unwelcome and unnatural.<sup>132</sup> Therefore, while their conjectures about the amount of alcohol consumed were likely close to correct (and there was plenty of corroborating testimony from chronic alcoholics themselves), medical writings on the appropriate setting in which to drink, or in other words physicians' critiques of the social context of drinking, were shaped by the impenetrability of the subject matter, as well as the authors' contempt for it.

The most important costs of chronic alcoholism manifested first where they could not be seen, physicians agreed, inside the body. As alcohol constantly infiltrated the blood stream and circulated, it interacted with and eventually affected each internal organ, a process physicians did not believe affected the internal organs of acute alcoholics, as the alcohol wasn't in their bodies long enough for these complex reactions to take place. Inflamed and irritated, the various organs and tissues of chronic alcoholics would excrete less carbonic acid, leading in turn to a lowered urine output, which then incited what many physicians termed "fatty degeneration." The final consequence was rapid aging, leading to death, if an accident or crime did not first claim the drinker.<sup>133</sup>

The costs of chronic alcoholism often began in the respiratory system: the larynx lost a great deal of its flexibility, the ability of the lungs to fight infection dropped, and in general the chronic alcoholic became more susceptible to tuberculosis.<sup>134</sup> As a result, persistent coughs were common among alcoholics, as were speech impairments, including slurring and stuttering. The

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<sup>132</sup> See W. Scott Haine, *The World of the Paris Cafe: Sociability among the French Working-Class, 1789-1914* (Baltimore, MD: The Johns Hopkins University Press, 1998).

<sup>133</sup> Benoit-Louis Fonrobert, *Des Troubles Nerveux de l'Alcoolisme Chronique* (Montpellier: Imprimerie typographique de gras, 1869). See also Louis Ducoeurjoly, *Alcoolisme chronique avec Démence et Paralyse Générale* (Paris: H. Jouve, Imprimerie de la Faculté de Médecine, 1905).

<sup>134</sup> French physicians were far more likely than their German, English, or American counterparts to list tuberculosis as an outcome of alcohol consumption because the French tuberculosis rate remained high in these years, while it dropped nearly everywhere else. Although it seems unlikely that this was entirely a result of the amount of alcohol consumed in France, it is possible that the higher average rate of consumption among the French depressed their immune systems in general. This is, of course, purely speculation based on anecdotal, not statistical, evidence.

stomach, which became congested and inflamed from repeated alcohol consumption, began to atrophy and ceased to secrete vital acidic fluids, in turn further irritating and impeding the digestive process.<sup>135</sup> While those who drank absinth often experienced stomach contractions and dramatic drops in the weight of the body's trunk, beer drinkers were much more likely to develop distended stomachs. Those with these overly enlarged beer stomachs were likely to lose their appetites, which in turn led to dramatic weight loss in the extremities, while the trunk of the body remained swollen.<sup>136</sup>

Long-term alcohol consumption would eventually alter the structure and composition of the liver and the kidneys. These organs could continue to function (liver and kidney failure were only discussed as the cause of an alcoholic's death on the rarest of occasions), but that functioning would be perverted and inefficient, impeded by the tightening and atrophying brought on by alcohol consumption.<sup>137</sup> The heart would beat faster and its tissues would become thinner, which meant that the heart of a chronic alcoholic often looked like it belonged to a patient twenty years older, upon dissection.<sup>138</sup> Furthermore, artery walls would either weaken or harden, leading to an aneurysm (due to the dilation of arteries, which in time would become too thin and burst) or gangrene (as arteries calcified, blood flow to certain tissues eventually ceased).<sup>139</sup> The contradiction in the assertion that a chronic alcoholic's aneurysm was caused by a weakening of arterial walls, while the gangrene was caused by overly strong arterial walls, by no means

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<sup>135</sup> Georges Penetier, *de la Gastrite dans l'Alcoolisme* (Rouen: Imprimerie E. Cagniard, 1865), 18-20.

<sup>136</sup> Dr. Frantz Glénard, *Études sur le foie et l'hépatisme* (Paris: G. Masson, Éditeur, 1895), especially 63-74, Paul Grodvolle, *Contribution a l'étude des Altérations du foie dans l'Alcoolisme* (Paris: A. Parent, Imprimeur de la Faculté de Médecine, 1875). It should be noted physicians rarely discussed the consequences of beer consumption in France, very likely because it was not consumed nearly so much as wine and distilled alcohols.

<sup>137</sup> Ernest Monin, *l'Alcoolisme: Étude Médico-Sociale* (Paris: Octave Doin, Éditeur, 1889).

<sup>138</sup> Jean-Paul Monet, *Étude sur la congestion pulmonaire alcoolique* (Paris: A. Cotillon et C, Éditeurs, 1888), Constantin J Manolesco, *Contribution a l'étude des lésions péritonéales dans l'alcoolisme* (Paris: A Parent, Imprimeur de la Faculté de Médecine, 1879), especially 5-10.

<sup>139</sup> Dr. Dujardin-Beaumetz, *Recherches Experimentales sur l'Alcoolisme Chronique* (Paris: Octave Doin, Éditeur, 1884), 52-59.



prevented physicians from endorsing these assertions and even diagnosing both in one patient at the same time. Long-term alcohol consumption had such dramatic, far-reaching consequences both because of its nature as a stimulant, and because the body was virtually powerless to develop defenses against excessive alcohol consumption, physicians argued, because it was constantly in flux.

The internal and external body temperatures of a chronic alcoholic was always higher than that of a casual drinker, but they also fluctuated constantly, which further stressed the body.<sup>140</sup> These persistent, rapid spikes in temperature excited the delicate vessels and tissues of the brain, where the ravages of alcoholism were likely most extreme, physicians speculated. In worst-case scenarios, rapid “bloody effusions” (hemorrhaging) from burst aneurysms deep within the brain would kill the chronic alcoholic. Much more common, however, was the development of lesions on the surface of the brain. These lesions, or wounds, as physicians often called them, were a result of the repetitive heating and cooling that chronic alcohol consumption instigated in the body, and could cause an almost endless variety of neurological problems. Epilepsy, madness, general paralysis, grand mal seizures, and death were all attributed to brain damage resulting from chronic alcoholism.<sup>141</sup>

Physicians routinely dissected the brains of patients they could already confirm were chronic alcoholics in life, or those they suspected suffered from the disease, reporting observation of the tell-tale lesions as confirmation of a corpse’s alcoholism.<sup>142</sup> These lesions also impaired

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<sup>140</sup> Dr. Ed Bertholet, *Action de l’Alcoolisme chronique sur les organes de l’homme et sur les glandes reproductives* (Lausanne: Giesser & Held, Imprimeurs et Éditeurs, 1913).

<sup>141</sup> Louis Richard, *Un mot sur quelques rapports de l’alcoolisme et de l’épilepsie* (Paris: A. Parent, Imprimeur de la Faculté de Médecine, 1876), Louis Leter, *de l’Alcoolisme considéré comme cause de dégénérescence et dans ses rapports avec l’épilepsie des descendants* (Paris: Henri Jouve, 1892).

<sup>142</sup> Today, physicians have a name for the concept that behavior and/or environment can create lesions that change an individual’s actions, morals, or personality: neuroplasticity. This umbrella term firstly recognizes that the brain changes significantly during an individual’s life. Patterns of behavior and routine reactions to commonly encountered stimuli encourage the brain to develop certain patterns of electrical behavior – much like pathways that

reasoning, causing the erratic behavior and psychological symptoms that were associated with alcoholism. This often led to poor decision making, and deadly accidents or suicide. When consumption ceased, they argued, the lesions would recede and heal. It was not, according to these physicians, intoxication that caused insanity or character changes amongst chronic alcoholics; it was brain damage resulting from consumption that produced long-term effects.<sup>143</sup> Equally important, it was not the lesions that caused alcoholics to drink. In this equation, chronic alcoholics were subject to the vicissitudes of irrationality even when sober. Lesions, however, would eventually heal in all but the most dramatic cases, which meant that if chronic alcoholics ceased drinking, they could once again regain their reason and function independently. Some physicians argued that the brain changes and resulting impairments in reason were so fundamental and so dramatic in alcoholics that the content of their dreams alone could act as important diagnostic tools.<sup>144</sup>

Unfortunately, the information provided regarding these commonly observed lesions was rather vague – there is no description of the size of the lesions, their exact location on the brain, or even their number. Similar lesions were reported on the brains of gerbils and guinea pigs given doses of alcohol over significant lengths of time, and physicians reported the guinea pigs displayed behavior that they interpreted as the madness and shaking associated with chronic alcoholism. Descriptions of the lesions are so sparse, however, that it is unclear whether physicians saw raised tissue or indentions on the brains that they dissected.

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get worn down in grass through regular walking. However, when the outside stimuli (an individual's experience) changes, so too can the physical structure of the brain. This is remarkably similar to the way in which French physicians explained the action of alcohol consumption on the brain. See Rebecca Jordan Young, *Brain Storm: The Flaws in the Science of Sex Differences* (Cambridge, MA: Harvard University Press, 2011).

<sup>143</sup> Henri Hugou, *Contribution a l'étude de l'épilepsie Alcoolique* (Montpellier: Imprimerie Firmin et Montane, 1913).

<sup>144</sup> Léopold Vedel, *de la Valeur Diagnostique du Rêve dans l'Alcoolisme chronique* (Paris: A. Parent, Imprimeur de la Faculté de la Médecine, 1878).

With the end of the nineteenth century came the beginning of modern neuroscience research, but when these physicians were writing, few heuristic models had been developed that reliably communicated the realities of how electrical processes and structural changes played out in the brain. It was only in the 1890s that a cell-staining procedure made it possible for researchers to observe neurons firing to one another. A number of case studies, most famous among them Paul Broca's work on the frontal lobe, had encouraged physicians to see certain areas of the brain as responsible for certain functions. By 1870, doctors had begun to search for the existence of regions of the brain that controlled specific activities and abilities. These were difficult to discover, of course, as imaging technology was unavailable and brains could only be examined post-mortem, but despite these limitations enthusiasm among medical professionals was notable.<sup>145</sup> It was at the Salpêtrière in Paris that some of the earliest work on the functions of different brain halves was done, which continued to solidify the institution's reputation as being on the cutting-edge of medical developments.<sup>146</sup> While physicians writing on alcoholism were not engaged in this type of brain research, they were aware of it, and of its potential. The language of these discussions concerning the brain's functions permeate medical texts on alcoholism. It was largely through their rather vague discussions of the consequences of damage to brain tissues that physicians were able to validate their assertions that physical changes in tissues affected the intellectual faculties of chronic and acute alcoholics.

This high level of interest in lesions on the brain reflected a general "physicalist" trend in nineteenth-century French medicine. During the fin-de-siècle the most prominent physicians in the

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<sup>145</sup> The phrenological movement had lost a great deal of its supporters following the assaults of Victor Cousin and his supporters during the July Monarchy. For more, see Martin Staum, *Labeling People: French Scholars on Society, Race, and Empire, 1815-1848* (Montreal, CA: McGill University Press, 2004).

<sup>146</sup> For more on this, see Anne Harrington, *Medicine, Mind, and the Double Brain: A Study in Nineteenth-Century Thought* (Princeton, NJ: Princeton University Press, 1987).

nation focused much of their research on the relationship between physical changes in the brain, social behavior, loss of motor control, and loss of rationality.<sup>147</sup> Jean-Martin Charcot, a pioneer in the field of neurology, based out of the Salpêtrière and one of the largest and most prestigious public hospitals in the world, devoted much of his time to the topic.<sup>148</sup> Unlike other physicalists, however, physicians studying alcoholism rarely argued that trauma to the head or other traumatic events could instigate alcoholism, and physicians studying alcoholism were likely to greet a patient's assertion that a head injury had forced him to drink negatively, brushing the brain trauma off as irrelevant.<sup>149</sup> Additionally, although there was some medical interest in the unconscious at the time, particularly in its ability to express pathologies that could develop over time, it never became a part of the medical discussion concerning alcoholism.<sup>150</sup>

There was no sense that alcoholics might drink to avoid or escape any but the most immediate of circumstances – for example, poor housing or a shrewish wife. Traumatic childhood experiences were never mentioned as possibly being responsible for alcoholism, either chronic or acute. Physicians understood alcoholism as producing certain emotions, and for encouraging irrational patterns of thought, and typically did not consider alcoholism as heightening other pre-existing emotions. Similarly, there was no argument that the brains of alcoholics could become

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<sup>147</sup> This shift away from the more “moral” understanding of mental diseases that Pinel in particular had advocated for (see Jan Goldstein, *Console and Classify*) and towards a belief that the body would expose physical defects in the brain is discussed in particular importance by Michel Foucault, *The Birth of the Clinic: An Archeology of Medical Perception*, trans. Alan Sheridan (NY: Vintage, 1975). Erwin Ackerknecht also demonstrates this shift in *Medicine at the Paris Hospitals, 1794-1848* (Baltimore, MD: The Johns Hopkins University Press, 1967). By the establishment of the Third Republic in 1870 this shift had mostly solidified, so that alcoholism was one of the first diseases that physicians outlined in a framework with a heavy preference for physicalist explanations.

<sup>148</sup> See, for example, Jean-Martin Charcot, *Leçons sur les maladies du système nerveux* (Paris: Charles Fréré, Éditeur, 1872-1883), Georges Didi-Huberman, *Invention of Hysteria: Charcot and the Photographic Iconography of the Salpêtrière* (Cambridge, MA: MIT University Press, 2004).

<sup>149</sup> Charles Salvan, *Alcoolisme et Traumatisme: Considérations sur le traitement des plaies* (Paris: A. Parent, Imprimeur de la Faculté de la Médecine de la Paris, 1879).

<sup>150</sup> The products of the unconscious, it should be clear, were not seen as objects to be “decoded,” but rather as warning signs of tendencies and desires that needed to be tamped down. For more on this, see Anthony R. W. James, “L'hallucination simple?” in *Revue d'histoire littéraire de la France*, 6 (1985): 1024-36.

accustomed to alcohol, or that brain lesions encouraged drinking. The lesions were only consequences of alcohol consumption, and because they only formed after long-term abuse could not be considered as an instigating factor.

The popularity of physicalist approaches was perhaps most vividly illustrated in the experiments physicians interested in alcoholism subjected guinea pigs, gerbils, and dogs to on a regular basis. Looking to prove that alcohol was, as they argued, a poison, physicians made use of the growing number of laboratory and clinical spaces (either provided by hospitals or, on occasion, self-constructed) to inject animals with various alcohols. These animals would invariably experience seizures and exhibit aggressive and violent behavior, all of which were taken as expressions of alcoholic crises, before dying. Upon autopsy, physicians reported lesions on the brains of their subjects, which aligned with those they observed or hypothesized in human alcoholics.<sup>151</sup> The language of these studies made sure to underline the nature of alcohol (particularly absinth) as a “poison” that undermined the control and coherence associated with “healthy” brains and bodies.

These explanations continued to highlight that the breakdown of small systems in the body, accomplished by what might strike the casual observer as minor stimulation (the consumption of three glasses of gin, for example), had surprisingly large effects on an individual’s functioning. The larger lesson of these studies and experiments was that the wrong type of alcohol consumption had far-reaching consequences, which were difficult to predict. This line of reasoning easily transferred to larger lessons concerning the fragility of society.<sup>152</sup> A well-ordered brain, like a well-ordered society, had to have highly developed capacities to silence the lower impulses and

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<sup>151</sup> For example, see Valentin Magnan, *De l'Alcoolisme, des diverses formes du délire alcoolique et de leur traitement* (Paris: A. Delahaye, 1874).

<sup>152</sup> For more on this, see Ruth Harris, *Murders and Madness*, 38-51.

elements, physicians concluded. If those capacities were weakened or shifted in any way, disaster would follow.

Case studies discussing patients suffering from chronic alcoholism were less common than those explaining acute crises, and generally far more complex, for several reasons. Firstly, chronic alcoholics were, according to the physicians who explained their pathology, far less likely to be seen by physicians. Nearly every patient diagnosed as being in an acute crisis was brought to a physician by a concerned family member or friend, or the police, but no such intervention was likely to happen in the case of chronic alcoholics. Those in acute crises, who posed an immediate danger to society and themselves, were legally required to remain in asylums until they had completely regained sobriety, while chronic alcoholics were believed to be of no immediate danger to those around them and very likely not intoxicated; as a result, their liberty was never in jeopardy, despite assertions from some physicians that they were just as dangerous as those in acute crises.<sup>153</sup> Secondly, physicians typically only saw chronic alcoholics when secondary complications arising from their drinking, such as general paralysis or epilepsy, significantly impaired the alcoholics' lives.

Assuming that they saw a small percentage of alcoholics, however, physicians argued that a much high number of French men and women suffered from undiagnosed chronic alcoholism.<sup>154</sup> Case studies of chronic alcoholics were generally longer than those of acute crises and took more factors into consideration when determining a diagnosis, as chronic alcoholism could only take root. They also more routinely contained information about a patient's life story and reproductive history (were his children intelligent? Did they suffer from chronic diseases?), as these factors

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<sup>153</sup> This issue will be returned to later, when we discuss medical discussions concerning alcohol consumption and the law in chapter 5.

<sup>154</sup> Dr. E. Decaisne, *La Statistique de l'Alcoolisme, ou l'eloquence de la chiffres* (Paris: Imprimerie de E. Donnaud, 1873).

were considered important elements of chronic alcoholism. As a result, studies of chronic alcoholics often provide more complete, nuanced, and sophisticated accounts of the diagnostic reasoning physicians employed than those describing the diagnosis of acute alcoholics. These case studies also reveal the wide variety of physical and neurological phenomenon that physicians interpreted as evidence of chronic alcoholism.

The case of François Perse, a fifty-six year-old man, born to two alcoholic parents who were both dead when he entered the departmental asylum in Cadillac in 1910, is exemplary of the typical chronic alcoholic presented in French medical literature, as well as the typical format of these case studies.<sup>155</sup> Perse did not suffer from syphilis and he was not illiterate (two litmus tests often used to indicate a patient's credibility), but the author, a physician in the departmental asylum, informed the reader that Perse had always been an "inveterate alcoholic," a term that was often used to indicate undiagnosed and therefore technically unverified chronic alcoholism.<sup>156</sup> At age twenty-three, having completed his military service, Perse had married and started to work as a druggist. Slowly he began to spend more time in the cabarets than his place of employment, and as a result before his 1910 internment had been confined three times earlier: he spent two years in a state-run asylum in the Gironde (no notes survived from this first visit), which he returned to for two months in 1897, suffering from trembling secondary to chronic alcoholism. Perse also spent an additional five months in a Gironde asylum closer to his home beginning in August 1902.

Seven years after this last stay, however, his drinking was once again causing problems. Beginning his day with one to two liters of white wine, Perse would typically consume two or

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<sup>155</sup> Henri-Célestin Bauvallet, *Alcoolisme Chronique et Paralysie Générale Progressive* (Bordeaux: G. Gounouilhou, Imprimeur de la Faculté de Médecine, 1911): 77-81.

<sup>156</sup> The combination of Perse's literacy and syphilis-free state might seem like an odd juxtaposition today, but this was the order in which the reporting physician presented the information. The intent seems to have been to link lowered education or intelligence to syphilis and similarly stigmatized diseases.

three *apéritifs* before both lunch and dinner.<sup>157</sup> Generally angry with his family when drunk, he would regularly try to kill his wife, who often took refuge with her daughter or neighbors. A multi-day drinking binge, during which he came to believe that animals were trying to tear him limb from limb, that he had inherited eight million francs, and that at his druggist job he had prepared a medication that was then used in a murder, preceded Perse's fourth hospital stay. At the end of the sixth day of his binge he was taken to a private room in the hospital, after notifying a police officer that he was the president of the Republic.<sup>158</sup> He spent several hours of yelling about the injustice of his situation, then fell into a deep sleep for nearly an entire day.

Upon waking the next day, he was unfocused and unable to remember even how many children he had. His swollen eyes and asymmetrical face were noted as signs indicating his predisposition towards degeneration, and he thought about little more than scheming a way to convince his jailers to give him alcohol. Although the delirious ideas were no longer present (he did not believe he was a millionaire or the president of the republic, for example), he remained sluggish, and while he could remember that he was in the hospital, he continually lost track of time

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<sup>157</sup> The most common *aperitif* was absinth, but it is unlikely this was Perse's drink, as physicians typically referred to absinth by name. A wide variety of alcoholic beverages and mixed drinks, known as *aperitifs*, intended to stimulate the appetite were common in the second half of the nineteenth century. While these typically had relatively low alcohol contents, consuming them on an empty stomach in rapid succession would easily lead to intoxication. Liguers, brandy, and fortified wines (wine that have distilled alcohols added, for example, port) were all popular *aperitifs* prior to World War I. Some physicians also prescribed them in order to encourage patients who had lost their appetites to eat.

<sup>158</sup> It seems that an alcoholic's level of intoxication and/or the progress of the disease itself was often estimated by the content of his hallucinations during acute crises. The more a hallucination was considered "inappropriate" given the alcoholic's position in life, the more advanced a physician would consider his alcoholism. In the case of Perse, the inclusion of a hallucination that he was the President of the Republic was meant to indicate that his alcoholism had become quite extreme, and that he was suffering from a mutually-exacerbating combination of acute and chronic alcoholism. If his hallucination had been that he worked as a machinist in a nearby factory, it is likely his case would have been considered less extreme. For a discussion of this type of medical reasoning, see Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Redwood City, CA: Stanford University Press, 1991).



and was unable to recall that it was morning when speaking with doctors.<sup>159</sup> The reporting physician referred to his state as one of “mental torpor.”<sup>160</sup>

Continually trembling and speaking with a heavy accent, his reflexes diminished over the next few days. His urine output grew alarmingly, and his lymphocyte (white blood cell) count became equal to his red blood cell count, a sign that general paralysis was about to set in, according to most physicians.<sup>161</sup> When nineteenth-century physicians said, “general paralysis,” they did not mean an inability to move (as the term today would seem to indicate), but instead an inability to control movements in multiple (and thus general) parts of the body. Uncontrollable twitching and flailing was often labelled general paralysis in acute and chronic alcoholics, as well as in hysterical patients.<sup>162</sup> Admitted to the Cadillac hospital, which was much closer to his home than the other institutions he had visited, Perse continued to recuperate, but when the case study was published his hands and tongue still trembled, and his ocular reflexes remained sluggish.<sup>163</sup> He needed to remain in the asylum for several more months at the very least, according to his physician, in order to completely remove the alcohol from his body.

At the end of the observation, Perse’s physician expressed some doubt that Perse had experienced symptoms arising from chronic alcoholism – the albumin measured in his urine had been higher than was expected in a case of chronic alcoholism, the physician asserted. However,

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<sup>159</sup> There doesn’t seem to be much of a distinction drawn between short-term and long-term memory storage. For example, in other cases, physicians would often complain that their patients could remember immediate events and events from years ago, but that the time in between those was missing.

<sup>160</sup> Henri-Célestin Bauvallet, *Alcoolisme Chronique et Paralyse Générale Progressive*, 80.

<sup>161</sup> Alix Joffroy, Roger Minot, *La Paralyse Générale* (Paris: Octave Doin et fils, Éditeurs, 1910): 301-304. Physicians who did not study alcoholism argued that physicians studying alcoholism had exaggerated the extent to which alcoholism could cause general paralysis, and encouraged patients suffering from pseudo-paralysis or hysterical paralysis to exaggerate their symptoms. For more, see A. Lacaille, *de la Pseudo-Paralyse Générale Alcoolique* (Paris: A. Parent, Imprimeur de la Faculté de la Médecine, 1881).

<sup>162</sup> Eugène Moreaux, *Marche de Paralyse Générale chez les alcooliques* (Paris: A. Parent, Imprimeur de la Faculté de la Médecine, 1881).

<sup>163</sup> The author did not specify how much time had passed between Perse’s admittance and the time of writing.

the progression of his symptoms, and particularly the amelioration of his urinary problems in conjunction with the end of his megalomaniac ideation led his physician to believe that in addition to the temporary madness of acute alcoholism, Perse suffered from (and would remain to for quite some time longer) the damage caused by chronic consumption alcoholism.

Similarly representative of chronic alcoholism and the wide variety of symptoms associated with it was the study of Florent O, a thirty-seven year-old worker brought to the hospital by his wife.<sup>164</sup> Military service in Saigon had corrupted Florent, who was suffering from syphilis as well as chronic alcoholism, his physician reported. As there was no history of alcoholism in either of his parents, or even their parents, his time in the army was pointed to as responsible for the transformation.<sup>165</sup> At age nineteen, either immediately before or after enlisting, he had contracted syphilis, one of three diseases that the French pointed to as so dangerous and so widespread that they threatened their nation's survival.<sup>166</sup> Once in Saigon, Florent fell victim to the seductions of absinth, which soldiers abroad often drank for its supposed medicinal purposes, and choum-choum, an alcoholic beverage fermented by the indigenous population.<sup>167</sup> Leaving the army at twenty-nine, Florent had married in the same year, and with his wife had produced three girls who were generally in good health. The reader was meant to conclude from this information that Florent did not have a hereditary predisposition towards alcoholism. The point was that it appeared his physiology was sound (he and his wife had an eight year-old daughter, despite having

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<sup>164</sup> Bauvallet, *Alcoolisme Chronique et Paralysie Générale*, 81-83.

<sup>165</sup> This complaint, that military service encouraged alcoholism, was a relatively common one among physicians. It was not the culture of masculinity, however, that they believed was responsible for the problem. Instead, it was the time spent in imperial climates and cultures that encouraged drinking.

<sup>166</sup> For more on French fears concerning syphilis and the problems related to its growth, see Anonymous, *Fleaux Nationaux: Depopulation – Pornographie – Alcoolisme – Affaïsement Moral* (Paris: Felix Alcan, Éditeur, 1909).

<sup>167</sup> The inclusion of this information in the case study is exemplary of the diagnostic interest physicians attached to consumption of non-French alcohol. Although Florent had not consumed choum-choum for almost twenty years when he entered the hospital, his physician believed that drinking it had perverted his preferences and style of consumption.

only been married eight years, and all his girls were generally healthy), and that his case was not entirely hopeless.

Florent had settled as a basket-maker after he had married (he had briefly considered a career as a painter, and taken a tour of France just after leaving the army, but decided the itinerant, anti-social lifestyle was not for him). Although initially well-respected, his professional status had diminished over the past two years. He did not drink enough to provoke acute alcoholic crises, but his wife reported that after consuming alcohol Florent on occasion became violent. Having left the workshop at which he was employed, he had been unable to find work for many weeks. The longer Florent remained out of work, the worse his symptoms became, although there was no report of increased alcohol consumption to accompany this development. During a four-day trip to a nearby town to find work he became drunk, lost his tools, and had to return home on foot. Suffering from a poor stomach after this trip, Florent's wife brought him to the hospital, where he was admitted and the case study began.

The report from this initial examination is exemplary of how physicians used physical symptoms to diagnose lesions on the brain as evidence of alcoholism. Physicians believed that changes to the brain (be it the development of lesions or an ice pick to the frontal lobe) manifested themselves via the drinker's actions.<sup>168</sup> These physicians would have considered the idea that a change in the brain's structure would not have any consequences in the body's functioning to be absurd.

The initial examining physician reported that while Florent appeared physically robust, even muscular, he gave the impression that an underlying weakness was about to manifest itself,

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<sup>168</sup> For more on the idea that an alcoholic's psychology could be explained primarily through the development of lesions, see Constantin J. Manolesco, *Contribution a l'Étude des Lésions péritonéales dans l'Alcoolisme* (Paris: A. Parent, Imprimeur de la Faculté de la Médecine, 1879), especially 7-8.

and his facial muscles showed signs of asymmetry, a symptom of extended alcohol consumption. His memory was oddly weakened – while he could remember the date, he was certain he had been in the hospital for two and a half years, when in reality he had only entered it the previous day. His tongue, hands, and face trembled, and minor, periodic twitches affected the rest of his body, all of which were evidence of a developing case of general paralysis. His walk became “spasmodic and uncertain” over the next few days, he shortened syllables so much that it became nearly impossible to understand his speech, and while he could still write (Florent had stayed in school until age thirteen), his characters were “deformed and hesitant...”<sup>169</sup>

In addition, his appetite remained elevated (a sign that his body was not getting enough nutrients, according to physicians who asserted that continuous alcohol consumption impeded the digestive process), and a lumbar puncture returned cerebrospinal fluid dotted with bloody globules, and lowered albumin levels, which indicated damage to the circulatory system. At the end of the account, Florent was sent to a nearby hospital for further observation. His physician was at that moment unsure whether the patient suffered from general paralysis, complications due to syphilis, or a rather idiosyncratic presentation of chronic alcoholism. Eventually, after an extended stay at the second institution, Florent’s case was pronounced one of general paralysis brought on by chronic alcoholism.

### **III. General Paralysis and the DT’s**

General paralysis was not the only muscular disorder that French physicians believed was brought on by excessive consumption of alcohol. Delirium tremens (today often referred to simply as “the DT’s”) were also common.<sup>170</sup> The difference between the diagnoses of the two diseases

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<sup>169</sup> Bauvallet, *Alcoolisme Chronique et Paralysie Générale*, 82-83.

<sup>170</sup> Those familiar with today’s diagnosis of delirium tremens likely find the above section somewhat confusing – the DT’s are today understood as the body’s reaction to a sudden cessation of alcohol consumption. In nineteenth century French medical literature, however, they were understood to be a symptom of excessive alcohol

was based on the mental state of the patient. A case study of a twenty-eight year-old alcoholic male provides a clear example.<sup>171</sup> Regularly consuming red and white wine, vermouth, and absinth, the young man had not slept well in at least a month, and following a “lively” discussion with his boss at a café where he worked, he had become delirious, irrational, and began to experience delirium tremens. The agitation became so great over the course of the following seven days that his pulse could not slow, his urine became progressively warmer, and his senses declined. Once taken to the hospital, the young man was placed in a *camisole de force*, a forbearer of the strait jacket. Over the following twelve hours he continued to decline. His pupils dilated, his breathing became labored, his pulse weakened, he was unable to speak, and fell into a coma. Eleven hours later, he was dead.

Alcoholics such as this unnamed youth suffering from delirium tremens experienced specific emotional states prior to their crises, according to French physicians. First, a deep and profound depression would strike the drinker. He would become taciturn, and often obsessed with random ideas, so much so that it would be as though “a cloud... covered his reason...”<sup>172</sup> This was sometimes called depressive ideation. The signs of depression, however, would be replaced (sometimes quite rapidly) by an excitation bordering on mania that also centered around one topic or idea. This mania could very easily be mistaken for an attack of acute drunkenness, but two symptoms in particular could alert the physician to the forthcoming onset of delirium tremens: changes in sleeping patterns (physicians believed both acute and chronic alcoholics slept poorly, as alcohol was a stimulant), and darkening of the complexion to an “earthy” shade. Additionally,

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consumption, often occurring simultaneous to acute crises. In both contexts, however, *delirium tremens* are a general uncontrollable shaking of the limbs. The *delirium tremens* were indistinguishable from general paralysis in French medicine in these years. It seems that physicians more commonly employed the term general paralysis, perhaps because it was widely known and recognized as a legitimate medical state, as opposed to *delirium tremens*, which was specific to alcoholism.

<sup>171</sup> Jules Tonnellier, *du Delirium Tremens* (Paris: A. Parent, Imprimeur de la Faculté Médecine, 1865): 47.

<sup>172</sup> Paul Lavat, *Contribution a l'Étude Clinique du Delirium Tremens* (Paris: Vigot Frères, Éditeurs, 1915): 19.

the tongue would often feel dirty, and overly thin, or “anorexic” – it is unclear if this was the drinker’s perception of the tongue, or an actual physical change.<sup>173</sup> In the two to three days that followed the appearance of these symptoms, drinkers would slowly develop what were referred to as “illusions,” often presented as precursors to hallucinations, which weaved together bits of reality with mistaken impressions. These illusions would then ultimately evolve into hallucinations. If left untreated, the patient would experience intense tremors indistinguishable from extreme cases of epilepsy and almost certainly die, either of an injury sustained during a fit or fall into a deadly coma, like that of the unnamed youth above.<sup>174</sup>

There were clearly not many differences between delirium tremens and general paralysis. Those who suffered from general paralysis were likely to remain lucid (they might, of course, mistakenly interpret reality as a result of an acute crisis), whereas a patient with delirium tremens always hallucinated. However, physicians often contradicted one another and themselves when discussing the symptoms of these two alcohol-induced disorders. Reading case studies underlines the similarities of the two disorders; unless a physician had already made clear that a text would only consider one or the other, it is difficult to predict from the symptoms if the diagnosis will be delirium tremens or general paralysis arising from an acute crisis.<sup>175</sup> Such inconsistencies underline the amount of flexibility that came along with the diagnosis of alcoholism, as well as the importance of a physician’s own perceptions in determining a diagnosis. Ultimately, however delirium tremens was left by the wayside of alcoholic terminology. By the 1900’s it was used more by German physicians than French ones, very likely because its diagnosis was so confusingly

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<sup>173</sup> Lavat, *Contribution a l’Étude Clinique du Delirium Tremens*, 21.

<sup>174</sup> Louis Richard, *Un Mot sur quelques rapports de l’alcoolisme et de l’Épilepsie* (Paris: A Parent, Imprimeur a la Faculté de la Médecine, 1876). The details concerning exactly how a coma killed a patient were unclear in these discussions.

<sup>175</sup> There should be one caveat: if a patient dies at the end of a case study, s/he will almost always be diagnosed with delirium tremens post-mortem. General paralysis was generally not associated with death.

similar to that of acute alcoholic crises, and because there was no reason to diagnose one and not the other.<sup>176</sup>

The accounts discussed above collectively underline the close relationship physicians perceived between brain and body. To put it simply, it was through a physical act (consumption of alcohol) that psychological processes were changed. In the case of Ferdinand, the head waiter, his nightmares and irrational interpretations of reality had grown as the amount of alcohol in his body, specifically his brain, accrued over time. Similarly, Florent, the unemployed basket-weaving alcoholic, became more lethargic and disinterested in fulfilling his responsibilities to his family as his alcohol consumption increased. In these discussions French physicians affirmed an intimate link between physical structures and the brain's capacity to regulate behavior. None of this, however, included a concept similar to addiction, which left a rather significant question unanswered: why did alcoholics drink? What made them alcoholics?

#### **IV. Heredity**

As we have seen, physicians believed that individuals could become alcoholics at nearly any point in their lives. They also believed that some were predisposed to develop the disease, as a result of their heredity. Early discussions of hereditary alcoholism argued that the children of alcoholics could suffer acute crises without ever drinking, but these claims soon vanished from the medical literature. Instead, doctors soon argued that the children of alcoholics were more prone to develop alcoholism than those whose parents did not drink excessively. This vulnerability, they asserted, was entirely the result of the father's alcohol consumption. Women *could* be alcoholics,

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<sup>176</sup> It appears that the term was used regularly in French medicine again beginning in the 1960's (although physicians never entirely dropped the phrase in the intervening years).

but their hereditary characteristics and their drinking while pregnant did not have as much influence on children's biological predisposition towards alcoholism.<sup>177</sup>

Medical discussions of heredity were common by 1849, and many of the most prominent physicians who addressed alcoholism were deeply involved in these discussions. Auguste Morel produced his influential *Traité de dégénérences*, which introduced a link between heredity, social environment, and racial peril, in 1857.<sup>178</sup> The popularity of this work, which created an interpretive framework in which the organization and healthfulness of urban environments shaped an individual's character, testifies to the growing medical interest in social conditions and the methodological principles of hygienism. Similarly, Morel's incorporation of terms familiar to psychologists underlined the wide variety of physicians interested in the diagnosis. This early work on degeneration argued, much like physicians studying alcoholism did, that physical variations of all kinds (ranging from psoriasis to deformed limbs) were the visible manifestations of degeneration taking place within the brain. Ideally, these variations could be read early on as signs that an individual was likely to commit crimes or neglect responsibilities.

Discussions of heredity were not limited to physical characteristics, or a "proneness" to certain diseases. Many physicians also considered heredity as important factor in determining an individual's ability to reason and to think complexly. Those with heredities tending towards degeneration acted on their most basic impulses, which were often violent, physicians asserted. Degenerates were also typically less likely to understand that pleasures should be pursued in moderation or in certain settings.<sup>179</sup> This did not, however, reflect a reliance on any one substance,

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<sup>177</sup> For more on this, see Chapter 4.

<sup>178</sup> Auguste Morel, *Traité de dégénérences physiques, intellectuelles, et morales de l'espèce humaine* (Paris: J. Baillière, 1857). See Daniel Pick, *Faces of Degeneration: A European Disorder, c. 1848-1918* (NY: Cambridge University Press, 1989).

<sup>179</sup> Dr. Étienne Lancereaux, *de l'Alcoolisme et de ses conséquences au point de vue de l'état physical, intellectual, et moral des populations*, (Paris: E. Donnaud, 1878).



as it was the general indolent pursuit of pleasure that defined degenerates. In this scenario, all pleasures were equal. Degenerates were as likely to suffer from obesity due to the overconsumption of sweets as they were from alcoholism.

Of course, any discussion of hereditary alcoholism invoked both Darwin's theory of evolution, as well as Lamarck's argument that acquired characteristics could be passed from generation to generation. Physicians who were inspired, but did not abide strictly by Lamarck's theories, often known as neo-Lamarckians, were common in France, and many elements of a neo-Lamarckian nature were included in the heterodox discussions of hereditary alcoholism. One of the most common elements of these discussions was the perception that the "alcoholic taint," as physicians often referred to a family history of alcoholism, could accumulate over time and pass down in one lump sum, creating an alcoholic out of nowhere, as it would seem to the casual observer. Often this accumulation would affect one child, almost always male, rather than an entire generation of siblings.<sup>180</sup> It also routinely skipped generations, meaning that a grandparent's drinking could jump to a grandson.

When physicians, regardless of their specific affiliations, discussed the relationship between alcoholism and heredity, they were almost exclusively interested in the father's history of alcohol consumption. As we will see later, doctors pointed to women as having more influence on children after their birth, but it was the male contribution to reproduction that they considered as formative, reflecting the continued influence of Aristotelian thought. Although a Lamarckian understanding of heredity did not argue that a mother was unable to pass characteristics down to her offspring, physicians nonetheless pointed to the father as almost exclusively responsible for a child's inherited alcoholism. The mother, physicians argued, was typically responsible for creating

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<sup>180</sup> M. Hippolyte Martin, *de l'Alcoolisme des Parents considéré comme cause de l'épilepsie chez leurs descendants* (Paris: Imprimerie de E. Donnaud, 1879).

non-hereditary alcoholics. This was an awkward position to argue, medically speaking, given the evidence studies of alcoholics' families provided. Put quite simply, the facts did not clearly demonstrate that fathers alone instigated alcoholism. As a result, physicians twisted themselves into paradoxical knots in their attempts to demonstrate the truth of their medical claims.

