

HISTORY OF MENTAL ILLNESS IN MADRAS PRESIDENCY, 1870-1946

**A thesis submitted to the University of Hyderabad in partial
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IN

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BY

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10SRPH03

Under the Supervision of

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I, **SUDARSANARAO ITHADI**, hereby declare that this thesis entitled **‘HISTORY OF MENTAL ILLNESS IN MADRAS PRESIDENCY, 1870-1946’** submitted by me, under the supervision of **Dr. V. Rajagopal, Associate Professor, Department of History**, is a bonafide research work and is free from plagiarism. I also declare that it has not been submitted previously in part or in full to this University or any other University or Institution for the award of any degree or diploma. I hereby agree that my thesis can be deposited in Shodhganga/INFLIBNET.

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This is to certify that the thesis entitled '**HISTORY OF MENTAL ILLNESS IN MADRAS PRESIDENCY, 1870-1946**' submitted by **SUDARSANARAO ITHADI** bearing Regd. No. **10SRPH03** in partial fulfillment of the requirements for the award of **Doctor of Philosophy** in the **Centre for Regional Studies** is a bonafide work carried out by him under my supervision and guidance.

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Further, the student has the following publication(s) before submission of the thesis/monograph for adjudication and has produced evidence for the same in the form of acceptance letter or the reprint in the relevant area of research: (**Note:** at least one publication in referred journal is required).

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He has made presentations at the following Conferences:

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Further, the student has passed the following courses towards fulfillment of course work requirement for PhD / was exempted from doing coursework (recommended by Doctoral Committee) on the basis of the following courses passed during M. Phil Program and the M. Phil degree was awarded.

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- Sudarsanarao Ithadi

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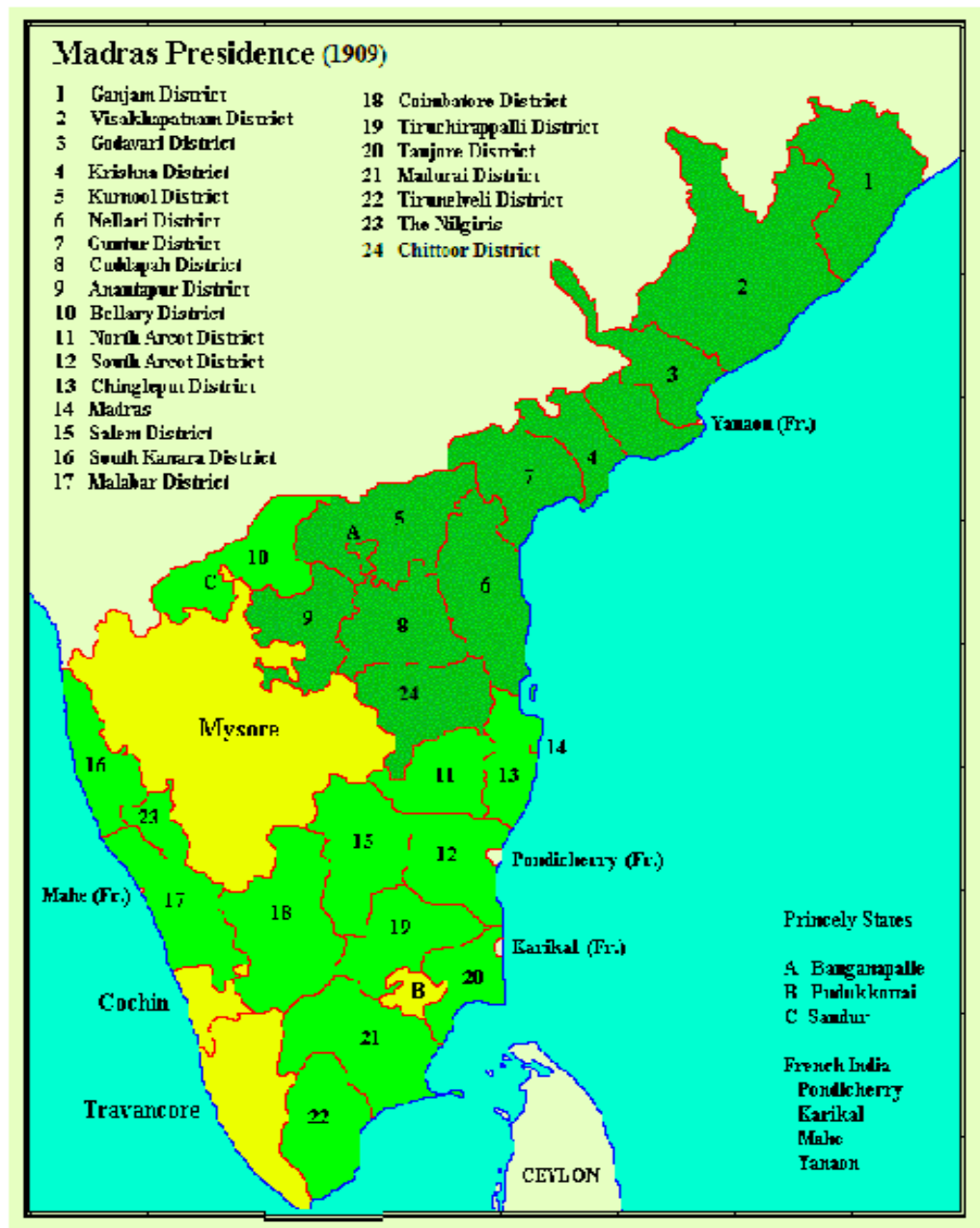
ABBREVIATIONS

TERM	DESCRIPTION
AMS	: Army Medical Service
AMSMH	: Association of the Medical Superintendents of Mental Hospitals
AMD	: Army Medical Department
BMA	: British Medical Association
BMJ	: British Medical Journal
CIP	: Central Institute of Psychiatry
CMC	: Carmichael Medical College
DMHP	: District Mental Health Programme
DPM	: Diploma in Psychological Medicine
ECT	: Electroconvulsive therapy
EIC	: East India Company
EEG	: Electroencephalography
FRCS	Fellow of the Royal College of Surgeons
GGH	: Government General Hospital
GMH	: Government Mental Hospital
GMHC	: Government Mental Health Center
GOM	Government of Madras
GO	Government Order
GOI	Government of India
ICS	: Indian Mental Health Act Indian Civil Service

IMHA	Indian Mental Health Act
IAMH	: Indian Association for Mental Hygiene
ICT	: Intermediate Care Team
IHDC	: Indian Hemp Drugs Commission
ILM	: The Indian Lunacy Manual
IMR	: Indian Medical Review
IMH	: Institute of Mental Health
IMG	: Indian Medical Gazette
IMS	Indian Medical Service
IRCS	Indian Red Cross Society
IGML	Indira Gandhi Memorial Library
IPC	: Indian Penal Code
IPS	: Indian Psychiatric Society
IPA	: Indian Psychoanalytical Association
KGH	: King George Hospital
MBBS	: Bachelor of Medicine, Bachelor of Surgery
LSG	Local Self Government
MHC	: Mental Hygiene Council
MD	Military Department
MD	Doctor of Medicine
MHP	: Mental Health Policy
MHA	: Mental Healthcare Act
MMS	: Madras Medical Service

NMHP	: The National Mental Health Programme
NCMH	: National Council for Mental Hygiene
NCMH	: National Committee for Mental Hygiene
OPD	: Out Patient Department
RMPA	: Royal Medico psychological Association
PHD	: Public Health Department
UK	: United Kingdom

MAP



DEDICATED TO

My beloved parents

Ithadi Kotaiah



Elishamma

Chapter-1

Introduction

The Problem of mental illness is a universal phenomenon throughout ages, it can be affected to anybody; no society is exempted from the clutches of this malady, it has been troubling the mankind for centuries. Though the word mental illness sounds singular, but in reality, it is a term of broader meaning, with several definitions, deferent identities and various categories. It is very curious to know about this subject but little research is available on this area, especially its institutions, care, treatment, its surrounding conditions and the social implications of mental illness in colonial Indian context. During the British colonial rule in India the mental hospitals were known as Lunatic asylums¹. According to The Indian Lunacy Act of XXXVI of 1858, Section-18, defined that “Lunatic” means an Idiot or persons of unsound mind². Until 1922 individuals with mental problems were referred to as lunatics, and mental hospitals were referred to as lunatic asylums in India³. To know much about this malady of mental illness, it is essential to study mental institutions in colonial India; both mental illness and mental hospitals are inseparable, because the systematic study and observation about this sickness started with the establishment of lunatic asylums in India during the East India Company rule. As part of the overall world-wide developments, a discipline called psychiatry has been evolved, which means the study and treatment of the mental illness, in this way the history of mental illness is also called the history of psychiatry. The term mental illness has deferent identities and classification in modern psychiatry, in a way all of them were come under a single derogatory identity called madness. The word madness is the very negative express of mental illness, and yet madness is no longer an acceptable term to use in polite

¹The word ‘lunatic’ is originated from Latin word, lunamoon, it is a popular old term alluding to an individual who is viewed as mentally ill, psychologically sick, crazy or foolish in Behaviour and considered as dangerous. Historically it credited to "lunacy". The word gets from lunaticus signifying "of the moon" or "moon struck". The lunatic cycle depends on the change of the moon. It is no longer in usage and legally not accepted in popular use.

² Government of Madras, Public Department, Letter No. 111, 29th January 1912, p. 3.

³Somasundaram, O, ‘The Indian Lunacy Act, 1912: A Historical Background.’ *Indian Journal of Psychiatry* 29, 1 (January 1987): pp. 3-14, p. 11.

company. Till the last two centuries, ‘madness’ was a term widely and unselfconsciously employed by both sufferers and their healers, as well as by society at large. Madness is not a medical term (though it was once widely used by medical men)⁴.

The present study has used the term ‘mental illness’ wherever possible in an effort to avoid the stigmatizing term ‘mad’. For the last few centuries persons identified with mental health problems were called with various names, they are Lunatic⁵, Mad, Insane, Unsound minds, Psychosis, *Unmada* (Sanskrit), *Pagal* (Hindi), *Loose* (Tamil), *Pichhi*, *Verri*, *Bhuddimandyam* (Telugu), and its local derogatory identities of that respective regions of the world. Whatever term generally prefers to it, the referents are disturbances of reason (deviating from broader social norms), the passions, and human action that frighten, create chaos, and yet sometimes amuse; that mark a gulf between the commonsense reality most of us embrace, and the discordant version some humans appear to experience. Its existence has given birth to elaborate sets of social institutions and systems of knowledge that seek to comprehend, to contain, to manage, and to dispose of powerful symbolic and practical challenges madness poses to the social fabric and to the very possibility of social order⁶.

In the modern period, a separate space was created for the care, treatment as well as disciplining these people in a confinement; that is called as lunatic asylums or the present-day mental hospitals, a whole industry has grown up, devoted to its management, care, cure and suppression. These places are considered as the convenient places for the inconvenient people to the world⁷. Ideal intension behind the establishments of lunatic asylums was ‘Peace and order, as well as humanitarian considerations, were both the objectives intended to guarantee ‘the protection of the

⁴ Andrew .T. Scull, *Madness: A Very Short Introduction*, New York, Oxford University Press, 2001, p.2.

⁵ The term “Lunacy” derives from the word *luna*, meaning moon in *latin*. Ancient’s believed that phases of moon could bring on mental illness came and went.

⁶ Andrew .T. Scull, *Madness: a very short introduction*, New York, Oxford University Press, 2001, p.3.

⁷ Roy Porter, *Madness a Brief History*, New York, Oxford University Press, 2002, p.7.

Public on one hand, and the relief of the most unhappy Class of human beings'⁸. Around this mysterious illness a medical sub-discipline came into existence called psychiatry, it had been a long trajectory of journey from 18th century to the present times. The term psychiatry is conventionally defined as a medical specialty concerned with the diagnosis and treatment of mental diseases⁹. It has gained popularity in the twentieth century, with the advances in scientific understanding of medicine in general and psychiatry in particular¹⁰.

Due to the prolonged period of colonialisation in India, the Britishers had implemented some Western medical and institutional practices, they continued the colonialisation of medical services till the end of their reign, and it affected the post-independence India also, it remained an important part of health services. In the post-independent India, the issue of mental illness was addressed by several psychiatric institutions, such as Public and Private mental hospitals, General Hospitals Outpatient services, special wards and even primary health centers dealing with this subject. Apart from them Non Governmental Organizations (NGOs) also engaged in several ways in assisting with mental health issues¹¹. Various national health policies have been formulating to develop the alternative mental health care in India in the form of The National Mental Health Programme since 1982, and National Mental Health Policy, 2001. The main objectives of these Programmes' are to provide a minimum mental health care for all, especially to the disadvantaged sections of the population. It has been encouraged application of mental health knowledge in general health care

⁸ Ernst Waltraud, 'Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', Cambridge University Press, *Comparative Studies in Society and History*, Vol. 39, No. 1 (Jan., 1997), pp. 153.

⁹ Roy Porter, op.cit, 2002, p.1.

¹⁰ M.A.M. Khan, "Indian Psychiatry: The British Connection" ", in S. P. Agarwal (Ed), *Mental Health an Indian Perspective 1946–2003*, Directorate General of Health Services Ministry of Health and Family Welfare, New Delhi, 2005, p.62.

¹¹The landmark analysis of mental illness by the U.S. ¹¹Surgeon General in 1999, *Mental Health: Report of the Surgeon General*, states that it is "the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." Mental health, on the other hand, is defined as "the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.

and social development, and promote community participation and self-help. However, people's needs remain very much unmet, and there is an acute shortage of personnel. Moreover, operational difficulties continued till the date, for reasons such as lack of psychotropic drugs, funds, political will, and professional involvement; inadequate recording and reporting; unavailability of doctors at health centers and financial problems of patients; lack of patients' privacy, storage facilities; and ignorance and cultural beliefs of the people.

Mental health is a major concern worldwide and India. If we evaluate growth in the field the pace appears to be mild. Along with the physical health, the mental health is inevitable for the sustainability of human being. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the interplay between mental illness and other health disorders. There remain considerable issues of priority-setting based on the burden of health problems and of addressing inequalities in relation to determinants and solutions for health problems.

In the Indian scenario the treatment gap, as measured by the absolute difference between the prevalence of mental illnesses and the treated proportion. One of the major reasons attributed to such a wide treatment gap is the problem of inadequate resources. In India, inadequacy exists in infrastructure as well as in human resources. Despite improvements in various health indicators, India contributes disproportionately to the global burden of disease. Our health indicators compare unfavourably with other middle-income countries and India's regional neighbours. A large proportion of the population ends up impoverished because of high out-of-pocket health-care expenditures and suffers the adverse consequences of the poor quality of care. Given the dire shortage in numbers of psychiatrists, psychologists, psychiatric nurses, and social workers; piggy-backing on primary care systems and employing innovative force-multipliers are future courses of action.