Theorization concerning the way that heredity influenced the development of alcoholism was complex, and changed considerably between 1860 and 1910. In their earliest arguments, physicians, particularly those who were strong proponents of bacteriological understandings of disease, asserted that a male alcoholic's sperm carried a "germ," that would then infect a fetus with alcoholism. This germ was transmitted by both chronic and acute alcoholics, but it was much less powerful in chronic alcoholics. If a father happened to be experiencing an acute crisis when the act of insemination occurred, the germ was far stronger. If a father experienced acute crises regularly, but was not drunk at the time of insemination, he would transmit only a ghost of this germ.<sup>181</sup> Further drawing on the argument that the body's temperature went up as more alcohol was consumed, physicians asserted that because the warmth of acute alcoholism stoked amorous desires (they saw no contradiction between this and the common argument that alcoholism increased violent tendencies because of the same rising body temperature). The belief that acute crises and reproductive sex went hand-in-hand was so common that physicians occasionally referred to the children of alcoholics as "children of Sunday." One grade-school teacher in the Bordeaux region claimed that based on the average level of a class's intelligence and its size she could guess the success of a wine harvest the year they were born.<sup>182</sup>

The germ theory of alcoholic heredity, awkward as it may seem, was useful as it helped to explain why the children of some alcoholics had no problem restricting their consumption, while

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<sup>181</sup> Lancereaux, *de l'Alcoolisme*, 25-41.

<sup>182</sup> M Wilfred Monod, *Dimanche et l'Alcoolisme* (Paris: Société pour l'observation du Dimanche, 1899).

others were apparently incapable of doing so. In this understanding, it made perfect sense for the children of some chronic alcoholics to be inveterate drunks, while others had no problems with alcohol, as a sperm that penetrates an ovum may or may not carry that germ. This idea also agreed with the generally held medical belief that male contributions to a child had more influence than female contributions. This was, of course, an outgrowth of a classic Aristotelian understanding of reproduction, in which the woman's contribution was the soil, the matter, and the man's was the seed, the spirit.<sup>183</sup> Although this idea had theoretically been discarded as medicine came to better understand reproduction in the nineteenth century, Aristotelian assumptions nonetheless suffused medical understandings of reproduction and heredity, particularly when discussing a child's unseen, predisposed nature.

The germ theory, however, did not last for long, as no one seemed to be able to find evidence of a germ in alcoholics. Nonetheless, the nearly obsessive number of family studies that hygienists in particular favored demonstrated that alcoholics were likely to have children who later developed alcoholism, epilepsy, were of sub-par intelligence, or suffered from a wide variety of physical birth defects. These studies were presented as more exacting and scientific than the case studies asylum physicians relied on, despite the fact that they were just as limited in nature. These methods served to underline the sophistication and precise nature of their training and analysis. Despite their claims, however, hygienists were rarely able to take into account significantly greater numbers than physicians who presented multiple case studies, which meant that their evidence was no less anecdotal than that of those they were attempting to supersede.

The best way to combat competing claims over the relationship between heredity and alcoholism, it seemed, was through scientific, laboratory-based inquiry. Physicians (not

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<sup>183</sup> See Thomas Lacquer, *Making Sex: Body and Gender from the Greeks to Freud* (Cambridge, MA: Harvard University Press, 1992).

necessarily hygienically-inclined) began to produce these types of studies around 1900, with varying levels of success. The question that was most important to answer and that earlier studies had been unable to resolve with any certainty was whether alcohol could make its way into testicles, sperm, ovaries, and ovum, and if one of these substances would prove to be more permeable than the others. Determining this was delicate, but not impossible, as physicians had created accurate procedures to measure the amount of alcohol in a liquid, and had become adept at introducing alcohol into the systems of animals by 1900.

It stood to reason that every bodily tissue could be affected by alcohol, as it was absorbed into the blood stream. There was no filtering mechanism that would protect the reproductive organs from this, and research had already shown that not only the liver, but also the heart and kidneys were affected by constant alcohol consumption. The most logical assumption physicians could make was that alcohol consumption would dehydrate all tissues - after all, experimentation had shown that putting objects in alcohol had the immediate effect of lowering their water content. As a result, physicians initially argued that alcohol consumption atrophied testicles and discouraged the production of sperm and semen, making it difficult for alcoholics to engage in sexual activity.<sup>184</sup>

If this were the case, however, how could it be that alcoholics still managed to reproduce regularly, with few observable limits on their fertility? If they were giving rise to a new and dangerous generation, as physicians argued, alcoholics had to be capable of having sex and of producing sperm, even if those sperm were of a “lower quality.”<sup>185</sup> It stood to reason that alcohol

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<sup>184</sup> Hector Ovize, *Alcoolisme et Dépopulation* (Saint-Étienne: Imprimerie A. Bardot, 1900).

<sup>185</sup> One of the most glaring gaps in these medical discussions of alcoholism is any talk concerning erectile dysfunction brought on by excessive alcohol consumption, which is particularly surprising given both the energy with which physicians argued that alcoholism was responsible for the declining French population, and the amount of medical talk devoted to undermining the masculinity of alcoholic men. I have not found so much as a veiled reference to the topic, although twentieth-century medical investigations and sexology reports indicate that it is a

was damaging cells critical to reproduction, but not to sexual function. The first step in proving this was to demonstrate the presence of alcohol in reproductive tissues. As physicians already had when attempting to determine the general pathology of alcoholism, they relied on experiments on animals to prove the veracity of their claims.

A number of studies produced on this topic were concerned with the rate at which alcohol left the body. One widely-quoted thesis, written in 1900 by a student named Nicloux at the School of Medicine in Paris, demonstrated that the muscle tissues of animals he forced to consume alcohol contained negligible amounts of the substance, regardless of how much the animals he was studying consumed.<sup>186</sup> It did, however, take some time for alcohol to disappear from the blood. For animals that were given one cubic centimeter of alcohol, it took anywhere between seven and twenty hours for their blood to be completely free of alcohol.<sup>187</sup> Given this, Nicloux concluded, it was reasonable to conclude that the genital organs absorbed alcohol the entire time it was circulating in the body. If the pancreas, the liver, the kidneys, and the heart all showed evidence of damage from alcohol consumption, why would the penis, the vagina, the testicles, or the ovaries be any different?<sup>188</sup>

Physicians continued to rely on animal experiments to find answers these questions. In one typical experiment, researchers forced three adult male guinea pigs to consume three cubic centimeters of pure alcohol for every kilogram that they weighed.<sup>189</sup> An hour and a half after this,

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common occurrence. I have no definitive explanation for this lacuna, only guesses that do not move beyond conjecture.

<sup>186</sup> Nicloux, *Recherches expérimentales sur l'élimination de l'alcool dans l'organisme. Détermination d'un "alcoolisme congénital* (Paris: O. Doin, 1900).

<sup>187</sup> It is interesting to note the method by which Nicloux introduced alcohol into his animals: removing blood, adding alcohol to it, and re-injecting the animal with it. This was in contrast to the two most common methods at the time, injecting animals with alcohol (this caused seizures and death, predictably), or forcing animals to ingest alcohol.

<sup>188</sup> It is interesting to note here that these physicians understood organs and muscle tissues to be very different entities, given this hypothesizing.

<sup>189</sup> Élisée Charra, *Contribution a l'Étude de l'Alcoolisme Héritaire* (Lyon: A. Roy, Imprimeur-Éditeur de l'Université): 34.

the guinea pigs were decapitated, and the physicians measured the amount of alcohol in their blood and in their testicles. In this experiment, they found the guinea pigs to have a blood-alcohol content of thirty percent. Their testicles were similarly analyzed, and found to have an alcohol content of twenty one percent.<sup>190</sup>

Researchers were apparently unable to perform studies on the alcohol content of the seminal vesicles in these contexts, but found it possible to study the effects of alcohol on human sperm, as they were not required to kill their subjects in order to complete the work.<sup>191</sup> Typically, men were asked to consumed various alcohols (never pure), let several hours pass, then provide a sample of their seminal fluid. Upon analysis, this fluid revealed negligible amounts of alcohol. Some physicians argued, however, that it was the long-term heavy drinking of chronic alcoholism, rather than the single heavy doses of acute alcoholism, that negatively affected sperm. This, of course, was difficult to demonstrate, as it was essentially impossible to determine the amount of alcohol ingested by chronic alcoholics and physicians could not induce controlled chronic alcoholism in patients.<sup>192</sup> One study of chronic alcoholism's effects on semen relied on a single case as verification of the author's hypothesis.<sup>193</sup>

Despite what appears to be rather thin evidence, physicians confidently asserted that “the passage of alcohol into sperm is then an accomplished fact.”<sup>194</sup> The results of this were two-fold:

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<sup>190</sup> Although the text is not explicit on this, it seems that this particular experiment was not intended to find either the content of *only* the semen or the blood in the testicles, but rather the testicles themselves, as a whole.

<sup>191</sup> This was also a lucky break, because human semen is uniquely composed, and not comparable on a chemical level to that of most other animals.

<sup>192</sup> Charra, *Contribution a l'Étude de l'Alcoolisme Héritaire*, 37.

<sup>193</sup> *Ibid.*, 38. See also Paul Souilhé, *Alcoolisme: Son Influence sur la famille et sur la depopulation* (Paris: Imprimerie de la Faculté de la Médecine, 1902).

<sup>194</sup> Charra, *Contribution a l'Étude de l'Alcoolisme Héritaire*, 39. It's important to keep in mind that physicians used the terms “semen” and “sperm” almost interchangeably in these discussions. In this case, although the physician references sperm, he means male reproductive fluids in general. See also Dr. Ed Bertholet, *Action de l'Alcoolisme chronique sur les organes de l'homme et sur les glandes reproductives* (Lausanne: Giesser & Held, Imprimeurs et Éditeurs, 1913).

some asserted that the urethra, which ejected semen from the body, atrophied as a result of the constant contact with alcohol, while others argued that alcohol adversely affected the seminal vesicles, which produce semen. As a result an alcoholic's semen became thicker, more granular, and yellow in color.<sup>195</sup> The atrophied urethra meant that the penis of a chronic alcoholic was ossified internally to the point that it could no longer become erect. While some physicians did assert that the semen of alcoholics contained such a low number of sperm cells that they were unlikely to fertilize an egg in most cases,<sup>196</sup> others argued that rather than lowering the sperm count in semen, alcohol made sperm too lazy to survive the trip to the egg. Either way, alcohol-ized sperm were either lethargic, or so fundamentally changed that they could not fertilize an egg, most physicians began arguing after the turn of the century.<sup>197</sup>

This explanation, which dominated medicine until the post-war era, was a refinement and a partial rejection of the initial “germ” theory, which was clearly open to several common-sense challenges. Why would only extreme alcohol consumption create a germ, and not overindulgence in other substances? Why would extreme consumption of coffee not create a similar germ? If there was a germ, why could it not be eradicated? If there was a germ, wouldn't it be revealed under a microscope? The theory that alcohol changed sperm negated these questions, without moving the focus away from the male contribution to reproduction, or removing heredity from conversations of alcoholism's long-term effects. Physicians also argued that lesions appeared on the genitals of alcoholics, which further interfered with reproduction. The exact nature of these lesions and their consequences, however, remained vague, and it often seems that physicians were implying their

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<sup>195</sup> Charra, *Contribution a l'Étude de l'Alcoolisme Héritaire*: 41.

<sup>196</sup> See Dr. John Lemoine, *L'Alcoolisme et l'Ivrognerie* (Paris: Imprimerie Rougier et C, 1883).

<sup>197</sup> For an example, see Hector Ovize, *Alcoolisme et Depopulation* (Saint-Étienne: Imprimerie A. Bardiot, 1900).

patients possibly also suffered from syphilis, which physicians believed was particularly common among degenerate alcoholics.

As we have seen, when discussions of alcoholism and heredity arose they centered almost exclusively on sperm and testicles, rather than ovaries, fallopian tubes, or ovum. This is not to say that physicians did not believe women's reproductive organs were not changed by alcohol consumption, but rather that "lesions of the female genital organs are less important than those of the male organs."<sup>198</sup> At times, it appeared to take quite a bit of certainty concerning the nature of the sperm's ability to transmit alcohol to argue this position in the face of information that seemed to demonstrate otherwise.

#### **V. The Ones That Didn't Last**

Physicians introduced, modified, and occasionally abandoned a variety of terms throughout their discussions of alcoholism. Perhaps the most influential of these terms was absinthisme. Valentin Magnan, a prominent Parisian psychiatrist, presented results to the French Academy of Sciences that popularized the argument that absinth was more damaging to the human body than other alcohols in 1864, but it was Théodore Challand, a member of the Paris Faculty of Medicine, who appears to have coined the term. Challand's basic argument, that certain alcohols invoked certain reactions, was an assumed fact concerning the nature of alcoholism in France. Challand, however, appears to be the first to argue that abinsth consumption was so different that it created a pathologically unique state, and that that state was far more dangerous than even acute alcoholism.<sup>199</sup>

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<sup>198</sup> Charra, *Contribution a l'Étude de l'Alcoolisme Héritaire*, 43.

<sup>199</sup> Théodore Challand, *Étude Expérimentale et Clinique sur l'Absinthisme et l'Alcoolisme* (Paris: A. Parent, Imprimeur de la Faculté de Médecine, 1871).



The unique nature of absinth consumption was a result of the toxic action that absinth oil had on the human body, Challand argued. To support his thesis, he conducted a number of experiments to determine the effects of pure absinth oil consumption on a variety of animals. In one experiment, he injected between twenty-five and thirty grams of absinth oil into the stomachs of several rabbits, who soon began to vomit. When Challand forced the rabbits to inhale the oil or injected directly into veins or tissues, they immediately experienced attacks of violent tremors, which often ended in death. The same results were reported when the experiments were repeated with guinea pigs, a pigeon, and a bulldog. Upon autopsy, typically conducted after one to five high-dose exposures, Challand observed that the hearts of these animals were filled with a thick, black substance, which he believed to be coagulated blood. The brains of the animals were covered in lesions, and their livers smelled of absinth. In the course of these experiments, Challand himself accidentally inhaled pure absinth oil, after which he reported feeling immediately despondent and depressed, and was unable to continue working for the rest of the day.

It was the attacks of tremors that made the results of absinth consumption different from that of other alcohols, as the tremors were not epileptic, according to Challand. In the years after his text appeared, physicians including Magnan continued to produce influential studies comparing the effects of alcohol and absinth consumption.<sup>200</sup> The term absinthisme became common in medical texts, and was taken up outside of France, even entering the medical lexicon in England, where absinth consumption was far more uncommon.<sup>201</sup> Following 1915, however, medical discussions of absinth and absinthisme stopped. This was largely a result of the military order

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<sup>200</sup> Léon Gautier, *l'Absinthisme Chronique* (Paris: A Delahaye et E. Lecrosnier, Editeurs, 1882), A Charpine, *de l'Absinthisme* (Paris: Henri Jouve, 1894), Eugene Ledoux, *L'Absinthe et l'Absinthisme* (Besançon: Typographie et Lythographie Dodivers, 1908).

<sup>201</sup> C.W.J. Brasher, MD, "Absinthe and Absinthe Drinking in England," in *The Lancet*, March 6<sup>th</sup>, 1930.

passed in that year that banned absinth production in France. With no one in France drinking absinth, there was no point in discussing the disease.

By the beginning of World War I there was a large body of evidence that alcohol consumption among pregnant females negatively impacted the development of a fetus.<sup>202</sup> This research was relatively easy to conduct. It only required forcing an animal (most commonly guinea pigs or dogs) to consume alcohol while pregnant, then either decapitating or suffocating the animal and analyzing the uterus, the placenta, umbilical cord and fetus itself for the presence of alcohol. The evidence gathered typically showed that the amount of alcohol the fetus came into contact with varied significantly, but it also clearly demonstrated that mothers who drank alcohol were passing it along to their children.<sup>203</sup> Surprisingly, physicians seemed unworried by this information.

This all sounds like an argument in favor of the mother's dominant influence on the fetus, at least during gestation. Nonetheless, one text from 1906 that summarized the current state of thinking concerning alcoholism and heredity closed by arguing that everything the mother did while pregnant could affect a fetus, and it was a father's duty to protect a woman from all the accidents and traumas that could harm the unborn child. This duty could not be fulfilled if he was an alcoholic.<sup>204</sup> The everyday actions of the mother were no more than another responsibility for the French citizen to manage.

Experiments intended to establish the effects of alcohol consumption on the reproductive organs also demonstrate some of the fundamental flaws that characterized medicine at the time, and help to explain how conclusions that seem unlikely today were reached in the nineteenth century. One study conducted on fertilized chicken eggs provides an interesting example.

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<sup>202</sup> For more on this, see Chapter 4.

<sup>203</sup> There was also a half-hearted attempt to link eclampsia and alcohol consumption, but this went essentially nowhere. For more on this, see Chapter 4.

<sup>204</sup> *Ibid.*, 58.

Anywhere between ten and forty-five eggs were injected with different types of alcohol, including ethanol, amyl alcohol, and butanol. The vast majority of these eggs ultimately hatched chicks with a wide variety of physical abnormalities, including twisted spines, cyclopia, and spina bifida. Although this initially seemed to demonstrate the importance of a pregnant woman's alcohol consumption, the thrust of the study pointed elsewhere. Its authors instead pointed to the length of time between incubation and the injection of alcohol as the critical factor. Eggs that were injected with alcohol immediately after being laid (this being as close to the moment of fertilization as possible) produced fewer live chicks, and more of those chicks had developmental abnormalities. Eggs that were injected with alcohol forty-eight hours after they were laid had a lower rate of abnormalities than eggs that were injected with water just after they were laid. This demonstrated that "if alcohol acts on the mother cells at the same moment that they begin their evolution, it will trouble them more easily..."<sup>205</sup> The text that included this experiment closed by arguing that the malformations caused by alcoholism, such as those observed in the egg experiment, were caused by the father's "alcoholic impregnation."<sup>206</sup> In other words, the results of the egg experiment confirmed that it was the father's contribution that mattered the most, rather than the mother's consumption, which would expose the fetus to alcohol.

What none of these physicians discussed was why alcoholics drank the way they did. Some had pointed to the father's or the mother's alcoholism as ensuring that of their children, but this only served to move the question back a generation. Everyone understood why alcoholics had originally drank, of course: everyone in France drank. But no one could explain why some men seemed unable to moderate their consumption. The concept of addiction was at no point present in these discussions. Physicians did at times argue that a relationship existed between alcohol

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<sup>205</sup> Ibid., 70.

<sup>206</sup> Ibid., 92.

consumption and a drinker's emotions, but only to argue that drinking could provoke emotional responses such as depression or anger. The emotions that were associated with alcohol consumption were in fact so negative that there was no sense that drinkers could want to provoke them. There was no sense that drinker's desires for alcohol were pathological or so strong that they could not be resisted. Of all the important characteristics that physicians included in the profile of alcoholism, none began to argue that alcoholics developed emotional connections to alcohol, or that they wanted to stop drinking but could not do so.

Nineteenth-century physicians theorized other diseases that today invoke addiction as a critical component. In France, this was referred to as *morphinomania* or *morphinisme*, but physicians pathologized the heavy use of morphine and other opiates throughout the industrialized West and its colonies, where the drugs were easily available. In nineteenth-century France, however, few seem to have believed that *morphinomania* and alcoholism had much in common. Opiates in any quantity seemed to cause anti-social behavior, whereas the correct style of alcohol consumption theoretically aided in creating sociability.<sup>207</sup> Most texts did not discuss the two disorders, or when they did, only noted that when alcohol was consumed improperly it brought about the same anti-social behavior as morphine use.

A variety other terms that physicians introduced and temporarily employed in medical discussions of alcoholism were eventually re-theorized or abandoned because they were not

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<sup>207</sup> The text that has dealt most thoroughly with opiate addiction in Europe is Howard Padwa's *Social Poison: The Culture and Politics of Opiate Control in Britain and France, 1821-1926* (Baltimore, MD: The Johns Hopkins University Press, 2012). Padwa offers insufficient evidence that addiction was a part of the discourse on opiate use in France, although it is clear that the concept was applied by physicians in Britain. Padwa argues that the term *toxicomanie* indicated addiction in France, but the word was not in regular usage, even in medical circles, before World War I. A search of the BNF's collections reveals that *toxicomanie* was used infrequently and imprecisely before 1915. At times it was employed to describe the effects of what appear to have been overdoses. *Toxicomanie* was regularly included in lists of disorders alongside *morphinisme* and *alcoolisme*, rather than as a state that applied to either condition. Whether or not physicians believed that opium and morphine users were addicted, however, did not bear on their theorizing concerning alcoholism.

relevant to evolving political or social concerns and debates. Increasing levels of detail, it seems, often confused issues that physicians wanted to present as clear-cut. As a result, physicians rejected them. This rejection did not take place through internecine squabbling, however. Instead, these terms were simply not incorporated into the dominant vocabulary employed in the growing number of works devoted to alcoholism. The phrase “subacute alcoholism” serves as a good example of this.

Dr. Leon Thomeuf’s 1890 work, *Alcoolisme Subaigu*, asserted that while women consumed alcohol, their consumption was fundamentally different from that of men. As a result of this, alcoholism in women was also distinct from alcoholism in men. Thomeuf argued that in order to reflect these pathological distinctions, different terms ought to be employed for female alcoholics. The phrase *subaigu*, or subacute, was intended to reflect the style of consumption that Thomeuf argued was particular to women: constant drinking while their husbands were away led to miniature crises. Some men could also fall prey to subacute alcoholism, Thomeuf argued, but this was generally considered a sign that they suffered from other pathological abnormalities that compromised their masculinity.

Although his argument concerning the nature of alcohol consumption among women both reflected and furthered the dominant opinion that alcoholism among women was a secondary version of the disease, perverted from its “typical” functioning among men, the phrase “subacute” never caught on in either popular or medical usage. Only a handful of texts ever employed the term, although physicians writing on alcoholism in women regularly referenced both Thomeuf’s conclusions and his research in support of the thesis that women drank differently from men.<sup>208</sup> The problem with *subaigu* seems to have been twofold – first of all, it created an ambiguous level

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<sup>208</sup> For example, Dr. R. de Ryckère’s *L’Alcoolisme Feminin* (Lyon: A. Storck et Cie. Éditeurs, 1899) uses the term subacute alcoholism to describe the pathology of alcoholism in women.

of disease in between acute and chronic, which was not only difficult to define, but also collapsed the space between the two labels, insinuating that types of alcoholic intoxication were not discretely defined, but rather existed on a spectrum.

Secondly, “subacute” did not offer physicians anything that acute and chronic did not. On the contrary, it made things more confusing, which seems to be the only explanation for its widespread, quiet rejection. There was nothing in Thomeuf’s studies that was outside the normal range of medical discourse on alcoholism. No one wrote to criticize the legitimacy of the subacute concept. It appears that the term’s limiting factor was that it did not offer greater clarity or organization, only ideological clutter. The failure of the term subacute, much like the failure of delirium tremens, demonstrates that physicians studying alcoholism did not adopt ideas and terms solely on the basis of their legitimacy alone. They cherry-picked what was useful to growing their social and political relevance, which Thomeuf’s assertions concerning the nature of female drinking did, and left behind the ideas that worked against those interests, in this case the designation “subacute.”

The most notable idea that French physicians rejected in their discussions of alcoholism was that of complete abstention from alcohol. Temperance in pre-World War I France was synonymous with one name: Dr. Paul-Maurice Legrain. Legrain put forward arguments against alcohol consumption in the same vein as most European and American advocates, which were based around the twin poles that alcohol was bad for the body, and that it cost far more economically and socially than most people realized. As a medical student of Magnan’s, Legrain had picked up an interest in both alcoholism and the national costs of hereditary degeneration, which informed his belief in the dangers of alcoholism. Unlike Magnan, however, Legrain argued

that *all* drinking was dangerous, and in 1895 he founded the *Union française antialcoolique* (UFA) to advocate for nationwide limited consumption.

Initially, it appeared that the UFA's message resonated with the French, as it quickly gained 45,000 members and government permission to establish branches in both the army and the public schools. These early successes did not last, however, in the face of the wine and absinth industries "healthful drinks" campaigns. Although the UFA did not ask its members to abstain completely from alcohol consumption (the most extreme pledge was in the youth branches, where members between ten and sixteen years of age were asked to not drink brandy, absinth, or distilled alcohol for one year, but were free to have as much wine as they liked), word of Legrain's personal teetotalism began to spread and membership dropped precipitously. Only 3,000 members signed a UFA petition in 1902, and when the remaining French anti-alcoholism groups organized into the *Ligue national contre l'alcoolisme* (LNA) in 1905, Legrain's organization was not asked to play a role. The LNA took a "moderate" stance on alcohol consumption, encouraging active men to limit themselves to one liter of wine per day.<sup>209</sup>

It was unlikely, given the centrality of alcohol consumption to sociability discussed in Chapter One, that temperance could have become popular in France. Furthermore, the national economy was reliant on the continuing cycle of wine production, purchase, and consumption. Local and national governments alike depended on the tax revenues generated by the absinth and the wine production industries. As the French were the largest consumers of their own product, a drop in drinking would be, almost paradoxically given Legrain's arguments that alcohol consumption threatened France's future, against the national interest. Given this state of affairs,

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<sup>209</sup> Patricia Prestwich, "Paul-Maurice Legrain, 1860-1939," in *Addiction* 92, no.10 (1997): 1255-1263. Much of the LNA's membership came from individual sections of the *Croix-Bleue*, a Protestant-affiliated anti-alcoholism organization that originated in Switzerland. The LNA similarly did not have a large membership.

few physicians, politicians, or private middle-class reformers, the three groups most likely to speak against alcohol consumption in similarly industrialized nations, were interested in temperance.<sup>210</sup>

All told, a great deal was taking place in the general medical literature on alcoholism. First and foremost was the attempt to create a nosology out of the enormous variety of symptoms physicians observed in alcoholics. This production of knowledge focused around several key topics, including the relationship between the brain and the body, the role of heredity, and the consequences for reproduction. This body of medical knowledge included some points of concurrence (for example, that chronic and acute alcoholism were separate phenomenon), as well as ideas and theories that were discarded (subacute alcoholism, for instance) or evolved (for instance, alcoholism and heredity). At the same time, however, the reason that alcoholics continued to drink was never theorized, and physicians did not argue that any type of addictive disorder was at play in their discussions of alcoholism. Taken altogether, throughout these discussions physicians gave shape to a body of medical knowledge with a wide array of symptoms. As we will see, these discussions gave physicians a unique opportunity to regulate and stigmatize social behaviors on the basis of both gender and class. Ultimately, however, they were unable to capitalize on that authority in a way that addressed their professional instabilities.

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<sup>210</sup> Patricia Prestwich, *Alcohol and the Politics of Social Reform* (Palo Alto, CA: Society for the Promotion of Scientific Scholarship, 1988).



### Chapter 3: Can They Be Cured?

In 1905, the mayor of the rather posh eighth arrondissement in Paris wrote that in order to begin to address the problem of alcoholism, “a large and liberal program is necessary. The family, the school, the associations, all must come together towards the same end.”<sup>211</sup> His text, *L'Éducation Antialcoolique*, went on to explain that alcohol consumption occupied such a fundamental place in French life that it would take a major social shift to undermine its hold on the population. In other words, alcoholism would have to be attacked from every possible angle to be defeated. But French physicians, aided by social reformers, would not be able to accomplish this goal – the rate of alcohol consumption in France would not change significantly between 1880 and 1914, and few treatment facilities opened for alcoholics in these years. An examination of French medical texts on the treatment of alcoholism and their recommendations for fighting the disease on a social level reveals that physicians generally favored an ad hoc approach that emphasized the dangers of alcoholic degeneration and the social costs of the disease. With no conceptual mechanism to explain that alcoholics might feel compelled or called to drink, physicians saw little point in employing a talking cure, or making use of other measures that worked upon the alcoholic's emotions and desires. Although treatment options that firmly rejected the physicalist understanding of alcoholism, such as hypnotism, were suggested by some, they made no sense to physicians within the disease paradigm. At the end of the century alcoholism treatment decisions remained informed by the physicalist explanation of the disease, and few alcoholics received long-term treatment that was not court mandated.

In cases of acute alcoholism, there was some hope of achieving a cure, as physicians believed these crises were irregular, and often occurred because of confusion over how to consume

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<sup>211</sup> Paul Beurdeley, *L'Éducation AntiAlcoolique* (Paris: Librairie Ch. Delagrave, 1905): 23.

alcohol without prompting a crisis, or because of accidents and misunderstandings. The popular saying “qui a bu, boira” (“anyone who has drunk, will drink”) perhaps best sums up medical opinion on the future of chronic alcoholics. For these patients, the best treatment was not overly optimistic, and sought to limit the damages of alcoholism, rather than to end the alcoholic’s drinking completely. A large number of the anti-alcoholism measures that physicians and advocates wrote about were more preventative than palliative or curative, and were directed towards segments of the population that (hopefully) had not begun consuming large amounts of alcohol regularly. This reflects the perception that once an individual began to drink in a certain way (alone, for example), or to drink a certain type of alcohol (almost anything distilled), s/he took the first of a series of inexorable steps down a road to degeneration and death. The treatment options that physicians recommended varied between chronic and acute cases, but none became popular enough to grow the number of alcoholics seeking treatment, or earned significant government support.

### **I. Education Efforts**

Given this state of affairs, if physicians wanted to lower consumption rates, it would be necessary to find ways to reach the youth of France and explain to them in compelling terms the negative consequences of drinking. Drinkers who had already developed troubling patterns would likely continue to reproduce them, but if the children could be reached in time, perhaps they would abstain from absinth and distilled alcohols. Finally, while it was unlikely that alcoholism could ever be eradicated entirely, reformers put forward a number of legal measures that would, they hoped, limit the public nature of consumption and inebriety. Although these measures did not constitute “treatment” in its traditional meaning, they should be considered as such because their architects intended them to change the social norms that shaped alcohol consumption. As a result,

social reforms could act as protections against alcoholism. These social recommendations, made on the basis of medical evidence, reflect the tone that defines physicians' perceptions of alcoholics: they could not be trusted, in any circumstances, and required extensive supervision.

Perhaps the most important step in spreading anti-alcohol knowledge was to convince a larger number of physicians that alcoholism was a dangerous disease that they wanted to fight. Physicians were on the front lines, interacting with patients on a regular basis and therefore more able to shape popular attitudes towards alcohol. Even more critically, they could lead by example. Education regarding the evils of alcohol, however, did not have a significant place in the curriculum of medical students, a fact bemoaned by physicians who pointed out that for most practitioners, alcohol consumption would shape the bodies of nearly every patient they treated.<sup>212</sup>

Attempting to educate more physicians and physicians-to-be about the dangers of alcoholism, in 1899 the hygienically-minded Dr. Charles Ruysen published *L'enseignement médical de l'Anti-Alcoolisme*, a textbook-style publication meant for future physicians. Ruysen began by explaining that death and medical complications resulting from the over-consumption of alcohol were new problems for physicians, and by no means simple ones. "The scope of observation is vast," Ruysen explained, and "the quantity and infinite variety of afflictions arising directly or indirectly from alcoholism inevitably call the attention."<sup>213</sup> Rhetoric of this style, which emphasized the new, complicated, and wide-ranging nature of alcoholism dominated Ruysen's text. This language not only marked out those who chose to study alcoholism as an elite group, even among physicians, but it also underlined how much autonomy these physicians had in their

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<sup>212</sup> For more on medical education in France in the nineteenth century, see Florent Palluault, *Les Ouvrages didactiques destinés aux étudiants en médecine à l'époque clinique : L'enseignement médical à travers les manuels et traits publiés par les professeurs de la Faculté de Médecine de Paris, 1794-1878*, January 2005, <http://enssibal.enssib.fr/bibliotheque/documents/dcb/palluault-vol2.pdf>

<sup>213</sup> Dr. Charles Russeyen, *L'Enseignement Médical de Anti-Alcoolisme* (Paris: Société d'Éditions Scientifique, 1899): 23.

professional lives. If they chose to practice without concerning themselves about alcoholism, there would not be an outcry from patients or their family members. “Do we count many physicians among the courageous?” Ruysen asked rhetorically in his introduction, meaning anti-alcoholism crusaders. “They are certainly found there, but not enough,” he answered, going on to argue that most French practitioners were ignorant of the damage caused by continued alcohol consumption.<sup>214</sup> Only the intellectual and moral elite, the author averred, would choose to address these problems. Presenting alcoholism as an exciting disease that few physicians were brave enough to confront, Ruysen and his contemporaries hoped to attract young, dynamic physicians to their cause.<sup>215</sup>

The first two-thirds of the textbook covered typical topics: the amount of alcohol consumed in France, the toxicity of that alcohol (most physicians considered the alcohol in absinth and other distilled alcohols much more harmful than what was found in wine – the issue was the alcohol itself, not the percentage of alcohol in a beverage), alcoholism’s influence on heredity, criminal behavior, degeneration, depopulation, and a discussion of alcohol consumption in other European nations (primarily Russia, Germany, and England). Indeed, if one were to read Ruysen’s text only for information of a more detailed or more complex level of information than what was available in general-audience anti-alcoholism writing, there would be very little to find. The third section of the book, however, addressed itself much more specifically to the future physician.

While Ruysen made use of medical terms when discussing the concrete facts regarding alcoholism (for example, discussions of acute and chronic, dipsomaniac episodes, indications of different levels of albumin in an alcoholic’s urine were all present), the dominant language employed by the author struck a philosophical, rather than medical, tone. He explained, for

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<sup>214</sup> Russyen, *L’Enseignement Médical de Anti-Alcoolisme*: 26.

<sup>215</sup> See also Dr. Galtier-Broissière, *l’Enseignement de l’Anti-Alcoolisme* (Paris: Armand Colin & C., 1897).

example, that instruction is meant to develop intelligence, whereas “education aspires to form consciousness.”<sup>216</sup> Ultimately, “to educate is to create habits of the spirit appropriate to the demands of the practical life.”<sup>217</sup> The life of the practicing physician, the text made clear, was very different from what he encountered in the classroom, where cases were laid out simply, with few complicating factors. In reality, “if a physician is to be a healer... he must remain a hygienist always and before everything.”<sup>218</sup> By “hygienist” Ruyseen meant an individual committed to methodical analysis and careful analysis. To remain ever-vigilant in this way would not be easy, and required a noble, high-minded individual. The level of rhetoric that Ruysen and his contemporaries employed regarding physicians focused on alcoholism made it necessary for them also to raise the profile and the stakes of the disease they battled. The practical consequence of this was that alcoholism, when discussed as a disease for an audience of medical students, took on an insidious, threatening character.<sup>219</sup>

This ideal of a dynamic and innovative physician, attacking an adaptable, enigmatic disease drove the sense of experimentation that characterized treatment of alcoholism. This mindset was apparent in medical treatment plans, as well as case studies detailing physicians’ attempts to treat alcoholism. It also appears that this rhetorical approach was at least partially successful – close to two hundred medical theses were written on alcoholism between 1860 and 1914 in France. By these numbers, alcoholism was by no means the most popular topic (In contrast, in these same years 580 were written on syphilis, 300 on cancer, and 2,877 on tuberculosis), it was also clearly gaining in popularity – over the same period only thirty theses were written on morphinomania, a

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<sup>216</sup> Ruyssen, *L’Enseignement Médical de Anti-Alcoolisme*: 163.

<sup>217</sup> *Ibid.*, 163.

<sup>218</sup> *Ibid.*, 160.

<sup>219</sup> It should also be noted that the emphasis placed on both the newness and the importance of the field is similar to the rhetorical arguments of other new fields of medical inquiry that emerged in the nineteenth century. Specifically here I reference the intellectual history laid out by Jan Goldstein in *Console and Classify* (Chicago, IL: University of Chicago Press, 1987).

disorder coined shortly after alcoholism. Alcoholism not only captured the attention of physicians in the second half of the nineteenth century, it attracted the newest generation, more so than other novel medical categories and diagnoses.

## II. Treatment Options

One of the most surprising aspects of the medical history of alcoholism in France is the limited nature of treatment options available, despite the large number of physicians and social commentators writing on the topic and the number of these institutions in North America and Western Europe, which was growing quickly in the same years. In France, however, there were only a small number of private treatment facilities available for those with the financial resources. The French middle-class were the exclusive patrons of these institutions, which were far too expensive for the vast majority of the working-class population, a fact that worried physicians as they believed that the working class suffered from alcoholism at the highest rates. As these institutions were privately run and appear to have not received any state funding, little information remains regarding their functioning. Along with her husband Paul-Maurice Legrain, the lonely temperance advocate, Maria Legrain, a practicing nurse similarly devoted to temperance, ran one of these institutions. The Legrains opened their facility, *La Source*, just outside of Paris in 1903. In it, the Legrains put into action the experimental treatments that were becoming common in Germany and Switzerland, including sun-bathing, hydrotherapy, massage, and gymnastics.<sup>220</sup> This facility was marketed towards middle-class patrons, who could appreciate the subtlety of the treatments, as well as the fine quality of food offered there. Upon the couple's divorce in 1909 *La Source* closed, and it does not appear that another facility opened in to fill this void. Overall, there was little demand among the middle-class for alcoholism treatment. After all, according to medical

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<sup>220</sup> Patricia Prestwich, "Paul-Maurice Legrain," in *Addiction*, 92, no. 10 (1997): 1255-1263.

opinion, the middle class was unlikely to develop alcoholism by the simple virtue of *being* middle class. Their identity precluded the disease.

The only public facility with a sizeable ward for alcoholics was the Ville-Evrard asylum, about six kilometers outside of Paris, which was founded in 1897. It remained under the direction of Dr. Legrain from its founding until 1912. Even Legrain admitted that his efforts there were “a complete failure.” This, he argued was due to the fact that few of the patients sent his way were “true” alcoholics, but rather suffered from a number of complications.<sup>221</sup> Other hospitals and asylums treated alcoholics, but hardly any seem to have checked themselves in to these institutions voluntarily, and were instead either brought by police or family members.

The vast majority of French alcoholics who received treatment in the years prior to World War I were seen at the public hospitals and asylums, which were mandated for construction by the law of 1838. These institutions were staffed primarily by medical practitioners and physicians who specialized in psychiatry. Many of these physicians were likely to hold views that were more hygienic and more bacteriologist. They were more interested in the chemical interactions that accompanied alcohol consumption, and rarely discussed alcoholism in the same blatantly moral terms as those who practiced treatment similar to the Legrains. In these institutions, after all, physicians were more likely to be interested in research tools requiring a laboratory, as that was where they had access to these tools. These physicians were also more likely to fill roles on local hygienic committees.<sup>222</sup> Like those who ran treatment centers devoted to alcoholism, asylum and hospital physicians believed that alcohol changed the brain, which in turn influenced the body, but they were likely to focus on reversing the bodily effects of alcoholism first, likely because they had less time with their patients.

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<sup>221</sup> Prefecture de la Seine, *Rapport sur le services des aliénés de la Seine, 1911* (Paris: Montevrain, 1912).

<sup>222</sup> Ann La Berge, *Mission and Method* (NY: Cambridge University Press, 2002): 113-147.

Of the patients who ended up in this system of public institutions, only a very small minority voluntarily entered. Many more were brought by their families, police officers, or court order, occasionally following long-term abuse of alcohol, but more commonly as a direct result of an acute crisis. Physicians were legally empowered to require patients to stay in the hospital or asylum as long as the patient was not lucid, but once the crisis had passed and rationality had returned, physicians had no authority to detain the patient any longer, despite any suspicions the practitioner might harbor that s/he suffered from chronic alcoholism. The longest that doctors could rationally argue a chronic crisis lasted was a week, and few seem to have been keen to keep unwilling patients for longer than four days. Physicians argued that this restriction on their ability to impose hospitalization made it impossible to do more than patch up alcoholics in the short-term, and that they needed to be granted the authority to require long-term (ideally six months at the minimum) stays, but this idea was never seriously discussed on the legislative front.<sup>223</sup>

Public asylums were of limited value to alcoholics, most physicians agreed, given the amount of alcohol that was consumed and was freely available in these institutions.<sup>224</sup> It was widely known that patients who carried out distasteful tasks in asylums were often rewarded with increased amounts of alcohol, which did little to encourage sobriety, and supervision of consumption was so lax that asylum workers would regularly bring alcohol from outside for those who requested it. Furthermore, physicians reported that alcoholics in mental institutions became demoralized, depressed, and frustrated with their fellow inmates, who often suffered from debilitating mental disorders.<sup>225</sup> These emotions did little to cool the brains of alcoholics, and in general the bleakness of these institutions did not encourage extended stays.

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<sup>223</sup> For examples of this argument, see Paul-Louis Barthés, *Alcoolisme, causes, début, traitements* (Paris, 1902).

<sup>224</sup> Prestwich, "Paul-Maurice Legrain," in *Addiction*, 92, no. 10 (1997): 1255-1263.

<sup>225</sup> Ch. Croll, *Asiles et Maisons de Relèvement pour Buveurs* (Paris: Imprimerie de Thèse de Médecine Ollier-Henry, 1903): 6-8.



The limited number of treatment options available to an alcoholic in early twentieth century France relied on creativity, inference, and observation. As discussed above, there were few facilities in France for alcoholics alone. Most physicians treated alcoholics in local hospitals, or *asiles*, alongside patients suffering from more traditional medical problems (tuberculosis or cholera, for example). When medical students wrote dissertations on alcoholism, they found their case studies both in local hospitals (in Paris, the Salpêtrière and the Sainte-Anne, the first a mental asylum, the second a medical hospital, both public, were rich resources where students typically worked with their advisers from the Paris Faculty of Medicine) and in the accounts of physicians throughout France. While the diverse nature of treatment options would have made it difficult for an alcoholic seeking a particular remedy to find it, this set-up also encouraged a proliferation of various therapeutic measures. Some were based in the scientific understanding of alcohol's effect on the body, others seemed to be evolutions of folk remedies, and still others were borrowed from treatments for similar maladies. Physicians typically employed one method at a time, rather than mixing and matching in order to address the idiosyncrasies of a patient's body.<sup>226</sup> This was likely a result of most practitioners' interest in revealing the physical basis of alcoholism – after all, if one treatment could fix the problem, there would be evidence of the disease's somatic nature.

Overall, a feeling of confusion and a sense of experimentation dominate most accounts of attempts to treat alcoholic patients. With little medical precedence to guide them when it came to treatment (in 1874, Magnan's defining work, *De l'Alcoolisme, des diverses formes du délire alcoolique et de leur traitement*<sup>227</sup>, despite its title, contained few accounts of rehabilitation, and

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<sup>226</sup> Smaller measures, also discussed below, would often be used in conjunction with a measure considered most likely to succeed, but these were understood as addressing particular physical ailments arising from alcoholism, not the alcoholism itself.

<sup>227</sup> For a complete consideration of Magnan's award-winning work, see Mignot, "Magnan et ses études sur l'alcoolisme" in *Annales medico-psychologiques*, 15, no.1 (1935): 738-747.

far more stories of alcoholics dying at the hands of doctors), physicians relied primarily on their own best judgment, rather than any standard practice. While a huge number of case studies of alcoholic patients had been published by 1910, there were few cases that ended in physicians curing their patients and sending them back home to live fulfilling, responsible lives. Most ended in continued alcoholism, prison sentences, or death.

It is in these accounts of treatment that the reader observes the most unvarnished understanding of how alcoholism changed the body and the brain, a topic gaining momentum in medical circles, as we saw in Chapter One. As a consequence of these discussions, case studies of treatment serve to reveal the assumptions and fundamental beliefs of French physicians regarding the nature of alcoholism. The diverse nature of those treatments, as well as the reasoning used to back up their application, underline the malleability and adaptability that marked the practice of treating alcoholism, as well as the distinct tactics employed against chronic alcoholism and acute attacks.

Opium was one of the most common medications prescribed by French physicians to treat acute alcoholism crises, particularly when the patient presented with delirium tremens.<sup>228</sup> The generally accepted state of medical knowledge in pre-World War I France held that opiates slowed down the nervous system and, when prescribed in high enough doses, could induce sleep.<sup>229</sup> Sleeping allowed the body to slowly correct the misfiring neurons and nerves that defined the crisis, and gave it a chance to lower its temperature, two processes that physicians agreed were confusing and frightening to the sufferer when s/he was conscious. There were some reports of mixtures of potassium and bromine (bromides) being effective in place of opium, but this was more commonly

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<sup>228</sup> It is important to note here that physicians in France were prescribing opium, not opiates, such as morphine.

<sup>229</sup> Ernest Bosc de Vèze, *de l'Opium et de la Morphine* (Paris: Bibliothèque des Curiosités, 1908).

administered to alcoholics that presented with the symptoms of an acute attack despite being sober.<sup>230</sup>

A number of factors made treatment of alcoholism with opiates attractive to physicians. The administration of opiates was relatively easy to monitor, physicians were typically familiar with prescribing the substance, and the large quantity required for an overdose meant if a dose was miscalculated or administered mistakenly, it most likely would not be fatal. Opium was available in any pharmacist's shop and several widely circulated books explained how to extract the syrup from the opium plants pod. The extracted liquid was boiled down several times, and most commonly rendered as a concentrated syrup, which then hardened into "little loaves," and were often sprinkled with poppy seeds.<sup>231</sup> Opium could theoretically be administered at home, since it was available in pharmacies and did not require special permission to purchase, but there are no accounts of it being administered to alcoholics outside the asylum. It could be that it was, and that this practice was simply invisible to physicians, but this seems unlikely. Opium treatment would be much more effective, safer, and inexpensive in asylums. It would make little sense for opium to be employed in the home, except in odd circumstances.

Perhaps most importantly, French physicians believed that opium did not present the same potential for developing a reliance (they did not use the word *addiction*, but instead employed *dépendance*) that came along with morphine. The phrase "morphinomania" had appeared in French medical literature shortly after the word alcoholism, and most physicians considered morphine to be more habit-forming, and more dangerous. It seems that concern over creating a more insidious disorder discouraged physicians from prescribing the substance as a treatment for

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<sup>230</sup> G. Gachet, *Traitement de l'Alcoolisme Aigu* (Paris: A. Parent, Imprimeur de la Faculté de Médecine, 1869).

<sup>231</sup> de Vèze, *De l'Opium et de la Morphine*, 14-15.

alcoholism in the years prior to World War I. All these factors combined meant that administering opium remained the most popular treatment for an acute alcoholic crisis.

Opium doses were given to acute alcoholics in such large quantities that it typically induced sleep in patients immediately. This effect must have also been attractive to physicians treating alcoholics, who were, they reported, likely to be rabble-rousers that worked up their companions in the hospital. The dose of opium was intended to force the body to shut down while alcohol was still circulating the system (physicians, remember, understood alcohol as a stimulant that excited the nervous system and raised blood pressure). The opium could not remove alcohol from the blood stream, but by acting with the opposite force, it could hopefully minimize the effects of alcohol consumption. Clearly, then, physicians used opium to mitigate attacks, but not treat chronic cases. It was only useful for achieving short-term goals, but could not actually undo any of the damage caused by the circulating alcohol, higher blood pressure, or raised body temperature that continued to affect the body while the alcoholic slept. Also, worryingly, patients who had not received opium previously occasionally had negative reactions to the drug, becoming *more* energetic and anxious than they were previously, and had to be restrained. Ultimately, opium did not work with every patient.

Injections of strychnine were supposed to calm acute attacks in much the same way as opium, but were also intended to be used as treatment for cases of chronic alcoholism. While Uldaric Bauzan admitted in his 1895 thesis on the subject that fewer French physicians were comfortable employing strychnine as opposed to opium, he argued that practitioners throughout Europe, particularly Russia and Germany, had achieved impressive results when using it to treat delirium tremens and general paralysis, so long as they closely monitored their doses.<sup>232</sup>

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<sup>232</sup> Uldaric Bauzan, *Du Traitement de l'Alcoolisme et de la dysomanie* (Paris: Éditions Scientifiques, 1895).

Additionally, Bauzan argued, the more commonly used opium was far more dangerous than strychnine, partially because prescribed doses varied considerably between physicians, partially because negative reactions to opium were common. Strychnine did not pose the same dangers, Bauzan argued, as relatively easy to measure and consistently produced the same results. There were multiple ways the physician could administer strychnine, and it was unlikely that complex or unforeseen reactions would take place when strychnine interacted with other substances in the alcoholic's body. Strychnine, Bauzan suggested, offered many of the same benefits as opium, including controlling the heart rate, and did not ever induce more aggressive or anxious behavior.

If anything, the true danger was that physicians would not use a high enough dose when prescribing strychnine, Bauzan went on to argue. This overly cautious dose had also been problematic – physicians did not prescribe sufficient amounts of strychnine, then wrote that it was ineffective. He claimed that patients could develop a tolerance to strychnine, and included several anecdotal cases of individuals who self-injected up to four centigrams of strychnine daily, apparently for the pleasure of it. The author also claimed to have seen “at the end of two to three days, six centigrams of strychnine injected until the disappearance of the symptoms that the patient presented with.”<sup>233</sup> There were several ways of delivering the medication: as a powder placed inside a pill capsule, which was uncommon by 1895, diluted in a lemon-flavored syrup (often referred to as lemonade), which was becoming more popular at the time of writing, or in the author's preferred method, as a subcutaneous shot delivered to the buttocks, without pushing into the patient's muscle. While the shot was more uncomfortable for the patient, it was also more

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<sup>233</sup> Bauzan, *Traitement*, 16-17. There is no indication in Bauzan's account that in these cases that the strychnine in the doses was diluted with other substances. Medical knowledge today, however, calls his figures into question, as it is estimated that 30-100 milligrams (3-10 centigrams) when ingested orally triggers a lethal reaction. In one case, an intravenous dose of 5-10 milligrams was enough to result in a fatality. More research is needed on this subject, perhaps in order to determine the chemical composition of the strychnine used in French medicine in the late nineteenth century.

convenient for the physician – the syrup, which contained around 1 centigram of strychnine, was consumed gradually throughout the course of an entire day. The injections were more easily monitored, and gave more control to the doctor, whereas the syrup would require the patient to follow instructions and be personally responsible, qualities physicians did not associate with alcoholics.

Use of strychnine did, of course, require the physician to be certain of the proper dosage. All of Bauzan's injected doses were diluted with 10 grams of distilled water, and his injections contained .04 centigrams (.4 milligrams) of strychnine initially; over the course of 24 – 36 hours physicians introduced between a milligram and a milligram and a half of strychnine into the patient's system, depending on his/her reactions. Over the next week the dose ought to be raised incrementally, until six milligrams of strychnine were injected in one day, for either male or female patients.<sup>234</sup> Following this peak, low doses would continue, in pill form, for several months.

While the use of strychnine, a poison often used for killing rats, likely induced some anxiety, the reported results would have appealed to any physician attempting to treat alcoholics in the short period of time that they could legally detain them. Bauzan reported not only that the attacks of delirium tremens and general paralysis occasionally ceased immediately after an injection, but also that patients sometimes lost all interest in consuming alcohol following strychnine treatment. If all went as it should, the patient's physical reactions were minimal. Typically, during the first two days, little changed, but as dosages crept upwards the patient's sleep became calmer and less interrupted, during the day s/he was generally less agitated, and the appetite returned, along with a settled digestive system. The few negative reactions that Bauzan

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<sup>234</sup> This dose is today not considered as likely to induce a lethal reaction in adults when orally ingested, but little research has been done on the results of injected strychnine, or the consequences of long-term low dosages.

admitted to seeing or hearing of, he assured the reader, had been among epileptics. In these cases the strychnine apparently triggered convulsions, which in rare instances led to death.<sup>235</sup>

There were other treatments that could address the immediate effects of alcoholism, however, which did not seem quite so risky. Cold baths and effusions addressed opium's inability to undo the processes taking place in the body of an acute alcoholic suffering a crisis, and never resulted in death. While it is unclear exactly where the practice originated, it seems likely that it was appropriated from folk medicine. Practitioners explained that the cold bath and its cousin, the effusion (in which only a portion of the body is submerged, or the patient is sprinkled with cold water) was intended to lower the temperature of the body and lower blood pressure, which would also theoretically minimize the anxiety an alcoholic experienced.<sup>236</sup> Physicians also regularly employed cold baths and "water treatments" for patients suffering from hysteria.<sup>237</sup> These baths routinely lasted between seven and fifteen hours. It appears that little was done to monitor the physical and mental states of the patient during the bath, meaning that the time spent in the bath was prescribed, rather than determined while treatment was in progress.

Antoine Bonnetty's 1866 thesis, *Essai sur le Traitement du Delirium Tremens* offered a detailed, scientific explanation of the medical advantages that physicians associated with cold baths and drinking plenty of cold water.<sup>238</sup> In it, Bonnetty argued that alcohol, once digested in the stomach, was introduced into the blood. While circulating in the blood stream, alcohol, which had bonded particularly well with fatty substances in the stomach, would often form "bloody globules"

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<sup>235</sup> This report reflects the current-day medical knowledge of how strychnine poisoning acts on the human body – resulting in violent muscle spasms that typically either suffocate the patient or induce rhabdomyolysis, which in turn leads to renal failure.

<sup>236</sup> Antoine Bonnetty, *Essai sur le Traitement du Delirium Tremens par les affusions l'eau froide* (Montpellier: Boehm et fils, 1866).

<sup>237</sup> Rachel Maines, *The Technology of Orgasm: "Hysteria," The Vibrator, and Women's Sexual Satisfaction* (Baltimore, MD: The Johns Hopkins University Press, 2001).

<sup>238</sup> Bonnetty, *Traitement*, especially 40-44.

in the brain and liver of alcoholics, absorbing disproportionate amounts of oxygen meant for arterial blood. Alcohol then lodged itself in these organs, Bonnetty went on to explain, and could only be broken down slowly over time into water and carbonic acid. To put it plainly, alcohol consumption affected the body chemically long after the visible symptoms subsided. The prolonged exposure to cold water, however, would lower not only the temperature of the skin, but also that of the internal organs, including the brain, allowing the globules to dissolve, as heat had enabled and maintained their bonding.

With this in mind, baths and effusions were necessary not only during an initial acute crisis, but also after the disappearance of general paralysis. In other words, they could limit the long-term damage of an acute crisis. Indeed, the specificity of Bonnetty's explanation of alcohol's longevity in the human body reinforced the common perception among most French physicians that alcoholism could only be treated successfully over long periods of confinement. According to Bonnetty, these versions of hydrotherapy, when done at the correct temperature, could both end acute alcoholic crises and accomplish more for chronic alcoholics than any other treatment option. The dangers were minimal (there were a small number of reports of cerebral congestion among chronic alcoholics, but no other recorded negative reactions), the cost was low, and the supplies were readily available.<sup>239</sup>

Bonnetty's argument was somewhat weakened by his evidence – or rather lack thereof. The work closed with only two cases. In both cases, physicians initially gave patients low doses of opium (no more than .15 grams), which merely served to increase agitation, so much so in the first case that the patient was tied into his bed. Following the failure of opium, cold effusions were

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<sup>239</sup> Cerebral congestion in the late nineteenth and early twentieth centuries referred to a variety of conditions including stroke, mania, headaches, coma, depression, and seizures. It was replaced by more specific terminology in the interwar period. For more on cerebral congestion, see Gustavo C. Román, "Cerebral Congestion: A Vanished Disease," in *Archives of Neurology and Psychiatry* 44, no. 4 (1987): 444-448.



administered in both cases. While Bonnetty doesn't explain what portions of the body were submerged, he does specify here that it was of the utmost importance that the water be fifteen degrees centigrade. When effusions were stopped, the attacks returned. While these attacks were not explained in detail, the information provided indicates that they consisted of both general paralysis and extreme mood swings, often involving violent behavior and anxiety. Despite the paucity of evidence provided by Bonnetty, most French physicians appear to have found the effusions effective. Little was written on the topic exclusively after 1870, although it was generally included in case studies as an employed method of treatment, indicating that it was not at all controversial. It seems to have become an accepted method of treatment, common in the arsenal of physicians confronting acute alcoholics. Some physicians concluded that effusions were valuable only in the treatment of chronic alcoholics, rather than during acute crises, but nearly all physicians agreed that cold water baths "exercise a direct sedative action on nervous erethism and on the blood, and, in diminishing nervous susceptibility, fights resulting weakness."<sup>240</sup> In short, cold water calmed agitated patients, and it seems to have done so more reliably and at a lower cost than opium.

The measures discussed above were often used without the aid of other substances or remedies. However, as the century progressed and alcoholics were increasingly appearing in public institutions (if for no other reason than physicians could recognize them more readily as the disease became better-known), physicians began to expand their repertoire of treatment tactics for alcoholism. The goal of most of these interventions was to calm the nervous system. Keeping in mind that physicians considered anxiety, delirium tremens, and general paralysis as symptoms of an acute alcoholic crisis, of which the most dangerous consequences were the agitated nerves in

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<sup>240</sup> Bonnetty, *Traitement*, 43.

the brain misfiring at a rapid pace. Any measure that could bring about physical exhaustion and a decreased level of both physical and neural activity was perceived as beneficial. This had recommended opium to physicians early on in the treatment of acute alcoholism, but opium could not solve all the problems of acute crises or eliminate all the symptoms on its own. As one physician put it, “we have demanded more of opium than it could give; that is why we have sometimes regretted employing it.”<sup>241</sup> The problem was not that opium was an imperfect treatment, but that physicians failed to employ medications that could support its actions. In order to preserve the use of opium, physicians began to develop “supporting” or secondary remedies that reinforced the effects of opium.

Emetics (substances that induced vomiting) were a popular secondary measure, particularly tartar antimony.<sup>242</sup> Tartar had the benefits of not only acting as a purgative, one physician explained, but also of slowing down the activity of the nervous system, and a weakening of cerebral functions followed vomiting. Others argued that the act of vomiting required so much physical exertion that alcoholics would need to sleep afterwards, in order to recover their strength. Some physicians asserted that administering opium and tartar together produced optimal results, but practitioners split on this issue.<sup>243</sup> Chloroform had also been used to induce sleep in some patients, but French physicians were hesitant to employ it for fear of unintended consequences, and perhaps also because of questions concerning their own conduct while a patient was rendered unconscious.<sup>244</sup> The general perception was that chloroform was a much more powerful drug than

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<sup>241</sup> Bonnetty, *Essai sur le Traitement*, 42.

<sup>242</sup> Antimony is a naturally occurring crystalline, metallic element (atomic number 51), often used as an active ingredient in emetics.

<sup>243</sup> Dr. Rousseau, “Du Traitement de l’Alcoolisme Aigu et du Délire Aigu,” in *Bulletin de la Société médicale de l’Yonne*, 22-23. One would expect that the vomiting that accompanied the tartar antimony would negate the ingestion of opium, although this was not addressed in the medical literature.

<sup>244</sup> There was a great deal of popular concern that physicians might take liberties with patients while they were unconscious. This physician-induced state of unconscious was unsupervised, and viewed with a great deal of

emetics such as tartar. Reports of patients emerging from chloroform-induced sleep even more agitated or nauseous than before similarly discouraged use of chloroform. Additionally, several medical investigations had tied it to exacerbation of some heart conditions, ending in death.<sup>245</sup> Physicians generally resisted employing chloroform to knock out alcoholics, and few case studies even mention it. Only in the most violent cases of delirium tremens, when attendants were unable to physically restrain the patient, was chloroform used.

Chloroform was an imperfect option, then, but many physicians disliked the purging associated with tartar, believing that alcoholics needed to avoid losing the calories and nutrient of whatever food they had consumed most recently. Some recommended having the patient consume *poivron*, a variety of bell pepper (sometimes this included the whole pepper, other times, the seeds alone). Most patients could easily ingest the recommended one dram dosage. A burning sensation would then slowly grow in the throat and mouth, and within an hour the sufferer would fall into a profound sleep. *Poivron*, however, was reported to work only when physicians encountered patients in the early stages of an acute crisis, which was very rare.<sup>246</sup> Several physicians reported achieving similar results by administering 15 grams of a tincture derived from foxgloves, which, depending on the method of preparation, could act as an effective purgative. This solution strengthened the pulse and helped the patient to sleep without disturbance, although French doctors viewed it with suspicion due to the potential toxicity of the substance.<sup>247</sup>

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suspicion. For more on this, see Elinor Accampo, *Blessed Motherhood, Bitter Fruit: Nelly Roussel and the Politics of Female Pain in Third Republic France* (Baltimore, MD: The Johns Hopkins University Press, 1<sup>st</sup> edition 2006).

<sup>245</sup> Rousseau, "Traitement de l'Alcoolisme Aigu," 23.

<sup>246</sup> *Ibid.*, 19-21.

<sup>247</sup> Bonnetty, *Essai sur le Traitement*, 42. In 1999 the FDA approved usage of foxglove (scientific name *digitalis*) to treat heart failure, but in large doses it results in fatality.

Many remedies were based less in medicine and more in practices that seem to be borrowed from folk healers.<sup>248</sup> It was important not to neglect the diet of patients while bringing them out of acute crises, more than one physician chided, as it was extended periods of poor nutrition that precipitated these states. Details such as cold compresses on the patient's forehead or aperitifs to stimulate the appetite were easy to forget, but could speed recovery. In fact, one doctor argued, if a patient went to sleep without first eating healthfully, the sleep would do more harm than good. If a patient with delirium tremens began to hallucinate (or, to use the medical terminology, if the tremens turned "febrile") diuretics might alleviate some discomfort, but particularly in those instances, writers warned fellow physicians, moderation of their natural inclination as physicians to intervene might be the best course. In fact, a small number practitioners who wrote on how to treat acute crises believed the best possible treatment was nothing – they argued that acute attacks were a natural reaction to the abuse of alcohol, and that the body had to go through them. These men viewed the autonomic hyperactivity that characterized the acute attacks of alcoholism as something that could not be escaped, much like the seizures of epileptics.

### III. Rejected Measures

Other treatment options were suggested, but failed to attract many enthusiasts. One of the most interesting of these drew on the principles of hypnosis. Hypnosis was viewed with skepticism by the French medical establishment as it had been put forward by the German physician Franz Mesmer, but in the final quarter of the nineteenth century Jean-Martin Charcot, one of the founders of neurology, had championed a revival of Mesmer's principles under the name hypnotism.<sup>249</sup> In

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<sup>248</sup> For more on the interplay between folk healers and physicians in France, see Evelyn Ackerman, *Healthcare in the Parisian Countryside* (Princeton, NJ: Rutgers University Press, 1990). a

<sup>249</sup> Ruth Harris's *Murders and Madness* (New York: Clarendon Press, 1989), especially chapter 5, discusses the anxieties of the French medico-legal community regarding hypnosis in the *fin-de-siecle*. Harris' discussion focuses on the concern that immoral men were hypnotizing and mesmerizing women, who would then carry out their master's nefarious wishes. Harris points out that by labeling women as more susceptible to hypnosis, late nineteenth

addition to his work at the *Salpêtrière*, the well-known Charcot also served on the committees of multiple medical theses examining questions related to alcoholism. As physicians delved further into the question of how lesions on the brain induced by the ingestion of alcohol affected the patient, they also drew themselves further into Charcot's work. Although mesmerism and the practice of hypnosis had been partially discredited by the turn of the century, it was far from uncommon or an entirely rejected practice among medical practitioners.<sup>250</sup>

According to a 1904 article, alcoholism could be simply and safely addressed via hypnotic suggestion. The author described hypnosis as a simple procedure – one need only make the patient “look at some point in order to settle his attention and say to him in a commanding tone ‘sleep, sleep...’ He goes to sleep... a profound, lethargic sleep. He does not react to a prick; his cornea is insensible.”<sup>251</sup> Once the patient was placed under hypnosis, the physician had two goals: to create a distaste for distilled alcohol and pure wine (wine diluted with water being, even for chronic alcoholics, a benign beverage), and “to raise the moral energy of these individuals... and to give to them a will permitting them to struggle with success against their deplorable weakness...”<sup>252</sup> It is important to note that the author included cases in which he successfully treated both men and women for alcoholism. Hypnotism, it seemed, could work on any alcoholic, regardless of gender.

This practice drew largely on a moral understanding of alcoholism, in which the alcoholic drank more because of depression or emotional upheaval, rather than the lesions that developed as a result of long-term abuse. In this understanding of the disease, the brain's malfunctioning could be cured through intangible therapy. The prophylactic aspect of hypnosis is perhaps its most

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century physicians brought up concerns over a woman's marital fidelity. These sorts of questions in turn fed into larger debates over the social order and changing gender roles.

<sup>250</sup> Alan Gauld, *A History of Hypnotism* (NY: Cambridge University Press, 1995).

<sup>251</sup> Dr. Feuillade, *Traitement de l'Alcoolisme par la suggestion hypnotique* (Lyon: A. Poinat, 1904): 1.

<sup>252</sup> Feuillade, *Traitement*, 7.

interesting component, particularly as no other medical treatment could make the same offer. Bauzan wrote about some patients losing an interest in alcohol after strychnine treatment, but he presented this as a potential side-effect, rather than an intended outcome. In the discussion of hypnosis, however, the ability of the treatment to prevent continued drinking was touted as its most attractive quality. If alcoholism was a physical result of a moral failing, the scientific practice of hypnosis offered a practical solution.

Even as these asylum physicians experimented with powerful chemicals and dosage schedules, other doctors in long-term asylum care extolled the importance of establishing healthful patterns of thinking while curing chronic alcoholics, whose brains were reestablishing normal functioning as the lesions receded and healed themselves. These physicians did not dispute that alcoholism was a physical malady – rather, they embraced that understanding, and argued that as the alcoholic healed, it was necessary to establish new neural pathways. For this reason, those physicians who discussed curing chronic alcoholics called for asylum stays of at least six months, and ideally a year. Otherwise, physicians argued, it was unlikely that they would be able to bring about a lasting change. Alcoholics, these doctors felt, could not be trusted with this fresh brain tissue.

As discussed above, however, the end of the century saw the construction of at least one private alcoholics-only facility, constructed to accommodate long stays. Madame Legrain's 1903 text, *Cure de Buveurs*, presented the most complete account of how this cure would ideally be administered. Describing the conditions at *La Source*, Legrain began by making clear that the facility's removed geographic location was not only important as it eliminated the temptation to socialize in the café, but also because it necessitated a great deal of physical labor. Without stores from which to purchase groceries or clothing, and with no handymen or workers nearby to tend to

the farm, patients were forced to take on a significant amount of work. This must have been unpopular, as *La Source*'s residents would have been middle-class, but reflected the dominant medical perception that alcoholics were members of the working class and would find solace in manual labor.<sup>253</sup>

Outdoor activities such as croquet and gymnastics were also a part of life at the facility, which forced patients to take “the cure of the air, and the cure of the sun.”<sup>254</sup> The measures employed by Legrain underline the connection that she and many of her colleagues perceived between brain and body. Alcoholism was, Legrain argued, “not a habit, not a vice, but it is an illness, of the same kind as tuberculosis... as typhoid fever...”<sup>255</sup> This illness resulted in physical ailments, some of which were easily visible and others that one might never observe, but that were nonetheless physical. Most important among these were brain lesions. These lesions, Legrain argued, would always leave slight traces, but an alcoholic could be trained to control their effects, when directed by the right influences. Thus, while the body and the brain healed, it was of the utmost importance that authorities inculcate appropriate values and principles, so that a stronger system could take root.

At *La Source* one could expect to encounter conversations regarding morality, obedience to the Church, masculinity and femininity, reproduction, honesty, and general ethical codes. Little medical therapy seems to have taken place in this institution— indeed, Legrain's text said nothing at all about drugs employed or the philosophy surrounding medical treatment. These interventions would be possible, as doctors staffed the facility, but they were carried out on a case by case basis.

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<sup>253</sup> It is worth noting here that the same principles, particularly the positive emphasis placed on physical labor, were used in many English, German, Swedish, and American treatment facilities, a fact that French physicians were cognizant of. For an example of this, see Dr. Piouffle, *Cure des Buveurs à Château d'Orly* (Paris: A. Maloine, 1914).

<sup>254</sup> Madame Legrain, *Cure de Buveurs* (Paris: Aux Bureaus des *Annales AntiAlcooliques*, 1903): 10.

<sup>255</sup> Legrain, *Cure de Buveurs*, 1.

The only portion of treatment at Legrain's facility that involved a consideration of the body's chemistry was the requirement that patients not consume *any* alcohol.<sup>256</sup> It was life in the institution, rather than medical interventions, that would force a moral reconsideration as the alcoholic dried out. For this reason, Legrain spent several pages detailing the interior décor of the ideal institution, explaining exactly how to avoid the environment of a prison or hospital. Once safely ensconced in an "atmosphere of family baubles..."<sup>257</sup> it would be impossible for the patient to not meditate on "the feeling of lost dignity."<sup>258</sup>

In addition to the family-oriented nature of treatment at *La Source*, the centrality of melodramatic, quasi-religious language employed there stood out from the style used in public asylums. Legrain informed the reader that, "in the cures that we have had the joy of realizing, we have seen nearly all our patients give themselves over to the apostolate."<sup>259</sup> Two portions of that phrase are illustrative of the language that typically accompanied descriptions of treating and eradicating chronic alcoholism – first, the verb, "give themselves over" (*s'adonner*), indicating a loss of personal control or resistance, and second, the religious tone of word choices like apostolate (*apostolat*).<sup>260</sup>

Given the emphasis that physicians and moralists alike placed on the typical alcoholic's lack of self-control, and the connections they routinely drew between this tendency and an individual's descent into alcoholism, encouraging alcoholics to give themselves up to other influences is surprising. Yet this understanding made sense to Legrain, as she argued that patients

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<sup>256</sup> In asylums and hospitals, wine and apertifis were widely available; patients were often rewarded for completing less popular or more physically demanding tasks with extra servings of alcohol. Temperance, which dominated both the English and the American anti-alcoholism discourses, was a little discussed topic in French circles. Only the Legrains and their small group of supporters advocated for the cessation of all alcohol consumption.

<sup>257</sup> Legrain, *Cure de Buveurs*, 9.

<sup>258</sup> *Ibid.*, 8.

<sup>259</sup> *Ibid.*, 17-18.

<sup>260</sup> Here "apostolate" refers to organizations of the laity that support the Catholic Church's mission.



needed to accept the authority and recommendations of others. As these patients had never had sufficient self-control, one of the most critical tasks of the treating physician was to establish himself as an authority. If patients tried to subvert their physicians, if they fought against treatment or snuck alcohol in a self-prescribed attempt to ease the symptoms of delirium tremens or general paralysis, Legrain explained it was more evidence of the alcoholic's irrationality and poor judgment. Chronic alcoholics, physicians urged, needed to accept medical authority because they possessed no self-control. Alcoholics had surrendered the privilege of making their own decisions as they had proved themselves too irresponsible to nurture their own bodies.

Examining the potential for future drinking that physicians perceived among chronic and acute alcoholics once they achieved initial sobriety underlines that few believed fully recovered drinkers could ever entirely reclaim the rationality they would need to exercise their rights and privileges. Even Madame Legrain, whose texts continually underlined that alcoholism was a disease, cast doubt on the possibility of recovery of personal responsibility, writing, "we are speaking only of curable drinkers. For the recidivists, that is to say, the delirious repeated drinkers, or those who come to an extreme period, for them houses of a different nature which we are not speaking of here become necessary, for them the cure has become impossible."<sup>261</sup> In other words, Legrain believed that some alcoholics needed to be locked away from society.

Ultimately, these two treatment options, which were based more in a moral than a physicalist understanding of alcoholism, failed to gain popularity. Hypnotism was almost certainly never employed more than a handful of times, as there are no case studies involving its use included in other texts. When the Legrains were divorced in 1909, *La Source* closed, and no similar institution opened to fill its void. This is likely in part a result of the moral treatment used at the

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<sup>261</sup> Legrain, *Cure de Buveurs*, 8.

facility, and in part a reflection of the paradox that defined *La Source*: it was an institution intended (and really only suitable for) members of the middle class, but members of the middle class could not, by definition, be alcoholics. Although its records do not survive, it seems unlikely that *La Source* was overwhelmed by patients in the six years that it was open.<sup>262</sup> Both hypnotism and morally-based treatments failed to attract support from physicians (via its use, or referrals) because they denied the physicalist principles that defined the disease.

#### IV. The Potential for Cure

On the whole, very few French physicians wrote about the potential for their cures to work in the long-term. The case studies included by Henri-Celestin Bauvallet in his 1911 thesis are exemplary of the why physicians believed this, and how they led their readers to reach the same conclusion. Bauvallet began with a medical history and reports from any other physicians who treated the patient, followed by a summary of how the alcoholic came to be in the hospital's care. Entering Sainte Anne in late December of 1880, "Auguste D" had already spent at least two significant periods of time in other facilities as a result of acute alcoholic crises. The second of these had required a two month stay in September of 1880, yet upon his release Auguste had immediately returned to his intemperate ways, as "he had committed his whole life to the excesses of drink..."<sup>263</sup> Discovering distilled alcohols upon his release, it took a mere three months for Auguste to return, this time presenting with symptoms including "ambitious, absurd, incoherent delirium... [he believes that] his great-uncle is the colonel Failly... [that] he has 150,000 franc

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<sup>262</sup> The scholarship that I've read that discusses *La Source* has pointed out that it was overseen by Madame Legrain, a trained nurse, but assumed that the "real" authority was that of her husband. As a result, *La Source* closed because the midwife Dr. Legrain next married did not have time to run the facility. I would like to suggest that this does not seem entirely likely, given *La Source*'s use of non-physicalist methods, which Dr. Legrain abided by strictly according to his own case studies. I would like to provide a somewhat alternate theory as a result of these factors: Madame Legrain was in charge of *La Source*, not Dr. Legrain, and that at the dissolution of their marriage Dr. Legrain was not qualified to run the institution, given the treatment style it employed, which accounts for its closure.

<sup>263</sup> Henri-Célestin Bauvallet, *Alcoolisme Chronique et Paralysie Générale Progressive* (Bordeaux: G. Gounouilhou, Imprimeur de la Faculté de la Médecine, 1911): 64.

fortune...” In short, “his intelligence seemed weakened...”<sup>264</sup> Delusions of this sort, in which the patient thought that he was more powerful than he actually was, were the most commonly reported type. The content of the delusion, then, was considered critical in judging the severity of the crisis<sup>265</sup>.

After one month, the patient had calmed himself considerably, and the only sign of alcoholism that persisted was an unequal contraction of the pupils. Initially it appeared as though even his intelligence had returned, when suddenly, just after his release in early March of 1881, he complained of “mental torpor” and quit his job. The administration of purgatives did nothing to relieve his complaints, and a week later Auguste suffered an apoplectic seizure in the night, dying in the early morning hours. An autopsy revealed a brain hemorrhage, the most common cause of death among chronic alcoholics, aside from accidents that would not have occurred if the drinker was sober.

All of the elements of Auguste’s case were commonly present in case studies of chronic alcoholics, as was the physician’s response to Auguste’s symptoms. The limited treatment given the fact that Auguste was a chronic, as opposed to an acute, alcoholic, was entirely in line with medical recommendations. Auguste’s death was similarly typical of the genre. Most studies terminated in death, or a patient leaving for further treatment at another institution. When physicians were unsure what happened to a patient after his/her time in the asylum, they often wrapped up by reporting that hospital employees had heard via village gossip that s/he was once again drinking. Finally, physicians occasionally closed their case studies by stating that patients remained in their care, with diminished, but not disappeared, symptoms.

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<sup>264</sup> Bauvallet, *Alcoolisme Chronique et Paralysie Generale Progressif*, 65.

<sup>265</sup> This was not a unique state of affairs. As Megan Vaughan has shown, analysis of delusions and a consideration of how “inappropriate” they were relative to the sick individual were also common in colonial psychiatry. Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Berkeley, CA: Stanford University Press, 1991).

Similarly typical was an in-depth discussion of a nameless 32-year old male patient who arrived at his hospital in July of 1879, suffering from an attack of acute alcoholism, which included fever and delirium. The patient had been under the supervision of another physician who had prohibited any alcohol consumption, but his doctors believed that the symptoms could only be explained if he had continued to drink. Convinced that he wandered in a forest, the patient refused to wear clothes his first days in the hospital, trembled constantly, and despite the immediate prescription of ten grams of potassium, his pulse remained rapid and weak. Two days and one seven-hour cold bath later, the delirium and the trembling had diminished noticeably; the disordered ideas remained, but even these were gone by the next day, and on his physician's recommendation, the patient left the hospital at the end of the month, free of symptoms.<sup>266</sup> The fact that the physician could not testify to his current state, however, was meant to indicate that he had begun drinking again.

Such case studies and their termination illustrate that physicians viewed alcoholism as a disease that could only very rarely be "cured," and that they should instead try to treat with few expectations. Physicians believed that alcoholism remained dormant in alcoholics, even when not inebriated, very likely for the rest of their lives. The alcoholic, or perhaps even the descendants of alcoholics, ticked away inevitably, and could at any time erupt in drunken rages or anxieties. This perception made it wildly difficult for physicians to argue, based on medical knowledge, that alcoholics could re-establish self-control.

## **V. Prevention**

These attempts to treat alcoholism were then, ultimately, not going to eradicate the disease, or the problems that it caused. Its effects could only be attenuated. With this in mind, the logical

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<sup>266</sup> Bauzan, *Du Traitement de l'Alcoolisme et de la dypsomanie*, 53.

step for physicians to take was to recommend preventative social measures. Most of these measures were either never implemented, or used to a limited extent. Clearly they could be no match for the force of the economic and social interests in favor of continued alcohol consumption.

With the establishment of the Third Republic in 1871, the public education system in France expanded rapidly. Schooling became mandatory for boys and girls throughout France in 1881, and began to move the onus of educating French youth away from the Catholic Church, and towards the state.<sup>267</sup> This new, centralized system, in which all students studied from materials approved by the state, made it theoretically possible for a small amount of pedagogical information to have a much greater impact than ever before.<sup>268</sup> State-approved textbooks demonstrate that all French instructors discussed alcoholism with students after 1897, when the government added an anti-alcoholism requirement to the curriculum. This information was often included in home-making courses, and was stressed particularly in books intended for girls who were unlikely to pursue education after age eleven (the minimum age mandated by the state at that time). It was the wife's responsibility to create a welcoming home that her husband would not want to abandon for the café, these books stressed. If a man descended into alcoholism following his marriage, young girls were taught, it was a reflection of his wife's failures.<sup>269</sup>

Unsatisfied with this level of information, however, a number of social commentators believed it was critical to provide more information than the rather brief pages the state authorized. Perhaps the most comprehensive of these was the jointly written *Contre l'Alcoolisme*, which

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<sup>267</sup> For more on the importance of this new education system in creating a unified France, see Eugene Weber's *Peasants into Frenchmen* (Stanford, CA: Stanford University Press, 1976).

<sup>268</sup> For a discussion of the contents of the textbooks, and particularly how they reinforced gender norms, see Linda Colley's *Schooling the Daughters of Marianne* (Albany, NY: State University of New York Press, 1984), Françoise Mayeur, *L'Enseignement et l'éducation* (Paris: Tempus Parrin, 2004).