The government remains the biggest single spender in the mental health sector. While most new interventions remain isolated and confined to urban areas, it is only the public health system through large programs which can reach the rural masses. Apart from the National and District Mental Health Programs, the National Rural Health Mission is on its way to becoming the vehicle for delivering mental health as a part of integrated primary care at the cutting edge of the public healthcare system. Seeing that

it partners with existing private and alternative care providers in a nonthreatening manner, shall help such large interventions synergize and succeed. The organized sector suffers significant loss of effective workforce through mental ill-health. Not only as a part of corporate social responsibility but also to maintain productivity, has it become important to engage with mental health awareness in a concerted fashion.

Considering that most of the earlier strategies to enhance mental health have not succeeded in India, the time has come to take on a new approach with renewed vigor. Mental health awareness can become both the means and the way of ending this apathy. Progressive government policies based on evidence-based approaches, an engaged media, a vibrant educational system, a responsive industry, aggressive utilization of newer technologies and creative crowd-sourcing might together help dispel the blight of mental illnesses. Progress in mental health service delivery has been slow in India. Barriers include the existing public-health priorities and its influence on funding; challenges to delivery of mental health care in primary-care settings; the low numbers of those trained in mental health care; and the lack of mental health perspective in public-health leadership. There have been numerous calls for invoking political will, for enhancing advocacy and for galvanizing community participation; all with scant improvement in outcomes.

Thus, it becomes now opportune to explore the paradigm of mental health awareness as a means of combating stigma, enhancing prevention, ensuring early recognition, and also stimulating simple and practical interventions within the community. Mental health awareness campaigns have yielded positive outcomes. Some of the strategies undertaken to target awareness and address stigma around mental illness include participation by family members, sensitization to treatment and social inclusion. Lack of knowledge about the mental illnesses poses a challenge to the mental health care delivery system. Research has highlighted the role of community-based systems in low-income countries and has also yielded positive results in creating awareness, thereby impacting participation. Awareness and health literacy are two sides of the same coin. Stigma and discrimination are negative consequences of ignorance and misinformation. There are a few studies which have measured mental health literacy in the Indian context.

Mental health literacy is a related concept which is increasingly seen as an important measure of the awareness and knowledge of mental health disorders. Health literacy has been described as “ability to access, understand, and use the information to promote and maintain good health. Mental health literacy encompasses recognition, causes, self-help, facilitation of professional intervention, and navigating the information highway. Attitudes which hinder recognition and appropriate help-seeking can be counter-acted by information which is already readily available in the public domain. The impact of stigma has led to the institution of various programs worldwide to challenge the stereotypes and discrimination that generate social disability. Mental health awareness programs have had favourable impact and can produce positive change in people's views of mental illnesses.

Limited access to mental health services, shortage of mental health specialists, and lack of awareness on mental health, stigma, lower literacy, and poverty coupled with the unwillingness or inability of families to care for their mentally ill members, appear to be the main contributory factors to mental health burden. Moreover, widely prevalent religious beliefs associated with mental illness pose significant obstacles in seeking appropriate mental health care services.

The development of psychiatric services in India, in contrast with economically rich countries, has occurred against the backdrop of almost no mental health services at the time of Independence. Almost all people with mental disorders live in the community; most often do not have access to any organized services, with their family providing care in whatever form it is able to do (ranging from isolation to committed care). At the time of Independence, the mental health infrastructure and specialist manpower was meagre. In 1947, India had 10 000 psychiatric beds for a population of over 300 million, compared to the UK, which, with one-tenth the population of India, had over 150 000 psychiatric beds.

For example, policy level actions such as the first Mental Health Policy 2014 and passing the Mental Healthcare Act 2017 superseding the Mental Health Act, 1987. Both the Mental health policies and legislations, with limitations, provide overarching directions on broader issues for ensuring mental health promotion, adequate human resource, and provisioning prevention and treatment services through public health

system. Programmatic attempts were made to create additional capacity for mental health workforce through establishing centres of excellence, emphasizing community based mental healthcare and expanding District Mental Health Programmes—DMHP under the National Mental Health Programme—NMHP. Moreover, we are witnessing various innovations successfully addressing gaps in the delivery of mental healthcare in India.

The National Mental Health Programme (NMHP) was formulated in 1982 to develop a national-level initiative for mental healthcare based on the community psychiatry approach. During the past 3 decades, there have been a large number of other community initiatives to address a wide variety of mental health needs of the community through programmes on suicide prevention, care of the elderly, substance use and disaster mental healthcare, and by setting up of day-care centres, half-way homes, long stay homes and rehabilitation facilities. The rapid growth of psychiatry in the private sector is another important recent development. Though mainly confined to large urban centres, private sector psychiatry is providing valuable services to the community. From a situation of nearly no services for persons with mental disorders in 1947, today there is a broad framework for mental healthcare in the public, private and voluntary sectors. In these developments, India has been influenced by the local situation as well as international developments.

Concept of Mental Illness

It would be useful to get the conceptual clarity about the mental illness. The term mental illness is a most complex word with which we are universally familiar, it is something that scares and curious to human beings for a long time. Throughout history, people with certain behavioral and emotional traits have been recognized by the societies in which they lived as differing significantly from the general population. To defines in a brief, mental illness as a ‘disorder’ that can profoundly disrupt a person’s thinking, feeling, moods, ability to relate to others and capacity for coping with the demands of life¹². Traditional societies some believed that it was possession by the devil, some cultures believed such individuals were overtaken by spirits that

¹² Thompson, Marie L, *Mental Illness*, Greenwood Press, Westport, Connecticut, London, 2007, p. 4.

could be either good or evil; some believed their strange behavior was caused by inner conflict. Such type of persons has been identified as mentally ill, they are treated as abnormal in the modernity that is why; it had been recognized it as a social problem in the modern times, to deal this subject, modern societies try to understand the problems in a systematic way. Historically, those suffering from what was once called lunacy or madness and is now known as mental illness or mental disorder have variously been treated kindly and cruelly. Attitudes toward and treatment of those unique individuals varied between cultures and changed over time. Even in the twenty-first century with medical, scientific, and psychiatric researchers working diligently to understand causes and develop effective treatments for mental illness misconception, misunderstanding, and mystery still surround the subject.

The term mental illness is generally used to encompass a large, and ever-evolving, number of diagnoses. According to modern biomedical sciences it became medical condition, unlike other physical illness mind also get affected with illness. Even though some argue that the mind cannot become ill, the theory that mental illnesses are as real as physical illnesses is widely accepted. Whereas physical illnesses manifest in the body, mental illnesses manifest as certain types of behaviour. Unlike physical illnesses, mental illnesses cannot be diagnosed by biological tests, such as viewing a virus under a microscope, imaging the brain, or doing blood tests. The exact origins of mental disorders remain difficult to describe; however, many researchers and scientists believe they arise from some physical occurrence in the brain caused by psychological, biological, genetic, or environmental factors, or from some combination of such factors¹³. Thus, It can affect the people of all social, economic, geographic, age, gender, religious, and occupational groups. An individual may experience mental illness over many years or over an entire lifetime, or symptoms may only develop later in life. The symptoms, their duration, and their intensity vary. Some individuals experience episodes of more extreme and less extreme symptoms; for some, symptoms go into remission; for others, symptoms are continuous. People with mild symptoms may function well without professional help, whereas those with more severe symptoms require professional treatment and often hospitalization.

¹³ *ibid*, p.4.

Mental illness cannot be viewed in isolation from physical functioning; the two are inseparable. Memory and cognition are mental functions, but because they are initiated in the brain, they are also physical functions. A change in brain chemistry a physical occurrence, caused, perhaps, by something as seemingly benign as stress can cause changes in mental functions that manifest as anxiety, panic attacks, or depression. Physical and mental are two inseparable components of the complete human experience. In attempting to understand the complexities of mental illness, it is important to understand that physical and mental, that is, body and mind, cannot exist in isolation from one another¹⁴. Along with these complexities, stigma surrounded with this subject which involved multi facets of exclusion in any society. The societal perception towards the persons affected with the mental illness are, unproductive individuals, burden to the family, threaten to the others, in overall unfortunate creatures on the earth.

The basic symptoms of mental illness are same to any country but it would vary the treatment practices from Region to regions of the world and periodically. In all the traditional societies everybody has their own forms of their institutional practices to take care of these individuals. The exact reasons for the mental illness are still unknown, though it is broadly categorized into three broad causes by psychiatrists. By taking all of these explanations into considerations the causes of the mental illness generally classified in three major categories, they are Biological factors of mental illness; Psychological factors of mental illness and Social factors of mental illness. Along with these factors, in the culture of madness (mental illness) reality and representations endlessly played off each other¹⁵.

This work has used the term colonial psychiatry as indicative of a field of concepts and practices that went into the making of this regime of knowledge. It further indicates that this thesis is a study of the making of a discipline by an examining the policy initiatives and the institutional histories of colonial asylums. In other words, the term is a short-hand that refers a series of practices, ideas and the institutional

¹⁴ Ibid, p.5.

¹⁵ Roy Porter, op.cit, 2002, p.64.

contexts that enabled the coherence of an emergent medicine of the mind¹⁶. As psychiatry occupies a unique space between the social and natural sciences, the discipline constitutes a crucial locus for study of the relationship between knowledge and power in colonial domination. The asylum in any context functions as both hospital and prison, and psychiatry's medical applications render the mental institution the ultimate "correctional facility." Under colonialism, where the ruling state is in almost constant tension with the population, the position of psychiatric knowledge becomes even more complex, this also would like to examine in the present study¹⁷.

Mental illness is a modern concept in the field of psychiatry. It has a history at least as long as recorded history. It's the basic concept is same to any country but it would vary the practice country to country in the worldwide and the periodically. In Indian context this field was developed with establishment of colonial lunatic asylums, having variety of unofficial intensions of the rulers as the broad picture of the developments of the global psychiatric developments.

To study treatment of mental illness, a broad discipline has been developing for the past two centuries that is known as Psychiatry¹⁸. It is considered as a sub-discipline to medical sciences and it became the medical specialty concerned with mental symptoms caused by disorders of the brain and mind, because medical attention to such symptoms stretches back to the Ancients. Psychiatry has a long history indeed, moreover a history thoroughly interleaved with the culture and society of the day¹⁹. Psychiatry as a discipline began in the last quarter of the eighteenth century with the founding of a new kind of asylum—the therapeutic rather than the custodial asylum. The term 'psychiatry' was coined by a German, Johan Christian Reil, in 1808, and was representative of a scientific rationality that could not be located elsewhere. The

¹⁶ Kapila Shruti, *The Making of Colonial Psychiatry, Bombay Presidency 1849-1940*, unpublished PhD thesis, SOSA, University of London, 2002, p. 7.

¹⁷ Keller, Richard, 'Madness and Colonization: Psychiatry in The British and French Empire, 1800-1962', *Journal of Social History*, Vol.XX1, No. 7, winter 2001, pp.296-297.

¹⁸ Psychiatry deals with people mentally ill, according to Roy Porter's *Madness a Brief History* 'Psychiatry is conventionally defined as a medical specialty concerned with the diagnosis and treatment of mental diseases'.

¹⁹ Shorter Edward, *A Historical Dictionary of Psychiatry*, New York: Oxford University Press, 2005.

world had known asylums since the middle Ages, hospices in which the insane were thrown together willy-nilly with the halt, the diseased, the senile, and the impoverished. Such hospices made no pretense of therapeutics and existed merely for the convenience of removing psychotic and demented individuals, those whose families were unable to care for them, from the streets of the big cities²⁰.

History of Madness in the Western Context:

The history of psychiatry may be divided into roughly three periods: the asylum period of the years 1770–1870, in which biological concepts held sway; the psychotherapy period of the years 1870 to around 1970, in which Freud’s doctrine of psychoanalysis came increasingly to the fore; and the second biological psychiatry, from the 1970s to the present, in which biology has come rushing back with a vengeance and psychodynamic explanations have largely been unhorsed, psychotherapy sliding from the psychiatrists to the psychologists²¹.

According to Michel Foucault the stigma, segregation and fear was attached to the leprosy asylums in the western Europe in the high middle ages, due to the reduction of the population in these asylums, this space was occupied by the another set of people such as incurables and madmen. The ‘great confinement of the insane’ identified as a trend in France and other European countries by Foucault in his seminal *Madness and Civilization* was clearly not characteristic of British India. In the Indian context the colonial government directly transplanted the western institutional practices of psychiatry. Which means it lacked discernible psychiatric foundations in India; the treatment to the mental ill has often been subsumed within histories of medical hospitals and colonial prisons. According to Sridhar Sharma the mental hospitals as they exist today were entirely a British conception.²²

The term madness is culturally defined phenomenon afflicting an unknown, but probably small, portion of the population into a condition which could only be

²⁰ Shorter Edward, op.cit, 2005, pp.3-4.

²¹ Ibid, p. 3.

²² Shridar Sharma, L P Varma, History of Mental Hospitals in Indian Sub-Continent, *Indian Journal of Psychiatry*, 26(4), 1984, pp. 295.

authoritatively diagnosed, certified, and dealt with by a group of legally recognized experts and which was now seen as deviance in society. In the eighteenth century only the most violent and destructive labeled insane they have been segregated and confined apart from the rest of the community²³. The British definition of a lunatic can be seen in the eighteenth-century treatise, *Commentaries on the Laws of England*: “A lunatic, or non-compos mentis, is one who had hath his understanding, but by disease, grief, or other accident, hath lost the use of his reason”²⁴. In England, the British had been ‘controlling’ lunatics through confinement for centuries prior to their involvement in India. The British, in keeping with Western medical tradition, chose to pass laws in order to define who was a lunatic and how they should be treated. The Western concept of lunacy was based on different cultural influences; these influences had little in common with India²⁵. Moral responsibility was a fundamental value of the Victorian era. Protecting lunatics who could not protect themselves was a chief concern of the medical community²⁶.

The rise of capitalism, urbanization, and the power and prestige of the medical community assisted the development of the asylum. Before the 19th century, those deemed ‘lunatics’ were not usually institutionalized, but were cared for by family, friends, or parishes. In other cases they were housed with the poor and the criminals. The loss of reason, a sense of alienation from the commonsense world we all like to imagine we inhabit, the shattering emotional turmoil that seizes hold and won’t let go these are some of the traits we associate with madness. Today, mental disturbance is most commonly viewed through a medical lens, but societies have also sought to make sense of it through religion or the supernatural, or by constructing psychological or social explanations in an effort to tame the demons of unreason. The loss of reason, a sense of alienation from the commonsense world we all like to imagine we inhabit,

²³ Scull, Andrew T, From Madness to Mental Illness Medical men as moral entrepreneurs, *European Journal of Sociology*, Vol. 16, No. 2, 1975, pp. 218-261, Published by: Cambridge University Press
Stable URL: <http://www.jstor.org/stable/23998602> Accessed: 28-11-2015 05:47 UTC, p. 218.