<sup>269</sup> For examples of this, see Maria-There de Solms Blanc and Mlle A. Chevalier, *Causeries de moral pratique* (Paris: Hachette, 1899).

contained prepared lessons for each week of the school year.<sup>270</sup> A number of similar texts were published within several years of these lessons, but none were so effective at concisely communicating the information the instructor would need, while simultaneously making it clear how the lessons would play out. With forty four weeks' worth of planned anti-alcoholism tutorials, there was no chance that students, or, for that matter, teachers, would miss the morals behind the lessons. Often, the writing in these manuals made use of religious language, similar to Madame Legrain's phrasing above, in order to stress their points. Calling the lessons in the manual a key part of the "crusade against alcoholism" underlined both the importance of the instructor's work, and mobilized religious themes that were familiar to the vast majority of the French population.<sup>271</sup>

The lessons, which were far from complicated, were built around maxims. "Water is the most healthful of beverages," "be suspicious of a little glass, it kills the body and the heart," and "the drunk hollows out his own grave" are exemplary of these weekly themes. Each week's lesson began with similar phrases or maxims. This was followed by a few paragraphs for the instructor to read aloud based on a medical text that was cited at the end of the section. Following this was the "problem," which students were meant to solve based on the information the instructor had read aloud, and a written assignment, which relied more on the student's creative writing skills than the facts they had just gone over. One such assignment posed the following problem: "a mother of a family is given to drunkenness. Describe the appearance of the interior of the household; the sad life of the husband and children."<sup>272</sup>

While some of the lessons and accompanying assignments discussed the fiscal costs of alcohol consumption, the vast majority underlined that when men or women over-consumed

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<sup>270</sup> Lemoin et Villete, *Contre l'Alcoolisme* (Paris: Librairie Classique Fernand Nathan, 1898).

<sup>271</sup> Lemoin et Villete, *Contre l'Alcoolisme*: 1.

<sup>272</sup> *Ibid.*, 24.

alcohol, they failed in their responsibilities to one another, to their parents and children, to their town or village, and to the French nation. Illustrative of this trend was one question headed by the phrase “alcohol and filial piety,” which asked the students to imagine whether they would always have their parents’ respect and affection if they made a habit of going to cabarets.<sup>273</sup> Another instructed students to explore the pain and suffering a worker who consumed a liter of rum in a few minutes caused for his family. The only questions that appeared more regularly than those that instructed students to imagine and describe the consequences of alcoholism were instructions to calculate if it was financially possible for a worker to support his family *and* go to the cabaret. On the whole, the material intended for public schools offered little variety, and emphasized the social and fiscal costs of alcoholism.

If anti-alcoholism efforts were to be successful in the face of a popular culture that equated time at the café with sociability and refinement, it would be necessary for reformers to produce content for leisure activities.<sup>274</sup> To that end, a small number of anti-alcohol plays, novels, and in one case, serialized stories, began to appear at the end of the century. While these were partially intended to provide alcohol-free enjoyment, they also served an overtly didactic aim. Anti-alcohol consumption arguments were couched in fictional narratives in these cases, but they were by no means subtle. They also reproduced, in downright unoriginal form, the pathology of alcoholism, both chronic and acute. Being familiar with the case studies physicians produced takes all the mystery out of the plot of these stories, and their dialogue seems to have been lifted from medical

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<sup>273</sup> Ibid., 19.

<sup>274</sup> For more on the centrality of the café to sociability in fin-de-siecle Paris, see W. Scott Haine, *The World of the Paris Café: Sociability Among the French Working-Class, 1789-1914* (Baltimore, MD: The Johns Hopkins University Press, 1998), Michael Marrus, “Social Drinking in the Belle Epoque,” in *Journal of Social History*, 7, no. 2 (1974): 112.

texts with very few changes. It is not difficult to see why these stories failed to become popular in the age of Zola.

Paul Chartron's series of anti-alcoholic short stories are a good example of this rather small genre. The series begins with the story of a young female protagonist named Madeleine.<sup>275</sup> In this first installment, 10 year-old Madeleine's teacher, seeing through the blonde-haired, blue-eyed girl's superficial happiness, asks after her home life, revealing the pain the protagonist feels over her father's drinking.<sup>276</sup> After examining her instructor's printed table regarding the poisonous effects of alcoholism, Madeleine confesses her shame over having a father who does not consume alcohol appropriately, and asks for advice regarding how to moderate his consumption. Her instructor sends Madeleine home with books on the dangers of excessive drinking and a package of food, which she prepares for dinner. Her father, overcome by the domesticity and the love he feels for his home at this table (the discerning reader would here note that Madeleine's mother had failed to do this for her husband, thus encouraging his alcoholism), spends his evening at home and reads the books that Madeleine casually passes on, rather than going out to drink with his friends. The educational nature of Chartron's story becomes explicit here, as Madeleine explains to her father how many francs workers typically spend while at the cafés and cabarets, each figured followed by an exclamation mark. Ultimately, Madeleine's father admits that he prefers the company of his family, and chooses to save his money and his sanity by staying at home, thus making it financially possible for Madeleine to continue cooking for him. Chartron's stories, initially never longer than ten pages, but later on occasionally divided into two longer chapters, were clearly intended for a young or only lightly educated audience – both the stories and the

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<sup>275</sup> These stories are grouped together under the name *Nouvelles AntiAlcoolique*, and were published by the Ligue Anti-Alcoolique. There is no evidence that they ever appeared in newspapers, as many series did in nineteenth century France.

<sup>276</sup> Paul Chartron, *Madeleine* (Paris: Ligue Nationale contre l'Alcooisme, 1904).



vocabulary never became more sophisticated than what a casually educated 10-year old could read, despite the series stretching to at least fifteen installments.

Louis Dewachter's *Jacques Abruti – Roman-Thèse sur l'Alcoolisme*, published by the Society for the Hygiene of Children, was also written with a clear pedagogical imperative, but required a higher level of education to read.<sup>277</sup> Just over forty pages, Dewachter's work, much like Chartron's, was none too subtle in its incorporation of the arguments of physicians concerned over the dangers of alcoholism, but it did present a much more complex narrative than those used in the short stories; as a result Dewachter was able to address several facets of alcohol consumption. At the beginning of the narrative, two young men, Jacques and Louis, both in the French army, are out enjoying their last free day before leaving their native village. As both are in love with the same girl named Marguerite, they each visit her in the course of the day. Jacques, a popular, handsome, and charming young man arrives after drinking a considerable amount of alcohol, but nonetheless wins Marguerite's heart over the sober and serious Louis. While Marguerite's widowed mother prefers Louis, she allows her daughter to choose her husband. Both young men then leave for their army service, Jacques with Marguerite's promise to marry upon his return. While Jacques' alcohol consumption is preventing him from achieving military success, Marguerite's uncle is busy quoting from Legrain on the topic of temperance and explaining to her mother the high likelihood that her grandchildren will be hereditary degenerates if Marguerite marries Jacques. According to her uncle, Marguerite's future husband is a criminal not because of his acts while under the influence of alcohol, but instead because he gave himself over to alcohol in the first place. His decisions not only harmed his future children, but society as a whole, by making it possible for alcoholism to spread. Marguerite refuses to listen to her mother and her

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<sup>277</sup> Louis Dewachter, *Jacques l'Abruti* (Lille: Le Bigot Frères, 1903).

uncle on this point, however, and two years after Jacques returns, the couple has married and had two children.

Jacques, who has continued drinking, cannot find work and is succumbing to increasingly violent attacks of acute alcoholism. Under the influence of alcohol he has begun beating Marguerite. Just after this information comes the death of Jacques, which requires only one paragraph, but Dewachter devotes three pages to his autopsy, lingering over the details of alcohol's consequences on the body, both physical and civil. The funeral has, quite literally, a sobering effect on the entire village, where Louis establishes a popular temperance society, which, in true French form only requires limited consumption. The novel closes with the marriage of Louis and Marguerite. This is less a joyous occasion, and more a fulfillment of Louis' obligations as a Frenchman, as Dewachter demonstrates by closing the novel with Louis proclaiming,

in marrying Marguerite I do my duty as a man and a member of society. In raising her children who will one day raise a family, I do my duty to my father and my spouse, but I also do my duty to France and as a patriot in giving them an education so that they will become strong and capable of one day defending the homeland.<sup>278</sup>

These examples underline both the relative simplicity of anti-alcohol literature intended for mass consumption, and the manner through which these texts connect medical knowledge to social issues in these texts.<sup>279</sup> The authors emphasized the alcoholic's shirking of responsibility, whether to family, as in Chartron's short stories, or to society, as Dewachter presented it, in order to explain the costs of alcoholism. Individual personal consequences, while not entirely absent from these stories, were not the authors' primary concern. Jacques, the degenerate alcoholic in Dewachter's story, did die, but the author presented his death as a positive development, one which

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<sup>278</sup> Dewachter, *Jacques l'Abruti*, 44.

<sup>279</sup> The circulation statistics of these publications are not known, but given the small size of the presses producing them, in conjunction with the lack of widespread popularity of the ideals they advocated for, it seems unlikely that they reached a wide audience.

not only taught his community to avoid alcohol consumption, but also made it possible for Marguerite to marry the responsible Louis. Good husbands, brothers, and sons (for none of the popular literature presented female alcoholics who were not tubercular, soon-to-be-dead, women without families or respectable forms of employment) would not consume alcohol, authors underlined, because they cared too much for their families, villages, and *patrie*. While those who had begun to drink had already started down the road of degeneration and most likely could not be brought off it, their progress could at the very least be halted, and, more importantly, the damage to their families and communities minimized.

## VI. Legislation

In another effort to protect against the spread of alcoholism, French physicians regularly wrote on the necessity of the National Assembly passing legislation that would tax alcohol, which would hopefully raise prices so much that most of the working-class would no longer be able to afford to consume alcohol in large quantities.<sup>280</sup> These reform-minded practitioners routinely argued fiscal policies in medical texts discussing alcoholism, in this way moving into territory typically covered by moralists and economists.

Given the support of taxation in the medical literature, it is surprising that in the years prior to World War I discussions about raising taxes on alcoholic beverages went nowhere.<sup>281</sup> To begin with, taxes on wine were unpopular not only with those who earned their living by working vineyards (between 7 and 10% of adult males in France were employed as a result of wine production or consumption), but also with the general French public, who consumed more wine

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<sup>280</sup> Of course, there was always the possibility that the raised prices would not have deterred consumers, but simply shifted more of a household's economy towards the café. Physicians never discussed this possibility, however.

<sup>281</sup> For examples of medical priorities that met with legislative successes, see Jack D. Ellis, *The Physician-Legislators of France* (NY: Cambridge University Press, 1990).

per capita than any other national group.<sup>282</sup> It is hardly an exaggeration to say that raising taxes on wine before 1900 would have elicited roughly the same reaction as Louis XVI proposing a new tax on bread. The economic plight of wineries (keeping in mind the destruction of wine harvests by the phylloxera outbreak, 1878-1892) made it impossible for them to pay more. Producers also made sure that their powerful lobbying arm made this clear to legislators. The taxation of distilled alcohol, typically referred to by physicians as industrial alcohol, was another story.<sup>283</sup>

As wine production had slowed during the phylloxera crisis, cheap industrial alcohols from northern France had filled the market void. In December of 1900, the legislature significantly restructured taxes on alcohol, lowering and simplifying the way “hygienic” (wine, beer, cider, and some juices) beverages were assessed, while raising taxes on industrial alcohols by about forty percent.<sup>284</sup> Additionally, numerous proposals, such as one to divert distilled alcohols for use in automobiles and generators, were clearly intended to remove some alcohol from the market, opening up more space for wine producers. Nonetheless, the French continued to consume the popular distilled alcohols at nearly the same rate after these tax changes. Despite the creation of multiple commissions to study the problem of alcoholism (From 1887-1900 three separate committees were established in the National Assembly), little else changed in the regulation or taxation of distilled alcohols, with one commission even rejecting measures intended to control the purity of distilled alcohols. The few small measures taken by the National Assembly accomplished little, perhaps because there was no advocacy for it from those whom it would impact the most.

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<sup>282</sup> Leo A. Loubere, *The Red and the White: A History of Wine in France* (Herndon, VA: State University of New York, 1978): 208-09.

<sup>283</sup> The term “industrial alcohol” was no accident – it communicated two critical medical ideas about these beverages: that they were consumed in urban settings by unskilled laborers, and that they were, because they were created through synthetic processes, not as healthful as wine.

<sup>284</sup> Prestwich, *Drink and the Politics of Social Reform*, 111.

It is not difficult to discern that the contradictory opinions physicians gave these commissions when testifying must have created an enormous level of confusion among the politicians over just how they should define “healthful consumption” (indeed, in 1907 the Secretary of the Hygiene Commission wrote an article entitled “Drink Wine” for an industry publication<sup>285</sup>). By not uniformly arguing that *any* amount of alcohol was damaging, and thus not in the nation’s best interest, the medical men who shaped the popular understanding of alcoholism created a much more complicated argument, in which alcohol consumption became a slippery slope, but one that they did not tell their patients to stay away from completely.<sup>286</sup> Some spoke against absinth, while others praised its restorative powers. Many argued that distilled alcohols were dangerous, and that cognac threatened the health of all those who consumed it; other physicians prescribed these substances to treat common medical complaints and extolled their restorative powers to the commissions.

Previous investigations of attempts to limit alcohol consumption through taxes have argued that French physicians had little influence, and that French politicians, under the guidance of the alcohol industry, did little to discourage consumption.<sup>287</sup> What this interpretation leaves aside, however, is that only a small number of practitioners in France advocated for complete temperance – instead, they encouraged what they deemed moderate consumption of wine (by moderate, they likely meant something like four glasses of wine a day) and other hygienic drinks, which is exactly what this fiscal policy was designed to accomplish. As much as it illustrates the confusion over which alcoholic beverages were harmful, the lack of a uniform taxation policy of all alcoholic

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<sup>285</sup> *Bulletin officiel du syndicat national du commerce en gros des vins, spiritueux et liequers de France*, June 15, 1907: 226-228.

<sup>286</sup> It is true the Legrain argued in favor of temperance, but most physicians did not support his opinion on this matter.

<sup>287</sup> Patricia Prestwich, *Drink and the Politics of Social Reform* (Palo Alto, CA: SPOSS, 1988).

beverages in France reflects the influence of the medical discourse on legislative decisions, and on the average French citizen's understanding of alcoholism.

Technically, the Third Republic had established a law intended to limit alcoholism in 1873. This law, which criminalized public drunkenness, theoretically limited the amount of alcohol that any establishment was allowed to serve and restricted commercial establishments from serving minors alcoholic beverages of any type, including wine. Contemporaries agreed, however, that these laws were rarely enforced – the signs explaining both were typically hung in dark corners, and police rarely made arrests solely for public drunkenness.<sup>288</sup> The restriction against serving those under the age of 18 likely seemed ridiculous, as French children drank wine regularly. Further easing these restrictions, after 1880 there was no legal requirement for café owners to gain official approval before opening their doors. They only needed to alert police to their business 24 hours before they began serving. In short, there were no legal restrictions that made it difficult for the average French man, woman, or child from to live in a constantly inebriated state if they so desired.

In 1903, Paul-Maurice Legrain's National League Against Alcoholism began to make a concerted attempt to influence parliamentary legislation. The anti-drinking group could claim a sizeable number of supporters in both the Chamber and the Senate by 1907, but they only achieved one national victory.<sup>289</sup> In 1911, a new bill passed limiting the number of *débits* (establishments that served alcohol, which included cafés, cabarets, or any other vendors who sold alcohol) to one for every two hundred people in a city, but this measure was recognized by all as relatively toothless – it would not apply to pre-existing establishments, or to those that exclusively served “hygienic” beverages (non-distilled alcohols). In other words, although the national ratio was more

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<sup>288</sup> W. Scott Haine, *World of the Paris Café*, 30.

<sup>289</sup> For more information on this, see Prestwich, *Drink and the Politics of Social Reform*, 108-142.

like one establishment for every one hundred individuals, because the law could not force businesses to close or to stop serving alcohol, it could only maintain the status quo.

There were more legislative successes for the anti-alcoholism movement in individual departments and municipalities, although the influence of these measures is questionable at best. Mayors and municipal councils routinely established “zones” of between fifty and two thousand meters around schools, hospitals, churches, and grave yards where new businesses that would serve alcohol could not be constructed, but whole villages could hardly be made alcohol free-zones, which would have been the practical effect on many small communities. Finally, home fermentation, which was particularly popular in rural communities made up primarily of farmers, remained unmonitored and unrestricted.

The most visible and widely-supported legal effort was the attempt to outlaw production and consumption of absinth, but even this attempt was only partially successful. The medical community had led the charge against absinth, coining the word *absinthisme* in 1864 in an attempt to pathologize those who drank large quantities of the anise-flavored beverage.<sup>290</sup> Unlike measures to limit the number of establishments serving alcohol, winemakers supported the legal campaign against absinth, as the drink threatened their market share. Absinth’s associations with other nations and with the well-known excesses of the bohemians in Montmartre made it an easy target for reformers. Several brutal murders that occurred in the 1880’s while the culprits were under the influence of absinth furthered the perception that the drink produced a particularly dangerous type of intoxication. By 1900, social commentators and members of the National Assembly blamed absinth for inducing the worst hedonisms of their time. In 1912, after two years of hearing evidence, the Senate concluded that the thujone in absinth was the real problem, as they believed it caused

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<sup>290</sup> The first text to use the term was Auguste-Félix Voisin, *De l’État mental dans l’alcoolisme aigu et chronique et dans l’absinthisme* (Paris: J.B. Ballière et fils, 1864).

the hallucinations reported by drinkers, and voted to ban all beverages containing the substance. The proposal was then sent to the Chamber, where it sat unvoted on until the outbreak of World War I. In 1915, in the midst of a flurry of enthusiasm to protect the health of the nation, a military order outlawed the production of the beverage. Shortly thereafter, producers began marketing a number of distilled alcoholic beverages that were devoid of both thujone and the high level of alcohol that characterized pre-war absinth. According to contemporaries, while these popular drinks did have a lower alcohol content than absinth, they tasted remarkably similar to the banned beverage.

Clearly, practitioners had a wide variety of options to choose from in their attempts to treat acute and chronic alcoholics, all of which were based off the physicalist understanding of alcoholism that privileged the body and the tangible structure of the brain and left no room for the concept of addiction. These tactics revealed doctors' mistrusts of alcoholics, as well as their skepticism concerning the potential of alcoholics to heal. Perhaps the most significant point that physicians emphasized and reinforced throughout these conversations was their understanding of the alcoholic as irresponsible, dishonest, and untrustworthy. Throughout these accounts, there is no discussion of how best to explain treatment to patients, or how to work with them to achieve the desired results. The alcoholic patient is presented as a slippery subject, to be acted upon quickly. This was why the chronic alcoholic had to agree to such a long stay – otherwise, he would not be completely under the physician's control, a necessity given his lack of personal responsibility. This understanding of the alcoholic's personal nature was not limited to questions of treatment, as we will see. Physicians extended the reach of these characteristics, so that they were applied not only to the alcoholic's feelings concerning treatment, but to all facets of the alcoholic's ability to fulfill social obligations and responsibilities. As a result of their physical inability to fulfill the most basic



social obligations, physicians explained, alcoholics let down their families, their communities, and their *patrie*. This medical logic became even more important in light of the incurable, permanently-damaged nature that most French practitioners also ascribed to alcoholics. Critically, this perception fed into other contemporary medical perceptions regarding alcoholism's ability to undermine an individual's rationality and his ability to function as a responsible citizen.

#### Chapter 4: Alcoholism in Women

George-Henri-Marie Wibratte's 1908 thesis, *Le Délire Alcoolique chez la Femme*, written to earn his degree in medicine at the University of Bordeaux, examined alcoholic crises exclusively in women.<sup>291</sup> In support of his claims regarding the particular nature of alcoholism among women, Wibratte based his thesis around a number of case studies that he considered representative of the disease's typical pathology. The story of Angelique, a thirty-three year-old laborer, was typical of Wibratte's patients. Married at age twenty-two to an inveterate drunk who gave her syphilis, Angelique's first seven pregnancies had ended in either abortion or miscarriage, although the product of her eighth was, in 1906, three years old. Despite her claim that she only a small glass of rum with her husband each morning, and some red wine later in the day, Wibratte informed the reader that in truth she drank very large quantities of both, well as white wine aperitifs (the basis for this assertion seems to have been Wibratte's interpretations of his observations of Angelique, rather than testimony provided from a family member).

When she was admitted to the hospital in 1906, where she came into contact with Wibratte, she complained of constant fatigue and claimed to be pregnant. An examination proved this impression to be mistaken, and the treating physician accused her of pretending to be ill. At this, Angelique became angry, and tried to attack the physician in question. Held against her will in the psychiatric wing, Angelique's sleep was troubled by gruesome nightmares in which her husband was decapitated. After this, even when awake, she was convinced that her husband's head was no longer attached to his body (it appeared that she nonetheless believed he was alive). Slowly, her hallucinations began to recede, and eventually she was only troubled by terror in the night. Angelique confessed to her physician that her mother's death five months earlier had shaken her

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<sup>291</sup> George Henri-Marie Wibratte, *Le Délire Alcoolique Chez la Femme à Bordeaux et dans le Gironde* (Bordeaux: Imprimerie de la Midi, E. Trénit, 1908).

significantly, amounting to an emotional trauma, at which point she had begun to consume more alcohol than usual. After around three weeks in the hospital, Angelique's husband came to visit. Seeing that his head was still attached to his body served to dispel even more of her delusions, and Angelique returned home shortly thereafter, at least partially healed.

Despite its brief nature (it filled not even two complete pages), Wibratte's work reflects the principle beliefs of the French medical community concerning the most common signs and symptoms of alcoholism in women: a high number of abortions and miscarriages, a husband encouraging her consumption, a tendency towards mendacity, violence, and irrationality, and an emotional flux preceding her descent into alcoholism, all of which made it impossible for the patient to fulfill her biological and social destiny as a woman. Despite these enormous upheavals, it is notable that physicians did not argue that female alcoholics became more masculine as a result of their drinking. Their alcoholism could not negate or mute their fundamental female-ness, only amplify its most dangerous qualities while preventing their bodies from fulfilling the duties that would ensure their health, as well as that of the nation. In this understanding, alcoholic women were still considered women, but their drinking had mutated them so much that their femininity was no longer healthy, and instead unbalanced. Any contemporary reader who had been educated in the basic pathology of alcoholism among women would have recognized the diagnosis of Wibratte's patient without the surrounding analysis, filled as it was with the signposts of alcoholism in women.

The most elementary belief that all physicians shared was that alcohol consumption among women was distinctly different from that of men.<sup>292</sup> Commentators of every stripe confidently

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<sup>292</sup> Simone de Beauvoir, the French philosopher, most persuasively expressed the idea that women are often presented as "secondary," as the "Other" of men, and that they are not defined independently of or as equals to men. Nonetheless, de Beauvoir argued, they are also not understood apart from men – women do not make sense without the counterpoint of men. This particular concept, that men and women must interact in order to create a healthful

asserted that women drank for different reasons, in different ways, and with different results than men. As a result of this fact, these authors argued, the disease's pathology diverged between men and women. In their writings, physicians argued that the physical symptoms of alcoholism in women were evidence of pre-existing deficiencies that shaped the rest of their lives, much as they had argued when discussing alcoholism in men.<sup>293</sup> Thus, despite the fact that the alcoholism of men and women played out differently, both were based on the same principles concerning the relationship between brain and body.

This idea was not developed solely among physicians discussing alcoholism, of course. Spurred largely by a combination of Freud's new theories and the implications of Paul Broca's research, psychiatrists and neuroscientists were exploring a multitude of pathways through which the brain and body were connected in these years. By studying the case of alcoholism, however, we may observe how this theorization interacted with the strong physicalist tendencies of French medicine. As their logic developed, physicians created a distinctive profile of the archetypal alcoholic woman, which focused attention on her mendacity, furtive nature, violence, and irrationality. Despite this, the medical understanding of the alcoholic woman at the outbreak of World War I did not emphasize masculine traits, or portray drinking her as rejecting femininity and developing manly attributes, either physically or mentally.<sup>294</sup> Instead, this discourse removed

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society, seems to be particularly popular in France (see, for example, Mona Ozouf, *Women's Words: Essays on French Singularity* (Chicago, IL: University of Chicago Press, 1998 first edition)). This has stymied French feminism – see Joan Scott, *Only Paradoxes to Offer: French Feminists and the Rights of Man* (Cambridge, MA: Harvard University Press, 1997).

<sup>293</sup> Of course, since the shift in scientific thinking in the seventeenth century at least, scientists and physicians had created systems and patterns of reasoning that made room for sex differentiation, even when it was far from convenient to do so (for example, Linnaean taxonomy based much of its animal classification around the lactating breast and shoe-horned plants into a confusing sexual system). For more on the centrality of gender to modern science, see Londa Schiebinger, *Nature's Body: Gender in the Making of Modern Science* (Newark, NJ: Rutgers University Press, 1993), Ludmilla Jordana, *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries* (Madison, WI: University of Wisconsin Press, 1993), Rebecca Jordan-Young, *Brainstorm: The Flaws in the Science of Sex Differences* (Boston, MA: Harvard University Press, 2010).

<sup>294</sup> I say notably here because alcoholic women were viewed as excessively masculine in other national medical discourses. For more on this, see Patricia Herlihy, *The Alcoholic Empire: Vodka and Politics in Late Imperial Russia*

a drinking woman's gender identity, effectively unsexing her through medical logic.<sup>295</sup> Examining this medical logic makes it clear that sex and gender did not exist on a continuum or scale of any sort, and that asylum physicians discussing alcoholism in particular did not perceive potential connections between the two. This understanding obviously served to shore up the perception, popular in France, that men and women were distinct and complimentary.

As we will see, however, the competing urges to separate the pathology of alcoholism between men and women, and to insist on the dangers of alcoholism to the French population as a whole proved problematic. Ultimately, the disease profile of the two sexes diverged significantly, as physicians claimed that alcoholism in women included paranoia, hysteria, and a loss of sense far earlier than it did in men. Furthermore, the brains lesions that were so important to the progression of alcoholism in men were rarely discussed in women.<sup>296</sup> In the end, however, contradictions of this sort between male and female alcoholism served to shore up the legitimacy of the disease model physicians put forward.

### **I. Do Women Drink?**

Some doctors did argue that women were unlikely to drink, and that their consumption did not rise above incidental levels. As a result, a small number excluded women from their statistical

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(Cambridge, MA: The Oxford University Press, 202), Clare Wright, "Doing the Beans: Women, Drinking, and Community in the Ladies Lounge," in *Journal of Australian Studies*, 76 (2003): 7-22. For a similar analysis of women and opiates, see Howard Padwa, *Social Poison: The Culture and Politics of Opiate Control in Britain and France, 1821-1926* (Baltimore, MD: The Johns Hopkins University Press, 2012).

<sup>295</sup> For more on women and alcohol in France, see Susanna Barrows, "After the Commune: Alcoholism, Temperance, and Literature in the Early Third Republic," in John Merriman, ed., *Consciousness and Class Experience in Nineteenth-Century Europe* (NY: Holmes and Meier Publishers, 1979), 179-206, Susanna Barrows, *Distorting Mirrors: Visions of the Crowd in Late Nineteenth-Century France* (New Haven, CT: Yale University Press, 1981), Patricia Prestwich, "Female Alcoholism in Paris, 1870-1920: The Response of Psychiatrists and Family," in *History of Psychiatry* 14, no. 3 (2003): 321-336, W. Scott Haine, "Privacy in Public: The Comportment of Working-Class Women in Late Nineteenth-Century Proletarian Parisian Cafés," in *Proceedings of the Annual Meeting of the Western Society for French History*, 13 (1986): 204-212, A. Lynn Martin, *Alcohol, Sex, and Gender in Medieval and Early Modern Europe* (NY: Palgrave, 2001).

<sup>296</sup> For more on the importance of this male-female divide to French society, see Joan Scott, *The Politics of the Veil* (Princeton, NJ: Princeton University Press, 2010).

analyses of French drinking patterns.<sup>297</sup> The chief physician of the Parisian police department went so far as to assert in 1904 that "alcoholism among women is still a rarity."<sup>298</sup> The vast majority of physicians, however, were convinced that women's alcoholism was a growing danger. Medical authorities and social commentators throughout France argued that for a variety of physical and psychological reasons, women were actually more susceptible to alcoholism than men. According to Dr. A.-J. Devoisins, one of the leading authorities on alcoholism, the disease was not less present in women than men. Rather, it was under-diagnosed, as the average woman became drunk after consuming relatively less alcohol than a man, so it was difficult to identify female alcoholics based on consumption patterns. Furthermore, female alcoholics were often more adept at hiding intoxication – indeed, covering up drunkenness was one of the first signs of alcoholism in women, while visible drunkenness was a sign that a woman's alcoholism was very advanced. Warning against the blind spots of his colleagues, Devoisins argued, "in reality, female alcoholics exist in all social positions and among all peoples..."<sup>299</sup> As another physician put it, "Alcoholism in women, previously very rare, currently tends to grow..."<sup>300</sup> A third was convinced that the secondary characteristics of alcoholism in women were more dramatic than those in men, writing "that alcoholism... has created a new type of general paralysis, and it grows, unfortunately, among women, a role more harmful than among men."<sup>301</sup> The growth of concern among physicians over

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<sup>297</sup> Joseph Reinach, *Contre l'Alcoolisme* (Paris: E. Fasquelle, 1910): 61-63. Many also argued that women's consumption varied from region to region, and that women who consumed more alcohol were likely to reside in the country (and therefore were less civilized). This argument was difficult to sustain, however, as most authorities also asserted that rates of alcoholism were lower in the countryside than in industrialized urban centers. Either women's alcoholism could be in less visible because it was under-observed due to its rural nature, or alcoholism was low in rural areas, but both propositions could not be true.

<sup>298</sup> Paul Garnier, "Alcoolisme et Criminalité," in *Annales d'hygiène publique et de médecine légale*, Jan. 1904: 120.

<sup>299</sup> A.J. Devoisins, *La Femme et l'Alcoolisme* (Paris: Imprimerie G. Rougier et Cle, 1885), 27.

<sup>300</sup> Paul Souilhé, *Alcoolisme, son Influence sur la Famille, sur la Dépopulation* (Paris : H. Jouve, Imprimerie de la Faculté de la Médecine): 23.

<sup>301</sup> Mlle. Mandjose, *Quelques Considerations sur les statistiques et l'etiologie de la paralysie generale des alienes chez la femme* (Montpellier: Gustave Firmin et Montane, 1901): 44.

alcoholism in women was, it seems, driven in part by the increasing number of ways that they believed women could develop the disease.

Physicians generally agreed that women most commonly became alcoholics as a result of their surroundings. Put simply, women who socialized with alcoholics were likely to drink more than those who lived with sober men. As one doctor put it, “She can resist at first, but little by little the influence of the milieu becomes stronger, and she gives in.”<sup>302</sup> One of the most common influences driving a woman to alcoholism was, according to medical experts, her husband. Forced to frequent cafés and cabarets by his wife’s poor housekeeping, the generally abysmal quality of his housing, and his own exhaustion, medical authorities asserted, a man would eventually bring his wife along to these establishments. There, she would not only drink with him, but also, by trying to imitate his habits, pick up a taste for distilled alcohol. Eventually, she would not only become an alcoholic, but also alienate her husband’s affections, both physically and emotionally. The source of the alienation was somewhat unclear, aside from the general proposition that men did not like drunk women.

Notably, none of these writers entertained the possibility that women would spend their evenings in cafés in order to relax after the stresses of their days in factories or shops, or to avoid housework and meal preparation, despite the fact that nearly all of them argued that those were the very factors that led most men to the cafés and cabarets. Married working-class women’s drinking was, in this logical framework, a derivative of their husbands’ consumption. As one author explained, the factory worker drank to escape the troubles of his life. As a result, “it is natural that, left to struggle without result, his wife follows him.”<sup>303</sup>

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<sup>302</sup> George Henri-Marie Wibratte, *Le Délire Alcoolique Chez la Femme à Bordeaux et dans le Gironde* (Bordeaux: Imprimerie de la Midi, E. Trénit, 1908): 54.

<sup>303</sup> M. Louis Grillet, *Étude sur la Question de l’Alcoolisme dans les villes ouvrières* (Paris: Imprimerie Nationale 1910): 13.

Working-class girls between fifteen and twenty years old could also become alcoholics if they were led by the examples of their brothers, uncles, and fathers.<sup>304</sup> Educational materials intended for dissemination in primary schools were full of stories of teachers who, hearing of female students with drinking fathers, prompted their students to keep their fathers at home with good food and stories read aloud, as much for their own health as for their fathers'. Although factors such as a parent's predilection for the café appear to be entirely social, it is critical to recognize that physicians included these elements in their medical discussions of alcoholism, and would have argued that they were just as much their purview as knowledge of how many drinks a patient consumed on an average day. What are today viewed as social behaviors were, in nineteenth century France, pathologized as expressions of alcoholism playing out, underlining the extent of the connection physicians theorized between brain and body, urge and action. In this understanding, urge did not only drive action, it was a symptom of a pathology.

Not all women who drank were married, of course, which made it necessary for physicians to explain how it was that a single adult female could become an alcoholic. Ultimately, these physicians most commonly pointed to a woman's employment as the factor driving her drinking. According to medical and hygienic experts, a woman's profession influenced not only whether or not she would consume alcohol in an unhealthy or dangerous fashion, but also exactly how that consumption would take place. Those women who worked outside the home but were not employed in factories spent large amounts of time alone or unsupervised, physicians theorized, and therefore their drinking often went undetected. Charting space between the rowdy and uncivilized cafés of the working class, and the privacy that they would use to characterize middle-class women's consumption, physicians posited a quasi-public, barely perceptible style of drinking

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<sup>304</sup> Raoul Brunon, *L'Alcoolisme chez les Femmes en Normandie* (Paris: Imprimerie Jean Gainche, 1899): 4.



for these single, working women. For many of these women, they argued, the day's drinking started early. It was particularly common in working-class homes for unnamed bottles of distilled alcohol to sit permanently in the center of dining tables, physicians asserted, in order to make it easy for a woman to begin her solitary day with a quaff from the bottle.

Each profession encouraged different habits, according to the patterns of their days. Spinners preferred to drink small glasses of alcohol throughout the day, maintaining a low, barely perceptible, yet constant level of intoxication that they could very likely hide when necessary.<sup>305</sup> Cooks and women who performed household tasks were far more likely to visit various markets each day, where “the small grocer, the vegetable vendor, the coal vendor... all sell or give drinks and attract clientele in this way.”<sup>306</sup> With each purchase the buyer received a small glass, which she quickly consumed before moving on to the next errand. Neighborhoods filled with these shops were often called “streets of the flask.”<sup>307</sup> The informal, unsupervised, social nature of their jobs made it all too easy for these women to pause in the cafés of these neighborhoods and consume a glass or two with one another before hurrying back to their employers' homes. In particular cooks, who had to visit multiple shops and vendors each day, often came home in exhausted stupors at the end of their chores and errands, nearly paralyzed by their mid-morning drinking. One physician related the case of a local cook who, becoming accustomed to drinking large quantities of alcohol as a result of her time spent in the market, often gulped eau-de-vie directly from the bottle in the middle of the day, an act so unheard of that scandalized household maids and astonished day-laborers would gather around her while she did so.<sup>308</sup>

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<sup>305</sup> Brunon, *L'Alcoolisme chez les Femmes*, 3.

<sup>306</sup> *Ibid.*, 5.

<sup>307</sup> *Ibid.*, 12.

<sup>308</sup> *Ibid.*, 6.

In spite of the high amount of alcohol most cooks consumed, washwomen were the most well-known drinkers among household staff, physicians asserted. They drank with a “cold-blooded” purpose, according to one doctor, as much to warm their hands as to satisfy their physical cravings. In many households laundresses were given distilled alcohol along with their meals as a matter of course, and washwomen who packed their own lunches at home had a designated bottle for their alcohol.

Even these women, however, could not challenge the *concierges*, typically older women who served side functions in cafés and cabarets, such as wiping down and bussing tables. These women were there primarily to drink at a deep discount, and did so indiscriminately, moving between absinth, vermouth, eau-de-vie, and cassis with no prejudice.<sup>309</sup> Their nervous systems, perpetually stimulated by their alcohol consumption, reportedly aged *concierges* prematurely. Their bodies, which after several years of heavy drinking were little more than hollow, dried out husks, could hardly survive without alcohol. They were, according to physicians, poisoned, yet incapable of surviving without their poison.

Working-class women were not the only females drinking in France, however. According to physicians, middle-class housewives, alone for most of their days and bored by the wait for their husbands to return home, often picked up bottles and flasks to pass the time. These women turned to alcohol primarily as a result of too much free time spent alone. As one doctor put it, “sometimes, they drink out of boredom, out of idleness, without motive.”<sup>310</sup> Despite her solitude, a lonely alcoholic homemaker would take a number of precautions to conceal her drinking from the potential of discovery from the occasional visitor, her children and household staff, or, most

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<sup>309</sup> Cassis was a liquor derived from blackcurrants. It is generally used in the French cocktail *Kir*. Brunon, *L'Alcoolisme chez les Femmes*, 8.

<sup>310</sup> R. de Ryckère, *l'Alcoolisme Feminin* (Paris: Masson et Cie, Éditeurs, 1899), 28.

importantly, her husband. These women also felt compelled to hide their drinking from one another, choosing solitude over sociability. Medical authorities pointed to this secrecy as both a symptom and a cause of alcoholism. Drinking alone induced feelings of shame in women that they could only assuage by turning to their bottles. This vicious circle would spiral indefinitely without most husbands noticing their wives' alcoholism, due to women's natural propensity towards sneakiness, which alcohol consumption only heightened. Many developed ties to the bottle that physicians characterized as emotional, and thus undercut their marriage vows. This pattern of hidden drinking also made it exceedingly difficult for physicians to diagnose many women as alcoholics. This secrecy, which doctors identified as one of the universal symptoms of alcoholism among women, led them to estimate that the disease was a common affliction of the middle-class, and that rates of alcoholism among these women must be much higher than they realized.

Despite this perceived dishonesty, few reports of women engaging in extramarital affairs made their way into the enormous numbers of case studies physicians included in their evidence concerning alcoholic women. Instead, according to the experts, women devoted these skills to hiding the evidence of their drinking. Most commonly, they concealed small flasks of alcohol in everyday objects that would not arouse suspicion. Reports of alcohol hidden away in sewing baskets, books, perfume bottles, pianos, behind picture frames, and even within hand-held fans were common, and were intended to emphasize not only their propensity towards deception, but also the inventiveness of the women who drank. When the extent of their consumption was discovered, alcoholic women typically became enraged, and defended their drinking and their stashes of alcohol with a surprising ferocity.<sup>311</sup> To be revealed was, physicians suggested, the worst

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<sup>311</sup> Much like was the case in depictions of male alcoholism, female alcoholics were never portrayed as coming to any type of personal realization concerning their drinking. There was no "recognition of the self" in discussions of how alcoholics dealt with their diagnoses.

possible outcome for these women, as the ensuing shame would be nearly unbearable. When the alcoholism of these women was uncovered, it was almost exclusively following crises involving the loss of reason, during which confused family members had called upon physicians.

Throughout these medical discussions of how women developed alcoholism there was little problematization or even discussion of sociable drinking taking place among groups of middle-class women. Physicians did not discuss drinking in exclusive female groups, which took place every day in the cafés of the *grands boulevards*, as damaging or capable of inducing alcoholism. The only visible consumption of alcohol that these authorities considered medically relevant was taking place in working-class cafés, where physicians believed a single-minded purposefulness to induce intoxication superseded any interest in sociability. This decision of contexts to discuss is interesting for two reasons. Firstly, it underlines that the impulses, desires, and wants of the drinker were considered to be evidence of a medical disorder, just as much as the albumin content found in alcoholic's urine. In this instance, medical reasoning pathologized personal preferences.<sup>312</sup> Secondly, this exclusion helps to demonstrate that physicians were engaged in a process of determination. They had to decide what information was relevant to their medical discussions. Not only instances of alcohol consumption were pertinent to discussions of alcoholism. Some were merely instances of healthful consumption. Although their in-depth examinations of where alcoholics drank strike us as social, rather than medical, this reaction does not reflect the nineteenth-century understanding of what "medical" meant. Physicians did not step over a boundary separating medical and social in these discussions; they simply understood the

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<sup>312</sup> A number of other investigators have discussed how preferences, tastes, and beliefs have been used in the nineteenth century as evidence of medical disorders, or of belonging in certain groups. For more on this, see Anna Davin, "Imperialism and Motherhood," in *History Workshop Journal* 5, no. 1 (1978): 9-66, Ann Stoler, Frederick Cooper, *Tensions of Empire*, (Berkeley, CA: University of California Press, 1997), 87-151, Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Reverie in Colonial Congo* (Chapel Hill, NC: Duke University Press, 1999).

boundaries of “medical” to include discussions of where drinking took place. Styles of consumption indicated whether a patient had a pathological relationship to alcohol, or a “healthy” sociable one.

## **II. The Pervasive Influence of Irrationality**

In addition to the aforementioned factors, physicians also argued that the beginning of menstruation could encourage alcoholism in young girls. Suddenly subject to new pressures and stimuli, the nervous system of girls undergoing their first menstrual cycles often went haywire, doctors argued. Generally the effects of this were so minor as to be imperceptible, but occasionally new tastes and preferences, excessive irritability, a disordered imagination, hysteria, or even epilepsy would emerge for the first time. Surprisingly, it was the new tastes, rather than the potential insanity, that these doctors found most troubling. It was in this first year of menstruation, physicians asserted, that many girls experimented with alcohol, drinking beverages other than wine for the first time. The associations between female sexuality, alcohol consumption, and vulnerability that this logic reinforced are striking. Already mentally unbalanced, girls just reaching puberty were, doctors argued, more likely than ever before to enter cafés and cabarets, where they would interact with older, more experienced men. These girls, already exposed, would then put themselves in an even weaker position by consuming alcohol, further undermining the small amount of sense and reason that their menstruation hadn't stolen from them. The consequences for girls in this situation were, according to medical experts, obvious: moral dissolution, sexual activity, unplanned pregnancies among the unmarried, and the production of “low-quality” children. By creating this timeline of individual degeneration and ruin, physicians elided several types of female vulnerability into the single package of alcoholism. Additionally, the complex relationship they had created between the brain and the body in their discussions of

alcoholism naturalized the perception that women's social vulnerabilities were in fact a medical phenomenon. In this way, discourses on women's alcohol consumption simultaneously played into, reinforced, and drew legitimacy from widely circulated narratives of degeneration.

Pre-pubescent girls could consume alcohol as well, of course. Physicians who addressed this topic argued that alcohol consumption among girls before they began menstruating could speed the physical development of sexual maturity, but it would produce a damaged and perverted woman. The premature menstrual cycles would be painful and damaging to the girl's reproductive system, and were unlikely to ever lead to full-term pregnancies. Reports of girls who drank before they reached sexual maturity were also characterized by the author's attention to the girl's lack of gender characteristics. These girls were not feminine, but they also did not tend towards the masculine, aside from gravelly voices, which physicians explained as a result of alcohol burning the delicate, still-forming tissues of the child's esophagus. There were no reports of these girls displaying either overtly masculine behavior, or the irrationality associated with adult female alcoholics. Young girls who drank were essentially paused in their development, but, like adult women, they were not shifted towards masculinity. They remained stuck at the age they were when they started drinking, waiting for a maturity that would never come.

It is particularly noteworthy that French physicians tied the "irrationality of menstruation" to the "irrationality of drunkenness," given that one constitutes the natural development of a woman's body, while the other is a temporary, artificially-induced state. By linking the two, medical authorities encouraged readers to perceive adult women as continually subject to the vicissitudes of heavy alcohol consumption, even when sober. Within this logic, the sexually mature female had a low capacity for rational behavior, regardless of the stimuli she encountered. As a

result, several physicians attempted to theorize a way through which hysteria could trigger alcoholism.<sup>313</sup>

This association between alcoholism and irrational behavior in women was likely in part a result of the confusion that husbands expressed when they discovered their wives behaving irrationally. The evidence presented in case studies indicates that some middle-class French women did drink significantly more alcohol than their husbands realized. When these women became drunk, their husbands called upon physicians to explain behavior that appeared irrational and quasi-hysterical. Although several early works, such as the 1891 thesis *Contribution a la etude de l'Hystérie d'origine Hérédo-Alcoolique*, or the 1890 work *de Hystérie Alcoolique*, argued that similar stresses and hereditary factors induced alcoholism and hysteria and that the two diseases enjoyed a symbiotic, mutually nourishing relationship, by 1900 physicians had distanced the diagnoses from one another.

There were several factors that likely encouraged this. Firstly, the diagnosis of hysteria was increasingly under the purview of psychiatrists in the late nineteenth century.<sup>314</sup> Physicians who were trying to distance themselves from psychiatrists wanted as little common ground between the two fields as possible. If alcoholism were secondary to hysteria, the best way to combat it would be treatment of the primary problem, which would marginalize non-psychiatric physicians studying alcoholism, as psychiatrists typically treated these cases. Furthermore, if alcoholism in women resulted from symptoms of another disorder, rather than alcoholism, physicians' arguments regarding the critical nature of alcoholism would be significantly weakened.<sup>315</sup> Psychiatrists

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<sup>313</sup> See Louis Camuzet, *Contribution a l'Étude de la Hystérie d'Origine Hérédo Alcoolique* (Paris: G. Steinhéil, Éditeur, 1891), Francisco Salmeron, *de l'Hystérie Alcoolique* (Paris: Henri Jouve, 1890).

<sup>314</sup> Jan Goldstein, *Console and Classify* (Chicago, IL: University of Chicago Press, 1987 first edition), 322.

<sup>315</sup> W. Scott Haine and Patricia Prestwich have both argued that psychiatrists were disinterested in treating alcoholics, based off the admission records in asylums. This interpretation, I think needs to be qualified. Some psychiatrists were certainly frustrated by alcoholics and discouraged them from staying in asylums for either acute

writing on alcoholism, of course, would not have had a problem with this, but medical physicians, who were equally interested in alcoholism, would have been wary of encouraging the closeness between the diseases.

Secondly, the treatment of hysteria was not based in measurable sciences of the body. Many physicians, however, wanted to enmesh alcoholism in statistically-driven terms and expressions that hygienists in particular were using to address contemporary crises in France. Associating alcoholism this closely with hysteria encouraged a relationship that problematized the physicalist model of alcoholism that was being advanced. Ultimately, creating a close connection between alcoholism and a psychological condition would not have helped many physicians to achieve the goals discussed earlier, in Chapter One. As a result, it made sense to encourage the associations between emotion, irrationality, and alcoholism, but not to go so far as to bring hysteria into the equation.

Physicians also theorized that menopause could encourage alcohol consumption among women. Dr. Leon Thomeuf's 1890 work, *Alcoolisme Subaigu*, argued that as women went through menopause they experienced a nervous upheaval of the same order as young girls menstruating for the first time. As a result, they were prone to the same disorders, including the impulse to try new types of alcohol. Similar discussions of menopause triggering alcoholism were not a part of most works, however. Dr. A.J. Devoisins' defining work, *La Femme et L'Alcoolisme*, written in 1880, did not address the topic, as did few of the many authors who elaborated on it in the following years, despite the fact that menopausal women often appeared in case studies. This paucity of interest reflects the uses that physicians had for discussions of alcoholism. After all, there was little social value for physicians to find in discussions of the health risks of menopausal women in early

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crises or chronic alcoholism. Others, however, were obviously interested – this was why they produced theses and journal articles on the topic.



Third Republic France, who of course would not be able to have children. The subject simply didn't offer any points of entry to the critical debates that physicians were using to grow their professional status as experts with relevant knowledge. Put another way, menopausal alcoholic women weren't sexy. It becomes clear here once again that although physicians proposed a number of theories regarding nineteenth-century alcoholism, only a small fraction of these were taken up, indicating that a number of social and professional motives as well as medical evidence drove these conversations. Ideas that did not grow physicians' relevance to topics with broad levels of salience did not gain an audience within the profession, and were discarded along the way.

In addition to creating distinct methods by which women became alcoholics, medical experts also argued that alcohol consumption had more severe consequences for specific systems within the female body than others. The most important among these were the reproductive organs. Many physicians asserted that alcohol's nature as a stimulant affected the vagina in particular, with the result that "the genital organ is in a state of permanent excitement."<sup>316</sup> In this theorizing, alcohol's ability to inflame the nervous system radiated downwards, resulting in increased blood flow and sensitivity, and a pattern of masturbation that one physician termed "unbridled." Some even went so far as to categorize these women as nymphomaniacs. There was little that could be done in these situations, doctors asserted, aside from discouraging their drinking.<sup>317</sup>

### **III. Fertility, Pregnancy, and Alcohol**

The growth in concern over drinking women dovetailed nicely with a number of other medical priorities in nineteenth-century France. Chief among these was the rapidly dropping population. In both Germany and England, where standards of living and rates of industrial development were comparable to those of France, national populations grew briskly in the final

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<sup>316</sup> Thommeuf, *Alcoolisme Subaigu, de l'Alcoolisme chez le Femme* (Paris: Libraire J.B. Bailliere et Fils, 1890): 16.

<sup>317</sup> Thommeuf, *Alcoolisme Subaigu*, 16.

quarter of the nineteenth century. Nonetheless, the number of French children born each year barely managed to reproduce the population.<sup>318</sup> This development engendered a great deal of public hand-wringing, as politicians, teachers, doctors, priests, and every other type of social commentator imaginable mulled over the consequences of having a small and “lower-quality” population if should war break out. Marriages were taking place at roughly the same rate, which led most observers to believe that endemic, rather than social, causes were to blame.

By arguing that a causal link existed between the perceived growth in alcohol consumption and the stalling birthrate, physicians were able to tap into one of the most sensitive veins of public discourse.<sup>319</sup> If no action was taken against alcoholism, they asserted, the population would continue to decline and France would “place itself in a position of manifest inferiority.”<sup>320</sup> Initially, physicians writing on alcoholism argued that alcohol consumption was restricting women’s fertility, thereby driving down the birth rate, although this position evolved considerably in the years leading up to World War I.

The onanism that physicians diagnosed in female alcoholics was, in their eyes, just as hazardous to marriage and healthy reproduction as the madness of alcoholism, as it destroyed a woman’s sexual interest in her husband. While French authorities perceived a relationship between alcohol and reproduction, unlike their British colleagues they did not detect evidence of an

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<sup>318</sup> For more on concern over the French population crisis, see Elinor Accampo, *Blessed Motherhood, Bitter Fruit: Nelly Roussel and the Politics of Female Pain* (Baltimore, MD: The Johns Hopkins University Press, 2010), Joshua Cole, *The Power of Large Numbers: Population, Politics, and Gender in Nineteenth-Century France* (Ithaca, NY: Cornell University Press, 2000), Karen Offen, “Depopulation, Nationalism, and Feminism in Fin-de-Siècle France” in *American Historical review* 89, no.3 (1984): 649-676.

<sup>319</sup> In Devoisins conclusion, he asserted that “the decrease in births seems to be in proportion to the growth of alcoholism among women.” (pg 69)

<sup>320</sup> Editorial Board, “Against Alcoholism” in *Annale d’Hygiene Publique et Medecine Legale* July (1914): 352. It is also interesting to note that this interpretation was at odds with the dominant opinion within the English medical establishment, where physicians opined that consumption of gin (a popular drink among the working class) actually *increased* fertility.

augmentation in family size among alcoholics.<sup>321</sup> In fact, many French hygienists and physicians argued that alcohol's ability to increase female interest in self-gratification was one the keys to understanding the relationship between the growing pace of alcohol consumption among women and the dropping size of the population. According to one of the earliest texts examining alcoholic women, the subject's onanistic preferences meant that "amorous desires disappear sometime before age thirty... and adultery of the husband is often the consequence of the genital lifelessness of the female."<sup>322</sup>

Another of the most common lines of attack used by alcoholism on women's fertility was dehydration. "The ovaries of female alcoholics diminish by volume," according to one physician, "and soon cease to be the seat of active engorgement which encourages menstrual flow."<sup>323</sup> While there were few physicians who argued that alcohol consumption in adult women definitively prevented menstruation, the vast majority asserted that at the very least it led to irregular cycles, which they believed made pregnancy highly unlikely, if not entirely impossible.<sup>324</sup> The inherent contradiction between the assertion that alcohol dehydrated women's reproductive systems, thereby draining the ovaries, while simultaneously encouraging blood flow to the genitals and thus producing nymphomaniacs, is exemplary of the contradictory logic that suffused medical writings on alcoholism.

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<sup>321</sup> See Mary Scharlieb, "Alcohol and the Children of the Nation," in *The British Journal of Inebriety* 5, no. 2 (1907): 63.

<sup>322</sup> Devoisins *La Femme et l'Alcoolisme*, 69.

<sup>323</sup> *Ibid.*, 68.

<sup>324</sup> It is interesting to note that these physicians don't draw a causal line between poor nutrition and irregular cycles. They do point out that individuals suffering from alcoholism will not absorb nutrients efficiently, but they reasoned that this was because alcohol consumption disturbed the functioning of the stomach lining and the acids that break down food, not because alcoholics cannot afford to purchase food. For more on this, see Chapter 2 of this work. They also asserted that this poor nutrition is likely to lead to "low-quality" infants. For more on this, see Chapter 5 of this work.

In 1890, physicians felt comfortable asserting that the most common result of continued alcohol consumption on the female body was a physical inability to become pregnant. Ultimately, “alcoholism among women leads to sterility,”<sup>325</sup> one doctor concluded. “Happily enough,” another physician added, “as atrophied ovaries upset the maternal functioning.”<sup>326</sup> This medical opinion, however, was modified over the following years in the face of overwhelming evidence that alcoholic women, and even alcoholic couples, routinely produced large families over the course of their lifetimes, and were often more prolific than their sober middle-class counterparts. Physicians demonstrated this largely through increasingly common family studies, which examined the hereditary effects of alcoholism in one genetic line through several generations.<sup>327</sup> If, as physicians had initially felt confident in asserting, alcoholism destroyed fertility, there should not have been a great deal of family history to study. Yet medical students and asylum physicians alike were able to publish texts tracing up to three and four generations in families of alcoholics, the vast majority of whom continued to reproduce with a much higher frequency than the rest of the French population, despite their abbreviated life spans.

This did not mean, however, that physicians abandoned blaming alcoholism for the drop in the national population. In 1900, a medical student used a family study to demonstrate that alcoholics died younger, and therefore deprived the French population of births, while simultaneously raising the death rate.<sup>328</sup> The study began with the family’s father, Pierre, a robust, intelligent man who worked as a supervisor on roofing projects. He had been given to alcoholic excesses prior to his nuptials, but after the wedding these bouts of heavy drinking came more and

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<sup>325</sup> Devoisins, *La Femme et l’Alcoolisme* 69.

<sup>326</sup> Dr. Ernest Monin, *L’Alcoolisme: Etude Medico-Sociale* (Paris: Bibliotheque Actualite Medicales et Scientifique, 1889): 101.

<sup>327</sup> For more on the theorized relationship between alcoholism and heredity, see Chapter 2 of this work.

<sup>328</sup> Hector Ovize, *Alcoolisme et Dépopulation* (Saint-Étienne: Imprimerie A. Bardiot, 1900): 60.

more closely together. By the end of his life, Pierre was drinking a bottle of wine to start each day, as well as four to five liters more of primarily wine and absinth while at work, classifying him as a chronic alcoholic. He contracted tuberculosis, began to suffer from delirium tremens, hallucinate, and was dead by age 45. His wife, who suffered from varicose veins and a large number of dental problems in addition to occasional bouts of acute alcoholism, gave birth to six children before Pierre's death.

The first, a girl, was 17 years old at the time of the writing. Intelligent and strong, she suffered the least from the symptoms of her father's alcoholism. Her next sibling, a 15 year-old girl, was also strong, intelligent, and healthy. As a young child, however, she had been undersized, sickly, and generally sad. The first boy in the family, who would have been 14 years old at the time of writing, had died at age three of an attack of meningitis. The next child, also a boy, was 13 years old. Whereas his sisters were described as particularly intelligent, this boy was classified only as normal, and as physically less vigorous than his older siblings. The next daughter, described as weaker than her sisters and prone to a chronic cough, suffered from pulmonary lesions audible through a stethoscope. The final child the wife gave birth to before her husband's demise died within the first six months of his life (while he was still being breastfed), making it impossible to determine his physical or mental character. The implication of this final death just as her husband's alcoholism was reaching its peak was that the wife had also succumbed to drink, which had made it impossible for her to nurse her child effectively. Furthermore, the decline in the children's health as the husband's alcoholism became worse underlined the disease's hereditary effects. Nonetheless, given such a productive family, it could not be denied that alcoholics were fertile.

The 1902 thesis of Paul Souilhé, produced at the Paris School of Medicine, is exemplary of the dominant logic that took hold around the turn of the century concerning alcohol's effects on reproduction and family size. Souilhé's text opened with reports from demographers in order to dismiss the idea that low levels of fertility had caused the depopulation crisis. Further undermining the initial thesis that alcoholic women were infertile, Souilhé provided statistics demonstrating that the *departements* with the highest level of alcohol consumption per capita were also those with the highest birth rates. If anything, the first third of the work concluded, "the drunk is a prolific being."<sup>329</sup> Another statistically-minded investigation from 1899 claimed that, on average, "alcoholic" families produced 4.72 children.<sup>330</sup>

Nonetheless, Souilhé continued on, alcoholism was to blame for depopulation, because it grew the morbidity and mortality of France. The 1899 study put it most plainly, saying "alcoholism shackles the growth of the population by causing the premature deaths of a great number of adults."<sup>331</sup> Even though the birth rate was growing, thanks to the irresponsible acts of drinkers, it could not keep up with the rate of death in France, these physicians concluded. This was largely because so many of the dying were young children of alcoholics. These children were doubly at risk, both because of their hereditary background, and because they were raised by alcoholic mothers. Repurposing much of the logic employed by his colleagues writing on female alcoholism, Souilhé explained that alcoholic women struggled to maintain their moral sensibilities because of the lesions alcoholism produced on their brains. As he explained it, "the maternal instinct suffers such serious ravages that [the mother] commits monstrous acts."<sup>332</sup> Relying on earlier investigators

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<sup>329</sup> Paul Souilhé, *Alcoolisme, son Influence sur la Famille, sur la Dépopulation* (Paris: H. Jouve, Imprimerie de la Faculté de la Médecine, 1902): 31.

<sup>330</sup> It is unclear here how the author decided what counted as an "alcoholic" family. René Arrivé, *Influence de l'Alcoolisme sur la Dépopulation* (Paris: Jove et Boyer, 1899): 14.

<sup>331</sup> Arrivé, *Influence de l'Alcoolisme*, 5.

<sup>332</sup> Souilhé, *Alcoolisme*, 66.

including Devoisins, Souilhé continued to insist that alcoholism was medically different among women. He agreed with Devoisins that “when the woman gives herself over to alcoholism, she falls more profoundly than the man,”<sup>333</sup> writing, “if it is the mother who is the alcoholic, the child will more surely and more profoundly inherit the stain of alcoholism, even if the father is completely healthy.”<sup>334</sup> This, he stressed, was because the children would be neglected and encouraged to drink distilled alcohol at a young age. The high rate of death among children became, at the end of this reasoning, evidence of high rates of alcoholism among French women.

Ultimately, the authors argued, the mental and emotional connections that mothers created with their children were of paramount importance, as women were the basis of civilization. As Devoisins put it, “more kind, more sensible, more impressionable, more admirable than us [men], the woman holds in her hands all the future through her preponderant influence on the child.”<sup>335</sup> It was the mother, he asserted, who gave children their tastes and preferences, their personal failures and weaknesses, and helped them to guard against damaging tendencies. Souilhé agreed, stating at the end of a case study looking for the determining factor in a youth’s development of alcoholism, “...the influence of the mother has had the most lasting results.”<sup>336</sup>

Reflecting the totality of this shift in thinking concerning alcohol’s effects on fertility, a 1910 thesis considering hereditary alcoholism accepted the connections between disease, alcoholism, and increased mortality rates as common knowledge, as well as the centrality of the mother in the child’s life. Faced with evidence that directly contradicted the early conclusions that alcoholics’ infertility was responsible for the depopulation crisis, most physicians ultimately revised their conclusions regarding the relationship between alcoholism and depopulation. The

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<sup>333</sup> Devoisins *La Femme et l’Alcoolisme*, 20.

<sup>334</sup> Souilhé, *Alcoolisme*, 66.

<sup>335</sup> Devoisins *La Femme et l’Alcoolisme*, 8.

<sup>336</sup> Souilhé, *Alcoolisme*, 90.

problem was not that alcohol consumption lowered the birth rate, most argued by 1905, but rather that it created a mentally inferior, physically weak population, which quickly succumbed to the most dangerous diseases in France.

Once physicians acknowledged that alcohol did not prevent the vast majority of women from becoming pregnant, it became important to discover whether alcohol consumption affected the development of a fetus or the course of a pregnancy, and if so, in what ways, recognizing the limits of the heredity experiments conducted in labs.<sup>337</sup> Many physicians readily admitted that it was difficult to identify the effects of alcohol consumption on a pregnancy with any degree of certainty, because women often lied about the amount of alcohol they consumed, and because there was no way to remove influencing factors aside from alcohol. As a result, it became standard to study only the poorest of families, reflecting the assumption that the working class were almost invariably alcoholics. While middle and upper class families might also suffer from alcoholism, it would be difficult for physicians to gain the access necessary to make a diagnosis. Since all women would claim to consume no more than the occasional modest amount of alcohol, restricting themselves to women they were certain suffered from alcoholism made the most sense to these physicians. There was no discussion, however, of how other factors particular to the working class might also affect fertility and heredity.

The first threat that physicians argued alcohol consumption presented to pregnant women stemmed from more general concerns regarding nutrition. As one advice manual for women explained, it was not necessary for women to change their hygienic practices significantly while pregnant, but they did need to be more cognizant of the foods and liquids that could induce nausea or vomiting. With this in mind, wine was recommended during meals, perhaps weakened by

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<sup>337</sup> See Chapter 2 of this work.



mixing it with a small bit of water. In parts of the country where quality wine was harder to find or more expensive, it was acceptable to drink beer or cider, although this was not preferred. Tea and coffee, however, were considered dangerous beverages, with none of the nutritional content of the alcoholic beverages, and physicians advised that they needed to be avoided. Since both physicians and uneducated men and women believed wine and beer to be nourishing beverages, there was no discussion of completely restricting them from pregnant women.

The biggest danger that alcohol posed to pregnant women came, much like it did for young girls, from its nature as a stimulant. The stimulating effects of alcohol consumption, physicians informed the reader, often induced abortions. The circumstances described in these instances very closely resembled events that are today referred to as miscarriages, yet physicians continued to use the word *avortement* to refer to both the intended termination of a pregnancy, and the natural death of an embryo or fetus, which the body then expelled. René Arrivé's thesis on alcoholism and depopulation in 1899 is exemplary of how the two categories were typically conflated. Arrivé named alcoholism, along with lead poisoning, poor hygiene, syphilis, tuberculosis, genital lesions, insufficient nutrition, and low levels of albumin, as one of the primary causes of abortion among French women. Although studies linking alcoholism and abortion were still thin on the ground and often relied on less than ideal methodology and evidence (Arrivé cited a study in which pregnant rabbits were injected with alcohol and subsequently produced still-born bunnies, or bled to death during delivery), the author felt confident in blaming alcoholism for a rate of abortion nearly double that of the non-drinking population.<sup>338</sup> Even if the fetuses that did not survive were "monsters whose arrangement of tissues is such that all development is impossible... it is necessary to not forget the misery and trauma... which the alcoholic woman or the spouse of the

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<sup>338</sup> Arrivé, *Influence de l'Alcoolisme*, 22.

alcoholic woman is submitted to...”<sup>339</sup> In other words, even though Arrivé believed that these abortions and miscarriages favored the overall health of the nation, he nonetheless considered them self-inflicted, painful, avoidable events. He also recognized the psychological toll that multiple miscarriages could have on both biological parents of a child as having unknown repercussions in the future. Keeping in mind the relationship Arrivé and his colleagues perceived between mental and physical well-being, it is likely that they believed these traumas would undermine the health of future pregnancies.

Hector Ovize’s 1900 thesis echoed many of these same themes. So far as Ovize was concerned, “once conception has taken place, alcohol acts in a way far from favorable for the fetus. When a woman is pregnant, if she drinks, the drops, the traumas, and carelessness of all sorts are feared as causes of abortion. The toxic products of alcohol itself... provoke abortions...”<sup>340</sup> The physical changes that a woman experienced as a result of drinking, in this logic, were the desired consequences of active attempts to terminate a pregnancy. Equating the decision to consume alcohol with the decision to abort a fetus, physicians created a conceptual space in which moral failings were written on a woman’s body. This system of reasoning worked backwards as well – pregnant women (particularly working-class women, who were, according to these physicians, nearly always drinkers, if not alcoholics) who suffered miscarriages had most likely induced them. Every miscarriage then brought with it the stigma of abortion, as well as alcoholism.<sup>341</sup>

The only word these physicians occasionally used to distinguish between abortion and miscarriage was the adjective *criminel*. But the slippage between miscarriage, miscarriage preceded by alcohol consumption, purposefully induced miscarriage, and medical abortions

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<sup>339</sup> Arrivé, *Influence de l’Alcoolisme*, 22

<sup>340</sup> Ovize, *Alcoolisme et Dépopulation*, 35.

<sup>341</sup> For more on this, see Rachel G. Fuchs, *Poor and Pregnant in Paris* (New Brunswick, NJ: Rutgers University Press, 1992): 175-199

performed by physicians, midwives, or unlicensed back-alley practitioners is obvious. All four were grouped together under the word *avortement*, which further solidified the medical links these physicians constructed between alcoholism and crime.<sup>342</sup> Through this relationship, physicians indicated that a woman's consumption of alcohol was little more than the physical expression of her mental/emotional desire to end a pregnancy. As a result, a woman who experienced a miscarriage was at the very least criminally irresponsible.

This logic mirrored both the general perception that alcohol consumption encouraged criminal tendencies in women, and the relationship between alcohol and purposeful abortion in France at the time. For most women seeking to end a pregnancy, the first strategy was to drink a combination of herbs, white wine, and absinth. Although this might have a purgative effect, the mixture was not capable of inducing an abortion, which physicians, if not working-class women, were aware of by 1880. Nonetheless, the association between distilled alcohol and abortion persisted in medical literature. It seems then that physicians were partially influenced by their surroundings, and partially playing off a stereotype that jibed well with their own reasoning when they continued to class absinth as an abortifacient.<sup>343</sup> The physicians perpetuating these stereotypes furthered their own ends, it would therefore seem.

#### **IV. Alcoholic Women as Mothers**

If an alcoholic woman did manage to carry a child to term, she would likely struggle to fulfill even the most basic of motherly duties, doctors argued. Chief among these was breastfeeding her child. Some physicians refused to even discuss the dangers of infants consuming breast milk tainted by alcohol, as they believed that drinking women would not be able to produce significant amounts of milk. Drawing on the same logic used by those who argued that alcohol consumption

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<sup>342</sup> The relationship between alcoholism and crime is more fully discussed in Chapter 5

<sup>343</sup> For more on absinth being used as an abortifacient, see Fuchs, *Poor and Pregnant*, 185-188.

impeded motherhood, these doctors explained that alcohol created malformations of the mammary gland, making it difficult for milk to be pulled out of the mother's body.

Medical authorities agreed by the late nineteenth century that a mother's milk was a far healthier and safer alternative to the previously-recommended wet nurse, unless the mother was an alcoholic.<sup>344</sup> Alcoholic women, however, were not likely to be able to breastfeed. According to some authorities, alcohol consumption impeded the flow of breast milk. Others argued that it weakened the nutritional content of the milk; still others asserted that through breast feeding women could pass qualities to their children that would make the child more likely to develop alcoholism later in life. In order to protect against these dangers, some physicians broke with the wisdom of their time, and encouraged bottle feeding of cow milk over breast feeding by women who consumed alcohol.<sup>345</sup>

One former *officier de santé*, Eugene Trousson, writing for his medical doctorate shortly after the passing of the Loi Chevandier (a necessity if Trousson wished to continue practicing medicine, given the law's eradication of the *officiers*), discussed the pros and cons of cow milk and breast milk extensively.<sup>346</sup> The thesis consisted primarily of the student recounting his most memorable experiences concerning breastfeeding women and their consumption of alcohol while working in the countryside. After years of observation, Trousson argued, it was clear to him, that mothers passed alcohol to children through both amniotic fluid and breast milk.<sup>347</sup> As a result, it would be far better for alcoholic mothers to be prevented from breast feeding (who would do the preventing was unclear, although it seems likely that he intended physicians to at the very least

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<sup>344</sup> See George Sussman, *Selling Mother's Milk: The Wet-Nursing Business in France, 1715-1914* (Urbana, IL: University of Illinois Press, 1982).

<sup>345</sup> Devoisins, *La Femme et l'Alcoolisme*.

<sup>346</sup> Eugène Trousson, *Contribution à l'étude de l'intoxication alcoolique chez les enfants* (Paris: A. Michalon, 1902).

<sup>347</sup> Trousson, *Contribution*, 19.

monitor breastfeeding mothers). Otherwise, Trousson argued, they ran the risk of saddling their children with an alcoholism that was essentially incurable. In support of this, Trousson recounted the story of one boy, an inveterate alcoholic by fifteen, who had followed “the impulses of his nature” and run off to Paris with his friends to become a prowler and burglar. He was arrested shortly after his arrival in the city, and continued to bounce in and out of prison for years. Trousson pointed to his mother, an alcoholic who had breastfed, as responsible for the boy’s nature as well as his actions. The implications of this case study were clear – the consumption of alcohol via breast milk had permanently corrupted the youth, leading him to incurable criminality early on, which the French state would pay for throughout the remainder of his life.

Breast milk tainted by alcohol also had short-term consequences on the infant’s health, as Dr. Henri Meunier demonstrated in his 1898 case study of a suspicious wet nurse.<sup>348</sup> The middle-class family Meunier treated were puzzled by the behavior of their second son, whose irritability and constant crying they found upsetting, particularly given their first son’s docile nature. The initial diagnosis by the family physician confirmed that there was no infection, but purgatives and chamomile, recommended to soothe what the local practitioner identified as an inflammation of the digestive tract, failed to quiet the child, who soon began to seize and convulse regularly. A well-respected local homeopath also examined the child, but was unable to provide a diagnosis, despite three days of tests, Meunier noted condescendingly. The only possibility that both practitioners could agree on was that the bones of the head were fusing too quickly, thereby exerting pressure on the brain. This led the men to recommend that one of them puncture the child’s fontanel to relieve the pressure, at which point the parents called upon Meunier. When he examined the infant, the author reported none of the telltale signs of degeneration brought on by a

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<sup>348</sup> Henri Meunier, *Convulsions du Nouveau-né provoquées par l’Alcoolisme de la Nourrice* (Paris: A. Cocoz, Librairie-Éditeur, 1898), 1-12.

mother's alcohol consumption during pregnancy, or a father's intoxication at the moment of conception. The head was well-formed, the eyes did not reveal any gaps in intelligence or sensibility, the pulse was regular when the child was not convulsing, and over the past five days of seizing the child had not lost any weight, a fact that Meunier pointed to as particularly surprising.

Meunier also noted that the child's wet nurse, a "woman of the country," gave milk easily. Almost too easily, he thought, and further noted that the milk was very thin. He also wrote that the child nursed with an unusual avidity. Arousing his suspicion even more was the single hour that the woman spent outside of the family's home each day. Although he found no support with the child's parents, Meunier became convinced that the wet nurse was a drunk when another mother informed him that her son had suffered convulsions when briefly nursed by the same woman. Meunier reported that when he interrogated her, the nurse became taciturn and secretive and denied his claims, which only served to confirm his suspicions that she was drinking during her hour-long sojourns. Despite their reservations, the family followed his recommendation that a new nurse be brought in immediately, perhaps also feeling it was far safer and simpler than drilling a hole in their son's skull. The child improved quickly, and Meunier's final satisfaction came several weeks later, when an acquaintance informed him that the nurse in question had begun working as a maid in a nearby household, where she was developing a reputation among the male staff members for drinking alcohol and coffee together. The implication of Meunier's closing note was not only that the wet nurse was an alcoholic, but that because of her alcoholism she had also developed improperly close associations with these male members of her new household. She was then in several ways a damaged woman.

Meunier's case study underlines a number of the topics that alcoholism made available to physicians. His greater level of authority as an asylum physician in the face of the family

practitioner and the traditional healer is underlined by his successful, simple, and safe diagnosis. Despite the fact that the family disagreed with his recommendations, they followed Meunier's instructions, an example that further reinforced his expertise to his readers. Although his reasoning was opaque to his patients in the end that did not prevent them from doing as he recommended. Furthermore, the nurse's natural inclination to mendacity when faced with direct questioning conformed perfectly to the predicted narrative of the alcoholic woman's mental functioning. Her tendency to keep secrets, in addition to her inability to answer even simple questions, were only further proof of her drinking, a reflection of the mental symptoms physicians associated with alcoholism. Evasion was evidence. Despite the complete lack of physical signs, as a result of the mental pathology these doctors had created for female alcoholics, which was able to stand in for physical symptoms, Meunier was able to diagnose the nurse.

Concerns over the nutritional content of an alcoholic's milk abounded, with most authorities agreeing that consumption of alcohol in general lowered the quality. Some further argued that alcohol turned breast milk rancid. A small number of physicians recommended that women merely wait three hours after consuming alcohol to breast feed, but this measure did not gain much traction in professional recommendations, perhaps because it required a greater level of self-policing on the mother's part, which the physician could not oversee.

Women who drank while breastfeeding were, physicians further argued, far more likely to give their children alcohol in attempts to calm them, whether the child was ill or only cranky. These children were, first of all, "fatally" called to alcoholism.<sup>349</sup> Secondly, they suffered disproportionate damage to their brains and livers, as their alcoholized blood overwhelmed the delicate, still-forming structures of their organs.<sup>350</sup> Finally, these children would come to see

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<sup>349</sup> Souilhé, *Alcoolisme, son Influence*, 86.

<sup>350</sup> Paul Baron, *Alcoolisme acquis du Nourrisson et de l'enfant* (Lyon: Imprimerie E. Schneider): 6.

alcohol consumption as a normal part of their daily routines, which made it impossible for them to understand that alcohol was a dangerous poison they should guard themselves against in adulthood.<sup>351</sup> All in all, complete abstinence (save from wine) was the best course of action for mothers to follow, both during and after pregnancy. Regardless of the occasional side debates the issue provoked, by 1905 it was clear to most physicians that alcoholic women either should not or could not breastfeed.

The consequences of this inability were, according to the medical wisdom of the day, severe, perhaps more so for women than for their children. The inability to breastfeed therefore confirmed the deficient nature of female alcoholics, since breastfeeding was, as one physician put it, "...the condition of the normal woman... It favors health, preserves the attributes of the sex, and protects against strange imaginings..."<sup>352</sup> To not be able to breastfeed was, in effect, to be incapable of fulfilling the most important responsibilities of womanhood, which were one and the same with the responsibilities of belonging in the French nation as a female.<sup>353</sup>

## V. Malfunctioning Women

According to the logic doctors fleshed out in these debates, alcohol played a rather unique role in disrupting a woman's mental health, which then rebounded on her physical functioning. When a woman, whether or not she was pregnant, consumed alcohol, these physicians typically argued, it destroyed her brain. It is notable that discussions of brain lesions in female alcoholics were uncommon, given the considerable amount of literature citing the primacy of these wounds in male drinkers. The paucity of these discussions is perhaps a result of the confusion over their

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<sup>351</sup> Souilhé, *Alcoolisme*, 87.

<sup>352</sup> Devoisins, *La Femme et l'Alcoolisme*, 48.

<sup>353</sup> For more on the relationship between motherhood and belonging in nineteenth-century France, see Alice Conklin, "Redefining Frenchness: Citizenship, Imperial Motherhood, and Race Regeneration in French West Africa 1890-1940," in *Domesticating the Empire: Race, Gender, and Family Life in French and Dutch Colonialism*, Julia Clancy-Smith, Frances Gouda, eds. (Charlottesville, VA: University of Virginia Press, 1998).



place in alcoholism's pathology and progression among women. Physicians had constructed a narrative in which lesions appeared relatively late in a male drinker's career, provoking madness, which signed that death was imminent. Physicians believed female alcoholics, however, suffered from mental symptoms, such as hysteria, increased irrationality and the perversion of their feminine nature much earlier, before it seemed likely that lesions could appear, even taking into account the more sensitive nature of female bodies. Given the unlikeliness of lesions playing a role so early in the progression of the disease, doctors instead argued that alcohol essentially rewired women's brains, very rapidly. This warped mental functioning then played itself out both on and through the body.

The earliest, and obviously most dangerous of these disruptions, aside from breast feeding, was the destruction of nurturing or motherly impulses. Case studies of alcoholic women who did have children included reports of the state of the child's health and the overall condition of the home as a way of indicating that a woman was an alcoholic. Keeping in mind that all alcoholic women would lie and claim to be sober when questioned, these non-physical symptoms were presented as critical bread crumbs on the way to an individual's diagnosis.

This absence of a woman's most natural impulses also likely encouraged alcoholic women to work as prostitutes, physicians explained. The association between alcoholism and prostitution was partially driven by the belief that no woman could stand to work as a prostitute while sober. The wife of the leading temperance advocate in France wrote that, "out of one hundred prostitutes, there are not two who are not alcoholics."<sup>354</sup> Mental consequences that are today considered common outcomes of alcohol consumption (particularly lowering of inhibitions), however, were not used to explain the link between alcoholism and prostitution. It was instead alcohol's ability

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<sup>354</sup> Madame Legrain, *Alcoolisme et Prostitution*, (Paris: Au Siège de L'U F.A., 1901): 7.

to destroy sentiments typically referred to as moral and noble, so-called womanly virtues, that made it possible for alcoholic women to sell their bodies. There was little discussion of the idea that prostitutes consumed alcohol in order to cope with their work, despite one who reported that she would have been unable “to work without an astounding daily habit of drinking perfume.”<sup>355</sup>

In discussions regarding the relationship between alcoholism and prostitution, alcoholism was pointed to as the cause of prostitution, rather than an outcome or a coping mechanism. It was common for physicians and social reformers alike to argue that lowering rates of alcoholism among women would also lower the number of prostitutes in France. Doctors further argued that alcohol’s ability to numb sensations in the genitals made it a convenient tool of the trade among women who had sex multiple times a day, but physicians made it clear that only women who had already significantly abused alcohol would be aware of this side-effect, re-affirming the basic “alcoholism first, prostitution second” equation.