²⁴Kymberly C. Brumlik, “Lunacy for Profit: The Economic Gains Of ‘Native-Only’ Lunatic Asylums In The Bengal Presidency, 1850s-1870s”, *Journal of South Asian Studies*, 02 (01) 2014. 01-10, p.2.

²⁵ *ibid*, p.2.

²⁶ *ibid*, p.3.

the shattering emotional turmoil that seizes hold and won't let go—these are some of the traits we associate with madness.

Madness may be as old as mankind²⁷. The earliest predecessor of mental hospitals on record was a Greek sanctuary at Epidauros. The fourth century AD witnessed the establishment of institutions solely for the mentally ill in Byzantium and Jerusalem. Thereafter, Christian and Muslim religious orders established places of refuge for the mentally ill and patients were treated by a variety of the procedures with religious coloring²⁸. Madness figures, usually as a fate or punishment, in early religious myths and in heroic fables²⁹. Violence, grief, bloodlust, and cannibalism have commonly been associated with insanity³⁰. Prevalent amongst pre-literate peoples the world over; such supernatural beliefs were then embodied in Mesopotamian and Egyptian medicine and in Greek myth and art.

In contrast, Muslims in the Arabic world had established several hospitals for the mentally ill; the first was in al-Qatai, Egypt in approximately 872 BCE. Although Muslims were able to establish mental hospitals outside India's borders, there were very few in India before British occupation, and little is documented about the few facilities that did exist³¹. The first psychiatric hospitals were built in the medieval Islamic world from the 8th century, the first hospital was built in Baghdad (705 AD) followed by hospitals built as Fes and Cairo. The first major modern mental hospital, the Bethlehem Hospital, was started in 1247 in London³². Initially, the treatment of lunatics even in Europe was in the hands of the Church, which even accorded death as the severest punishment for insanity. Mental hospitals had a long history in the Arab

²⁷ Roy Porter, op.cit, 2002, p.10.

²⁸ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p.7.

²⁹ Roy Porter, op.cit, 2002, p.10.

³⁰ Ibid, p. 12.

³¹ Kymberly C. Brumlik, op.cit, 2014, p.2.

³² Nizamie S. Haque and Nishant Goyal, op.cit, 2013, p.7.

world, and the growing Muslim influence in India lead to the establishing of similar hospitals³³.

“Foucault never defines madness; madness is not the object of knowledge, whose history must be rediscovered; one might say instead that madness is nothing but this knowledge itself: madness is not a disease, it is variable and perhaps has a heterogeneous meaning, according to the period; Foucault never treats madness except as a functional reality: for him, it is a pure function of a couple formed by reason and unreason, observer and observed. And the observer (the man of reason) has no objective privilege over the observed (the madman).” (Basu, 2004).

Hundreds of years ago, those with mental illnesses were forced out of sight and locked away alongside the poor, criminals and others considered to be “unwanted”. Authorities exploited the incarcerated community as cheap and idle labor, and the treatment was oftentimes cruel and dominating. Eventually, psychiatric asylums were designed and those with mental health issues gradually started to be treated more humanely. Slowly, the approach to mental illness grew to be rooted in psychology.

He claims that in the classical age madness was regarded as a unity of the mind and body—as a case that occurs when the mind blindly surrenders to the desires of the body, when the mind displays an “incapacity to control or to moderate” the passions of the body. Foucault maintains, “*Madness begins where the relation of man to truth is disturbed and darkened*”.

For Porter, the author of ‘*Madness: A Brief History*’ the history of the asylum is emblematic of the instability of both the theory and practice of psychiatry. From the time of Bedlam in London (originally called St Mary of Bethlehem then Bethlem Royal Hospital, used specifically for the mentally ill from 1402 onwards), the madhouse was the product of a genuine desire to create a safe and relatively salubrious environment for people otherwise exposed to mistreatment by themselves

³³Sanjeev Jain, “Psychiatry and confinement in India” Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, Cambridge University Press, New York 2003., p.273.

and others. Initially, Pinel, Battie, Chiargui, and other pioneers saw asylums as places of moral reform rooted in respect and concern for the patient. Yet, economic and social pressures, and the inability of psychiatry to get any positive results, soon transformed asylums into ware houses or mere “dust bins for hopeless cases”, while, not coincidentally, providing psychiatry with subjects for therapeutic experimentation. Bloodletting and purging gave way to psychosurgery, shock therapies, and, by the mid-20th century, psychopharmacology, transforming no-hope asylums into hospitals and giving psychiatry a much needed “lifeline back into mainstream general medicine”. Is this progress? The discipline of psychiatry may have weathered the storm of Szasz, Laing and the antipsychiatry movement, and in wealthier countries psychopharmacology may be reducing the need for institutionalization.

By the late 18th century, the condition of mentally ill patients in these institutions was one of the neglect, restraint and abuse with poor clothing, unhygienic conditions, poor nutrition, restricted movements due to chaining of hands, feet and lack of stimulation, largely contributed to by scarcity of funds, lack of interest among the ruling aristocracy and over-crowding of mental hospitals³⁴.

The social history of insanity is a recent growth area within medical history. Before the 1970s historians and social scientists showed relatively little interest in the history of psychiatry or the institutions where their patients were housed. One explanation may lie in the limited prestige enjoyed by psychiatrists within a medical profession which had been greatly expanded by the growth of welfare states but which had devoted few resources to mental health provision. As numerous scholars have noted, physicians who claimed a professional expertise in healing the insane were limited by the weakness of their scientific credentials and the evidence that large numbers of incurable patients were languishing in asylum care for decades. Whilst psychiatric medicine struggled to establish its prestige within the wider medical profession after 1945, the renewed debates on the role of mental institutions in the regulation of deviance and the future of psychiatric care in the community raised profound reservations about the success of the facilities developed to care for the mentally ill. These debates gave urgency to the historical reappraisal of the asylum system which

³⁴ Nizamie S. Haque and Nishant Goyal, op.cit, 2013, p.7.

received a powerful stimulus from Michel Foucault's brilliant work on the Enlightenment, *Madness and Civilization*³⁵.

Together, both Western psychiatry and British hegemony became aligned as they entered the native asylum, and this served to enforce the walls against multiple kinds of people and practices, rather than encouraging their mixing. Thus, the walls of the asylum became less permeable, and the practices within became more opaque and rigid³⁶.

The modern psychiatry is largely a development of the twentieth century and that early during the preceding century especially social and political and not medical problems posed by the mentally ill were a major concern in Western Europe³⁷. However, the establishment of psychiatry was a long, complicated process involving the introduction of the new discipline to the universities and medical schools (which were set up much later in India); the formulation of a classification scheme for mental diseases (ignoring completely the pre-existing classificatory schemes); and publication of text books (which in the days of the Raj, and even now to a certain degree, came from Great Britain). The psychiatric text books of the period made no mention at all of the indigenous etiological factors and treatment methods. Any illness that did not fit in the Western classification was bizarre, exotic, and esoteric, thereby sowing the seeds for cultural-bound syndromes³⁸.

Not until the early 1700s did the supernatural explanation for mental illness shift. The mentally ill became known as lunatics and were perceived and treated as wild animals. Until the 1700s, they were usually cared for at home by their families, most

³⁵ Joseph Melling and Bill Forsythe (ed), *The Politics of Madness The State, Insanity and Society in England, 1845-1914*, Routledge Taylor & Francis Group London and New York, 2006, p. 1.

³⁶ Anouska Bhattacharyya, *Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858-1912*, PhD theses, The Department for the History of Science, Harvard University Cambridge, Massachusetts, 2013, p. 4.

³⁷ Horacio Fabrega Jr, *History of Mental illness in India A Cultural Psychiatry Retrospective*, Motilal Banarsidass Publishers, Delhi, 2009, pp. 551-552.

³⁸ Dinesh Bhugra, Roland Littlewood (Ed) *Colonialism and Psychiatry*, a chapter "The Colonized Psyche: British influence on Indian Psychiatry" by Dinesh Bhugra, Oxford University Press, 2001, p.53.

often locked away in basements or attics for years or for their entire lives. Then the practice of institutionalization began. No distinction was made between the mentally ill and the criminally insane, and thousands of mentally ill—particularly the poor—were locked up in prisons with violent criminals in dark, dank cells, often unmercifully chained to the walls. Thousands more were sent to government welfare poorhouses (lunatic asylums), which were being established to house them. In either case, although the inmates received very basic care, conditions were appallingly overcrowded and unsanitary. Treatment consisted primarily of intimidation, physical abuse, and restraint in order to subdue the wild spirit within; the mortality rate was high. One of the most famous, or infamous, of these institutions was St. Mary of Bethlehem in London, England, commonly known as Bedlam—a name that has long since been used as a term to describe uproar or confusion³⁹.

Western Medicine and Public health in Colonial India

Political geography of Colonial India is different from the present India. It was divided into the British Indian Provinces and the Princely States. While the British Indian provinces were directly under the control of the British government, on the other hand, several large and small states ruled by princes, called the Princely States, enjoyed some form of control over their internal affairs as long as they accepted British supremacy. The British colonialism in India has introduced many modern institutions and developed for their administrative convenience; such as Modern Medicine, British Judiciary systems, Press, ect. Modern Psychiatry has developed as part of the Modern Medicine in colonial India.

Various doctrines concerning the social responsibilities of the colonial state and the nature of its obligation towards its citizens contended, and this had an immediate effect on the organization and power of lunacy provision and Western medical services. Each of the utilitarian, liberal, romantic, conservative, and evangelical ideologies had a different contribution to make in formulating colonial and medical policies.

³⁹ Thompson, Marie L, op.cit, 2007, p. 11.

The discourse of colonial and medical dominance has been very successful and enduring as we still tend to think of European medical science as having been beneficial in practice on a grand scale for European expatriates and Indians alike. In a sense, the European medicine was even a "tool of empire." Yet medicine made its most decisive and lasting contribution to the colonial cause by creating a great colonial myth that Western medicine and psychiatry were practically and clinically efficient and effective and that the benefits of European medical practice could, and did, therefore outweigh and excuse the hardships and social problems concomitant on colonial domination⁴⁰. During the East India Company trade in Bengal and other parts of India, the first medical officers in the employment of the East India Company were surgeons on board the ships. Later, with the expansion of the trading rights and establishment of various factories, one medical officer was allocated to each permanent factory. The Bengal Medical Service came into existence in 1763 when its constitution was formed. However, it was not till the middle of the eighteenth century that the British found it necessary to employ surgeons with troops as well as at their factories.

According to David Arnold (1989) the involvement of the military in the medical interventionism of the imperial period is one of its most striking and significant features. It reflected the prominence of the army in the establishment and maintenance of the imperial regimes in general, as well as the extent to which the health of the military remained one of the prime incentives behind wider medical action⁴¹. In the closing years of the nineteenth century (the period during which the asylums started to appear on the subcontinent), medicine had become a demonstration of the superior political, technical, and military power of the West, and hence a celebration of imperialism itself⁴².

Perspectives from the histories of medicine have located two significant moments of shift in the latter half of the nineteenth century. The period 1860-90 has been assessed

⁴⁰ Ernst Waltraud, 'Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', p. 172.

⁴¹ Dinesh Bhugra, Roland Littlewood (Ed) op.cit, 2001, p. 50.

⁴² Dinesh Bhugra, Roland Littlewood (Ed) op.cit, 2001, p. 52.

in terms of the manner in which colonial concerns for the health and well being of European "enclaves" (including the army) necessitated medical and sanitary initiatives beyond the enclave and had a profound impact on Indian society⁴³.

How and When Indians made available of western medicine with the establishment of the Company, the coexistence of a new medical system with multiple old systems lasted only a short time. The European doctors were often presented to the courts of the royal and princely families in India. The acceptance of Western methods of treatment in the preference to the traditional *hakims* and *vaid*s by the ruling class was bound to influence the choices was becoming increasingly limited⁴⁴.

Domination of Western Medicine India: As David Arnold remarks with reference to medicine in colonial India, "Part of the power of Western medical discourse as it emerged in the early 19th century lay in the manner in which it self-consciously conceived itself as a science, as something secular in outlook and based on close and careful observation of the body, eschewing both the ill-informed 'speculations' of the past and the rank 'superstition' attributed to Indian notions of healing and disease"⁴⁵. Although the triumph of Anglicists over Orientalists in 1835 ended the colonial patronage of Indian medicine, interest in indigenous medicine was revived in 1837 with the opening of indigenous classes at the Calcutta Medical College, and with the conversion of classes into formal schools in the 1880s.

However, this ideology of humanism and scientific care was not transplanted on Indian soil in *toto* for several reasons. There were, for instance, variations in the interpretations of ideology and in the application of the methods between parishes and between asylums in Britain itself owing to the ambiguity with which the ideology and many of these methods were conceptualized in the first place. It is not surprising; therefore, that ideology and methodology were interpreted variously when they were

⁴³ Shruti kapila, op.cit, 2002, p.12.

⁴⁴ Dinesh Bhugra, Roland Littlewood (Ed), op.cit, 2001, p.51.

⁴⁵ Monda Parthasarathi I, 'Freedom in the Imperial Imagination: Mental Asylums, Ideology, and Political Economy in Colonial India', *Sociological Bulletin*, Vol. 58, No. 2 (May - August 2009), pp.236.

being established in India. Furthermore, many of these modifications owed themselves to the 'compulsions' of colonial rule which, in turn, can be traced to the variety of doctrines which, amongst other things, deliberated on and visualized the nature of imperialism and the colonial state. 'Each of the utilitarian, liberal, romantic, conservative, and evangelical ideologies had a different contribution to make in formulating colonial and medical policies'. There were variations not only between Britain and India, but also between asylums located in the different Presidencies and provinces depending on the ideologies of colonial governance which predominated in these political entities⁴⁶.

But one wishes for more analysis of how Western medicine or psychiatry entrenched itself in Indian society. There is a tendency to explain this encroachment in terms of the "supremacy" of Western medicine over its Indian counterpart, and the use of Western medicine as a "tool" to strengthen the colonial position-without elaboration as to how this was accomplished.

Provides a useful discussion of the establishment of "colonial enclaves" where Western medical policies could be implemented to justify the monopoly of occidental medicine. The author also gives a detailed account of public health facilities and the Indian Medical Services as offshoots of colonial policies. First, Western medicine never achieved its desired monopoly, because it was forced to compete with a number of different medical professions in India's pluralistic society. Second, Western medicine was enriched by the appropriation of and accommodation to indigenous forms of medical practice; at the same time, it distanced itself from these other forms, becoming an "oligopoly." In any case, to construe the history of medicine in colonial India as a history of subjugation seems a less than heuristic construction.

As David Arnold has shown for British India as a whole, vaccination campaigns were one of the few areas where the colonial state did mobilize its resources to further Western biomedical practices outside the 'colonial enclaves' of the army, the prisons,

⁴⁶ Mondal Parthasarathi, op.cit, 2009, p.236.

and the European population⁴⁷. (P.407). Foucaultian accounts of psychiatry as a discourse of control and hegemony merged during the 1980s with the portrayal of medicine and psychiatry in south Asia in terms of its colonial provenance, as ‘colonial medicine’ and ‘tools of empire’, as suggested in David Arnold’s influential *Colonizing the Body*⁴⁸.

As Arnold (1989) goes on to emphasize Medicine had to reflect the imperial determination in order to organize the environments of the ruled, and had to fashion indigenous societies and economies in the light of its own precepts and priorities. The regime believed that all health problems could be solved by using scientific methods and resolutions to overcome any local opposition and dissent and the beliefs of the individual and the rationality of the indigenous medicine were simple obstacles to be conquered. Medical intervention, therefore, was allowed to assume ‘an unprecedented right’ over the health and bodies (and minds) of its colonized subjects⁴⁹.

Madness in Pre-Colonial India

Prior to colonial imperialism of India, the confinement of the mentally ill was not commonly practiced in Indian society. The history of mental illness their institutional systems in pre-colonial here lie some of the most profound forms of human suffering – sadness, isolation, alienation, misery and the death of reason and of consciousness. In every society they have their own forms of their institutional practices to take care of these unwanted citizens of the world. In pre-colonial Indian context it was believed that such persons were possessed with the evil spirits. Conceptualization of madness was missing before British, because details on medical or psychological treatment are not available much. Systematic developments of the field has started with the

⁴⁷Jonathan Saha, “Madness and the Making of a Colonial Order in Burma”, *Modern Asian Studies*, Volume 47, Issue 02, March 2013, pp. 407.

⁴⁸ Waltraud Ernst, “Crossing the Boundaries of ‘Colonial Psychiatry’, Reflections on the Development of Psychiatry in British India, c. 1870–1940”, Published online: 31 August 2011, *Cult Med Psychiatry* (2011) 35: p. 537.

⁴⁹ Dinesh Bhugra, Roland Littlewood (Ed) op.cit, 2001, p. 52.

establishments of the colonial lunatic asylums there were the major source of information to know about the evolution the discipline of psychiatry in India.

Little has been written about this pre-asylum era, the medical compendia of ancient India are replete with references to mental health covering a spectrum of diagnoses, classification and treatment methods. A description of insanity – *unmada* (oonma-tha) – dating back to 1500 BC exists in the *Atharva Veda*, the most ancient authentic Indian medical scripture. Descriptions of conditions similar to schizophrenia and bipolar disorder appear in the Vedic texts; these texts differentiated doctors practising magical medicine from scientific physicians and surgeons, who lived and practised in cottages surrounded by medicinal plants. An ancient textbook of Ayurvedic medicine, *Therapeutics and Surgical Practice* by Charaka and Susrutha, has a vivid description of schizophrenia. It states clearly that only an expert in the field of mental health should treat people with this illness. Other traditional medical systems, such as *Siddha*, which recognises various types of mental disorder, flourished in southern India. The great epics such as the *Ramayana* and the *Mahabharata* made several references to disordered states of mind and means of coping with them. The *Bhagavad Gita* is a classical example of crisis intervention psychotherapy⁵⁰.

India has developed an endogenous, alternative body of knowledge which is more suited to Indian conditions. The ancient Indian thought emphasized the theory of unity of body and soul and also explained how to deal with health and mental health problems in a psychosomatic way. A concern with mental health has long been a part of Indian culture, which has evolved in a variety of ways, attempting to understand and negotiate psychological disorder⁵¹.

India knew traditional ways of healing and dealing with madness. Prior to British occupation of India, the confinement of the mentally ill was not commonly practiced

⁵⁰Thara R, Padmavati R and Srinivasan T N, “Focus on Psychiatry in India”, *The British Journal of Psychiatry*, (2004)184: 366-373.

⁵¹ Nizamie S. Haque and Nishant Goyal, op.cit, 2013.

in Indian culture⁵². The tradition of wandering, including vagrancy was a recognized aspect of an ascetic lifestyle in colonial India. The Indian in his ignorance does not know that insanity is a disease, a curable disease, and a preventable disease. It goes on from one generation to the next in the firm belief that insanity is due to possession by a benign or a malignant spirit, and, as such, that is neither preventable nor amenable to any treatment except exorcism⁵³.

It is necessary to give brief introduction to the history of mental illness and its treatment practices prior to colonial period. As we know that every country has their own forms of psychiatric delivery systems like the way Indians too have a variety of its treated practices. Before the arrival of the British there were no particular practices of institutional confinement to keep the mentally disordered persons, but there were indigenous systems of treatments available for the mad peoples. There were some psychiatric practitioners and caring practices have been known in the south Asian region from antiquity, but there is little documentary proof of their existence⁵⁴. During those days, most people deemed ‘lunatics’ were cared for by family, friends, and the temple⁵⁵. During the pre-colonial period medical care in India was based on *Ayurvedic*, *Sidha* and *Unani* derivative systems, delivered by professionals trained by study and apprenticeship⁵⁶. And often the role of religious and faith healers, by and large continues in India.

A concern with mental health has long been a part of Indian culture, which has evolved in a variety of way, attempting to understand and negotiate psychological

⁵²Kymberly C. Brumlik, op.cit, 2014, p.1.

⁵³ C. J. Lodge Patch, *A Critical Review of the Punjab Mental Hospitals from 1840-1930*, Monograph No. 13, Punjab Govt. Record Office Publications, Lahore, 1931, 119. Sited from Amit Ranjan Basu, *A New Knowledge of Madness-Nineteenth Century Asylum Psychiatry in Bengal*, *Indian Journal of History of Science*, 39.3,(2004), pp, 247-277.

⁵⁴ Roy Porter and David Wright (Ed), op.cit, 2003, p.273.

⁵⁵ Francine Millard, *Lunatic Asylums of British India: A National Library of Scotland Collection*, Through Internet, p.1.

⁵⁶ Roy Porter and David Wright (Ed), op.cit, 2003, p.273.

disorder⁵⁷. Wild disturbances of mood, speech, and behaviour were generally imputed to supernatural powers. Hinduism has a special demon, *Grahi* ('she who seizes'), who is held responsible for epileptic convulsions, while in India a dog-demon is also accused of seizing the sufferer. (Canine traits and madness have often been linked, as in the widespread belief in werewolves lycanthropy, or 'wolf-madness' in which the madman prowls about graves and bays at the moon, or, in the use of the term 'the black dog' for depression.)⁵⁸.

In the Hindu tradition, insanity was treated through Vedic prayer and Ayurvedic practices. In *Ayurvedic* practice, insanity is seen as a poisoning of the mind from following the wrong path of life. Today, *Ayurvedic* practice remains popular and the insanity treatment has remained the same. Treating insanity consists of activities that promote peaceful thinking such as yoga and a healthy diet⁵⁹. The occurrence of mental illness has been identified and very few times documented since ancient times⁶⁰. The descriptions of various mental illnesses in ancient India texts are probably the oldest such accounts. The ancient Indian scripture, *Atharva-Veda*, mentions that mental illness may result from divine curses⁶¹. A vivid description of schizophrenia is also found in *Atharva Veda*. Two well-known *Ayurvedic* manuscripts, the *Charaka Samhita* by Charaka, and *Sushuta Samhita* by Sushruta, have established the roots of modern Indian medicine. Ayurvedic texts describe various kinds of the mental illness. An interaction of personality, food, and other extraneous factors, including the position of stars, was responsible for various kinds of madness and distress. *Charaka Samhita* remains the primary exposition of *Ayurveda*, the science of life. It is the science of causes and symptoms of diseases, of their medication, and of the maintenance of health.

⁵⁷ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p.7.

⁵⁸ Roy Porter, op.cit, 2002 p.12.

⁵⁹ Kymberly C. Brumlik, op.cit, 2014, pp.1-2.

⁶⁰ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p.7.

⁶¹ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p. 8.

Ayurvedic texts describe various kinds of mental illness. An interaction of personality, food, and other extraneous factors, including the position of stars, was responsible for various kinds of madness and distress. The texts like *Charaka Samhita* remain the primary exposition of *Ayurveda*, the science of life. It is the sciences of the causes and symptoms of diseases, of their medication, and of the maintenance of health⁶².

Ayurveda has eight branches, of which *bhuta-vidya* (psychiatric knowledge) is one⁶³. *Ayurvedic* texts described evil spirits as responsible for the possession and mental disorders. These spirits would enter the body unnoticed, as an image enters a mirror. In addition to various types of management in different texts, *mantras* (religious verses), *yoga* and *mula* (roots of herbs) formed the basis of treatment. The practitioners who were proficient in *bhuta-vidya* (study of evil spirits) were called *narendra* and could counteract or destroy the evil spirits by using mantras, or trying roots to the writs⁶⁴. The great sage 'Agastya' formulated a treatise on mental diseases called as 'Agastiyar *kirigai Nool*', in which eighteen psychiatric disorders with appropriate treatment methods were described⁶⁵. *Ayurveda* has extensive literature on this subject, which has been reviewed from time to time by Dr A. Venkoba Rao and Dr O. Somasundaram⁶⁶.

Other traditional medical systems such as *Siddha*, which recognize various types of mental discords, flourished in South India⁶⁷. The *Sidha* system of medicine developed in parallel with the *Ayurvedic* system, but came into its own in the post-Vedic period. The *Sidhars* sought ways to stop degeneration through yoga and personal discipline

⁶² Bugra Dinesh, Roland Littlewood (Ed) op.cit, 2001, pp.47-48.

⁶³ ibid, p.47.

⁶⁴ ibid, p.48.

⁶⁵ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p.8.

⁶⁶ M.A.M. Khan, op.cit, 2005, p. 62.

⁶⁷ S.Haque Nizamie, Nishant Goyal, op.cit, 2010, p.8.

and searched for drugs that, unlike herbs, could be stored indefinitely without losing their potency⁶⁸.

In addition, *Natyasastra* (which deals with drama and dance) covered psychological, social, and cultural practices in different regions of the country. The basic premise here was the correlation of psychological states with clear determinants and consequences. Song dance and music played an important role in therapy. These systems are still practiced in India⁶⁹.

The early references of the establishment of the *arogyashalas* (literally places of health) could be available from *Ayurvedic* texts. In one of the ancient scriptures reference exists to the endowment for hospitals with trained physicians and the 'pious men who erect such hospitals. These texts refer to special hospitals for surgery, medical diseases and disorders of the brain⁷⁰. The asylums and mental institutions are said to have existed up to around AD 300⁷¹. In later periods, references to hospitals constructed in the tenth, twelfth, and thirteenth centuries are well known. The attitudes of the public towards the mentally ill have been described to be that of compassion and a desire to help without sense of fear, frivolity, and prejudice. In a temple in South India where patients were treated as well in the ninth century, there appears no mention of segregation of psychiatric patients⁷².

During the Muslim rule, in India, Arabic medicine took the form of the *Unani* system. Un Hammod (AD 1222) described seven varieties of mental illness and a mental hospital was said to have been established in central India between 1436 and 1439⁷³. Najabuddin Unhammad (1222 AD), an Indian physician propagated the *Unani* system of medicine as he described seven types of mental disorders; *Sauda-a-Tabee*

⁶⁸ Dinesh Bhugra, Roland Littlewood (Ed) op.cit, 2001, p.48.

⁶⁹ ibid, p.48.

⁷⁰ ibid, pp.48-49.

⁷¹ ibid, p.48.

⁷² ibid, p.49.

⁷³ ibid, p.49.

(Schizophrenia); *Muree-Sauda* (Depression); *Ishk* (Delusion of love); *Nisyan* (Organic mental disorder); *Haziyan* (Paranoid state) and *Malikholia-a-maraki* (Delirium). Psychotherapy was known as *Ilaj-I-Nafsani* in *Unani Medicine*⁷⁴. Though there is not much evidence for development of psychiatry in the Moghul period. However, earlier than this there is a reference of some asylums in the period of Mohammad Khilji (1436-1469) during the fifteenth century. There is evidence of the presence of a mental hospital at Dhar near Mandu, Madhya Pradesh where the physician was Maulana Fazlur Hakim⁷⁵.

Kakar refers to *Ayurveda* as a principal architect of the Indian view of person and body. Its interpretation of the person presumes the identity of psyche and soma, and health is seen as a state of dynamic equilibrium among factors within the person and between the person and the environment of which s/he is a part. *Ayurveda* has significant implications for the philosophy of medicine and psychology and for clinical practice, a notable one being its emphasis on physiological therapy for the psyche. Kakar's consideration of issues ranging from the meanings of bodily hygiene to human freedom suggests that various Indian views of body, cosmos, and spirituality substantiate a conception of 'mental health' broader than that of the West's more specialized psychotherapeutic. Kakar rightly emphasizes that *Ayur Vedic* medicine views the person more broadly than does Western medicine, and treats not only the physical aspects of the body but the psychological, the social, and the metaphysical dimensions as well.

Mental illness in India under the rule of East India Company

The History of Lunatic Asylums in India began with British Colonialism. Institutional provision for lunatics in Bombay is reported to date back as far as 1670, when some rooms in the Presidency Hospital were set aside for them. Provisions for the confinement of the mentally ill were first made in Calcutta some time prior to 1787. In 1794 the Madras lunatic asylum was opened for unrestrained lunatics. Earlier these

⁷⁴ S.Haque Nizamie, Nishant Goyal, op.cit, p. 8. & Parkar SR, Dawani VS, Apte JS, 'History of Psychiatry in India', *Journal of Postgrad Med*, 2001; 47:73-6.

⁷⁵ Sharma Shridar, Varma L P, op.cit, 1984, pp.295.

hospitals were meant for Europeans alone. According to a decree made by the Court of Directors of the East India Company in 1802, lunatic asylum for the reception of both criminal and freely wandering insane Indians was decided to establish in Bengal. By 1820 a number of lunatic asylums for the exclusive reception of Indians had been established. In the Bengal Presidency, such asylums were established in Culcutta, Bareilly, Benares, Dacca, Murshidabad, and Patna, and in Madras, one in the capital itself and other in Chittour, Tiruchirappalli and Masulipatanam while Bombay had only one asylum in Kolaba.