A number of medical investigators argued that the relationships between whorehouses and cabarets reflected a popular, if unsophisticated, understanding of this association. The two establishments, they asserted, were often built particularly close in order to ease the recruitment of prostitutes. Women who spent significant amounts of time in cabarets, whether as patrons or as *concierges*, already occupied at best a liminal space between acceptable and unacceptable behavior. The line had been blurred enough by the end of the century that prostitutes simply posed as dates when cabarets and cafés were raided by police.<sup>356</sup> Particularly in the countryside, it seems, cabaret owners often also operated informal brothels located just steps away from their bars. While some authors acknowledged that this might aid in the recruitment of customers, the geography was

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<sup>355</sup> Madame Legrain, *Alcoolisme et Prostitution*, 7.

<sup>356</sup> W. Scott Haine, “Privacy in Public: The Comportment of Working-Class Women in Late Nineteenth-Century Proletarian Parisian Cafés,” in *Proceedings of the Annual Meeting of the Western Society for French History*, 13, (1986): 204-212.

intended to recruit brothel staff. The fact that these cabarets were meant to be more popular among women than men was presented as evidence of this intention. Without alcohol, local authorities reported, young women would not enter, much less become familiar with, such establishments.

Further solidifying this perceived link between alcoholism and prostitution, the number of women in prisons, who were almost exclusively arrested for their involvement in solicitation, was rising steadily over these years, almost in tandem with estimated rates of female alcohol consumption, doctors asserted. Just as concerning was the spread of syphilis, which French authorities also blamed in part for the decline of their national population.<sup>357</sup> By linking the disease to prostitutes, physicians were able to argue that alcoholism was also “one of the most frequent causes of the spread of syphilis in the country.”<sup>358</sup>

In support of this relationship between alcohol consumption and prostitution, one author recounted the story of a young girl from the country who moved to Paris looking for work in a private home. Taken in by an advertisement, she arrived in the home of a single male, who encouraged her to try a liquor she did not recognize. This was followed by two glasses of champagne, which he explained would revive her after her long trip. Following these three drinks, the girl stated only that she “acted as a prostitute,” and felt ashamed of her behavior.<sup>359</sup> The girl’s story closed with the author explaining that she would not have behaved in this way (what “this way” meant was never fully explained) if not for the consumption of alcohol.

It is striking that the country girl in this anecdote was immediately blamed for her decision to accept alcohol. The man who encouraged the girl to drink was neither castigated nor even mentioned in the post-narrative discussion of the events. The author did not so much as indict him

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<sup>357</sup> For more on medical approaches to syphilis in nineteenth-century France, see Jean Pierre Bardet, ed., *Peurs et terreurs face à la contagion* (Paris: Fayard, 1988).

<sup>358</sup> Devoisins, *La Femme et l’Alcoolisme*, 29.

<sup>359</sup> Legrain, *Alcoolisme et Prostitution*, 5-6.

as a pimp corrupting young girls. He, after all, had only done what every man did – consume alcohol. It was the girl who had acted unnaturally, and as a result, fallen. According to physicians, drinking alcohol had changed the functioning of her brain on a physical level, which then affected her behavior. The end point of the author’s analysis underlines that alcohol was not perceived as a tool with which one could be manipulated.

Despite this disinterest in seeing alcohol as a tool one person could use to influence another, physicians obviously spent an enormous amount of time worrying about the social consequences of alcohol consumption, and the ways drinking alcohol could change a woman’s behavior. Perhaps the most worrying of these social concerns was the relationship between alcohol consumption and crime.<sup>360</sup> Physicians argued that the consequences could be far worse than prostitution, which was, after all, primarily an individual’s problem. More troubling was the threat that alcohol’s ability to shift the drinker’s mental state could lead to criminal acts. Given the (perceived) dramatic increase of alcohol consumption among women in particular, many physicians, reformers, and hygienists became anxious that a female-led crime wave was nearly upon them.

The end of the Paris Commune had contributed a significant portion to the association between criminality and alcoholism in women. As the troops from Versailles had worked their way through the city in May of 1871 a number of buildings had been burned, including the Hôtel de Ville, the Tuileries palace, and a large portion of the fashionable Rue di Rivoli. Although close examinations of trials and convictions following the Commune have demonstrated that these buildings were burned almost exclusively by male Communard forces, rumors that women started the fires took on the cadence of truth in the early years of the Third Republic. Referring to these

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<sup>360</sup> Susanna Barrows, “After the Commune: Alcoholism, Temperance, and Literature in the Early Third Republic,” in John Merriman, ed., *Consciousness and Class Experience in Nineteenth-Century Europe* (NY: Holmes and Meier Publishers, 1979), 179-206.

women as *pétroleuses*, those wishing to discredit the Commune depicted female Communards as irrational, unnatural, wild creatures. They closely associated the madness of the *pétroleuses*, as well as the general disobedience of the Commune, with alcoholism. The political power controlling the Versailles military forces, victorious at the end of Bloody Week, encouraged the perception that the combination of alcohol and women's political activity had resulted in chaos, death, and an inferno the likes of which Paris could not survive a second time.<sup>361</sup>

Unquestionably, these associations were a part of the assumptions and stereotypes that influenced physicians formulating medical knowledge regarding alcoholism. The idea that alcohol consumption among women encouraged arson did not originate from doctors, but they did contribute an enormous amount of talk to this discussion, which asserted alcoholism could not only encourage pyromania, but also intensify a number of rather particular criminal impulses. This talk in turn created a legitimate, scientific narrative that validated a certain set of not only social, but also political, views. The narratives of these physicians lent greater authority to those who argued that female supporters of the Commune were not truly reasoning, rational political subjects. Those women, who also demanded enfranchisement, were, according to these doctors, suffering from a medical ailment. Their demands were inherently irrational – the proof of that was in the demands themselves. Their ideas were symptoms of a problem, but not one with a social origin or potential social solution. Instead, this activity was read as a symptom of a medical disorder.

## **VI. Irrationality, Disorderliness, and Criminality**

Alcohol consumption, physicians assured their readers, fundamentally altered the way women interpreted the reality surrounding them, making them more unreliable than the typical sober woman. As one medical student explained in his 1908 thesis studying delirious alcoholic

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<sup>361</sup> For more on the Commune, see Gary Gullickson, *Unruly Women of Paris: Images of the Commune* (Ithaca, NY: Cornell University Press, 1996).

crises in women, “it is only after the accomplishment of an impulsive act that our patient has a conscience and becomes capable of reflecting on the act’s gravity...”<sup>362</sup> When drunk, however, alcoholic women could not even confess their crimes, let alone make sense of them. As the same author confidently informed his readers, “It is impossible to make a woman who drinks talk.”<sup>363</sup> This point, that alcohol consumption encouraged mendacious behavior as a result of alterations within the brain, had already been established in discussions over the basic pathology of alcoholism in women. To argue that these secretive, protective, and violent tendencies extended beyond hiding her consumption, to all parts of the alcoholic woman’s life, was simple; in fact, it made more sense than arguing that alcoholic women’s impulses towards secrecy only applied to her drinking. If alcohol consumption changed the brain as a whole, its effects would not be localized to a small number of behaviors. Essentially, by arguing that alcohol consumption encouraged criminality, physicians were merely extending their logic to its natural borders.

Meunier’s 1898 case study of the deceptive wet nurse, who drank in secret, reflected a middle stage in this evolution. Not only was the nurse hiding her consumption, a predicted symptom of alcoholism, she was also endangering the well-being of her charge, in both the short and the long-term, certainly a criminal act in the face of the population concerns that dominated physicians’ minds. The implicit logic of Meunier’s indictment, that the nurse’s deceitful behavior surrounding her alcoholism necessitated her criminal behavior in other areas of her life, continued to grow as the nineteenth century wore on, and increasingly made its way into medical texts considering alcoholism.

Further compounding the associations between alcohol consumption and criminal deviation was the perception that females who drank lacked fundamental reasoning capabilities.

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<sup>362</sup> Wibratte, *Le Délire Alcoolique*, 68.

<sup>363</sup> *Ibid.*, 69.

Alcoholic women were incapable of engaging in even basic conversation for more than a minute or two. By turns sarcastic, silent, and unable to stay on topic when questioned by sober men, alcoholic women never confessed to their actions while drunk, whereas at least a portion of their male counterparts could own up to their crimes.<sup>364</sup> A significant number of medical investigations of intoxicated women addressed the question of whether their subjects were responsible for their actions, criminal and otherwise, while under the influence. Indeed, many authors were concerned that women could not remember what they did, much less understand that their actions had real-world consequences, after even small amounts of alcohol.

Along with mendacity, anti-motherly feelings, pyromania, and a general propensity towards crime, physicians argued that alcohol consumption could encourage a wide variety of violent impulses. In reading physicians' case studies, it becomes clear that these impulses most commonly found vent on the bodies of those who were closest to female alcoholics. The inability to understand the real-world consequences of their actions, combined with this propensity towards violence, and the mistaken beliefs resulting from alcohol-induced nightmares could make for deadly mistakes, as the case study of the sleepwalking daughter in chapter one demonstrated.

Looking all the way back for a "first mover" that had encouraged female alcohol consumption, after 1900 many physicians pointed to feminism. "Until these times," one author sarcastically noted in 1908, "the nearly exclusive monopoly of alcoholism seemed reserved to man. With the progress of feminism, we see that there is little by little a leveling between the two sexes; in intemperance, the woman demands her part... it is permitted to hope that, progress continuing onward, this will soon be an accomplished fact."<sup>365</sup> Feminism, as these doctors saw it, was driving alcohol consumption rates up among women. According to this discourse, feminists found

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<sup>364</sup> For more on male criminality and alcoholism, see Chapter 5 of this work.

<sup>365</sup> Wibratte, *Le Délire Alcoolique*, 11.

themselves unhappy and alone because no reasonable man wanted to spend time with them. This had created a troubling cycle, in which feminist women who eschewed masculine authority drank distilled alcohol to prove their equality, and to enter the sociable circles of men. Paradoxically, however, this drinking estranged them from their own feminine natures, and their de-sexed bodies held no appeal to men. Healthy women also avoided their habits, and as a result, feminist alcoholic women also became distanced from their own gender identity. The unnaturalness of this state in turn encouraged more drinking, thus engendering a vicious circle, as physicians saw it. The unnaturalness of a woman's incursions into the masculine territory of alcohol consumption was, medically speaking, to blame for the rest of her ills, which naturally cascaded one upon another. A feminist was only an alcoholic woman, it turned out, someone who was pathologically estranged from her true nature, rather than an individual with legitimate complaints. It is critical to note that by constructing logic that so closely related alcoholism and feminism, physicians collapsed the diagnostic space between the two states and created a pathology out of a political stance. This line of reasoning ultimately constructed a Gordian knot that identified both feminism as a prominent cause of alcoholism, and alcoholism as the instigator of feminist principles among women.

It is notable that physicians practically never depicted these drinking women as taking on masculine traits. Although accounts emphasized that drinking women were unnatural and unhealthy, they were not similar to men – indeed, their consumption and its results not only remained distinct from that of their male counterparts, it also served to amplify the most dangerous qualities of their feminine natures, the ones that made them rowdy, unpredictable, and violent. The discourses surrounding female alcohol consumption negated the feminine nature of the drinker, but they did not attach much masculine freight to her. Compared to the situation in England, for example, where drinking women were often portrayed as having abandoned their gender identity



in favor of more masculine traits, the French medical depictions of female alcoholics were remarkably striking for their lack of masculine traits.

More than any other theme, that of the “unnaturalness” of women’s alcohol consumption runs through nearly every medical discussion on the subject in the late nineteenth century. Whereas male alcohol consumption was perceived as primarily degenerative, bringing about backwards slides in intelligence and physical strength, women’s drinking was understood as capable of creating changes that would not otherwise take place in nature, changes that made it impossible for her to fulfill some of her most important duties as a woman. These perversions created new pathological states, which either rejected motherhood and its trappings, or made it impossible, despite the fact that it was the most “natural” way in which a woman’s body could function. Pointing to feminism as both the cause and the outcome of alcoholism, French physicians brought beginning and end together in an impenetrable thread. This complex pathology, which created an intimate and fast-acting relationship between the functioning of the brain and the body, always rebounded negatively on women, marginalizing them in the calculus of the dominant social and cultural narratives of nineteenth-century France.

## Chapter 5: Responsibility, Belonging, and Alcoholism

Jean Lanfray, a French laborer living in the Swiss city of Commugny, spent the morning of August 28<sup>th</sup>, 1905, the way he spent many days of his adult life: drinking in his home. Before having a mid-day meal, Lanfray consumed one glass of coffee mixed with cognac, six glasses of brandy, seven glasses of wine, and two large glasses of crème de menthes.<sup>366</sup> After this, he ate a sandwich, which he washed down with two glasses of undiluted absinth. Although wildly drunk at this point, Lanfray not only maintained consciousness, but also managed to argue with his pregnant wife. When she refused his request to polish his shoes, Lanfray became so angry that he retrieved his gun and shot her once in the head, killing her instantly. He then used the gun to kill his two daughters, both under the age of five, shot himself in the jaw, and made his way into the garden, where the police found him several minutes later. Incredibly, Lanfray survived his injuries and was soon put on trial for the murders.

Although Lanfray had committed his murders in Switzerland, his case attracted French interest. A number of factors were responsible for this interest: the criminal being a Frenchman, of course, as well as the involvement of absinth, which French physicians had for years been warning was far more dangerous than any other time of alcohol. Perhaps most interesting for the doctors following the case, however, was the question of responsibility. There was, of course, no doubt that Lanfray had committed the murders. Instead, the critical point was whether he should be punished the same way that a sober man would be. According to the pathology physicians had developed surrounding alcoholism, it questionable whether Lanfray's brain could still function rationally when he committed the murders, and whether he was consciously making decisions, or

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<sup>366</sup> Crème de menthes is an alcoholic beverage, often used today as an ingredient in mixed drinks. In nineteenth-century France, it was regularly diluted with water to weaken the taste (it does not have an above-average alcohol content and compared to abinsth is rather weak).

simply reacting involuntarily to events around him. Given these questions, the argument he had with his wife just before he killed her took on a new significance. According to the logic concerning alcoholism's effects on the brain that physicians had developed by 1900, it was possible that Lanfray's anger was more extreme, more easily aroused, and legitimately impossible for him to control due to the lesions developing on his brain as a result of his chronic alcoholism. These lesions could also fatally impair his ability to restrain himself from acting on emotions, particularly when drunk. As French physicians saw it, Lanfray might not be responsible for the murders because he was a chronic alcoholic, because he was drunk when they were committed, and because he had argued with his wife just before he killed her.

The trial for the murders began on February 23<sup>rd</sup>, 1906, and lasted only one day. Although a Swiss psychologist testified that Lanfray had been suffering from *absinthisme* and therefore should not be held responsible for the murders, the prosecution successfully undermined the defense by arguing that the abinsth consumed was minor in comparison to the other alcohols, and therefore could not be considered as capable of exercising an unstoppable influence.<sup>367</sup> At the end of the day, Lanfray was found guilty, but because he was drunk when the crimes were committed, he legally could not face the death penalty. Instead, he was sentenced to thirty years imprisonment. Three days later, he committed suicide in jail.<sup>368</sup>

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<sup>367</sup> The proportion of absinth to the other alcohols consumed was important in this case, as the Swiss, like the French, believed that absinth had a remarkably strong ability to alter mental functioning. Swiss physicians were, particularly after the Lanfray case, remarkably concerned over absinthisme. For more on absinthisme, see chapter 2 of this work. This should also point up that while many physicians believed absinth was a particularly dangerous alcohol, few asserted that one or two glasses of it were sufficient to induce the madness of *absinthisme* (unless the consumer happened to be a woman).

<sup>368</sup> If anything, Lanfray's suicide served as further evidence that his alcoholism was so advanced that he should have been held only partially responsible for his actions. Suicide, many physicians argued, was evidence of mental instability typical of advanced chronic alcoholism. Following these murders, the canton of Vaud, which contained Commugny, outlawed absinth on the recommendation of a petition carrying over 80,000 signatures. In 1908, the Swiss passed a constitutional amendment outlawing absinth throughout the nation. The French did not outlaw absinth until 1915, as conscription for the war intensified concerns over absinth's effects on health.

Although it does not seem that the French public viewed the Lanfray case as a particular cause for concern (it was reported in *Le Temps* and *Le Figaro*, but not enough to qualify as a scandal. The story, while gruesome, was far from surprising by 1905, and could not attract many non-medical readers. It was referenced in French texts intended for consumption by medical students), it neatly incorporated the most complex and compelling themes that confronted physicians grappling with alcoholism. At the heart of Lanfray's case were not, of course, questions surrounding his guilt – he had obviously committed the crime. The controversy in the case rotated around whether Lanfray belonged in a jail or a hospital. Had his drinking so eroded his ability to reason, to control emotions and impulses, and to make sense out of the world around him that he was no longer capable of making decisions independently? The lurid details of Lanfray's case sharpened these issues considerably, and intensified the relevance of their studies to the non-medical world, a tactic that French physicians incorporated into their case studies as well, which often read as though written by Zola.

The medical dialogue surrounding cases such as Lanfray's was attempting to make sense out of overlapping discussions concerning alcohol consumption, criminality, and responsibility. This in turn raised two intertwined questions. The first was by far the simpler question: did alcohol consumption encourage criminal behavior, and if so, what types?<sup>369</sup> The answers to this first question, however, had far-reaching implications, and led to a much more complex second problem: should alcoholics be held responsible for crimes they committed, or was their ability to reason autonomously so compromised that their actions became involuntary? Reaching an answer

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<sup>369</sup> Of course, this also touches on questions raised in the previous chapter, concerning women and alcoholism. This chapter will not discuss prostitution and alcoholism, and will instead focus on violent personal crimes, which physicians did not associate with female alcoholics. At times, of course, drunk women did commit violent crimes, including murder, but those crimes were not considered a pathological outcome of female alcoholism. They were aberrations, unlike violent criminals among male alcoholics.

required intricate deliberations, which took into account a patient's hereditary background, status as a chronic or an acute alcoholic, the exact level of intoxication at the time the crime was committed, any additional mental diseases that might have played a role in the crime, and the patient's responses in multi-day interviews with a physician. While assessing alcohol's incursions on a patient's reasoning and decision-making functions, physicians employed their medical knowledge to provide expertise that had significant legal ramifications, as well as a great deal of influence over popular attitudes towards alcoholics.

The links between alcoholism, responsibility, and crime, I aim to demonstrate, were not forged haphazardly, nor were they based on social attitudes towards excessive drinking. Rather, they were a logical extension of the medical knowledge concerning alcoholism that physicians had been constructing since 1849. Physicians' arguments concerning alcoholism's ability to cause physical changes in the brain had allowed for the incorporation of a variety of social behaviors into the disease profile while simultaneously insisting alcoholism was a medical problem that required medical solutions. This all served to naturalize the perception that a mutually influential, countervailing relationship existed between excessive consumption (or a lack thereof) and responsibility. Indeed, as Ruth Harris and Susannah Barrows in particular have shown, popular attitudes towards alcoholism in the fin-de-siècle linked excessive alcohol consumption to the working class and to violence, on both an individual and a larger social level.<sup>370</sup> I contend that while this did take place, there was very little need for or reliance on mediation and synthesis between social expectations and medical knowledge – the medical profile of alcoholism had

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<sup>370</sup> See Ruth Harris, *Murders and Madness* (Oxford, UK: Clarendon Press, 1989), Susannah Barrows, "After the Commune: Alcoholism, Temperance and Literature in the Early Third Republic," in John Merriman, ed., *Consciousness and Class Experience in Nineteenth-Century Europe* (NY: Holmes and Meier, 1979), Susannah Barrows, *Distorting Mirrors: Visions of the Crowd in Nineteenth Century France* (New Haven, CT: Yale University Press, 1981).

already incorporated those social expectations, and was engaged in a process of reproducing them as evidence of good health.

### **I. Social Expectations and Medical Reasoning**

By 1871, physicians had already done an excellent job of instigating a medical narrative that flowed seamlessly into their social environment, so that the progression of the disease and its social characteristics made sense to the casual observer, even if s/he did not have a medical education. Even physicians' case studies fit into their milieu, as they practically incorporated the drama and pathos of crime, tragedy, and possible redemption that characterized contemporary popular literature. Ultimately, doctors argued, the physical changes in the alcoholic's brain (brought about by the rapid temperature shifts of the alcoholic's body) accounted for a wide variety of behaviors alcoholics exhibited. These somatic explanations of crime and its relationship to alcoholism, it should be noted, were nuanced, employed sophisticated reasoning, and were put forward by some of the most prominent French hygienists, psychiatrists, and general physicians practicing at the time. These explanations were not based in contemporary social norms, but instead in the medical knowledge that physicians had put together. That their analyses and recommendations often seemed to contradict one another and themselves mattered little. In fact, as we will see, these inconsistencies likely strengthened their arguments.<sup>371</sup>

Clearly, the thinking and theorizing taking place in texts discussing alcoholism and how it could influence crime and responsibility continued to underline the physicians' unique set of qualifications, as well as the critical nature of those qualifications to the French national

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<sup>371</sup> Ideologies survive and thrive not *in spite* of their inconsistencies, but *because of them*. For a full explanation of this theoretical stance, see Stuart Hall, "Signification, Representation, Ideology: Althusser and the Post-Structuralist Debates," in *Critical Studies in Mass Communication* 2, no.2, (1985): 90-114. Hall also underlines that Marxists in particular are willing to "play with" these contradictions, which he terms differences, "so long as there is the guarantee of unity further on up the road."

community, much the same way discussions of alcoholism's effects on the national birth rate had.<sup>372</sup> In these instances, as they had in so many others, physicians once again used concerns raised by alcoholism to underline the relevance of their professional knowledge to problems with significant salience to larger social and political debates. If order was to be maintained and punishments were to be fair, doctors argued, their expertise was necessary, particularly given the ubiquity of crimes that involved alcohol consumption.

The way physicians oriented themselves around the question of whether alcoholism encouraged crime serves to underline once again that they were working to exclude what they viewed as irrelevant social factors from their analyses, and were focused solely on medical evidence. The obvious social explanation for the relationship between crime and alcohol consumption (drinking encourages the alcoholic to neglect his or her regular duties including employment and at the same time, the constant consumption of alcohol becomes costly. As a result, it would be logical to expect that some alcoholics would turn to employment on the margins of the law, in order to support their addiction), was rarely so much as referenced by physicians writing on alcoholism. Instead, they relied on medical explanations that once again utilized their understanding of physical changes within the brain to make sense out of changes in social behaviors. This line of reasoning, in which the brain was to blame for all social behavior, rather than any social conditions or limits, commanded a consensus among physicians who studied biological criminality, as well as those who discussed the moral and intellectual limitations of

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<sup>372</sup> For more on professionalization of physicians and the evolution of medicine in France, see Jan Goldstein, *Console and Classify* (NY: Cambridge University Press, 1987), Jacques Léonard, *La France médicale au XIX<sup>e</sup> siècle* (Paris: Gallimard, 1978) Matthew Ramsey, *Professional and Popular Medicine in France, 1770-1830* (NY: Cambridge University Press, 2002), Andrew Robert Aisenberg's *Contagion: Disease, Government, and the "Social Question" in Nineteenth-Century France* (Berkeley, CA: Stanford University Press, 1999), *The Great Stink of Paris and the Nineteenth-Century Struggle against Filth and Germs* (Baltimore, MD: The Johns Hopkins University Press, 2006).

colonial populations.<sup>373</sup> While much of this medical knowledge confirmed social norms, it was nonetheless backed up by logic that physicians argued was scientific and provable in nature. Experiments, statistics, family studies, and individual cases, all of which were based in scientific principles and practices, proved their assertions.

Crime, the vast majority of nineteenth-century physicians contended, was not caused by social or cultural conditions. Instead, it was an expression of biological malformations, in both an individual's brain and body. Social conditions might on some occasions create a situation that would lead an individual to commit a crime, but most crimes were caused either by hereditary predisposition, by passion, which heated the brain to the point of short-circuiting, by an individual's anti-social character, or some mixture of the three.<sup>374</sup> According to this logic, cold-blooded crimes could only be committed by those who had a pathological disregard for those around them and the well-being of their communities, local and national.<sup>375</sup> Put simply, something was fundamentally wrong in the brains of people who cared enough about themselves and so little

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<sup>373</sup> For more on the concept of biological criminality, see Mary Gibson, *Born to Crime: Cesare Lombroso and the Origins of Biological Criminality* (NY: Praeger, 2002), Nicole Hahn Rafter, *Creating Born Criminals* (Chicago, IL: University of Illinois Press, 1997), Peter Becker, "New Monsters on the Block" in *Cuerpos Anómalos*, ed. Max S. Hering Torres (Bogotá: Universidad Nacional de Columbia, 2008). For more on European physicians discussing the importance of evolution from a eugenicist standpoint and the ways in which the brain's structure can limit an individual's intellectual and moral capabilities, see Anne Carol, *Histoire de l'eugénisme en France: Les médecins et la procréation, XIXe-XXe siècle* (Paris: Seuil, 1998), Anna Davin, "Imperialism and Motherhood," in *Tensions of Empire*, eds. Ann Stoler and Frederick Cooper (Berkeley, CA: University of California Press, 1997), Michael Osborne, *Nature, the Exotic, and the Science of French Colonialism* (Bloomington, IN: Indiana University Press, 1994), and William Schneider, "The History of Eugenics in France," in *The Journal of Modern History* 54, no. 2 (1982): 268-291.

<sup>374</sup> Of course this is a generalization, and only meant in broad terms. Physicians pointed to passion and an individual's anti-social character most commonly, but they were far and away from being the only pathological mental states that led to crime. For more on the importance of passion and its perceived ability to override rational thought, and the use of this defense in the courtroom, see Edward Berenson, *The Trial of Madame Caillaux* (Berkeley, CA: University of California Press, 1993), M. Kaluszynski, "Le retour de l'homme dangereux," in *Varia* 5, (2008).

<sup>375</sup> For more on the development of the concept "anti-social" in nineteenth-century France, see Robert Nye, *Crime, Madness, and Politics in France* (Princeton, NJ: Princeton University Press, 1984), Peter Becker, Richard Wetzell, eds., *Criminals and Their Scientists* (NY: Cambridge University Press, 2008), especially Peter Becker's "The Criminologists Gaze at the Underworld," 105-133.



about others that they wanted to cheat, injure, or otherwise harm their fellow citizens. Furthermore, crimes committed in moments of extreme emotion reflected the fact that changes to the functioning of the brain were necessary for an individual to undertake a crime – intense emotions, according to these experts, temporarily reshaped the brain. In critical cases, that reshaping could be dramatic enough to take hold even after the alcoholic crisis had passed.<sup>376</sup> Alcoholism, physicians argued, both increased emotional instability and decreased concern for the community, which then led to a general increase in crimes, particularly violent ones.<sup>377</sup> This explanation of passion jibed well with the heating and cooling of the brain that physicians associated with alcoholism, and abided by the physicalist structure that was so integral to how physicians viewed alcoholism in these years. By using scientific explanations to confirm a belief that so many assumed to be true, physicians lent their theories concerning alcoholism credibility.<sup>378</sup> Nonetheless, these theories were proved through medical exams and scientific studies. Social norms informed research and guiding questions, but conclusions were, by contemporary standards, medical. This is not to say that social norms mediated or massaged medical thinking, but rather that middle class social norms were included in the medical thinking concerning alcoholism, which ensured their survival.

Employing the same understanding of the relationship between perception, consciousness, and brain changes, physicians pointed to the hallucinations of *delirium tremens* and acute alcoholism as the principle parties responsible for alcoholic criminality.<sup>379</sup> They also argued that

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<sup>376</sup> Today it makes more sense for us to discuss these changes as a “rewiring” of the brain, but I am specifically avoiding using this language as it was not employed by these physicians. They did not point to electrical changes to explain how alcoholism affected the brain; instead they focused on its physical changes, particularly the appearance of lesions, as we discussed in Chapter 1.

<sup>377</sup> Roger Grebaut, *de l’Alcoolisme dans ses rapports avec la Criminalité* (Paris: Ancienne maison L. Larose et Forcel, 1900), Dr. Gallavardin, *Alcoolisme et Criminalité* (Paris: Librairie J. Baillié et fils, 1889), M. Marambat, *L’Alcoolisme et La Criminalité* (Paris: Imprimerie de la Société de Typographie, 1887).

<sup>378</sup> This line of reasoning is somewhat at odds with the work of Ruth Harris in particular.

<sup>379</sup> It is important to point out that although this association between alcoholism and violence has continued in Western culture (for a recent example, see the [New York City Health Department’s “Two Drinks Ago…” campaign](#), which appeared in city subways throughout 2013 and 2014), the link between violence and alcohol consumption is

chronic alcoholism made it much easier for acute crises to develop, and that “minor” crises or particularly extreme cases of chronic alcoholism could impair judgment in a similar way. Increasing levels of paranoia often characterized these crises. Paranoia among alcoholics then fueled aggressive, protective outbursts. Similarly, brain changes could produce monomania, which would then find expression in violent obsessions, pyromania being chief among these.<sup>380</sup> Although physicians only argued that alcoholics were likely to experience mental instability, which could manifest itself in a variety of ways, they consistently highlighted violence when discussing this instability.

## II. Senseless Violence: The Crimes of Alcoholism

Of course, the crimes associated with alcoholism were all violent, but so too were outbursts directed towards the self. Suicide, a number of physicians writing on the general dangers of alcoholism warned, was one of the more gruesome tendencies that alcoholism encouraged. The evidence for this claim is unconvincing today, both in the statistics that peppered general discussions, and in the limited number of case studies that involved suicide. Nonetheless, alcoholism and suicide were tied together throughout the nineteenth century, likely more so because of the link physicians created between alcoholism and self-harm than because of any actual correlation.<sup>381</sup>

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socially constructed. In different cultural contexts, there is no expectation that violence will accompany intoxication. As a result, there are essentially no violent outbursts among drinkers. For more on this, see Jeff Collman, “Social Order and the Exchange of Liquor: A Theory of Drinking among Australian Aboriginals,” in *Journal of Anthropological Research* 32, no. 2 (1979): 209-224, Pertti Alasuutari, *Desire and Craving: A Cultural Theory of Alcoholism* (Albany, NY: State University of New York Press, 1992).

<sup>380</sup> For more on monomania, see Jan Goldstein, *Console and Classify* (Chicago, IL: University of Chicago Press, 1987).

<sup>381</sup> For a historical discussion of the concept of suicide in France and the associations physicians developed between it and other diseases, see Dominique Godineau, *S'abrèger les jours. Le suicide en France au XVIIIe siècle* (Paris: Armand Colin, 2012), Emile Durkheim, *Suicide*, trans. John A. Spaulding and George Simpson (NY: Simon & Shuster, 2010 edition).

The case of “J” is exemplary of the inescapably close relationship physicians perceived between alcoholism and violent crime.<sup>382</sup> At forty-six years old, J was a healthy, albeit pale man, who often wore a doleful expression (this poetic description came from the medical thesis presenting J’s case). Nonetheless, his manners were excellent, and when he discussed topics that were already familiar, he was judged to be of average intelligence. In the course of seven years, however, J had been placed into various hospitals as a result of alcoholic crises eighteen times. Importantly, there was no hereditary predisposition towards alcoholism – his father had lived until age eighty-eight, having never over-consumed, his mother was still alive at age seventy-six, and his two brothers were productive workers. Just after having married at twenty-eight, J had purchased a small café-restaurant. He claimed to have had average drinking habits, on par with his contemporaries, before this purchase. The restaurant changed that, however. J began drinking throughout the entirety of the day, enjoying the lifestyle of the proprietor, which physicians writing general texts on alcoholism often warned was a dangerous one, as it made alcohol easily available at a low cost. This drinking, which the author referred to as a “slow poisoning,” went on for eleven years without any negative side effects manifesting.

Without warning, however, J began suffering from sudden-onset vertigo in 1894, which made it impossible for him to sleep. When he did sleep, he was troubled by nightmares. Entering the hospital at Sainte-Anne, he stayed for twenty six days, long enough to dispel the symptoms of the acute alcoholic delirium that had caused the vertigo, but not long enough to treat the underlying chronic alcoholism, according to the physician he saw. He entered the hospital for the same reasons and stayed for the same period of time twice more before 1897. His fourth stay, however, was

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<sup>382</sup> Henri Guiard, *Les Alcooliques Recidivistes: Etude Clinique et Médico-Légale* (Paris: L. Boyer, Imprimeur-Éditeur, 1902): 27.

under different circumstances. By 1897 J had become unmanageably violent towards his wife, who left him and demanded a divorce just before he entered the asylum. His niece tried to run his household after he was released from Sainte-Anne, but proved unequal to the task. J began to drink slightly more than he had previously.

Just nine days after his release from his fourth stay, J was once again interned for a little over two months, this time for a violent outburst. Upon his release, however, he expressed hopeful resolutions that indicated he wanted to make significant changes to his lifestyle, although the recorded medical opinion was that he had not stayed long enough to undo the long-term damages of alcoholism (chief among these, violent outbursts). Since having left him, his wife had been unable to obtain a divorce, and was attempting to get court approval to force the sale of their property. J's sister testified that his wife had no legitimate claims, and the treating physician at the asylum of Sainte-Anne (Dr. Legrain, the chief advocate of temperance in France) wrote a letter to the court asserting that J was much improved, and could soon be considered cured. With her financial options exhausted and no support from the judge, his wife had no choice but to "reconcile" with J and return home.

Twelve days later, however, he was forcibly committed to the care of the well-known Dr. Garnier, whose work on alcoholism continued to shape medical opinion, before being handed back to Legrain. J showed a number of physical symptoms associated with both chronic and acute alcoholism, but most problematic was the "menacing" (most likely violent, in the terms of nineteenth-century physicians) behavior he had exhibited towards his wife. Just more than a month later he was released, and, taking money that his wife needed to cover household expenses, he left to visit his parents and drink in his old home. When he returned to his wife, he once again beat her before attempting suicide. This early August trip to the asylum brought J's total up to five visits in

1897, and seven overall. After this stay, Legrain wrote a recommendation asserting that J would not become better without a year-long stay. His pattern of behavior demonstrated that his chronic alcoholism had begun to facilitate more frequent acute attacks. The frequency of his violent outbursts underscored that he was continuing to drink, despite his claims to the contrary. As a result, Legrain was able to hold J until April 8<sup>th</sup>, 1898. After this release, J typically remained free for around a month before his wife brought him back to the asylum, complaining that he was beating her and threatening to kill her or them both. The police would often become involved in those disputes as well. J would stay for a month, then repeat the same pattern upon release. By June of 1899 the situation was so bad that Legrain's notes stated that allowing J his freedom was a danger to others. Legrain's legal options, however, were limited.

Legrain attempted to keep J in the hospital, but J wrote a number of letters complaining that his rights were being violated. Under the Law of 1838 (which had established a nationally-funded system of mental asylums throughout France) physicians could only hold patients in institutions against their will if they lacked rationality, which J argued he clearly possessed.<sup>383</sup> Six months later the prefecture of the police declared that J should be allowed to leave, over Legrain's strenuous objections. The old pattern of liberty and forcible stays in asylums once again resumed, and J continued to beat his wife. He totaled sixteen forcible internments by 1901, as the beatings he gave his wife became more extreme.

While the physicians involved in this story found J's violence towards his wife troubling, they seem to have done little if anything to prevent it from continuing. The two physicians who saw J most frequently, Drs. Garnier and Legrain, did not intercede with courts to speak in favor of

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<sup>383</sup> For more on the restrictions physicians had on their ability to keep patients in treatment facilities, see Chapter 3 of this work.

the wife's attempted divorce or the sale of their property, which would have made it possible for her to leave – Legrain had actually helped to prevent this from happening, despite having voiced concern that J had not stayed long enough in the asylum to cure his chronic alcoholism. Clearly, their concern was not her wellbeing. Instead, what most worried them about J's violence was that, in their eyes and according to their reports, it was escalating, which indicated that his alcoholism was worsening. If that continued, it would soon spill over into the larger social body. The doctors did not understand his violence as limited to one individual, but rather viewed it as a seed that would eventually expand to threaten society. There is no record that they investigated whether he beat his wife while sober – in fact, on several occasions they reported his abuse as evidence of intoxication, when J's drinking could not be corroborated. The violence was not evidence of a bad relationship between husband and wife. Rather, it was a symptom that would continue to spin itself out, expanding its reach as J's alcoholism worsened.

Hallucinations, mistaken realities, and paranoia were not the only components of alcoholism that encouraged crime, however. Physicians used case studies and longer investigations, called medico-legal analyses, to prove that alcoholics also experienced an increased sense of self at the expense of those around them. This theory reflects the perception that alcoholism instigated what French physicians termed “anti-social feelings” in drinkers. In nineteenth-century medical language, anti-social did not refer to a preference for being alone, or a limited enjoyment of social interactions. Instead, “anti-social” denoted a privileging of the desires of the self above and beyond those of the community. Worry over the dangers of anti-social feelings was demonstrated in other medical diagnoses and concerns.<sup>384</sup> For example, several physicians worried themselves over

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<sup>384</sup> Vagrancy was on occasion folded into discussions of alcoholism – a small number of physicians included it as a symptom of the disease. For more on vagrancy, see Jean-François Wagnart, *Le vagabondage à la fin du xix siècle* (Paris: Belin, 1999), Gerard Noiriel, “The Identification of the Citizen,” in *Documenting Individual Identity*, eds. Jane Caplan and John Torpey (Princeton, NJ: Princeton University Press, 2001): 28-50.

vagrancy, as it demonstrated a rootless existence that was unnatural in individuals with well-developed social natures. Only the anti-social could prefer this lifestyle, they asserted.<sup>385</sup> The anti-social, in their turn, never demonstrated an affinity for the proper, “French” style of consumption, which physicians described as increasing good feelings towards those around the drinker. If an anti-social individual consumed drinks stronger than wine, as one asylum physician put it, “his intelligence seems to be covered by a cloud.”<sup>386</sup> This limited ability to reason or make sense out of his surroundings further discouraged cheerful conversation or concern for neighbors, which were already limited impulses in the anti-social.

According to the experts, this anti-social disregard for the people surrounding them was one of the most fundamental factors driving criminal behavior among alcoholics. Physicians’ discussions of crimes committed by alcoholics highlighted the macabre, senseless, passionate, bloodlusty, and just plain unintelligent nature of crimes committed by chronic drinkers and those experiencing acute crises. The most common of these were murders for which witnesses, the attacker, and physicians alike could not identify a motive. Sometimes the victims were strangers, but incidents where the attacker and victim were close were far more common. A preexisting level of emotion, whether it was positive or negative, physicians argued, more easily facilitated the growth of irrational patterns of thought that had to develop quickly for the alcoholic to attack; physicians emphasized accounts of these incidents in their case studies. Following attacks (and the surprisingly common post-attack nap), acute alcoholics often expressed violent yo-yos of shock and regret, particularly if their victim was killed, whereas physicians described chronic alcoholics

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<sup>385</sup> Interestingly, the style of alcohol consumption that physicians extolled – limited quantities, primarily wine – was believed to produce the opposite of these results. Instead of becoming taciturn or unfriendly, the proper, “French,” style of consumption reportedly made the drinker more social, more lively and caring, and a better conversationalist. For more on the “proper” style of consumption, see Chapter 2 of this work.