Western medicine had been transplanted in India during the British East India Company regimes. Health problems of personnel of the Company and of civil servants and military stationed in India were major concerns. Maintenance of their health at alien space was of overriding importance. But the care of British subjects who were mentally ill was of secondary importance to the colonialists' goal of maintaining optimal levels of health among its personnel. This is hardly surprising for a number of reasons. In the colonialist context, incidence and prevalence of mental illness and psychiatric disability was not taken into consideration, in part because the science of psychiatry during the eighteenth century and even later lacked a framework that allowed the conception of mental illness other than as dilapidated behaviour (insanity). More to the point, mental illness, even broadly conceived, posed levels of morbidity and disorder that were overshadowed by public, physical health especially infectious disease. However, when one looks at this general problem of possible neglect of 'mental illness' and insensitivity of human sensibilities of Indians in the colonialist context, the morbidity, mortality, and overall burden that general medical diseases imposed on a people were far greater than those devolving from conditions of psychiatric interest.

Lunatic asylums began to emerge in India towards the end of 18th century. Basu observed the journey of Lunatic asylums started way back in 1740s, when in Bombay (now Mumbai) back of a hospital was converted to a place specified for lunatics at the cost of Rupees 125 Anna and paisa 45 while these facilities started for soldiers and *sepoyees*, by 1820, colonial government has organized many asylums in each of its presidencies at Bengal, Madras, Bombay and that too for criminals and freely

wandering insane Indians and Eurasians of lower rung⁷⁶. Ernst (1997) observed that Asylum establishment intended to treat both Indian and European insanes. She noted, medical and public opinion had come to believe that madness could be cured and that confinement in an institution could not fail to be beneficial both for European and Indians. Furthermore, Europeans in India could not usually rely on any family or parochial networks, so the East India Company had to assume responsibility and increasingly make institutional provision for these employees until they could be sent back to Britain.

The British in India had by the early nineteenth century developed distaste for things Indian. They had come to view nearly any idea that originated in Europe as the ultimate yardstick against which to measure policies in the East⁷⁷. Furthermore Europeans in India could not usually rely on any family or parochial networks, so the East India Company had to assume responsibility and increasingly make institutional provision for these employees until they could be sent back home to Britain⁷⁸. English people had to adapt themselves to completely new environment and the tropical heat. All these factors contributed to their mental ill health. Some of them broke down completely and became unmanageable and dangerous to their friends and neighbours⁷⁹. Various doctrines concerning the social responsibilities of the colonial state and the nature of its obligation towards its citizens contended, and this had an immediate effect on the organization and power of lunacy provision and Western medical services. Lunatic asylums began to emerge in India towards the end of the eighteenth Century⁸⁰. Along with these reasons, it is necessary to understand the political developments in India during that time. The emergence and growth of Asylums paralleled the historical turmoil in India that was occurring with the decline of Mughal Empire, a marked resurgence of Sikh and Maratha movements, and the fight for the supremacy between the British and the French in South India. This political

⁷⁶ Basu, Amit Ranjan, 'A New Knowledge of Madness- Nineteenth Century Asylum Psychiatry in Bengal', *Indian Journal of History of Science*, 39.3 (2004) 247-277, p.249.

⁷⁷ Ernst Waltraud, op.cit, 1997, p.154.

⁷⁸ ibdi, p.153.

⁷⁹ L P Varma, op.cit, 1953, p.32.

⁸⁰ Ernst Waltraud, op.cit, 1997, p.153.

instability was linked with the psychological and social turmoil in the Indian Subcontinent⁸¹. Parallel to these situations by the end of eighteenth and the early decades of the nineteenth century, the three small institutions in the provincial capitals of Madras (Chennai), Mumbai (Bombay), and Calcutta (Kolkata) emerged and these asylums became an integral feature of key urban locations.

Why did EIC establish the Insane Hospitals in India

There is some evidence that modern medicine and hospitals were first brought to India by the Portuguese during the seventeenth century in Goa, but their impact was limited⁸². It is not known whether the Portuguese hospitals made a specific provision for the mentally ill. During the first half of this period, between 1500 and 1750, there was a growing awareness of European medicine. European practitioners were often attached to the courts of kings all over India, including the Mughal Emperor. The Portuguese established a hospital in Goa, which served the needs of their sailors and soldiers⁸³. Several other European doctors did make their mark in India. Manucci, a Venetian, became a self-proclaimed doctor, towards the end of the seventeenth century, and describes treating a few mentally ill patients with leeches, cupping and various native medicines, often with success⁸⁴. The East India Company is alleged to have obtained permission to set up a trading post in Calcutta, which proved to be the most important for its long term interests, as a favour for medical help provided by Boughton, an English physician, to ladies of the Court of Shah Shuja, the brother of the Mughal Emperor, in 1638. Almost a century later, another physician, William Hamilton, was to provide medical help to the then Emperor, and was rewarded with further concessions in Madras and Surat. Throughout the colonial period, medicine and politics would continue to be linked⁸⁵.

⁸¹ Shaw, W.S, The Alienist Department of India, *Journal of Mental Science*, LXXVIII, 1932, p. 331.

⁸² Sharma S. D, op.cit, 2005, p.25.

⁸³ Roy Porter and David Wright (Ed), op.cit, 2003, p. 274.

⁸⁴ ibid, p. 274.

⁸⁵ ibid, p. 274.

In Indian context the systematic ways of thinking about mental illness and its institutions are the products of the British rule. These related ideas took shape and developed in the western societies starting around the late eighteenth century. It was during Warren Hasting's regime in 1784 when the Pitt's India Bill was introduced and the activities of the government of the East India Company came under a Board of Control. Systematic reforms and welfare measures were undertaken during Lord Cornwallis' rule from 1786 to 1793. During this period practice of confining the lunatics has started. The Britishers first tried to concentrate their efforts in Madras, Calcutta and Bombay. Initially, these centres developed largely as British enterprises and the need to establish hospitals there became more acute, mainly to treat the Englishmen and the Indian *sepoys* employed by the British East India Company⁸⁶.

What then were British officialdom's measures towards the European mentally ill in India? In Madras, first attempts towards the clarification of authority structures in the administration of the asylum and rules about the extent to which it was subject to medical as well as government control had been made as early as 1808. Similarly, the Bombay authorities made provision for the maintenance in the asylum of both military and civil employees of the Company (and even, from 1801, for individuals unconnected with it). Rules for the internal management and public control of asylums were also drawn up in 1801. In Bengal the situation was less clear – mainly because here the only asylum for Europeans was left in private hands until almost the time of the Indian revolt of 1857. However, even in Bengal the policy of regularly shipping inmates back to Europe was implemented from 1818 onwards and some control, however restricted, was exercised over the asylum proprietors' regime of management and their admission and discharge practices. Long before, from 1788 onwards, lunatics of all sorts – albeit mostly those of purely European origin – were routinely admitted to the province's asylum and the expense for their maintenance was charged to the exchequer's accounts⁸⁷.

⁸⁶ Agarwal S. P, (Ed), op.cit, 2005, p.25.

⁸⁷ Ernst Waltraud, op.cit, 2010, p.17.

Causes for the mental illness to the Europeans in India

Some 'mysterious transformation' is said to have affected Westerners once they proceeded East of Suez. The view that experience of life in an alien Eastern country set travelers and expatriates apart from their fellow countrymen was common amongst those who reflected upon the effect on generations of Europeans of life in the Orient.

So much was the East-West encounter perceived as leaving its mark on people's personality that those who had lived in the Orient for some time were regarded as a 'distinct species'. Their peculiar views, attitudes and behaviour were both excused and explained by reference to life abroad and on return to Europe they were treated 'either with awed bewilderment or humorous ridicule'. What sparked off this 'mysterious transformation' has since the eighteenth century been subject to speculation.

However, at the beginning of the late 18th century, it was believed by the British medical experts and administrators that tropical climate was one of the major causes of mental disorders. Some assumed that it was the alien environment that was to blame, in that polite manners and sociable behaviour were 'jungled out' of those exposed to prolonged life in the tropical forests and arid plains of the Indian peninsula.

Others were inclined to see the lack of 'restraint of parents, relatives and friends' as upsetting the mental balance and emotional inhibition of a number of those young, predominantly male, *griffins*, or green newcomers who, being 'thrown together' with others of their age, became 'violent and intractable'.

A variety of explanations have been advanced for the European's alleged character change under conditions of 'heat and dust' in the Orient's plains and hills, but one has commonly been agreed upon: travellers, merchants, diplomats and soldiers from a variety of different lands were susceptible to it.

The psychological metamorphosis of the English has, nevertheless, been characterized as quite distinct from the process of cultural adaptation incurred by members of other European nations. It was the ‘insularity of the English character’ which made the English ‘persist on their customs and habits of life even in most unfavourable circumstances’.⁵ The melancholic traits to which the ‘inhabitants of England were doomed by geographic accident’ were said to have made it difficult for them to endure solitude or ‘the ordinary misfortunes of existence’— let alone unfamiliar circumstances ‘in a clime so remote from their own’. The upshot was the exacerbation of those character traits which in the British Isles were merely looked upon as signs of eccentricity or a sensitive or nervous disposition.

In India, so it has been suggested, they turned into ‘an exaggerated and vulgarised edition’, ‘modified by climatic conditions’ and more visibly and literally out-of-place because of the lack of ‘the tradition and continuity of English society’. Despite variation in emphasis, these images of what made the English in the Orient a ‘species apart’ have been reproduced time and again during the last three centuries. Such popular speculations, taken up and dwelled on by many a scholar, may contain a grain of truth.

Exposure to unfamiliar cultural conditions can have psychological consequences characterized by a variety of emotional and behavioural coping strategies, of which anxiety, anger or depression are the most common, usually followed by a tendency to either over-adapt or respond aggressively to the alien environment. It is certainly the case that British government officials and military officers in India remained in most circumstances aloof from their Indian subjects.

Most British accounts of the alleged ‘mysterious transformation’ of character during the British Raj are in fact limited to the English, ignoring the contribution of the Scottish, Irish and Welsh to British—Indian policy and social life. The possibility of highly diverse impacts of the ‘alien’ on Britons of different regional backgrounds and diverse behavioural responses to life in the East is neglected⁸⁸.

⁸⁸ *ibid*, pp.1-2.

Apart from a few authors such as the ubiquitous Kipling, most widely-read accounts of the British in India have conveyed the myth that colonial society was differentiated simply into an English ruling elite. Such oversimplification has served a still lingering imperial ideology, fixed on the idea of a homogeneous ruling class, united by a noble vision and devoted with supreme self-confidence to the colonizing duty.

Oversimplification is however not a monopoly of imperial ideology and ‘heat and dust’ fiction. A number of anti-imperialist accounts have in their turn been based on the similarly sweeping assumption that colonial society could simply be dichotomized into the white colonialist elite on the one hand and exploited ‘natives’ on the other. In fact, the European community in areas administered by the East India Company by the end of the eighteenth century consisted of people with an English, Scottish, Irish, or Welsh regional background, interspersed with people of mixed race and nationals of European countries who had been taken on in recruiting depots on the Continent, as well as a large number belonging to what could be called the poor or lower classes.

For people of such a variety of cultural and social backgrounds life in India not only had different meanings, but also affected them in many different ways. For a start the decision to sign on for a passage to India in the service of the East India Company would in the case of lower-class soldiers most typically have been induced by harsh economic necessity and the guarded hope that some of the recruiting sergeants’ promises might come true. Members of the upper or middle classes, in contrast, while not devoid of material motivation, would at least potentially have been in a position more socially advantageous to reflection on the East’s serendipitous material bounties as well as its spiritual and cultural offerings and mysteries. Lacking interest in the latter, they could indeed be free –to the extent of snobbish ennui – to engage in social activities characteristic of decadent upper-class life at home⁸⁹.

However, there is some evidence that modern medicine and hospitals were first brought to India by the Portuguese during the seventeenth century in Goa, but their impact was limited. Naturally, the early institutions for the mentally ill in the Indian subcontinent were greatly influenced by the ideas and concepts as prevalent in

⁸⁹ *ibid*, p.2

England and Europe at that time. Primarily, mental asylums were built to protect the community from the insane and not to treat them as normal individuals. Accordingly, these asylums were constructed away from towns with high enclosures, in dilapidated buildings like the barracks left by the military. Their function was more custodial and less curative. To understand the development of mental hospitals, it is relevant to relate the political developments in India during that time⁹⁰.

In the Indian context, the eighteenth century was a very unstable period in Indian history. With the decline and fall of the mighty Moghul powers in Delhi, there was a consequent rise of Marathas in most of Central and South India, and of Sikhs in the North. At the same time, there were fights for supremacy between the French and the English in south India. These events gave rise to political instability, and also contributed to psychological and social turmoil in the Indian subcontinent. It is notable that the development of lunatic asylums in Calcutta (Kolkata), Madras (Chennai) and Bombay (Mumbai) were almost parallel to the political events taking place in each region. Initially, these centres developed largely as British enterprises and the need to establish hospitals there became more acute, mainly to treat the Englishmen and the Indian sepoys employed by the British East India Company. It is worth mentioning here that there was a close relationship between political developments and the establishment of mental hospitals⁹¹.

Modern psychiatry in India also allows one to examine how the traditional conceptions and institutions involving problems of mental health have fared under this new hegemonic 'regime' of psychiatric knowledge and practice. More specifically, modern psychiatry in India allows the clarification what influence, if any, traditional Indian understandings and modes of handling emotional and behavioural problems have had in the clinical neuroscience program of psychiatry that is commonplace in Western nations and regnant in India today⁹².

⁹⁰ Agarwal, S.P. (Ed), op.cit, 2005, p. 25.

⁹¹ibid, p.25.

⁹² Horacio Fabrega Jr, *History of Mental illness in India A Cultural Psychiatry Retrospective*, New Delhi Motilal Banarsidass Publishers, 2009, p.550.

Modern ideas and practice about conditions of psychiatry has roots in colonial rule in India, historical materials provide their documentation. In Indian context the origin and the growth of the psychiatry has started with the establishment of British lunatic asylum. Shridhar Sharma and L P Varma (1984) have rightly said that “The history of modern psychiatry in the Indian sub-continent is the story of the establishment of mental hospitals in India”⁹³. But the term psychiatry acquired an official currency only towards the end of the nineteenth century in the colonial Indian context⁹⁴. This work would like to trace in the development of modern psychiatry in India by studying the Mental hospitals. Modern psychiatry in India also allows one to examine how the traditional conceptions and institutions involving problems of mental health have fared under this new hegemonic regime of psychiatric knowledge and practice⁹⁵.

In India, Western healing practices for the mentally ill was introduced by the East India Company. Psychiatry in India during most of the nineteenth century has been represented and perceived in most recent publications as essentially colonial psychiatry and as permanently and intrinsically linked with the British civilizing mission and British control over India. The early mental institutions in the Indian sub-continent were greatly influenced by the idea and concept prevalent in England and Europe during those days. Primarily the asylums were created to protect the pride and prestige of the white race in the India because some European vagrants’ created tensions to the white superiority. This approach to psychiatric care delivery system was transplanted in India from contemporary Britain. Mental hospitals were constructed in isolated areas with the aim of segregating those who, by reasons of insanity, were considered troublesome and dangerous to their neighbours. The overriding concern was to protect the citizens without regard for appropriate care and cure of the patients.

Early asylum’s proprietors were to set in train both a lucrative business and a procedure for the disposal of insane persons, which was regarded as most humane.

⁹³ Sharma Shridhar and Varma L P, op.cit, 1984, p.295.

⁹⁴ Kapila Shruti, op.cit, 2002, p.7.

⁹⁵ Fabrega Horacio, Jr, op.cit, 2009, p.550.

There two aspects of individual profit and institutional care were to characterize the affairs of the asylum during first half off the nineteenth century.

To mental hospitals are major source to study the mental illness in the colonial Indian context. Modern ideas and practice about conditions of psychiatry has roots in colonial rule in India. Historical materials provide their documentation. It we examine the contemporary Indian scene of psychiatric phenomena; we can found their roots or legacy in the British rule. The history of asylums in India provides an opportunity to study the spread of ideas about mental illness, and notions of care and responsibility for the mentally ill across cultures and time⁹⁶. This chapter is to take a comprehensive look at mental illness and it's treated institutional conditions and its developments in India. It approaches the subject from the perspectives of history and its attempt to paint a picture of the way mental Institutions have historically been understood and treated in India during the colonial rule. The Chapter talks especially in its historical discussions of the colonial period, inevitably includes the whole of Colonial India. This work intended to write story of mental illness in colonial India.

The social history of insanity is an interesting area of inquiry because of some important reasons. The legacy of colonial psychiatric practices and the policies are still visible in Indian Psychiatric institutions and their practices. Through studying this area, it would be helpful to know society's attitudes towards madness, and it offered a mirror image of itself, its norms, its values, and its fears. The study intended to see the evolution of the mental hospitals, the history of psychiatry and asylums in India provides an opportunity to study the spread of ideas about mental illness, and notions of care and responsibility across cultures and time⁹⁷.

Establishment of Lunatic Asylums (1784–1857)

Systematic reforms and welfare measures were undertaken during Lord Cornwallis' rule from 1786 to 1793. It was during his rule that reference to the first mental

⁹⁶ Roy Porter and David Wright (Ed), op.cit, 2003, p. 273.

⁹⁷ Jain S & Murthy P, 'Madmen and specialists: The clientele and the staff of the Lunatic Asylum, Bangalore', *International Review of Psychiatry*, August 2006; 18(4): 345.

hospital at Calcutta was recorded in the proceedings of the Calcutta Medical Board of 3 April 1787. It suggests that the need for a hospital was felt much earlier. The credit for the establishment of this hospital goes to Surgeon George M. Kenderline. However, this asylum could not be recognised by the Medical Board as he had been dismissed from service for neglect of duty in 1777. Later, a private lunatic asylum was constructed, recognised by the Medical Board under the charge of Surgeon William Dick and rented out to the East India Company at a rent of Rs 400 per month. Almost at the same time, another lunatic asylum was opened on 17 April 1795 at Monghyr in Bihar, about 400 miles north of Calcutta. This hospital was specially meant for insane soldiers. The remnant of this building are still to be found at Shyamal Das Chakravarty Road and is known as the '*Paghla Ghar* building' (house of lunatics).

One of the earliest mental hospitals in India was set up in Bombay in 1745, and a beginning was made to construct a small lunatic asylum in Colaba in 1806.³ The city of Bombay was transferred from the Portuguese to the British in 1662 as part of the dowry given to Charles II of England when he married Catherine Braganza of Portugal. It may be added that the Britishers first tried to concentrate their efforts in Madras, Calcutta and Bombay. As mentioned earlier, the beginning to establish mental hospitals was made in Calcutta in 1787 by Surgeon G.M. Kenderline. In 1817, a Surgeon 'Breadmore' tried to improve the conditions of the hospital at another site behind the Presidency General Hospital. It appears that this hospital had between 50 and 60 European patients, with clean surroundings and a garden.

During this period, overexcited patients were treated with morphia and opium, and were given hot baths. Sometimes leeches were applied to suck their blood as it was believed the blisters were useful for chronic patients and were also helpful in controlling their periodic excitement. In 1855, in Dacca, now part of Bangladesh, another lunatic asylum was opened in Murli Bazar. Music as a form of treatment to calm down excited patients was also experimented with, for the first time during that period at the Dacca hospital. There is also some evidence on the use of cannabis to treat anxiety and stress disorders. In the state of Bihar, which was also under the British, two hospitals were opened: one in 1795 at Monghyr for insane soldiers and the other in 1821 at Lower Road, Patna. Madras was another seat of British rule.

Here, the East India Company was fighting Tipu Sultan, the ruler of Mysore. After Tipu's defeat in 1792, the British began gaining power in South India. At Kilpauk in Madras, the first mental hospital was started in 1794 for 20 patients by Surgeon Vallentine Conolly, who was the first superintendent as well as the owner of the hospital. A few years later, in 1799, the government obtained the lease of premises and another surgeon, Morris Fitzgerald, was appointed as the medical superintendent. Later, in 1807, the hospital was expanded to house 54 Europeans and 15 housekeepers under the charge of Surgeon James Dalton. Until the early part of the nineteenth century, mental asylums were located only at the major cities of that period like Madras, Bombay and Calcutta.

Growth of Mental Asylums (1858–1904)

The asylum is a disciplinary site and the psychiatric practices were disciplinary techniques, where surveillance, judgement, patriarchy and physical coercion were combined and focused on the individual to 'impose in a universal form, a morality that will prevail from within upon those who are strangers to it'⁹⁸. After 1858, there was a more systematic expansion of the British Empire when the British Monarch took control of the Indian Government from the East India Company. This also brought many changes in the administration and healthcare system, which later resulted in the establishment of more lunatic asylums during the next 20 years in the eastern part of India, which included Bengal, Bihar and Orissa. By 1874, there were at least six such asylums at Bhowanipore in Calcutta, Patna, Dacca, Berhampur, Dulanda (in Calcutta) and at Cuttack (Orissa). The year 1874 is also important in Indian history as Assam was separated from Bengal, and by 1876 a new asylum was opened at Tezpur to cater to the needs of the mental patients of Assam. In the South, in Madras Presidency, new hospitals were opened at Waltair and Trichinopally in 1871. In May 1871, a new hospital was also opened for 145 European and Indian patients in the city of Madras. In the Western part of India, in Bombay, a similar expansion was noted and by 1865 five such institutions were opened at Colaba, Poona, Dharwar, Ahmedabad and Ratnagiri. Similarly, new asylums were established

⁹⁸Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, pp.6-7.

in 1866 at Jabalpur and Ellichpur in Berar. A hospital was started at Banaras in 1854, at Agra in 1858 and later at Bareilly in 1862.² In this phase, there was a discernible growth in the number of mental asylums, located away from the major metropolitan cities in the provinces, and the local population was also permitted to avail these facilities. However, most of these asylums were set up primarily near cantonments, where the British army units were stationed⁹⁹.

Originally these are intended for the European insane and a small number of Indians of the better classes were able to enter into them. Natures of these asylums were primarily custodial in nature and mostly catered to the British and the Indian *sepoys* employed by the British. It appeared that the East India Company's administration concerned itself only with its own countrymen and their Indian employees. The large masses of the local population were mostly left unattended and uncared for. The mentally ill from the general population were taken care of by the local communities and by traditional Indian medicine doctors, qualified in *ayurveda* and *unani* medicine¹⁰⁰.

During the course of the nineteenth century, the system was gradually extended to dangerous and unruly 'natives', though British India focused initially on mentally ill European soldiers. Resulting pressure and agonised debates over the perceived need to establish different asylums for Europeans and 'natives' are known. This separation was to maintain the superiority of the white ruling race¹⁰¹. During this period, the British began to establish asylums for the mentally ill; these facilities would be categorized as either 'European' or 'Native-Only' establishments. The asylums, particularly the 'Native-Only' facilities, appear to have been established to help the mentally ill of India. The British used 'Native-Only' asylums as a place to confine Indian wanderers and vagrants¹⁰².

⁹⁹ S. P. Agarwal (Ed), op.cit, 2005, pp. 26-27.

¹⁰⁰ *ibid*, p. 26.

¹⁰¹ Shilpi Rajpal, "Colonial Psychiatry in mid-nineteenth century India: The James Clark enquiry", *South Asia Research* Vol. 35(1): 61–80, downloaded from sar.sagepub.com, on July 24, 2015, at University of Hyderabad, p.62.

¹⁰² Kymberly C. Brumlik, op.cit , 2014, p. 1

Mental Health Legislations

Prior to the Mutiny of 1857, the enactment of legislation for the management of criminal lunatics created the context for the instituting of colonial psychiatry's agendas, at least within the realm of the governmental¹⁰³. During colonial era, to create public awareness about mental patients several laws were enacted to regulate asylums, prisons and other associated matters as a whole. The history of laws relating to the mentally ill summarized as English laws applied to India during East India Company Rule. These were English Act of 1774 which were replaced by Country Asylum Act of 1808¹⁰⁴. Indian Acts have their origins in the 1845 English Acts-the Lunatics Act and the Lunatic Asylums and Pauper Lunatics Act¹⁰⁵. The most important thing was that all these initiatives were exclusively for the European soldiers. Even after their admission in a mental hospital, if they did not improve they were sent to England for further treatment and the costs were borne by the East India Company. But with the passage of time, this financial burden was called into question. In order to regulate this matter, in the year 1851 'Lunatics Removal Act' was passed. In the following years three subsequent Amendments were enacted. These were Lunacy Regulation Act of 1853, Lunatics Care and Treatment amendment Act, 1853 and Lunatic Asylums amendment Act 1853¹⁰⁶.

It can be difficult to separate the political events of 1857-1858 from contemporary social or cultural events in India. The "Mutiny" was so much more than a military rupture, invoking so many changes in sovereignty, employment, agency and the colonial encounter; it is easy to make a causal argument for any developments in India at this time as being a consequence of these uprisings. When, in 1858, the Crown took over the political administration of British India, it was also to take charge of public institutions previously established by the East India Company. The Company's legacy of jails, penitentiaries, hospitals and dispensaries (and to a lesser extent of

¹⁰³ Kapila Sruti, op.cit, 2002, p. 6.

¹⁰⁴ Agarwal, S.P. (Ed), op.cit, 2005. p. 531.

¹⁰⁵ Somasundaram, O, op.cit, 1987, p.6.

¹⁰⁶ Somasundaram O, op.cit, 1987, p.6.

orphanages, workhouses and schools) was impressive. There existed also several lunatic asylums. The intrusiveness of the colonial state can be seen in its imposition of Western science and medicine after 1858: the Crown increased its public health efforts with vaccinations and attempts to contain the late-nineteenth-century plague epidemics¹⁰⁷. We can see the 1858 Lunacy Acts as part of this trend for increased intervention, but after the initial legislation, the first generation of native asylums were essentially left alone, managed only by individual British superintendents at each site, with little knowledge of his peers in other asylums, and no real colonial agenda to impose. In fact, the new Government of India was not simply “hands-off” with its native lunacy project; it lacked any responsibility for Indian insanes and native asylums for almost a decade. Even though there was some continuity with the EIC’s social reforms from the earlier half of the nineteenth century, this delinquency of responsibility was very different from the policies the Crown had enacted as part of its imperial project to consolidate sovereignty¹⁰⁸.

The year 1858 is significant, also because the first Lunacy Act, known as Act No. 36, was enacted by the British Parliament during December of that year. The 1858 Act not only laid down guidelines for the establishment of mental asylums, but also set the procedures for admitting mental patients. Actually three Acts came together with Queen’s proclamation. First, the Lunacy (Supreme Court) Act, 1858 (Act XXXIV of 1858); second, the Lunacy (Districts Courts) Act, 1858 (Act XXXV) of 1858 and third, the Indian Lunatic Asylums Act, 1858 (Act XXXVI of 1858)¹⁰⁹. This Lunacy Act, famously known as Act No. 36 enacted during this year. According to which not only it gave guidelines for the establishment of mental asylums but also set the procedure to admit mental patients. The provinces of Bengal, Bombay and Madras each boasted an asylum for the reception of Europeans, whilst nearly every district had its own ‘native lunatic asylum’¹¹⁰. The period is important as the British, for the

¹⁰⁷ Harrison Mark, *Public Health in British India Anglo-Indian Perspective Medicine, 1859-1914*, New Delhi Cambridge Press, 1994, pp. 99-116.

¹⁰⁸ Bhattacharyya Anouska, op.cit, 2013, pp.8-9.

¹⁰⁹ Basu Amit Ranjan, , 2004, p.263.

¹¹⁰ Ernst Waltraud, op.cit, 2012, p.39.

first time, set about providing specific legislation designed to deal with cases of mental illness in the Indian population. Act XXXVI of 1858 was the first act dedicated to providing a legal framework for incarcerating those Indians considered mentally ill by the British who had not come to the attention of the authorities through criminal behaviour¹¹¹. This Act was later modified by a committee appointed in Bengal in 1888, which gave elaborate instructions and guidelines for admission and treatment of criminal lunatics. Asylums for the insane were originally built in India, as in other countries, primarily to protect the society from those who by reasons of insanity were troublesome and dangerous to their neighbours¹¹². The timing of the 1858 Act, in the first instance indicates the manner in which the management of the insane was part of the constitutive practices and administrative consolidation of the colonial state. This brings to the fore a critical departure in the genealogy of colonial psychiatry in relation to its metropolitan elaboration¹¹³. The series of legislative measures introduced after 1858 by the government to regulate the mental illness, the nature and role of the medical profession in delivering mental health care to the people in colonial India.

The British enacted in India lunacy laws similar to the English laws and tried to create asylums similar to those in England in order to ensure the same type of care to Britons serving in India. These Legislations are relating to the management and confinement of the mentally ill. These laws were designed primarily to protect the society from ‘dangerous’ lunatics, rather than for safeguarding the interests of the mentally ill, and the other major objective was to prescribe the procedure for managing the states of those found incompetent to manage their affairs due to insanity. The enactment of legislation for the management of criminal lunatics created the context for the instituting of colonial psychiatry's agendas, at least within the realm of the governmental¹¹⁴.