<sup>386</sup> Victor Vetault, *Étude médico-légale sur l’Alcoolisme* (Paris: J.B. Ballière, 1887): 43.

as muted and emotionally spent in similar situations, regardless of their words. Whether the attacker was a chronic or an acute alcoholic, however, if they attacked a loved one rather than a stranger, physicians were more likely to hold the alcoholic responsible for the attack. The insensibility of attacking those they didn't know acted as a convincing proof of the alcoholic's inability to reason when the crime was committed, it seemed.

In addition to violent attacks, physicians asserted that alcoholics were likely to steal, and were often attracted to inexplicable objects that had little personal or monetary value. These crimes were not, of course, long-term schemes. They were instead committed with little forethought, and typically in front of witnesses. Overall, the nature of crimes committed by alcoholics that physicians chose to highlight in their case studies and in-depth analyses were impulsive, irrational, and destructive. As a result, they were also fascinating, functioning naturally as vignettes, into which physicians incorporated an astonishing level of drama, pathos, and suspense, as well as medical knowledge. The detailed level of information that physicians included in these case studies was an important component of the genre, and, as we will see, was a key element that enabled their assertions concerning the nature of crimes committed by alcoholics.

### **III. Legal Repression**

Perhaps more than anywhere else, it was in questions of the alcoholics' personal responsibility that differences in medical opinion between physicians were pointed up, despite the attempts of some to establish hard and fast rules by which to judge alcoholic criminals. For a very small number of physicians, the alcoholic's responsibility for criminal actions was either complete, or nonexistent, regardless of the crime. The vast majority, however, argued that cases could only be decided on an individual basis. There was also no tendency towards certain levels of guilt that a faction of physicians was likely to favor. Psychiatrists, for example, were no more or less likely



than any other type of physician to argue in favor of full responsibility for an alcoholic. Physicians of all types (psychiatrists, general medical practitioners, hygienists) were jockeying not only between their specialties, but also within their own cohorts, for status and authority when they analyzed these cases. The one commonality that almost every physician interacting regularly with alcoholic patients shared was that they were practicing medicine in asylums. Even these were not entirely uniform, however, largely a result of variations between rural and urban populations. All these doctors, however, chafed under the constrictions of the Law of 1873, which criminalized public drunkenness and set out a system of penalties judges were forced to use on those found guilty.

Two laws in France specifically addressed questions of individual intoxication. The first, the Law of 1873, was far more structured than the second, Article 64 of the penal code, but it was the latter that physicians relied upon to assert the legal importance of alcoholism. Under the first the mere act of being intoxicated outside the home became a crime in and of itself in the Third Republic. The Law of 1873 not only criminalized public drunkenness, it also created a strict set of guidelines that judges were required to abide by when sentencing offenders.<sup>387</sup> Because the law defined “public” as almost anywhere outside the home (this included not only city streets, but also inside cafés and cabarets), its reach was considerable.<sup>388</sup> Shaping the law with a particular eye towards punishing recidivism among drinkers, its framers created a system of punishments that escalated with each conviction.

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<sup>387</sup> For a complete legal explanation of the Law of 1873 from a medico-legal point of view, see Marius Evrard, *L'Yvresse et l'Alcoolisme devant la loi civile et la loi pénale* (Lille: Imprimerie Librarie Camille Robbe, Éditeur, 1907).

<sup>388</sup> For more on the definition of public and the growing distinction between public and private in nineteenth-century Europe, see Jurgen Habermas, *The Structural Transformation of the Public Sphere* trans. Thomas Burger, (Cambridge, MA: MIT Press, 1991).

The repercussions of a first-time offense were relatively minor – a fine of one to five francs, at the judge’s discretion (five francs was just over the average worker’s daily wage in Paris). Every subsequent offense within one year of the first, however, led to greater penalties. The second arrest would require the intoxicated individual to appear before a legal tribunal, pay a fine between sixteen and 300 francs (again, determined at the judge’s discretion), and spend between six and thirty days in jail. A third arrest and conviction led to a number of consequences that demonstrated the state’s fundamental mistrust of alcoholics, and the fear that those who drank regularly could not function as autonomous, reasoning citizens. It suspended the alcoholic’s right to vote, to be elected to public office or serve in other public capacities (as a member of a jury, for example) or as an employee of the state, and it withdrew his or her right to bear arms for the following two years. A further violation in the same year would make the punishment irrevocable, essentially removing the privileges of the adult male in France, demoting the alcoholic to second-class citizenship.<sup>389</sup>

Despite its intentions, on close examination the Law of 1873 introduced two paradoxes that seemed likely to grow the number of alcoholics in France, rather than control it. These punishments, particularly the restrictions assigned to those arrested three times, simultaneously created and reified the anti-social nature of the alcoholic. Because the drinker was believed to lack the capacity to function within the social body, he was excluded from it, then additionally condemned within

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<sup>389</sup> Marius Evrard, *L’Ivresse et l’Alcoolisme devant la loi civile et la loi pénale* (Lille: Imprimerie Librarie Camille Robbe, Éditeur, 1907): 81-82. It should also be noted that this law imposed strict penalties on cafés and cabarets that served intoxicated individuals, or those under the age of sixteen. This further underscores the point that French lawmakers saw alcoholics as irresponsible. Clearly, legislators placed some of the burden of responsibility (and the blame) on café owners. The same structure of escalating punishments for repeat offenders, with fines that increased, applied to the café owners. Based on popular accounts and depictions of cafés, it seems unlikely that the age restriction was seriously applied. Instead, as W. Scott Haine has argued, creating a legitimate basis for their presence in drinking establishments made it possible for the French police to monitor political meetings held there, which were primarily socialist and/or working-class in nature.

the medical literature for supposedly being ruled by anti-social tendencies, when in fact he was forcibly ejected from public sociability. Furthermore, at its essence, the law criminalized drunkenness that took place outside the privacy of the home. Drinkers who abided by it would either need to live in large homes that could accommodate guests, or drink alone, thereby creating the very anti-social tendencies that French physicians railed against as one of the many dangerous consequences of alcoholism. Realistically, in urban areas the only drinkers that could consume multiple drinks without potentially running afoul of the police were the middle class, who had homes large enough and comfortable enough that they could have friends and family over to visit, and would want to spend extended periods of time there. This bias was clear to all, particularly as the police often declined to arrest middle-class drunks, and instead escorted them home.

While the Law of 1873 could have been used in a variety of ways by both law enforcement and physicians, its enforcement appears to have been minimal. The “moral order” governments made the greatest use, with arrests in Paris peaking at 17,632 in 1877. After this, however, the number of arrests steadily declined, and would not rise above 5,000 before 1914.<sup>390</sup> In the case of the physicians, it seems likely that the strict structuring of the law would have been unappealing, given the freedom they were accustomed to in their work on alcoholism and how to best combat it. The Manichean categorization and strict punishment structure (there was, after all, no discussion of stages of drunkenness or varying levels of personal responsibility) also made the expertise of the physicians irrelevant. Any police officer could identify a drunk man or woman stumbling in the street or passed out at the café. A medical degree was wholly unnecessary to pass judgment in these situations, which meant that the text of the law left not even a hint of the need for physicians

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<sup>390</sup> W. Scott Haine, *The World of the Paris Café*, 30-32.

to testify in these cases. Judges would never need to rely on a physician's recommendation in order to make a sentencing decision<sup>391</sup>.

Other regulations (or lack thereof) also made it difficult for the French to control alcohol consumption and sales. In 1875 the National Assembly had reestablished the right of people in the countryside to distill their own liquor (*boilleurs de cru*), which had been previously overturned in 1851. With this, it became exceedingly difficult to estimate how much alcohol was consumed in France every year, as it could not be monitored. The one point that physicians all agreed on was that more alcohol was consumed following the lifting of the ban, as they knew that production in the countryside grew after 1875 and that national production of previously licensed alcohols and total imports stayed constant. In 1880 a new law had been passed that required future café or cabaret proprietors to announce the opening of their establishment to the requisite local authority. This requirement, however, was no more than a formality, and only had to be accomplished twenty-four hours before the establishment opened. Taken together, these measures did little minimize alcohol consumption, and provided few openings or points of relevance to physicians studying and treating alcoholism.<sup>392</sup> As a result, they were rarely discussed in the medical literature on alcoholism.

Historically, in criminal trials there had been no consideration of drunkenness when determining the verdict. The Code of 3 Brumaire year IV (often called the Code of Offenses and Penalties, adopted in 1795) offered few opportunities for physicians interested in alcoholism to

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<sup>391</sup> Throughout the nineteenth century physicians were successfully establishing themselves as expert witnesses in criminal trials. In France, psychiatrists in particular were successful in these attempts, as Jan Goldstein's *Console and Classify* (Chicago, IL: University of Chicago Press, 1989) demonstrated. Establishing themselves as knowledgeable specialists with critical information was, as Goldstein underlined, one of the most successful strategies of psychiatrists working to consolidate their authority and professional status in *fin-de-siècle* France.

<sup>392</sup> For more on measures taken by the French state to discourage alcohol consumption, see Chapter 3.

advise a court. The code held that "...the jury cannot be asked to consider the question of whether the accused was drunk at the time of the offense in order to make this a defense in the law."<sup>393</sup> This attitude reflected the opinion of the ancien regime, and was carried into the Penal Code of 1810: drunkenness was an entirely voluntary state, and did little to alter the moral character of an individual. As a result, it was not considered as a mitigating factor even when sentencing individuals for their crimes. Article 64, section 1 of the penal code of the Third Republic, however, offered an interesting opportunity to French physicians, because for the first time it created a legal space in which an acute alcoholic crisis was in some circumstances a reasonable legal defense. The clause stated that there was neither a crime nor an offense committed if the defendant was "in a state of dementia at the time of the action or if he had been controlled by a force that he could not resist."<sup>394</sup> It was the meaning of dementia and personal control that physicians studying alcoholism focused on. The work of French physicians had emphasized several points that undermined the rationality and freedom of action of alcoholics, leading to a reassessment of their responsibility. These physicians immediately began to argue that some, but not all, types of alcoholic intoxication acted on the brain to create damage similar to the lessened state the clause indicated. One physician queried in 1887, "is this aberration [dementia] not the fatal consequence of drunkenness, which always perverts the functioning of psychic and sensorial centers?"<sup>395</sup> In these cases it would make sense to attenuate, if not entirely dismiss, an individual's level of criminal responsibility following consultation with a physician-expert, of course.

A small number of physicians attempted to systematize the responsibility of alcoholics by creating three "stages" of drunkenness. This effort reflected the concern among the most well

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<sup>393</sup> Vetault, *Étude médico-légale*, 33-34.

<sup>394</sup> Henri-Antoine-Raphël Royar-Collard, *Alcoolisme, Coma Alcoolique et Reponsibilité Légale des Alcooliques* (Bordeaux: Imprimerie Vve Cadoret, 1891): 52.

<sup>395</sup> Vetault, *Étude médico-légale*, 62.

known physicians “that what damages the prestige of legal medicine is the tendency to admit madness caused by insanity, by transitory alienation, too easily.”<sup>396</sup> A more well-structured system could, theoretically, decrease the number of criminals physicians cleared via alcoholism. The most popular method of organization among physicians was the tri-level: doctors attempted to identify and label three stages of drunkenness, each with their own corresponding amount of criminal responsibility. In the first, all personal culpability remained, in the second the alcoholic was only partially responsible, and in the third, he was completely stripped of responsibility. The markers for these stages, however, could never be fully agreed upon. It seemed difficult that there were no physical symptoms that all stage-three-ers suffered from, but no stage two-ers. Those in the second stage might suffer from partial tremens, for example, yet still be capable of making rational, reasonable decisions, while those in the most severe of acute crises on occasion actually seemed to gain greater control of their motor functions and to access previously unseen levels of strength. Further hindering physicians’ ability to agree on methods of identifying these stages was the widespread belief that different alcohols produced different effects: wine made drinkers happy, absinth made drinkers violent, cognac made drinkers grumpy, and beer made them rowdy.<sup>397</sup> If two or more beverages were mixed together, the science of alcohol effects became far more complicated.

The closest that any physician seems to have come to establishing an agreed-upon formula was Ernest Monin.<sup>398</sup> Monin argued that chronic alcoholics continued to possess operational consciences. Only in acute crises, when a man was manic, could he no longer employ his conscience or control his impulses. In this mental state, Monin wrote, crime became a sort of

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<sup>396</sup> Ernest Monin, *L’Alcoolisme: Étude Médico-Sociale* (Paris: Octave Doin, Éditeur, 1889), 130.

<sup>397</sup> For more on this, see Chapter 1.

<sup>398</sup> Ernest Monin, *L’Alcoolisme: Étude Médico-Sociale* (Paris: Octave Doin, Éditeur, 1889).

involuntary mental reflex that could not be continued. Not even Monin's system was infallible, however, as not all those suffering from acute crises were manic – some became extremely sleepy, but if roused would respond violently. Furthermore, colleagues argued, drunkenness did not necessarily produce alienation, even if it did elicit manic behavior. Prior degeneration and hereditary predisposition also needed to be taken into account for Monin's system to approach a comprehensive level.<sup>399</sup> The bulk of family history weighed individuals down more if it included ancestors with alcoholism, making it more difficult for some to maintain not only sobriety, but also rationality once they began drinking, doctors asserted. That these factors could influence one another only added to the level of complexity involved in this line of reasoning.

Given the consequences on mental functioning that physicians had attributed to alcoholism, both chronic and acute, physicians argued it was reasonable to conclude on medical grounds that alcoholics should not be held responsible for crimes they committed while in the throes of a crisis. Rather than create a system or method by which to measure an individual's responsibility for criminal acts, which easily could have become unmanageable, physicians arrived at their conclusions using what amounted to ad hoc metrics. The only point that all physicians agreed upon was that the condition of chronic alcoholism alone was not enough to mitigate punishment. A criminal had to be suffering from an acute crisis when a crime was committed for personal responsibility to be lowered.<sup>400</sup>

#### **IV. Criminal Responsibility?**

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<sup>399</sup> Vetault, *Étude médico-légale*, 57. For more on the importance of family history in diagnoses of alcoholism, see chapter 2.

<sup>400</sup> Interestingly, this underlines that both chronic and acute alcoholism were considered "states" (albeit hard-to-escape ones), rather than identities. By recognizing this, it becomes clear that alcoholism was, at this point in time, a label applied to others, rather than one voluntarily taken up by an individual.

Predictably, when doctors were instructed to use their own judgment to answer complex questions, with little more than suggestions on how to come to their conclusions, they arrived at contradictory answers that created confusion, not clarity. With no manual or list of criteria to rely on, physicians attempting to determine an alcoholic's level of responsibility for a crime would typically look first for evidence concerning a patient's mental state prior to, and during, a criminal act. This was intended primarily to determine whether a patient's memory of a crime was intact. Most physicians argued that if alcoholics could not form memories, they had not acted on decisions, but rather on what amounted to involuntary reactions. In essentials, this meant that physicians believed if the brain was too damaged to store accounts of what happened, it could not understand the consequences of actions were real. As a result, alcoholics should not be held responsible for their actions.<sup>401</sup>

Speaking on the authority gained by their understanding of alcohol's action on the brain, psychiatrists in particular asserted that intention could not exist without memory. With this assertion, they drew on the work of Richard von Krafft-Ebing, a well-known Austro-German psychiatrist, who argued that without memory there was no "self" and therefore no responsibility.<sup>402</sup> According to physicians, rapid large-scale consumption so dramatically reshaped the brain that the lesions on their brains prevented alcoholics could from forming memories. This inability was then often equated with irresponsibility. Writing on whether alcoholics were criminally accountable for their actions, Monin asserted in 1889 that during the autopsy and brain dissection of a chronic alcoholic who had regularly committed crimes, he was able to see that the physical structures in the brain that managed the man's memory were still intact. As a result, Monin

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<sup>401</sup> W. Babilée, *Des Troubles de la Mémoire dans l'Alcoolisme et plus particulièrement de l'amnésie alcoolique* (Paris: A Parent, Imprimeur de la Faculté de Médecine, 1886).

<sup>402</sup> Krafft-Ebing is, of course, most well-known for his work on homosexuality.



asserted, the man remained legally responsible for all his crimes, a position he had also argued before the man's demise.<sup>403</sup> Essentially, the ability to remember events became synonymous with the ability to reason, according to French physicians. It was this section of Monin's work, rather than his proposed tri-partite classification system, that gained the most traction.

This line of reasoning created several more problems that doctors had to address in the years leading up to World War I, however. How much alcohol had to be consumed before the brain could no longer create memories? What of individuals who decided to commit a crime, then purposefully became drunk beforehand? How could physicians be certain that a patient wasn't lying about his memory in order to escape punishment? Should individuals not be held accountable for any of their actions while drunk? What if they signed a contract, impregnated a woman, or quit a job? Finally, could this system of determining responsibility subvert the authority of the physician, in the favor of the patient, as it relied almost solely on the patient's reports of his or her mental state? Take, for example, the case of a twenty-eight year-old man initially referred to by his physician as "U."<sup>404</sup> Before the course of events that led him to commit a homicide, U was a man of average intelligence. His father, a wine merchant, drank excessively but never experienced alcoholic crises, or delirium tremens. Although he inherited some money from his father, who died in 1870, U quickly lost it all, and was forced both to work for a living, and to marry a woman with personal wealth in order to maintain the barest minimum of bourgeois standards. He continued to drink significant amounts, as he had before his father's death, and worked only irregularly. Employed as a foreman in a factory in 1874, he was struck in the head and lost consciousness for several hours. He spent a month and half in a hospital following the accident, where he constantly

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<sup>403</sup> Ernest Monin, *L'Alcoolisme: Étude Médico-Sociale* (Paris: Octave Doin, Éditeur, 1889): 140.

<sup>404</sup> Vetault, *Étude médico-légale*, 76.

experienced hallucinations. Although it took him some time, U eventually seemed to become accustomed to the work in the factory after his accident. One of the only changes that his supervisor noted after the accident was that U became sad and angry when drinking, rather than convivial, as he had before. U also claimed that following the accident he became drunk much more quickly and easily than he had before he was injured.<sup>405</sup> The only changes associated with U pertained to his consumption of alcohol, and his own explanation made it clear that he was aware of these changes before the homicide took place.

These changes, the physician discussing U's case explained, were not a direct result of his accident. Instead, it was the time he had spent in the hospital, drinking little more than wine, which was responsible for the new way that alcohol acted upon U's brain. His body had eliminated all the "bad" alcohol from his system during his stay in the asylum, which meant that when it was introduced once again (primarily through the consumption of absinth), its influence and debilitating force was far more extreme, as his body and brain were no longer familiar with the beverage and its effects. It should be noted here that U had not mentioned the type of alcohol he was consuming following his injury; his physician was operating purely off of assumption and conjecture. On the night of the murder in question, U had drunk three glasses of absinth before dinner, then continued to drink throughout the meal (what he was drinking while eating was not specified).

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<sup>405</sup> It may sound as though "U" was experiencing a lower level of physical tolerance to alcohol, as a result of his abstinence while in the hospital, but this understanding would not have been employed by physicians in the nineteenth century. There appears to have been a rudimentary understanding of how the body could build a tolerance through repeated exposure, but it was rarely referenced, and therefore it is unlikely it was every considered medically important in diagnosing alcoholism.

By the end of dinner, U was drunk, but not “drunk as a door, [or] lead-footed,”<sup>406</sup> which would indicate that he had lost control. He was violently, spiritedly drunk. He then, almost randomly, killed an acquaintance whom had disagreed with him on a triviality. At this point, the account of events terminated, and the analyzing physician concluded that U (whose name at this point was inexplicably revealed to be Jean) was indeed responsible for the murder committed, arguing that there was evidence of his continued mental functioning following the trauma. This functioning meant that he could act with intention, and as a result was responsible for his actions. Rather than trying to label the different stages of U’s alcoholism, the author merely asserted its “lively” (at least partially cognizant) nature, and argued that as a result he was responsible for the homicide. Often crimes that appeared similar to one another would be decided very differently, at times by the same author. This might have undermined a physician’s credibility, but it seems that if a doctor decided cases using medical logic that reflected middle-class values, his recommendations carried weight, even if they contradicted one another.

Physicians had also interpreted Article 64 to mean that as mental responsibility weakened, so too did criminal responsibility. This point was key, as it would require physicians to evaluate nearly every criminal and crime involving alcohol and rule on the subject’s culpability, in all but the most obvious cases of either extreme intoxication or unquestionable sobriety. Given the potential sliding scale of culpability, doctors asserted, their unique knowledge and ability to interpret complex phenomenon were ever more crucial to seeing justice served.

The most important condition used to possibly attenuate responsibility was whether an individual had intended to become intoxicated when he began drinking. Physicians were concerned

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<sup>406</sup> Vetault, *Étude médico-légale*, 78.

that alcoholics might, if it were legally allowed, feel entitled to become drunk and commit crimes.<sup>407</sup> One physician warned his colleagues that alcoholics might begin to think “I don’t worry about killing since I’m drunk.”<sup>408</sup> It was the question of the will that mattered most in these circumstances. The case of “A,” a twenty-eight year-old man working in a butcher’s shop, offers a window into the way physicians interpreted the will and worked through what they hoped was an almost mathematical equation of guilt (predictably, this was hardly ever the case).

For most of A’s life his strong build had helped to distract those around him from the slight trembling in his face, tongue, and forearms, a minor but common symptom of alcoholism. He occasionally suffered from nightmares, which intensified during two separate bouts of pneumonia, during which A experienced powerful hallucinations. Despite evidence that he drank regularly, however, the physician recording his case asserted that he had never suffered an acute attack. Instead, A was the type of chronic alcoholic who “drank all his days, who kept himself continuously infused with alcohol.”<sup>409</sup> A’s demeanor could change based on the alcohol he ingested (eau-de-vie made him noisy, whereas absinth instigated, as the physician described it, a burning alcoholic furor). It was this furor that characterized A’s behavior when his crimes were committed.

His employer had asked him and a co-worker to pour wine into small bottles, an opportunity that offered a temptation he could not resist. A spent his day with the co-worker, drinking wine in a dark underground cellar, which the French call a *cave*, where the air did not circulate. In this environment, the wine gave off fumes that built up in A’s body. Although wine

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<sup>407</sup> For more on these types of anxieties among physicians, see Andreas Killen, *Berlin Electropolis* (Berkeley, CA: University of California Press, 2006).

<sup>408</sup> Albert Lemercier, *Repression Thérapeutique et Sociale de l’Alcoolisme* (Paris: Henri Jouve, 1898): 9.

<sup>409</sup> Vetault, *Étude médico-légale*, 79.

was a healthful drink, his consumption combined with the olfactory suffusion was enough to overwhelm his system. When he and his co-worker exited into a sharp, biting wind, A was quickly thrown into an alcoholic furor (the exact science here is unclear. The author had explained the “alcohol-as-stimulant” thesis earlier in his text and asserted that it was correct. In that model, a cold wind should have slowed A’s brain activity, not excited it). The two men walked together for some time in a drunken stupor, before A seized a knife and, for no discernible reason, stabbed his friend. He was immediately arrested, stayed in a delirium all night, and finally slept in the morning. When A awoke he had no memory of the incident, could not explain why he would do such a thing, and expressed profound regret for his actions.

As there was no question of A’s guilt, the only issue to be determined was his responsibility. If the case had concerned only a normal drunk, the author contended, the answer would be clear: full responsibility. A, however, had been ordered by his employer to work with the wine, and its vapors had played a significant role in bringing about his intoxication. Because of this, his alcoholic crisis had not been voluntary, although it had been more easily provoked due to his chronic alcoholism. Furthermore, A’s lack of memory of the events coupled with the utterly irrational nature of the attack revealed to the physician that his conscience had been paralyzed by alcohol. Unable to process or reject any impulses, he lacked moral liberty. Directed to work in the cellar by his employer, A had also been helpless to avoid becoming drunk. As a result, his responsibility was significantly attenuated (the physician did not include the judicial decision in the case study). Since A’s drunkenness had not been premeditated, much like the crime itself, he should not be held fully responsible. According to the medical analysis, A’s intentions (or lack thereof) were the critical factor in determining his responsibility.

Similarly detailed accounts were common, as alcohol figured in nearly every individual's day-to-day life in France. Trials for violent crimes, such as assault or murder, provided an interesting array of issues for physicians to study, engage with, and write up in accounts that they termed "medico-legal studies." The stories of tragedies wrought by drunken men in these accounts were always exciting, dramatic, violent, and pathos-heavy. These studies did not have a particularly formal or well-established format, but generally consisted of a summary of the accused crimes, a discussion of family history and contributing hereditary factors, and a medical conclusion whose legal ramifications the author then explained. The most significant difference between this and a case study, aside from the length of the documents, was the interview with the accused and the accompanying analysis of that conversation that case studies included.<sup>410</sup> Case studies did not typically have the bibliographies or citations to relevant works that were a part of medico-legal studies and medical theses. Longer medico-legal studies examining crimes in which alcoholism played a determining role appeared in medical journals, and occasionally were excerpted as pamphlet-length stand-alone pieces. Finally, a small number of medical students and law students wrote theses in support of their degrees on the criminal responsibility of alcoholics. It was more so in these documents as well as in the shorter, more traditional case studies that physicians confronted and grappled with the totality of questions concerning personal responsibility and belonging in the national community of France that their discussions of alcoholism had raised. The results of these investigations were far from uniform, and created a level of uncertainty that served to enhance the necessity of the physicians' expertise. If these questions were so difficult for even experts to parse, how could the average jurist hope to do so?

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<sup>410</sup> It should be noted that medico-legal studies were written on a wide variety of cases, most of which did not concern alcoholism.

These medico-legal studies demonstrated that some points could be quickly and easily agreed upon by all. For example, if an individual decided upon a crime to commit, then consumed enough alcohol to be considered drunk and committed the crime, s/he would still be legally responsible for the actions undertaken while drunk. The drinker's motive to drink was clearly a part of the equation used to calculate responsibility and blame, as A's case had also underlined. Although no authors did not employ a colloquial similar to the modern-day "liquid courage," their analyses of these situations demonstrate a very close approximation of this concept. Even this, however, could spark some debate – what of hereditary alcoholics, who some physicians argued did not have the capacity to not drink? They should be excluded from legal punishment for any crime, some asserted, and instead placed inside asylums before they could do further harm.<sup>411</sup> Further complicating matters was the belief that among male drinkers, alcohol often revealed pre-existing mental conditions (*in vino, veritas*). If alcohol was revealing a person's true nature, rather than changing it, that person should be prosecuted and punished for criminal acts, many argued.<sup>412</sup>

Consideration of these issues opened up several of the most sensitive strands that ran through discussions of personal responsibility and alcoholism. On the one hand was the concern that alcoholics were irresponsible and easily controlled by others. For instance, a smooth talker could convince an alcoholic to enter into a contract (or perhaps vote for a certain candidate) that would not be in his best interest, or the best interest of the community.<sup>413</sup> The alcoholic, unable to exercise his own reason could easily harm himself and his family. As a result, some physicians

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<sup>411</sup> See, for example, Henri-Antoine-Raphaël Royer-Collard, *Alcoolisme, Coma Alcoolique, et Responsibilite Légale des alcooliques* (Bordeaux: Thésés Médecine, 1890-1891): 52-53 . This population was rather small, according to some physicians, as they were unlikely to reproduce, and hopefully their numbers would not expand.

<sup>412</sup> Monin, *L'Alcoolisme*, 153.

<sup>413</sup> All contracts could be nullified with no penalties within twenty four hours if one of the signatories had been drunk when it was signed, and contracts made in cafés and cabarets could not be enforced unless all parties agreed to them once again in a second location

asserted, alcoholics should not be able to engage in the privileges of citizenship accorded to adult men.<sup>414</sup> Pathological drinkers, in their view, lacked the mental capacity to be held accountable for their actions. The ascending ladder of punishments employed by the Law of 1873 seemed to confirm this view, as it slowly stripped away the individual's opportunities to make public use of his reason. On the other hand, the possibility that alcoholics, or even people who were not suffering from an alcoholic crisis, might try to blame their actions on alcohol while they were still in control, clearly concerned physicians. The suspicion that characterized the typical medical approach to criminal alcoholics reflected the field's fears that the theories they had created to explain the behavior of alcoholics could be used by the most savvy to escape penalties. Once again, the only way to guard against this possibility would be to have physicians diagnose possibly alcoholic criminals, then recommend either full responsibility, or partial responsibility and a sentence including a stay in the asylum for treatment. Clearly, this system not only underlined the expertise of the physician, but also helped to ensure a steady stream of patients.

## V. Partial Responsibility?

It wasn't only concerns over the potential for criminals to feign alcoholism in order to escape punishment that worried physicians, however. Few doctors were absolutely certain of how to determine the level of responsibility of chronic alcoholics, who after all retained enough of their rationality that they continued to function in their day-to-day lives. Acute alcoholics, most

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<sup>414</sup> For more on the relationship between masculinity, femininity, class, citizenship, and anxiety over all these in France, see Joan Scott, *Only Paradoxes to Offer* (Cambridge, MA: Harvard University Press, 1997), Joan Landes, *Women and the Public Sphere in the Age of the French Revolution* (Ithaca, NY: Cornell University Press, 1988), Lynn Hunt, *The Family Romance of the French Revolution* (Berkeley, CA: University of California Press, 1993), Mary Louise Roberts, *Disruptive Acts: The New Woman in Fin-de-Siècle France* (Chicago, IL: University of Chicago Press, 2005), Judith Surkis, *Sexing the Citizen* (Ithaca, NY: Cornell University Press, 2011), Lisa Tiersten, *Marianne in the Market* (Berkeley, CA: University of California Press, 2001). These works all argue that in France an individual's social masculinity was central to both social and political identity in France. Therefore, when a man's masculinity was undermined socially, the legitimacy of his right to vote and to participate in civic activities was also called into question.



observers agreed, when at the height of a crisis that precluded short-term memory production, lacked the mental capacity to act rationally, and could not be held accountable for what they did. Cases of chronic alcoholism clearly posed a more difficult problem.

The example of a forty year-old man named Isidore, written by the same physician discussing U, helps to illustrate this point. Isidore, initially from the countryside, moved to Paris at twenty-one and began working as a valet. His wife remained at home, eventually raising their three children. Analyzing these relationships, the physician found no evidence of intellectual deficits or emotional mutations in Isidore. He was, however, quickly and easily moved towards extreme emotions. As a result, he occasionally became violent. He had one formal charge against him, for assaulting his employer in a city hall somewhere in the Midi, but he claimed self-defense and the charge seems to have been dismissed.

Having spent eight months in Montevideo as a valet in 1882, Isidore returned to Paris late in the year, unhappy with the tropical climate. He soon found a position as a valet to a notary in Auberville, located in northern France, along the coast of Normandy. He did not enjoy the home, however, as both the maid and the female cook conspired against him, making problems where none should have existed because, for no reason Isidore could name, they disliked him. Frustrated, Isidore continued to drink the same amount of alcohol that he had always consumed, but now he became more emotional than usual while drinking, at times menacing to those around him. On February 1<sup>st</sup>, 1883, having consumed his normal amount of alcohol, Isidore attacked both women in the kitchen with a revolver before being subdued by one of his employer's secretaries, who reported that Isidore was quite confused and talking nonsense at the time. Isidore was subsequently charged with attempted murder.

Although Isidore could explain why the revolver was in his employer's home (a precaution that had been taken following an attempted burglary), he had no memory of taking it into the kitchen, where it was not normally stored. Those memories were gone, the physician explained, because Isidore's drunkenness had combined with an event eliciting his anger, which created a lively mental state, which appears to have been very similar to that of U. The examining physician in this case determined that Isidore was not in an acute crisis, he did not suffer a psychic break, and was not deprived of his reason. Nonetheless, the final recommendation was that his level of responsibility be lessened – essentially, the doctor concluded, alcoholism had made it much more difficult for Isidore to prevent himself from attacking the female servants, who had been making his life quite difficult over the past two months.

The differences between the two cases, while small, were critical in the physician's assessment of individual responsibility. The majority of these differences were contained in the background information. While U/Jean came from a family with close ties to alcohol consumption, Isidore was from the country, likely a peasant family, therefore escaping the urban stigma of alcoholism. U/Jean had drunk away one fortune and been forced to work in a factory, while Isidore's career as a valet, despite being relatively humble, seemed to be so successful that he could choose to spend a short period of time exploring Uruguay and return to employment with little trouble. Both men had histories of becoming excitable while drunk, but because of Isidore's personal history, this excitability was interpreted as a side effect he could not control, while Jean's was seen as yet another expression of his unstable, untrustworthy, practically un-bourgeois personality. Ultimately, Isidore had lacked the criminal spirit of U/Jean, thus at least partially clearing him of responsibility.

As these two case studies also illustrate, when a physician did try to determine an alcoholic's responsibility for a crime, analysis could become confusing. The only qualification that virtually every physician, psychologist and general practitioner alike used as a litmus test in determining responsibility was whether the patient had a memory of committing a crime. If the patient could no longer form memories, it seemed he was almost certainly suffering from an acute crisis, and should not be held responsible for his actions. The mistrust that physicians had for alcoholics, however, meant that a patient claiming to have no memory could not be taken at face value. This led physicians to almost paradoxical conclusions in some case studies.

The study of "M," a forty-three year-old business manager in Auxerre with limited intelligence, illustrates the complexity of physicians' analysis, and the confusion that it likely engendered.<sup>415</sup> M's intelligence was pointed to often in his case study: he had received little education as a child, a bout of typhoid fever had weakened his mental faculties, and alcohol had further degraded his intellectual capacity as an adult. Neither M's chronic alcoholism, nor his lack of intelligence, however, were so extreme that he was unable to function until his drinking began to encourage perceptions of persecution.

Specifically, M began to worry that his neighbor, "C," wanted to seduce his wife. In an attempt to fend off C's imaginary advances, M reported him to the gendarmerie, before resolving to kill him and his wife. When questioned later on, M said that the justice of the peace had advised him to take this action. Obsessed with this affair (whether it was imagined or not is unclear in the case study), M drank increasing amounts of alcohol and neglected his work, but resisted killing either his wife or C. Soon, he demanded "certificates of morality" from everyone he came into

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<sup>415</sup> Dr. Cullerre, *Alcoolisme et Délire des Persécutions* (Paris: Imprimerie de E. Donnaud, 1875): 5-8.

contact with. He came to know a man named “B,” who he believed sympathized with C’s cause. After having consumed a particularly large amount of alcohol one evening, M shot and killed B.

As many alcoholic criminals seemed to do in France, M then went home and slept soundly. When he was arrested a few hours later, he showed no feelings of guilt, and was unconcerned by anything that did not involve his wife. Over the next few days he slowly began to exit the state of extreme drunkenness that had taken hold in the days leading up to the murder, but showed only limited signs of mental turmoil, unlike most alcoholic criminals. He repeatedly recounted a hallucination that surrounded the murder, explaining that B had confronted him along with two other friends, and that his actions had been entirely in self-defense.

Even as he admitted his crime, M showed no remorse for his actions and repeatedly said that B was to blame for what happened. He was placed in the public asylum for eight months, during which a psychologist closely observed him.<sup>416</sup> His hallucinations receded, but his belief that his neighbor and wife were conducting an affair while he was in the asylum continued. Given all this, the question of guilt was easy enough to answer (M having confessed to the three murders that he believed he had committed, although in reality he had only killed one man), but responsibility was somewhat more difficult to sort out. M suffered from a paranoid mania that had shaped his reality, regardless of his acute alcoholic crisis. The acute crisis had merely made it possible for him to act on these beliefs. As the examining physician put it, “the alcoholic avenged the persecuted.”<sup>417</sup> M’s case study closed with the assertion that the simplicity of his mental system had allowed for the alcoholism and the paranoia, although separate mental problems (most physicians agreed that alcoholism induced paranoia, but the author argued that M suffered from

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<sup>416</sup> For more on the establishment of public asylums, see Chapter 3 of this work.

<sup>417</sup> Cullerre, *Alcoolisme*, 7.

paranoid delusions regardless of the alcoholism), to coexist in his brain. In other words, his limited mental activity had left enough room, physically speaking, for two pathologies to coincide with one another. M had been able to check the violent impulses of his paranoia when at a lower level of intoxication – instead of attacking C, for example, he had gone to the gendarmerie. His hallucinations, which ended in the asylum when he was forced to stop drinking, were clearly induced by alcohol. As he had freely chosen to consume the alcohol that induced the hallucinations, he was held responsible for the murder of B, and at the end of the eight months in the asylum, sent to prison. This, despite the fact that it could be argued that M was more mentally troubled than Isidore had been.

Aside from an individual's intent to drink, most physicians could also agree that, the presence or absence the "criminal spirit" was important when deciding the alcoholic's level of responsibility.<sup>418</sup> While the term "criminal spirit" remained vague and almost entirely undefined, it seemed that most physicians considering it would have agreed on two points: a significant portion of it was held in whether or not the alcoholic had intended to cause harm, and physicians knew it when they saw it. This intent, however, could not be measured; it could only be identified on the basis of a criminal's interviews with physicians. When coupled with the self-reported nature of an alcoholic's memory of events, it becomes clear that physicians had to rely on alcoholics in order to make their final recommendations concerning responsibility, a state of affairs that left physicians oddly at the mercy of those they were pronouncing on. As a result, attempts to shape a certain diagnosis became, for many physicians, post-hoc evidence of an alcoholic's criminal spirit.

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<sup>418</sup> This phrase was not universally used, but the idea appears in every medical text concerning alcoholism and legal responsibility. The phrase itself comes from Henri-Antoine-Raphaël Royer-Collard, *Alcoolisme, Coma Alcoolique, et Responsabilité légale de alcooliques* (Bordeaux, Imprimerie Vve Cadoret, 1891): 54.

The case of Joseph Caillot illustrates how physicians' concerns over the possibility that criminals might manipulate them were often expressed, and the evaluative criteria used either to dismiss or legitimate them when these fears invalidated a patient's testimony.<sup>419</sup> The story of Caillot's crime was presented in an awkward, disjointed narrative that left many details of what took place unclear.<sup>420</sup> Dr. Lagardelle, chief physician of the asylum at Marseille when writing and the director of medicine in the Allier department when the crime took place, admitted that he had relied on Caillot's nine year-old daughter, Valentine, to reconstruct the events of the morning that the attack took place. According to Valentine, Caillot had been threatening both his wife and sister-in-law for some time, but the women had not taken his talk seriously, assuming that he was trying only to frighten them. At 7:30 on the morning of April 4<sup>th</sup>, 1874, Caillot was standing at a window in the family's second-floor apartment. His wife was within arm's reach, and his sister-in-law in the middle of the room, while Valentine sat on a bed across from her father. Caillot had been holding a small axe, which Valentine said she believed he was going to use to fix the trellis outside the window. With no warning, she reported, he whirled around and struck his wife twice with the axe. Before she had fallen over, he had also struck and killed the sister-in-law. Telling the crying Valentine to never share what she had just seen, Caillot ran into the street, reported that the women had been trying to murder him and that he had acted in self-defense, before leaving town. Several days after, when Caillot was found on a road to Lyon and arrested, he initially claimed his name was Jean Perrin, but eventually admitted his identity.

The facts of Caillot's life were much harder for the reporting physician to pin down, as Caillot had a long history with the penal system and moved constantly, both before and after his

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<sup>419</sup> For more on concerns among physicians that alcoholics or criminals posing as alcoholics were manipulating them, see Harris, *Murders and Madness*, 280-284.