¹¹¹Mills James H., op.cit, 2006, p.334.

¹¹² S. P. Agarwal (Ed), op.cit, 2005, p.26.

¹¹³ Sruti Kapila, op.cit, 2002, p.10.

¹¹⁴ Kapila Sruti, Making of the Colonial Psychiatry, p. 6.

The Indian Lunatic Asylums Act, 1858 was passed which would have an impact on the Indian population in several ways. First, the act officially took control of Indian affairs from the East India Company and transferred it to the British government. It is important to note that this included the management of asylums. Clauses 4 & 5 of the act specifically address the collection of insane wanderers and vagrants, with the requirement specifying that a magistrate must deem them legally insane, which would be followed by incarceration in a Native-Only asylum¹¹⁵.

The Indian Lunatic Asylum Act was one of three acts passed by the legislative council of India in 1858 with the explicit aim of bringing the legal situation in India in line with that in England and Wales. It provided a uniform legal basis for the establishment of public lunatic asylums by the executive governments of each province and aimed at preventing one of the threats most dreaded by the Victorians: wrongful confinement. At the same time it allowed for the maintenance within public institutions of lunatics who were neglected or treated cruelly by their relatives or friends. The act's main purpose was certainly (like its English model) to facilitate the growth of publicly funded and controlled asylums in place of privately owned institutions – an important step in that it accorded well with the general tendency towards the consolidation and centralization of the colonial state. Special concessions were however made to Indian circumstances. The most important was that the erection of asylums was made optional rather than compulsory. In so doing the act reflected the authorities' general conviction that whilst intervention by the colonial state in civil affairs was seen as necessary, the high maintenance costs of public institutions were considered a drain on state revenue and the specifics and idiosyncrasies of colonial administration in the various parts of British India were expected to impede any imposition of uniform requirements. The Indian Lunatic Asylum Act also empowered the executive governments to grant licences for private asylums¹¹⁶. What in fact the Indian act provided for was the possibility of two separate types of institution: one (public) for paupers and lower-class people, and one

¹¹⁵Kymberly C. Brumlik, "Lunacy for Profit: The Economic Gains Of 'Native-Only' Lunatic Asylums In The Bengal Presidency, 1850s-1870s", *Journal of South Asian Studies*, 02 (01) 2014. 01-10, p. 3.

¹¹⁶ Ernst Waltraud, op.cit, 2010, p.32.

(private) for upper class lunatics¹¹⁷. Colonial discourses on asylums for lunatics in British India as a part of the new discipline of mental science took prominence in mid nineteenth century.

The legal provisions for criminal lunatics of the various administrations of India were also standardized in Chapter XXVII of the Criminal Procedure Code which was passed in 1861¹¹⁸. Alongside this legal framework the British expanded the institutional network in which to detain the subjects of the new legislation¹¹⁹. The authorities empowered to order the admission of lunatics are follows:

1. Officers exercising the powers of a Magistrate, in respect of wandering or dangerous lunatics, or lunatics who are neglected or maltreated (Sections 4 & 5 of Act XXXVI of 1858).
2. Judges of the principal Civil Courts of Districts, in respect of all other lunatics except the two classes hereafter mentioned (Section 8 of Act XXXVI of 1858).
3. The Local Government as regards criminal lunatics (Sections 390, 394, 396 of the Criminal Procedure Code).
4. Military Officers commanding Divisions, in respect of native non-commissioned officers and soldiers afflicted with insanity (Section 41, page 291 Bengal Military Regulations).
5. The Inspector of Jails, as regards the removal of any lunatic from one public asylum to any other within the circle of his inspection (Section 11, Act XXXVI of 1858)¹²⁰.

The Rules there are further details provided about criminal lunatics. Persons confined under the provisions of Chapter XXVII of the Criminal Procedure Code, whether unsentenced but found guilty of the act charged (Section 394) or already sentenced (Section 396) or found unsound of mind on trial by the Court of Sessions (Section

¹¹⁷ *ibid*, p. 33.

¹¹⁸ Mills James H, *op.cit* , 2006, p.334.

¹¹⁹ *ibid*, p. 334.

¹²⁰ *ibid*, p. 335.

389) or deemed of unsound mind by the Magistrate after recording the examination of the Civil Surgeon of the district or some other Medical Officer (Section 388) shall be admitted into the asylum under the order of the Local Government to which the case shall be reported through the usual channel by the Magistrate or Court of Sessions, or other officer, as the case may be (Section 390 & 394)¹²¹.

Beginning with the first set of pan-Indian lunacy legislation in 1858, this project traces the establishment of native lunatic asylums, which only tenuously responded to official rule during their first couple of decades. However, they began to lose their permeability, the fluid way in which people from all social strata could enter and influence asylum practice within, as the government embarked on numerous interventions to consolidate the asylum network, such as an asylum-wide survey in 1868; parallel movements in the rise of university education in India and the professionalization of psychiatry served to underline these government interventions by the turn of the twentieth century¹²². The 1861 Indian Penal Code, the amendments to the Lunacy Acts in the 1880s, and the administrative transference of the lunatic asylums from the judicial to the medical branch of the government¹²³.

After 1858, there was a more systematic expansion of the British Empire when the British Monarch took control of the Indian Government from the East India Company. This also brought many changes in the administration and healthcare system, which later resulted in the establishment of more lunatic asylums during the next 20 years in the eastern part of India, which included Bengal, Bihar and Orissa. By 1874, there were at least six such asylums at Bhowanipore in Calcutta, Patna, Dacca, Berhampur, Dulanda (in Calcutta) and at Cuttack (Orissa)¹²⁴. The new asylum at Lucknow, a major city and cultural centre on the plains of northern India, was part of a programme in the 1860s and 1870s that developed a coherent colony-wide approach to those the colonial authorities considered to be “insane”. This programme

¹²¹Home [Public] December 19 1868, 51A.

¹²² Anouska Bhattacharyya, *op.cit*, 2013, pp. 3-4.

¹²³ *Ibid*, p.33.

¹²⁴ Agarwal S P (Ed), *op.cit*, 2005, p.27.

benefited from new legislation, Act XXXVI of 1858, that determined the policy for both the “civil” and the criminally insane. The programme also saw the rapid expansion of the asylum network in India, as 16 of the 26 asylums that operated under the jurisdiction of the Indian Government by 1880 had their origins in the 1860s and 1870s¹²⁵. The 1858 Indian Lunacy Act was later modified by a committee appointed in Bengal in 1888 and elaborates instructions, and guidelines for admission and treatment of criminal lunatics were given. The Act of 1858 was to stay in force until the end of this period when the Indian Lunacy Act, IV of 1912, was passed. This Act was to remain the backbone of the legal apparatus for dealing with those considered ‘insane’ until 1987¹²⁶.

It seems then that after the initial period of enthusiasm for asylum expansion between 1858 and 1880 the medical authorities rarely succeeded in convincing the government those grand building projects were necessary, and even where they did there was no guarantee that these projects would be realized in any short space of time¹²⁷. Between 1858 to 1904 there was a discernible growth in the number of mental asylums, located away from the major metropolitan cities in the provinces, and the local population was also permitted to avail these facilities. However, most of these asylums were set up primarily near cantonments, where the British army units were stationed¹²⁸. The significance of the period 1858 to 1914 is lies firstly in the commitment of the British to building across India a series of hospitals dedicated to providing space and specialist treatment for those deemed mentally ill¹²⁹.

Besides these admissions from the civilian population, a considerable proportion of the patients were classified as criminal. Self-admissions all seem to have been vagrants and beggars who identified the asylums as places of refuge from their harsh

¹²⁵ Mills James H, op.cit, 2000, pp. 141-142.

¹²⁶ ibid, 2006, p. 334.

¹²⁷ ibid, 2006, p. 341.

¹²⁸ S. P. Agarwal (Ed), op.cit, 2005, p.27.

¹²⁹ Mills James H., op.cit, 2006, p.334.

life¹³⁰. The period 1858 to 1914 may have seen the asylums fill with 'ryots, servants and beggars' but after 1914 the suggestion is that more Indians were incarcerating members of their communities in the hospitals and indeed that wealthy and well-to-do Indians were making use of the facilities¹³¹. Institutional usage began to increase by all sections of the Indian society.

In course of time, this Act was modified by a committee appointed in Bengal in 1888. After modification, elaborate instructions and guidelines for the admission and treatment of criminal lunatics were given. But it is worth mentioning that by the end of the nineteenth century, overcrowding of the insane made an adverse impact on the overall living condition of the insane¹³². In such a colonial set up, during the beginning of the twentieth century when *Swadeshi* fragrance was blooming in the air, the distressed condition of these asylums drew attention of the Indian intelligentsia. They made severe protest against this malady through press which in turn reflected even in the British Parliament. However, this scenario ended in the Vice regal Lodge of Simla on Monday the 18th September 1911 with Baron Hardinge of Penshurst presiding over the Council of the Governor General of India. The Hon'ble Mr. Jenkins introduced a Bill to consolidate and amend the law relating to lunacy. The intention was to consolidate the various lunacy laws in India and to introduce certain amendments and especially to bring the law in certain important particulars in line with the modern English law i.e. the Lunacy Act 1891.

By the end of the nineteenth century there was an increase in admissions, asylums were by now overcrowded. With the increase in the number of lunatics, quality of service and living condition got worst very rapidly. During the 1890s, many proposals were put forward by local governments to close district level lunatic asylums and an integration to control cost. Prior to 1892, harmless lunatics were housed at the local jails. Later they were transferred to lunatic asylums. Long stay Patients in the Asylums was also one the reasons for the overcrowded in the asylums. This one of

¹³⁰ *ibid*, 2006, p.336.

¹³¹ *ibid*, 2006, p.341.

¹³² Trivedi J K, 'The Mental Health Legislation: An Ongoing Debate', *Indian Journal of Psychiatry*, 44 (2002), p. 95-96.

reasons that the asylum system was felt burden to government in this period. There was also little hope of these patients paying for their treatment as the asylum population until 1914 was mainly from the poorest sections of Indian society¹³³.

Review of Literature

Scholars on the British and French colonial history have in the last decade produced important works that revise our understanding of both colonialism and the social history of medicine and psychiatry. They have studied, the establishment, administration, and practice of mental health care for both European and indigenous populations in Asian and African possessions from the early nineteenth century to the period of decolonization¹³⁴.

The historians of psychiatry and the mind sciences focused almost entirely on Western Europe and North America, until the 1990s. In part this was a legacy from medical history and the historiography of science: science and medicine were by definition a Western endeavour, thus to write a history of either beyond the West was somewhat meaningless. This was certainly true for the history of psychiatry: the term 'psychiatry' was coined by a German, Johan Christian Reil, in 1808, and was representative of a scientific rationality that could not be located elsewhere.

Recent decades have witnessed a turn in both the order of questions and the methods of Indian historical research. Questions of political economy and the high politics of empire and nation have increasingly given way to a historiographical agenda that has focused away from the structures of elite politics and towards the study of those marginalized. While socio-political and economic structures have increasingly been scrutinized in the making of the "subaltern", the role of the less obvious elements (though no less ineffectual) in the effecting and preservation of structures and ideologies of power have become part of the agenda for history writing¹³⁵.

¹³³ Mills James H., op.cit, 2006, p.335.

¹³⁴ Keller Richard, op.cit, 2001, p.295.

¹³⁵ Sruti Kapila, op.cit, 2002, p.14.

One can perhaps highlight four or five major impulses for the increasing interest and changing focus in the writing of the history of colonial medicine over the past generation: the development of social history and with it the social history of medicine as an academic subject in Europe and the USA over the last few years or so; the growth of social constructionist analyses¹³⁶ in the social sciences under the influence of Michel Foucault, which have underlined the importance of medical discourses, and shown their centrality in the evolution of the modern state and its powers of surveillance; the creativity of medical anthropology and the increasing recognition of the centrality of health and disease as social metaphor and biological condition¹³⁷.

Michel Foucault a French thinker and historian done a most influential writing called *Madness and Civilization* is a significant contribution to the field of psychiatry. This work embarks upon a genealogical history of the experience of madness between the sixteenth and nineteenth centuries. It is consisting with full of ideas, were well understood and commonplace during the middle Ages and the Renaissance and far into the age of reason. He not only raised serious questions toward these kinds of histories but also opened up possibilities to a new range of studies on mental hospitals and psychiatry. Instead of carving out a 'reality' out of the past, Foucault was more interested to see how discourses in a specific context produce episteme that govern our thinking in a particular way. He generated hostility, with his study on madness from the mainstream medical historians, as he was keener to look at insanity in the age of reason, rather than a history of psychiatry.

According to him the segregation, fear and stigma was attached to the leprosy asylums in the western Europe in the high middle ages, due to the reduction of the population in this asylums this space was occupied by the another set of people such as incurables and madmen. The 'great confinement of the insane' identified as a trend

¹³⁶ Social constructionism is a theory of knowledge in sociology and communication theory that examines the development of jointly-constructed understandings of the world that form the basis for shared assumptions about reality.

¹³⁷ Shula Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', 1997 *The Society for the Social History of Medicine*, 1997, pp. 205-219.

for France and other European countries. His work seems to be compounded the idea that psychiatry was purely a Western construct. He argued that Western European culture actually lost some of its reasons or homogeneity by silencing the voices of madness in its midst. He explained how asylums and prisons became sites of disciplining and punishing of the self and for surveillance and judgement. While discussing the methods of treatment practised in the asylum, he pointed out that the underlying principle was that madness will be punished in the asylum. The primary concern of the mental hospital was to sever and to correct, therefore, according to him, therapeutics did not function in the infirmary. He similarly argued that mental illness must be understood not as a natural fact but as a cultural construct, sustained by a grid of administrative and medico-psychiatric practices. The history of madness properly written would thus be an account not of disease and its treatment but of questions of freedom and control, knowledge and power.¹³⁸

Social historians accused him of not doing justice with historical evidence and making a rather hasty generalization from the specific case of France. His perspectives appear to share the problematic tendency of stopping at the level of universal theory, so failing, deliberately, to accommodate the mundane minutiae of historical detail and evidence of diversity and heterogeneity on both sides of the bipolar divide¹³⁹. These deliberately avoided explicit critique of any lack of local focus and issues of 'subalternity'. Foucault's contentions that psychiatric power responded to a wider scientific episteme in the modern era by delineating artificial barriers between reason and madness to protect the former from the latter's incipient threats has sparked wide-ranging criticism. Some argue that Foucault ignores historical truth when he describes a "Great Confinement" beginning in the mid-seventeenth century, as only a tiny fraction of the French population ever experienced psychiatric incarceration. Others agree that Foucault plays fast and loose with the historical record, but agree with his emphasis on the social implications of psychiatric confinement and treatment.