<sup>420</sup> M. Lagardelle, *Affaire Caillot Rapport Médico Légal* (Paris: J. Bazire Libraire, 1877).

marriage. Dealings with his brothers-in-law, who believed that he was responsible for lighting one of their homes on fire, complicated the number of offenses he was potentially guilty of, as did testimony claiming that he regularly stole, drank, and beat his wife. For Lagardelle, whose job it was to decide whether Caillot had been sane at the time of the murders, these previous petty offenses complicated matters considerably. Taken together, constant relocations that prevented him from making ties to a community, arson, violence towards his wife, and small thefts (he was once convicted of having stolen lard), along with reports of regular alcohol consumption, pointed towards anti-social tendencies brought on by chronic alcoholism. At the same time, however, the physical signs of chronic alcoholism were not present. Caillot's limbs and eyes did not tremble, and he had little trouble comprehending what was happening around him – at one point, Lagardelle's report complained that the patient had habitually tried to read what his questioners were writing. Not only was this an unlikely action for a chronic alcoholic, given the shaking eyes and short attention spans they typically presented with, according to physicians, it also illustrated Caillot's interest in shaping his diagnosis.

Although Caillot had a long history of engaging in behaviors that physicians associated with alcoholism, chief among these his anti-social tendencies, the doctors evaluating him were hesitant to label him an alcoholic because his deceptions were self-conscious and shrewd. In the list of crimes and faults associated with alcoholics (particularly alcoholic men), mendacity ranked low, and was always described as being transparent. An alcoholic would lie about obvious things, such as the amount of the time he spent in a café, or whether he owned a cat. Caillot's initial lie upon arrest, regarding his name, was the first and most damning clue pointing towards his rationality at the time the murders were committed. His attempt to avoid recognition was, according to Lagardelle, a sure sign that Caillot knew he had committed a crime.

Caillot, however, insisted that he could not remember anything from the end of March until the middle of the night that he was arrested on the road to Lyon, when he “came back to himself.”<sup>421</sup> This self-reported temporary amnesia was the reason Lagardelle had been called upon to examine Caillot, but the physician remained unconvinced. Caillot had a strong constitution, could answer questions quickly and reasonably, and seemed canny, according to Lagardelle’s reports. Further impugning his defense, Caillot continually spoke of fear that he was going to be poisoned. Although this sort of paranoid ideation was routinely viewed as a symptom of chronic alcoholics about to experience acute crises, Lagardelle not only dismissed it as a self-aware impersonation of alcoholism, but also used it as evidence that Caillot had remained sane during and after the murders, as he had expressed similar fears before he killed the two women.

In the course of his questioning, Lagardelle had made clear that Caillot’s description of what had happened did not match up with a medical condition, because Caillot had denied consuming more than incidental amounts of alcohol. The few words Lagardelle had spoken about alcoholism were, in his opinion, enough to get Caillot’s wheels turning, and immediately thereafter the patient claimed to have suddenly remembered the large amounts of distilled alcohol he drank every morning, as well as the small amount of food that he consumed throughout the day. He also began to feign problems with his memory, claiming to not know what he had discussed with Lagardelle only days earlier. Lagardelle viewed these symptoms as contrived.

The perception that Caillot was attempting to shape his diagnosis ultimately condemned him more forcefully than the rest of his behavior. Leveraging his expertise over Caillot’s inept performance, Lagardelle pointed out that such a self-conscious effort served only to underline that

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<sup>421</sup> Lagardelle, *Affaire Caillot*, 4.



Caillot perfectly understood the consequences of his actions, as he was trying to escape them. If anything, he showed tendencies towards monomania, but this would not cause him to lose his memory. Frustrated by Caillot's deceptions, and insulted that the patient had thought he could fool him, Lagardelle closed his account by asserting that Caillot had demonstrated he was a criminal (rather than merely someone who engaged in crime), that he had murdered the two women, that he had acted on his own free will, that his amnesia and memory loss were faked, and that he was and remained at all times fully responsible for his actions.

Ultimately, the most significant factor leading Lagardelle to reject the thesis that alcoholism trumped criminal responsibility in Caillot's case was the subject's attempt to subvert the expected power dynamic between patient and physician, and shape the diagnosis himself.<sup>422</sup> Instead of conforming to the typical narrative of a passive alcoholic, Caillot had tried to force Lagardelle to recognize him as an alcoholic by underlining certain symptoms. This violated one of the most basic components of alcoholism diagnoses – the physician was supposed to read the disease onto the body of the alcoholic. Alcoholism was not recognized or taken up by the patient. There was no sense of self that could be retrieved by a patient who claimed to be an alcoholic. In fact, an attempt by a patient to appropriate the identity of “alcoholic” operated as a sure sign that the patient did not suffer from the disease. Nonetheless, physicians' ability to categorize their patients, as in the Caillot case, relied a great deal on the accounts of the alcoholics themselves, as

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<sup>422</sup> Today, the moment that an alcoholic “admits” s/he has a drinking problem and accepts this new identity is widely considered transformative. The alcoholic cannot begin to heal until this moment (hence why “admitting you have a problem” is the first of Alcoholic Anonymous' twelve steps). This, of course, was not only not a part of treatment in nineteenth century France, as we saw in chapter 3, it was also considered a usurpation of the physician's role. It should be clear from this analysis that our contemporary state of affairs concerning alcoholism, in which the individual must admit to being an alcoholic and incorporate that role as a fundamental part of his or her identity, did not exist prior to World War I in France. For more on the rise of the importance of “self-recognition” in alcoholism, see Trysh Travis, *The Language of the Heart: A Cultural History of the Recovery Movement, from Alcoholics Anonymous to Oprah* (Chapel Hill, NC: University of North Carolina Press, 2013), Marian Valverde, *Diseases of the Will* (NY: Cambridge University Press, 1998).

well as on the testimony of those that physicians deemed unreliable at best (in this case, Caillot's nine year-old daughter).<sup>423</sup> Clearly, the physicians' ability to know and control the lives of alcoholics, while in some ways growing, remained imperfect, and was complexly mediated by a number of other actors.<sup>424</sup> Doctors could not have all the information they needed to make a diagnosis on their own, which inherently limited their ability to know, and as a result to diagnose. Physicians tended to dislike patients active attempts to shape information, seeing it as the most significant impediment to their work. In many cases, including Caillot's, these self-conscious attempts to present information that would confirm a diagnosis actually worked against the patient.

## VI. Are Alcoholics French Citizens?

At the heart of cases such as these were the issues that animated debates over citizenship and belonging in Third Republic France. Through complex discussions that employed science in the name of discovering "social truths" and created elisions between biological and social realities, physicians were drawing their own conclusions over who could truly belong to and actively participate in forming the national community. Those who suffered from alcoholism lacked a fundamental "Frenchness," that those who drank respectably embodied without trying. True

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<sup>423</sup> Further reflecting the distrust and investigative spirit that permeated the writings of physicians working on these cases was the assertion that some alcoholics were aware of when they were hallucinating. As a result of this awareness, doctors concluded, they could separate reality from fiction. Despite these "troubles with sensibilities," then, some alcoholics suffering from intense crises should still be held accountable for their actions. Only the most sensitive and discerning of professionals, of course, could be counted on to read through the accounts and identify these individuals. Vetault, *Étude médico-légale*, 192.

<sup>424</sup> See especially Michel Foucault, *Discipline and Punish*, trans. Alan Sheridan (NY: Vintage books, second edition 1995). This bears out Foucault's general theory of power relations over the body and how they began to change in the nineteenth century. Much of this work has emphasized the different types of behavior and social functions that physicians employed, but it is important to note, at the same time, the limits and imperfections of physicians' influence. Power relations changed rapidly between cases, as Caillot's example makes clear – Caillot's attempts to read over his physician's shoulder in order to craft responses that would decrease his personal responsibility, as well as his physician's outrage over this behavior, are exemplary of how quickly those changes can take place.

<sup>424</sup> Vetault, *Étude médico-légale*, 192. Physicians were able to bring under their purview and make relevant in these years, but it is important to note, at the same time, the limits and imperfections of physicians' influence.

French citizens did not *want* more than a small amount, and as a result they did not need to limit themselves.<sup>425</sup> Bourgeois character and its synonymous nature with French citizenship created a natural distaste for more than the respectable amount of alcohol, physicians claimed.

If physicians' analysis of crimes committed by alcoholics had been boiled down to a mathematical equation, it would have looked like this:

**Responsibility = premeditation + memory**

However, the equation could also be just as accurately expressed as this:

**Rational Capacity = ability to premeditate + ability to create memories**

Or this:

**Legitimacy of Citizenship = ability to premeditate + ability to create memories**

Given the lack of trust that physicians had for the self-reporting of alcoholics and their inability to examine a brain for the telltale alcoholic lesions pre-mortem, the most accurate measure of an alcoholic's responsibility became the rationality of his actions, which was judged on the basis of whether there was a discernible motive for them, and whether he remembered them. Based on the case studies physicians presented and interpreted, if one of these two points was called into question, the criminal was likely to receive an assessment of lowered responsibility. At times, this required physicians to contradict their own assertions concerning the progression of alcoholic crises. Take, for example, the previously discussed case of "A," who had stabbed his friend after working in a cellar with wine. According to the medical logic the physician had employed in his text, A should have been guilty, as the cold air would have slowed his crisis, not sped it up. The

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<sup>425</sup> Of course, it is questionable how small this amount actually was. Very likely, it was more than one or two glasses of wine a day, but the exact amount was not specified.

interpreting doctor's inability to explain the crime, however, led him to lessen the man's level of responsibility.

The word responsibility did not bear only on criminal acts, however. Responsibility also applied to the rights of citizenship. As this discussion concerning alcoholic responsibility spun itself outwards from the strictly medical, the collapsed space between working-class drinking patterns and alcoholic drinking patterns gained greater social and political resonances, which physicians not only helped to build, but also drew upon. In other words, this discourse on alcoholic responsibility created legitimate claims of expertise on social behaviors for physicians with medical educations. A great deal of this newly acquired authority centered around what it meant to be a man in the Third Republic. It also affected notions of how men and women ought to interact with one another, of how gender relations should play out in civil society. In other words, discussions of alcoholism were almost *never* just about alcoholism.

The accounts that physicians chose to present in their collections of case studies served to undermine the masculine qualities of male alcoholics. Given the close link between masculinity and citizenship in the Third Republic, this tactic effectively, yet covertly, called into question whether alcoholic (which was, as we have seen, often a code word for working-class) men should have the same rights and responsibilities as their sober (aka middle-class) counterparts. The case study of M, the man who believed that his wife was having an affair, provides a good example of how this logic often spun itself out. At no point in the case study did the physician reveal how much M drank, or what type of alcohol he consumed, despite the fact that physicians routinely pointed to these details as critical in diagnosing alcoholism. In fact, there was no information given concerning his alcohol consumption at all. The only tangible evidence that M was suffering from

alcoholism, rather than solely a case of paranoid-delusion, was that he acted on his paranoid fears and murdered a man after consuming alcohol.

The subtext of this case study, the unspoken script that every reader would have been able to follow, was that no true French man would worry that his wife was disloyal to him. M's belief that his wife could potentially be disloyal was a sign that he lacked the characteristics of responsible, middle-class French citizens. This lack of confidence in his own masculinity, in turn, encouraged the physician to point to alcoholism to explain why M would doubt his own masculinity. If M's confidence in this was missing, physicians could assume two important things: something was fundamentally wrong with M, and that something likely involved his brain. In this way, his social behavior was read back onto his body as an expression of a medical problem.

This is not to say that all physicians would have read the bare facts of M's case study and come to the conclusion that alcoholism was the root of his problem. Physicians described a huge number of mental pathologies and defects over these years, which collectively both drew on and helped to structure expectations of "normal" functioning among men and women. This "normal" functioning privileged middle-class patterns of behavior and created pathologies out of many working-class habits. This was particularly useful as there were a large number of occupations and roles in urban centers such as Paris that occupied a gray area between working-class and bourgeois. Drawing firm lines between acceptable and unacceptable served to mitigate many anxieties caused by these gray areas.<sup>426</sup>

So, how much did these discussions affect daily life? Of course, the Law of 1873, as demonstrated above, had the opportunity to impact the most fundamental rights of citizenship. But

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<sup>426</sup> For more on this, see Leonard Berlanstein, *The Working People of Paris* (Baltimore, MD: The Johns Hopkins University Press, 1984).

it was also rarely employed after 1880. Defenses of alcoholic insanity rarely saved criminals from punishment (many of the case studies examined here were produced for juries attempting to determine sentencing of convicted criminals, it appears).<sup>427</sup> Laws regulating alcohol were not popular, and the temperance movement, as previously discussed, never gained many adherents in France.<sup>428</sup> When war suddenly descended on the French in 1914, however, it became clear that the medical discourse concerning the effects of alcohol consumption had suffused the nation. Absinth, which physicians had pointed to as more dangerous than all other alcoholic beverages, was outlawed in 1915 with little protest. Doctors examining conscripts reported that evidence of chronic, acute, and hereditary alcoholism was common, indicating a high level of familiarity with the disease. It seems that the discourse on alcoholism at the very least had a greater salience than its legislative history over these years initially indicates.

Perhaps the best illustration of the way in which physicians' thinking on alcoholism helped to shape their world, however, can be seen through a case study made prior to the creation of the Third Republic. Article 64 of the Third Republic's penal code (established in 1871), as previously discussed, had created a legal space in which alcoholism could be used as a criminal defense. In some cases, extreme alcoholic intoxication could eliminate an individual's criminal responsibility, similar to an insanity defense. It is critical to note, however, that the interpretation of alcoholic intoxication as a limited defense existed in medical opinion before the space was created for it in the new penal code. This indicates that the reasoning physicians had developed through discussions of alcoholism, especially in the early works of the 1860's, was not a result of a loophole in the Third Republic's penal code, but rather that physicians created their logic, then identified

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<sup>427</sup> Harris, *Murders and Madness*, 254-256.

<sup>428</sup> See Chapter 2 of this work, as well as Patricia Prestwich, "Temperance in France: The Curious Case of Absinthe," *Historical Reflections* (1979): 301-319.

and utilized an avenue to express the importance of their work.

The case of Emile Hacquin, from 1870, illustrates that physician's theorizing concerning alcoholic responsibility was not a post-hoc construction, spurred by the creation of legislative decisions.<sup>429</sup> In Rembercourt-aux-Pots (in the Meuse departement of northeastern France), on March 2<sup>nd</sup>, the fifty-nine year-old Hacquin had struck his thirty-two year-old son, Hippolyte, on the head during a party in his home. Three days later, Hippolyte died. A large number of friends had witnessed the attack, and police arrested Hacquin shortly thereafter. While questioning him, police began to doubt his rationality, and sent him to the local asylum, to be assessed by the reporting physician, Dr. Dauby.

After speaking with Hacquin as well as his neighbors and surviving family members, Dauby concluded that Hacquin had been suffering from chronic alcoholism for years. Although he had no family history of alcoholism, and had lived most of his life as a moderate drinker, following a freak hunting accident during which Hacquin had injured another man he had begun to consume significantly more alcohol. This continued for eight years, during which Hacquin's health declined. He became less and less sociable (eventually he stopped visiting friends), and he slowly developed the constant tremors, the creeping paranoia, and the chronic hallucinations that physicians identified as hallmarks of chronic alcoholism. He also began to abuse tobacco, according to one neighbor.

Although Hacquin's symptoms of chronic alcoholism did lessen significantly when he temporarily stopped drinking (sidelined by a bout of illness, perhaps pneumonia), he seemed unable to keep himself away from the bottle, and was back to his old drinking patterns about two

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<sup>429</sup> Dr. Dauby, *Affaire Hacquin* (Paris: Imprimerie de E. Donnaud, 1875). Although the text was published in 1875, the author is careful to specify that this took place in 1870.

weeks later. In an effort to underline how quickly his alcoholism had once again become unmanageable, Dauby informed the reader that Hacquin's wife had been so offended and scared by his temper at this point that she contemplated leaving him. It was at this point that she had organized a party at their home. Hacquin had spent the party becoming progressively more drunk and disorderly, embarrassing his wife. Hippolyte, frustrated by the scene his father was causing, began to reprimand him, at which point Hacquin had struck Hippolyte on the head. Carried across the street, Hippolyte died three days later.

While under Dauby's supervision, Hacquin refused to believe that his son was dead, or that he had struck him. He asserted instead that Hippolyte had been plotting to kill him (Hacquin's neighbors denied this, and asserted that Hippolyte had been the most loving of sons). Given Hacquin's continued rejection of the realities surrounding him, his history of doing so in the past (one neighbor volunteered that Hacquin believed himself to be an excellent accordionist, but was in fact quite terrible), his physical presentation of advanced chronic alcoholism, and his constant hallucinations, Dauby concluded that Hacquin had been suffering from an alcoholic crisis at the time of the attack, which was brought on by his chronic alcoholism, that he could not understand the consequences of his actions, and that at the time of the attack he had not been in control enough to resist the impulse to strike Hippolyte. As a result of all this, he should not be held criminally responsible, but he was nonetheless a danger to society. Dauby recommended confinement to an asylum, which the judge appeared to have agreed with, as Hacquin was still in the asylum five years later.

The most notable feature of this case was that the medical reasoning employed was identical to the reasoning physicians used to determine guilt under the guidance of Article 64 of the penal code. While it would be inaccurate to draw a straight line between this case and the



establishment of Article 64, similarly, it would be naïve to believe that the existence of a line of reasoning and the subsequent creation of a legal space that incorporated that line of reasoning were not related. The pattern of thinking that physicians had begun to construct in the 1860s, which created complex relationships between alcohol consumption and the physical capabilities of the mind were clearly not ignored, nor was it so far out of the mainstream that it only spoke to an insignificant minority of physicians. The case remained so relevant, in fact, that in 1875 it was included in the January edition of the *Annales medico-psychologique*, then published individually, as a short study.

The second identifiable influence of the medical discourse on alcoholism was more diffuse. Discussions of alcoholism were able to reinforce assertions that the poorest, the weakest, and most mentally troubled in the nation were that way because they chose to be. This same discourse served to maintain standards, provide cohesion, and help to define what it meant to be a part of that middle class. To be bourgeois in France was, inside this logic, a biological fact. In this way, alcoholism helped to both unite and to exclude, to simplify and justify class differences on scientific grounds.

The discourse concerning alcoholism and the question of criminal responsibility was also significant for its resonance with discussions concerning other types of responsibility. Alcoholism became a part of a larger discussion concerning rationality and responsibility that discredited, undermined, and generally worked against the working far more than the middle class. The key point to note is that discussions of responsibility were not limited only to an individual's ability to intentionally carry out or abstain from certain actions. These conversations also defined his ability to fulfill obligations. If a man was not equipped to handle the consequences of his actions, as physicians asserted criminal alcoholics were not, it was necessary to restrict his interactions with the world by placing him in an asylum. By addressing the first type of responsibility, then

recommending how to protect against those who could not be held to its standards and restricting their access to fulfill the obligations of citizenship, physicians were creating a slippage between *responsabilité* and *devoir*, one that they could justify on a medical basis.

This slippage also drew heavily on the practice of “protection” that physicians had enshrined in their recommendations for the treatment of alcoholism. As we have seen, medical recommendations on how to manage and cure alcoholics were aimed primarily at removing them from society for extended periods of time – ideally a year, at the very least six months. Treatment recommendations encouraged the perception that society had to be guarded from alcoholics, that alcoholics were dangerous to the political and social order. Physicians’ continued highlighting of violations to the most basic principles of the nation further expressed the general medical opinion on alcoholism: alcoholics lacked the fundamental abilities needed to function in society.

Physicians also often portrayed alcoholics as posing a danger to their society by undermining expected gender relations, arguably the most fundamental relationship structuring life and society in the French nation. This was often done through discussion of a criminal’s relationship with his wife. Although case studies of criminal alcoholics centered almost exclusively around men (save, of course, when prostitution was concerned), the interactions patients had with women were often used to underline that the male subjects had veered sharply from the social order. Consider the case of “J,” the chronic alcoholic who was unendingly admitted and released. One of the earliest signs of how severe J’s alcoholism was had come not from a discussion of advanced symptoms such as hallucinations, but instead through the inclusion of his wife’s early attempts to leave him. Ultimately, the wife had failed in her efforts, and with no money to support herself should she leave, had “reconciled” with her husband. J’s violence towards his wife then escalated throughout the case study, although there was no evidence of physicians in the

home or interacting with J's wife. Nonetheless, this violence was used as a sign-post of his increasingly dangerous alcoholism. Likewise, the fact that Caillot had relied on his daughter to hide his crime similarly undermined his masculinity, as well as his parental authority.

It is, of course, impossible to say if J's violence towards his wife increased, or decreased, or even took place over these years, just as it is impossible to say if J actually had a drinking problem. Our analysis of these events is limited by what the physicians were able to observe, and what they chose to communicate in their case studies. It is critical to recognize that when doctors wrote case studies, they made strategic choices to include some pieces of information and to exclude others. It was no accident that physicians included J's continuing violence towards his wife, just as it was no accident that M's case study incorporated detailed information about the nature of his paranoia over his wife's affair with his neighbor. As we have noted, in discussions of alcoholism social behaviors became evidence of mental deficiencies, and medical discourse equated social as well as mental characteristics with physical abnormalities in the brain.

The point that I would like to underline in closing is not that physicians insisted on a close relationship between alcoholism, irrationality, and irresponsibility, but rather that medical explanations of how alcohol consumption affected the body created a socially deterministic pathology. This pathology, with its enormous number of complex truth-claims and scientific backing, rose to prominence, despite all its contradictions and inconsistencies, because it confirmed a particular way of understanding the world.

## Conclusion

The history of alcoholism in France underlines a number of truths concerning medical knowledge. The first and most obvious of these is that medical knowledge is not a reflection of a physical reality, but rather, like all other forms of knowledge, constructed, mediated by a host of social and cultural factors that determine the meaning of each physical symptom. Alcoholism is particularly well suited to demonstrate this, because the meaning of “proper consumption” clearly varies between cultures and social settings. My current social milieu would have no trouble agreeing that drinking wine at six am is a sign of well-developed alcoholism, but that is exactly how silk workers in Lyon started every day of work in the nineteenth century, without raising more than the very occasional eyebrow.

The French definition of alcoholism was shaped in large part by beliefs concerning gender and class, which were fundamental to the nature of “belonging” in the nation. As a result of this, physicians were simultaneously creating a new body medical knowledge and reaffirming widespread social beliefs, lending them the weight of scientific authority. Physicians created an understanding of alcoholism that relied on noting a patient’s physical behaviors both while intoxicated and while sober to arrive at a diagnosis. These understanding did not, however, mean that these physicians believed the brain was unimportant to the pathology of alcoholism. Instead, they came to believe that the brain was reshaped by alcoholism, via the lesions caused by long-term excessive alcohol consumption.

A number of conditions unique to France had encouraged a high level of consumption of alcohol. The importance of the wine industry to the national economy, as well as the quasi-mythical status that wine took on (arguably a result of the industry’s marketing tactics) had discouraged politicians from restricting the industry. The production and popularization of distilled

alcohols had exploded in the final quarter of the century, paradoxically driving demand up and prices down. Establishments serving alcohol proliferated in urban areas, where there were few other affordable spaces to spend leisure time. At the same time, physicians were looking for diseases that could aid them in their internecine conflicts and underline their professionalism and value to the entirety of the French nation. The lack of a forceful temperance movement combined with the importance of alcohol consumption to social life in France led to conditions in which the concept of alcoholism offered a high level of social utility to physicians.

The disease profile of alcoholism split the disease into two branches: male and female. Each of these paths also branched immediately, between chronic and acute. While the fundamental understanding of chronic (long-term excessive consumption, not necessarily resulting in extreme drunkenness) and acute (severe short-term intoxication) was the same for males and females, the markers of the disease varied considerably between the sexes. Male alcoholism, however, was pointed to as the first mover, whereas female alcoholism was understood as a mutation of the disease, different because it had to adapt to the weaknesses of the woman's body. In all cases, physicians believed that alcohol acted as a stimulant, driving the drinker's nervous and circulatory systems into a frenzy of activity. This understanding of alcohol-as-stimulant made it possible for physicians to argue that every internal organ, including the brain, could be damaged by long-term (chronic) alcohol consumption, as every organ was influenced by the activity of the nervous and circulatory systems. The most dangerous consequence of this constant consumption, they argued, was the formation of lesions on the brain of the alcoholic. This served to indict the sanity of all alcoholics at all times, whether or not they were drunk, as the lesions remained after the intoxication had passed. Between 1870 and 1914, physicians created a complex and oftentimes contradictory image of the typical alcoholic, which they argued was defined by physical symptoms.

The repercussions of these physical symptoms reverberated in the very core of the alcoholic's personality and being.

Although physicians expressed optimism that if alcoholics were willing to stay in a facility for at least six months, they could cure the disease, few elected to do so. The lack of facilities dedicated to alcoholism – there were only ever a handful of these wards – certainly did not encourage patients to seek treatment. The underlying distrust of alcoholics, which characterized most physicians' approaches to treating alcoholism, also likely discouraged many from relying on physicians. Medical discussions of curing alcoholics focused on patients' subterfuges and lies, all of which undermined physicians' efforts to cure them. Accounts of treatment also served to further stigmatize alcoholics, as they developed a social profile that explored his/her failings. The most significant of these, physicians argued, was the alcoholic's inability to fulfill social obligations to his/her family, immediate community, and *patrie*. The ultimate result of this discourse was to delegitimize the alcoholic's rationality and independence, and therefore his/her ability to belong to the French nation. This also, of course, served to reinforce the healthfulness and desirability of lower-volume drinking patterns that physicians asserted were practiced by the middle class.

In women, physicians argued that alcoholism acted much faster than it did in men. The presence of lesions was relatively under-discussed, compared to the topic's prominence in discussions of the disease among men. Although physicians did highlight the vicious, angry natures of alcoholic women, these reactions were not the product of disordered relationships to alcohol, but rather the effect of drinking on women's feminine natures. The emphasis on anger and potential violence was intended to underline that excessive alcohol consumption had worn away the defining characteristics of femininity, making it impossible for women to fulfill their most basic duties (producing and breastfeeding healthy infants), not a particular connection that drinking

women felt to alcohol. In their writings on both male and female alcoholism, physicians also continued to reinforce the perception that the male contribution to the reproductive process was the critical one to determining the nature of child. A woman's ability to move her child towards alcoholism was almost entirely a product of her influence in the early years of his/her life, rather than the time spent in utero.

It was in discussions of the relationship between alcoholism and criminality that physicians fully explored the meaning of their assertions regarding alcoholism and different forms of responsibility. Close examination of the reasoning employed by physicians demonstrates that this analysis was defined less by careful organization and correlation of symptoms, and more by its malleable nature. This equation, not despite, but rather because of its flexibility, carried the potential to undermine both the rationality and the responsibility of alcoholics, which also weighed against their ability to carry out the full duties and partake in the privileges accorded to citizens. Because none of this theorization discussed the possibility that alcoholics had developed emotional connections to drinking that compelled them to drink when they did not want to, it became all the more damning. In this equation, alcoholics did not feel conflicted over their drinking, and they did not drink in spite of themselves. As we have seen, physicians' ability to affect the tangible lives of daily citizens remained circumscribed. Nonetheless, this discourse stabilized and reinforced prejudices that marginalized working-class patterns of consumption. It also lent scientific authority to economic biases, and jibed well with the dominant social discourses of the early Third Republic.

Taken altogether, the medical discourse on alcoholism underlined the outsider status of alcoholics and their lack of belonging in the national French community. The deeply textured profile of the disease created a convincing image of the alcoholic (whether male or female) as untrustworthy, unpredictable, incapable of fulfilling the most basic expected duties, and unlikely

to change. All truly French men and women could drink alcohol responsibly without overindulging, whereas the alcoholic was incapable of doing so. Without addiction, however, this overindulgence was merely a reflection of his or her deeper nature. Even if s/he stopped drinking, if the brain lesions receded, the alcoholic would still be flawed. Different investigators have pointed out that various diseases are often used as convenient short hands for various characteristics, which Susan Sontag has called “cheap shots” for their superficial nature.<sup>430</sup> In the early Third Republic, however, alcoholism was more detailed and contained more depth than this. It was no cheap shot, but rather a complex one, all the more convincing for its density and intricacy.

Because this idea of alcoholism did not include the concept of addiction, these outsiders were all the more abhorrent to physicians. The tone of these authors was oftentimes pitiless and full of frustration over the men and women they discussed. The representations that physicians put forward, detailed as they were, came to form the basis of the social depiction of alcoholism. The result was a disease with effects that clearly spilled over into other areas of life, including citizenship, criminality, and national welfare. Studying the medical history of alcoholism provides another point of entry to debates over those subjects in the early Third Republic, as well as a new perspective on contemporary debates over acceptance and inclusion.

With the 1915 military order outlawing the production of abinsth, French interest in alcoholism dropped off precipitously. There were several reasons for this order, but the two most significant appear to be that physicians conducting incoming medical exams were reporting that the consumption of absinth had significantly damaged the bodies of recruits, and that absinth posed a constant threat to the overall health of the soldiers. Throughout the course of World War I,

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<sup>430</sup> Susan Sontag, *Illness as Metaphor* (NY: Farrar, Straus, and Giroux, 1978).



alcohol production and consumption levels remained low for France, but in the interwar period prices dropped down and consumption climbed back to pre-war levels. Anti-alcoholism efforts became even less popular than they had been before the war, as the specter of America's anti-alcoholism movement, which pushed through Prohibition in 1920, loomed.

By 1950, however, the French state had two economic imperatives that overrode the influence of alcohol lobbyists: one, the state had taken on nearly all citizen's health care costs and now saw alcoholism as a costly disease that could be eradicated, and two, overproduction (which was driving prices down and making alcoholism low-cost for the consumer) violated the principles of rational economic development that the state was promoting. Organizations by alcoholics, for alcoholics, began to spring up in the mid-1950s, and government interventions (for example, the inclusion of anti-drinking measures to a highways bill or the establishment of a High Committee to promote the study of alcoholism) created a complex patchwork of state and private interventions that continues to evolve today.

French medicine did eventually incorporate theories of addiction, which included an emotional component, into the profile of alcoholism. The word *toxicomanie* was used sporadically throughout the 1980s, but did not appear to achieve much resonance. At the most basic level, *toxicomanie* indicated a madness or wildness for alcohol, a drug, or tobacco. Excesses of energy did not characterize all those who had disordered relationships with these substances, however, and at times it seemed that *toxicomanie* merely rephrased the dependency (*dépendance*) that physicians had long ago formulated when they said that alcoholics relied on alcohol. It wasn't until 1993 that medical practitioners regularly discussed addiction as a key component of alcoholism. In 1994, a conference paper entitled "L'Addiction, un concept pour accepter sa dépendance" called for physicians to incorporate the concepts of addiction and addictive behavior into their clinical

profiles of alcoholism.<sup>431</sup> The editors of the journal *Alcoologie*, founded in 1979, changed the name to *Alcoologie et Addictologie* in 2000, reflecting the similarities that physicians had begun to recognize between addictive disorders involving drugs and alcoholism. Even today, however, French attitudes towards alcohol consumption appear to favor slightly heavier drinking than their contemporaries.<sup>432</sup>

There are a number of potential reasons that the French did not incorporate addiction into their understanding of alcoholism as early as their industrialized counterparts. The one that seems most plausible to me is that physicians do not appear to have put much stock in patients' accounts of their mental state while sober. They were only interested in what an alcoholic was thinking if s/he had committed a crime while intoxicated. There was virtually no medical interest in the emotional reasons that a person might drink. My research led me to only one account of an addictive disorder from a patient's perspective. *Six Années de Morphinomanie*, published in 1910, was an autobiography from an anonymous author of his experiences during the six years that he used morphine recreationally, in which he spoke about the emotional connection that he enjoyed with the drug.<sup>433</sup>

In America, where patients' voices were incorporated into physicians' accounts and treatment programs were more widely available than in France, addiction was a part of the medical model of alcoholism much earlier. It seems that Americans began discussing the idea that alcoholics did not want to drink, but felt compelled to do so, prior to the Industrial Era.<sup>434</sup> It seems likely to me that these divergent understandings are at least partially related to the religious

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<sup>431</sup> J.L. Venisse, "L'Addiction, un concept pour accepter sa dépendance," *Psychologie médicale*, Vol. 26, No. 10. 1994, 1018-1020.

<sup>432</sup> World Health Organization, Status Report on Alcohol and Health in 35 European Countries, 2013

<sup>433</sup> Anonymous author, *Six Années de Morphinomanie* (Paris: Éditions du "Livre Moderne," 1910).

<sup>434</sup> Those ILL articles

differences in the two contexts, particularly due to the evidence that Protestant priests in America were among the first to discuss addiction. It could be that the emphasis Protestantism placed on the individual's choices and involvement encouraged a more thorough consideration of the individual's will.

With the creation of Alcoholics Anonymous in 1935, patients in the US had more networks through which to disseminate their experiences and concerns. The Center of Alcohol Studies (originally at Yale, now a part of Rutgers) also opened in 1935 and became the hub of addictive disorder studies. It seems that the more physicians spoke with alcoholics, the more they came to believe that alcoholics were drinking *in spite* of themselves. French physicians, meanwhile, were arguing that alcoholics were drinking because that was who they were. That argument, that alcoholism defined a drinker's identity, then became basis of their assertions concerning alcoholism's salience to questions of responsibility, citizenship, and belonging.

Of course, there are many other differences between France and America: the consumption of alcohol never took on the same meaning in America as it did in France, and it was never as central to sociable conduct. But the religious differences, combined with the increased attention to personal experiences that accompanied the growth in treatment facilities seems to have been critical in the development of addiction. Without individuals discussing their own experiences with alcohol, there was no evidence of the longing and the emotional relationship that many alcoholics report as defining their relationships to drinking. Without these reports, there was no reason for physicians to consider whether their patients felt conflicted over their drinking.

The medical understanding of the nineteenth century did at times incorporate thinking that is not dissimilar from how the current-day Diagnostic and Statistical Manual explains addictive disorders. Physicians were clearly creating an understanding that eventually evolved into our

contemporary conception of addiction (although that word is beginning to enjoy less and less popularity, as its exclusion from the DSM-V indicates). At times, the reasoning employed by these nineteenth-century physicians was indistinguishable from what doctors would say today. The salient point here is that this relatively brief moment in medical history is both a picture of how alcoholism was understood in the past, as well as how it might be understood in the future. Our perception of alcoholism is continually evolving, and could easily one day come back around to favor a more physicalist understanding of the brain-body relationship that leaves little room for the emotional components, the craving and desire that are so embedded in addiction today.

Although it is difficult to draw many conclusions concerning the lives of average alcoholics based on physicians' accounts, which after all tended to favor the most sensationalist stories, it is more than fair to say that few alcoholics received an ideal level of support in overcoming their disease in nineteenth-century France. As much as I am loathe to criticize those I study, who were legitimately attempting to help a group that no one else was particularly interested previously, it seems quite clear that few individuals who had chaotic, unhappy relationships with alcohol in nineteenth-century France received meaningful assistance from the medical establishment in resolving their problems and moving towards long-term health. If nothing else, this study uncovers the potential consequences of excluding the voices of patients. This is obviously a history of what was, but it is also a study of other ways that information can be processed, of other methods of making sense out of the same phenomenon, and the tangible results of those understandings.

While studying the medical history of alcoholism in nineteenth-century France uncovers a great deal about the malleability of disease, prejudice, and professionalism, it also points up new questions that deserve further study. The first of these is also perhaps the simplest: what did patients think about the ways that their physicians discussed alcoholism? How much did the

diagnosis resonate with them? Did it come to shape drinking patterns, or was it ignored, not given so much credence as would be needed to inspire spiteful, against-orders consumption? It is essentially impossible to find the voices of patients in medical sources, as when they do appear, they are inevitably filtered through the prism of a physician's eye, shaped by that individual's prejudices, and reproduced only to demonstrate that the physician was correct. Where to find these voices is a question I have not yet answered to my own satisfaction. The sick and the poor rarely keep journals, and few people are inclined to save accounts of their struggles with stigmatized disease.

In any case, it seems unlikely that a cache of working-class journals is about to be uncovered in a forgotten attic. Court testimony concerning alcohol consumption has been mined for usefulness in other investigations of alcoholism. It may be that these records (and not only in trials where alcohol consumption defined the case) hold more evidence still on the popular response to the diagnosis of alcoholism. Even more promising, in my opinion, are military records from World War I, which include accounts not only of the amount of alcohol consumed, but also the judgments passed on that drinking. Although these norms were likely different in the army, the information could help to round out our understanding of where the line between acceptable and unacceptable began.

Finally, the study of alcoholism, a disease that failed to exert tangible influence in France, points up the importance of closely examining other diagnoses that failed to gain traction, or evolved considerably. Physicians have not been successful in their attempts to pathologize a variety of behaviors, and those failures, like this one, can reveal just as much as studies of their successes. Why did physicians allow discussions of morphinomania to fall by the wayside following World War I? What brought up the shift in hereditary theory that dealt the final blow to

Aristotelian theory? The crescendos and diminuendos of diseases and hypotheses, when considered alongside each other, will likely reveal more about the texture and flow of medical thinking and the connections that bound physicians together. A comprehensive examination of a shift from the physicalist understanding of the brain to a more psychoanalytic theory would likely stretch into the postwar period, and require the thorough study of multiple diagnoses.

These more immediate research goals aside, however, larger questions remain. The most obvious of these is simple to phrase, but difficult to begin to address: what does it mean today, popularly, to be addicted? The frequency of its use obscures our confusion over the term. Students and friends regularly claim to be addicted to certain routine behaviors, but then stop engaging in them when it becomes inconvenient, or they have other financial priorities, without experiencing any more than the most minor mental or physical discomfort. This casual reliance on the word addiction leads me to believe that most of us have not carefully considered what it means to be addicted, particularly if we have not struggled with a clinical addiction or been very close to someone who has. While the casual usage does not change the definition of addiction (now addictive disorder) in the DSM, it does encourage us to think of all habits as addictions that can be overcome relatively easily. This, unfortunately, is not the case for those with clinically diagnosed addictions. Through casual conversations and more formal ones, as well as plenty of subway eavesdropping, I have become increasingly interested in the disjuncture between the medical understanding of addiction and the addiction that we all invoke so confidently in our daily lives.

As I have dove deeper into the minutiae of French physicians' writings on alcohol's effects on the body, I have begun to wonder more and more about the same details in other national medical traditions. It seems quite clear that the same particularities that produced the French understanding did not exist in other nations, but a comparison with later-to-industrialize nations

will, I believe, help throw into relief the relationship between concern over alcoholism and industrialization, and uncover different ways of making sense out of high levels of drinking. Additionally, it can hopefully help to uncover transnational interactions and exchanges that helped to spread the relatively uniform understanding of alcoholism found in industrialized nations.

In sum, the fundamental importance of the history of medicine is tied up in its ability to model different ways of making sense out of the same phenomenon. If we pay attention, this history has the potential to explore how people make diverse meanings out of the body and its reactions. Becoming aware of the choices physicians made in this instance helps us to make sense out of the consequences of a disease that is too often taken as ahistorical. The deployment of alcoholism against those who failed to conform to expected social codes, however, underlines the malleability of disease's stigmatizing power. Ultimately, the study of alcoholism helps us to think not only about the tangible effects of medical beliefs on our world, but also about the potential flexibilities and choices we make in our methods of understanding disease, and the broad influence of those choices.

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