¹³⁸ Roy Porter, op.cit, 2002, p.3.

¹³⁹ Ernst Waltraud, 2010.p. xii.

Regardless of the positions that post-Foucauldian historians have taken, however, the result is a spate of correctives that alternately test and complement Foucault's analysis through interrogations of psychiatric professionalization, the connections between psychiatry and politics, the importance of gender and race for mental health discourses, and the ways that medical technologies have combined with social policies to enhance psychiatry's coercive power in the twentieth century. But as good as many of these works are, they focus exclusively on Western developments, and present a narrative of reform, professionalization, and technological innovation relevant to Europe and America. Studies in ethnopsychiatry offset the discourse of Western psychiatry to some extent, but like their Eurocentric counterparts, they ignore the role of contact between Western and alternative psychiatric medicine. By their very nature histories of colonial psychiatry disrupt these accounts, elucidating the ways in which Western medicine's alliance to colonial authority¹⁴⁰.

Roy Porter's *Madness: A Brief History* is a brief historical survey of the madness, it is a good read, full of provocative insights; somewhat immodestly described by the author as 'brief, bold, and unbiased' account of its history. The book seeks to assess the credibility of mainstream views of the history of psychiatry as a steady march towards progress and enlightenment. Drawing upon eyewitness accounts of doctors, writers, artists, and the mad themselves, he tells the story of our changing notions of insanity and of the treatments for mental illness that have been employed from antiquity to the present day. Through conceptions of madness as an acute phase in the trial of souls, as an imbalance of "the humors," as the "divine fury" of creative genius, or as the malfunctioning of brain chemistry, he shows the many ways madness has been perceived and misperceived in every historical period. As Porter shows in his work, thinking about who qualifies as insane, what causes mental illness, and how such illness should be treated has varied wildly throughout recorded history, sometimes veering dangerously close to the arbitrariness.

He takes us on a fascinating round of treatments, ranging from exorcism and therapeutic terror-including immersion in a tub of eels-to the first asylums, shock therapy, the birth of psychoanalysis, and the current use of psychotropic drugs. Porter

¹⁴⁰ Keller Richard, op.cit, 2001, pp. 295-96.

is a laying all the salient facts and interpretations out before us in as unbiased a manner as possible a history of unsatisfactory diagnoses and treatments in the field of mental illness. Aetiology remains speculative, pathogenesis largely obscure, classifications predominantly symptomatic and hence arbitrary and possibly ephemeral; physical treatments are empirical and subject to fashion and psychotherapies still only in their infancy and doctrinaire.

Throughout, the work he offers a balanced view, showing both the humane attempts to help the mentally ill as well as the ridiculous and often cruel misunderstanding that have bedeviled our efforts to heal the mind of its myriad afflictions. Though it is a brief historical survey of the madness from ancient times to the present, but he makes no attempt to define true madness or perfect nature of mental illness. In spite of the title, this is not really a history of madness but a history of psychiatry or rather of the faltering, inconsistent, faddish and often hubristic attempts to determine who is mad, why, and what can be done about it. Moreover Historians of psychiatry find that much of the material in this work is familiar.

In Richard Keller's *Madness and Civilization: Psychiatry in British and French Empire 1800-1962*¹⁴¹, he thrusts the importance of psychiatry under colonialism. He says 'As psychiatry occupies a unique space between the social and natural sciences, the discipline constitutes a crucial locus for study of the relationship between knowledge and power in colonial domination. The asylum in any context functions as both hospital and prison, and psychiatry's medical applications, render the mental institutions the ultimate "correctional facility" under colonialism where the ruling state is in almost constant tension with the position of psychiatric knowledge became even more complex¹⁴². He also has pointed out that the European doctors monopolized the medical profession, allowing Indians to initially occupy only the most menial positions in the asylums. He further stated how asylum physicians in Britain advocated work as a means of 'moral management' of mental illness¹⁴³.

¹⁴¹ *ibid*, pp.295-326.

¹⁴² *ibid*, pp. 297.

¹⁴³ Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, Oxford University Press, New Delhi, 2015, p. 6.

Andrew T. Scull in his fascinating work on ‘*Madness in Civilization: A Cultural History of Insanity, from the Bible to Freud, from the Madhouse to Modern Medicine*’ beautifully illustrated history of the human encounter with unreason, and traced the long and complex history of madness and it attempts to treat it. Today, mental disturbance is most commonly viewed through a medical lens, but societies have also sought to make sense of it through religion or the supernatural, or by constructing psychological or social explanations in an effort to tame the demons of unreason. Beautifully illustrated throughout, the book takes readers from ancient to present, painting a vivid and often harrowing portrait of the different ways that cultures around the world have interpreted and responded to the seemingly irrational, psychotic, and insane. From the Bible to Sigmund Freud, from exorcism to mesmerism, from Bedlam to Victorian asylums, from the theory of humors to modern pharmacology, the book explores the manifestations and meanings of madness, its challenges and consequences, and our varied responses to it.

It also looks at how insanity has haunted the imaginations of artists and writers and describes the profound influence it has had on the arts, from drama, opera, and the novel to drawing, painting, and sculpture. Scull describes the different forms that madness was believed to take in these sites, as well as the causes, cures, and societal judgments imparted upon the suffering. He continually represents his disagreements with Foucault as concerning matters of fact whereas they seem to agree, substantively although certainly not entirely, on almost every point of significance. I do differ on some points. One matter of emphasis is geographic. There are some nods to China and the Arab world, mostly at the beginning, but the book is heavily devoted to countries in the North Atlantic Treaty Organization. Latin America, Russia, Africa, and Asia receive scant attention. Scull finds the amount of scholarly attention given to psychoanalysis to be curious relative to its influence. It’s hard, of course, to quantify just how much attention is warranted, but Scull’s own account gives reason to think psychoanalysis deserves plenty of attention.

David Arnold’s *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*. It focuses on the scientific dimensions of the process of European overseas colonization. He emphasizes the history of epidemic diseases,

medical intervention and the different forms of Indian responses in the nineteenth century. The major argument of Arnold is that the introduction of western medicine has created cultural hegemony in a powerful and authoritative way.¹⁴⁴ The western medicine was not only contested and resisted; it was also increasingly appropriated by Indian elites and the middle classes. He suggests that the western medicine mediated hegemonic relations between the British Raj and the Indian people, and that these relations were dialectical.

It discusses medical practice in the early days of British rule in India, is based on a detailed analysis of colonial policies, the work discuss how the monopoly of Western medicine runs through subsequent chapters. There is a tendency to explain this encroachment in terms of the "supremacy" of Western medicine over its Indian counterpart, and the use of Western medicine as a "tool" to strengthen the colonial position without elaboration as to how this was accomplished. It provides a useful discussion of the establishment of "colonial enclaves" where Western medical policies could be implemented to justify the monopoly of occidental medicine. The author also gives a detailed account of public health facilities and the Indian Medical Services as offshoots of colonial policies. He concentrates his research and writing on the impact of Western medicine. In fact, the core of this volume is devoted to case studies on British administrative and medical responses in colonial India, to three epidemic diseases smallpox, cholera, and the plague and the varying reactions of different colonized groups to these measures. It also traces early British responses to the omnipresent problem of disease in the Indian environment. As earlier studies have shown, and Arnold's research confirms, medical influence did not flow solely from the West to Asia. In fact, well into the nineteenth century, indigenous medical techniques and prescriptions were adopted, with varying degrees of reticence, by individual doctors and government administrators struggling to lower the very high mortality rates of Europeans in the subcontinent.

Arnold's nuanced discussion of the predominance of environmentalist explanations regarding the etiology of disease in India. Arnold explores in considerable depth the ways in which this cultural linkage informed the earliest, systematic efforts by the British to contain disease in specific sites, such as prisons and military garrisons. But

¹⁴⁴ David Arnold, op.cit, 1993.

he has surprisingly little to say about the important ways in which environmentalist assumptions of both the natural and cultural sort shaped town planning and European housing design, as well as arguments for racial segregation, in the late eighteenth and throughout the nineteenth century. One consequence of this often quite conscious association between Western medicine and the extension of colonial control was that Western approaches to healing and disease prevention, particularly when they were enlisted to contain epidemic diseases, became key sites of contestation between colonizers and colonized.

Many of the author's arguments do not take important facts into account. For instance, the statement that the practice of *Ayurveda* (Indian medicine) did not include dissection is contradicted by the fact that dissection and examination of the human body were essential components of Indian medical practice. Although he ably explores the class and gender ramifications of state manipulation of and Indian resistance to Western medicine, Arnold never fully integrates the relevant theories of either Michel Foucault or Antonio Gramsci into his exploration of the hegemonic uses of medicine by the colonial state

One of the important authors on public health in British India is Mark Harrison. His work on *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, explains European attitude towards India and its inhabitants, and the way they reflected in medical literature and colonial medical policy. The key dimension of preventive medicine -professional, cultural and administrative have been chosen to illustrate the range of factors affecting the development of public health in India and its broader social and political significance to the colonised society. He argues that the medicine is an instrument of 'social control' in the colonies, providing means of 'knowing' the indigenous population and also rationale for social segregation.¹⁴⁵ His argument is that the medicine was a "tool of empire", though in his narrative he finds that it was not such an important determinant for the consolidation of colonial power in India.

According to Harrison, medicine both shaped and reflected an increasingly negative view of India and its people: though there was a desire to control and contain the

¹⁴⁵ Harrison Mark, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, Cambridge University Press, New Delhi, 1994, pp.1-5.

indigenous population, it was checked by the political and economic imperatives of colonial rule. The formulation of public health policy is, perhaps, best understood as a contest between two different conceptions of empire: one is, authoritarian and paternalistic, with an emphasised on Europe's "civilising" mission in the tropics, and the other, liberal and decentralist, stressing the constraints imposed upon government action by shortages of revenue, indigenous resistance, and competing claims on the resources of local and central government. He argues that the international pressures to restrict the passage of Indian vessels through the Suez Canal exposed a cleavage between the British and Indian governments. However, the fate of indigenous medicine under colonial rule demonstrates both competition and accommodation between western and traditional systems. He also looks at people's responses to public health measures and the role of Indians in the policy making process at municipal and district levels.

Health, Medicine and Empire: Perspectives on Colonial India, edited by Biswamoy Pati and Mark Harrison, is a collection of essays related to social history of health and medicine in colonial India. Its focus ranges from analysing Europe's relationship with India's indigenous medical systems, to case studies of two mental asylums, the location of the leprosy asylum, the technological aspects and social implications of the colonial vaccination policy, and to colonial interventions related specifically to cholera and plague in the pilgrimage centres of Puri and Pandharpur. It also examines indigenous initiatives associated with the Indian drug industry and the *Unani* medical system and their interactions with the colonial health establishment and modern medicine. It explores how imperial medicine adapted to colonies for their own requirements. The authors maintain that medicine soon become the site for an ideological encounter not only in terms of a contest between 'native' and Western systems of medicine, but also at a more fundamental level. This is seen as one more instance of the 'complicity' of 'forms of knowledge' in patterns of domination. Whereas colonial supremacy ensured the ascendancy of modern medicine, the colonial state had no inclination to create a comprehensive modern public health system for the Indian people. The rising consumption of Allopathic drugs in the

nineteenth century reflected the acceptance of modern medicine among some indigenous sections.¹⁴⁶

In another volume, *Social History of Health and Medicine in Colonial India*, these editors brought together thirteen articles, somewhat furthering their earlier historiographical concerns. It analyses the diverse facets of the social history of health and medicine. A set of unique themes that capture the diversities of India, such as public health, medical institutions, mental illness and politics and economics of colonialism, based on interdisciplinary research, the authors of articles offer valuable insights that have received scholarly attention. The articles analysed two contemporary arguments, one is the colonial legacy of public health, and whether or not the British made much progress in this regard, and the second is public health measures in the light of colonial power, as a means by which the state aimed at knowing and controlling its subjects, as it was argued by Michel Foucault in a different context.¹⁴⁷

Anil Kumar's work, *Medicine and the Raj: British Medical Policy in India, 1835-1911* is a unique compendium of events that lead to the development of practice of western medicine in India. He has worked diligently to acquire the data on anecdotes, episodes and events occurring in British India, with historical accuracy to demonstrate the process of establishment of hegemony of western medicine in India. By way of analysing the nature and growth of hospital system and pharmacies in India, author demonstrates that British medical policy in India was clearly subservient to the politico-military needs of the empire and that it was another tool of economic imperialism.¹⁴⁸

The origins of the contemporary interest in Britain in the history of health and healing in colonial countries date mainly from the early 1990s when the works of Arnold

¹⁴⁶ Biswamoy Pati and Mark Harrison (ed.), *Health, Medicine and Empire: Perspectives on Colonial India*, Landon: Sangam Books, 2000. pp.1-30

¹⁴⁷ Biswamoy Pati and Mark Harrison (ed.), *The Social History of Health and Medicine in Colonial India*, Primus Books, Delhi, 2013.

¹⁴⁸ Kumar Anil, op.cit, 1998.

(state medicine and epidemics), Ernst (psychiatry), and Harrison (public health) all appeared within the short span of four years, thereby establishing the field as an independent area of investigation for historians of colonial South Asia. It is also true of course that research on the social history of mental health (either male or female, 'native' or European) in colonial India itself is still in its infancy.

The social history of insanity is a recent growth area within medical history. The development of psychiatry in British India has been examined by historians mainly in relation to the trajectory of British colonialism. The historians and social scientists showed relatively little interest in the history of psychiatry or the institutions where their patients were housed. The *History of Mental Asylums in India* provides an opportunity to study the spread of ideas about mental illness, notions of care and responsibility for the mentally ill across cultures and time. In this domain the name Waltraud Ernst a psychologist turned social historian is very important. She has been contributing several books and articles on various aspects of colonial mental health, among them the pioneering study on European insanity in colonial India is published as 'Mad tales from the Raj: Colonial Psychiatry in South Asia, 1800-1858' (2010). It is an authoritative assessment of Western psychiatry within the context of British colonialism in India. It provides a comprehensive study of official attitudes and practices in relation to both India and European patients during the East India Company rule. It is first and foremost a careful study of the treatment of the European insane in India and it also offers revealing insights into the British colonial experience more generally. The text examines the ideological and bureaucratic influences on policies towards the European insane in the three presidencies they are Madras, Bombay, and Calcutta, the structure and operation of the institutions that housed mad patients, the career patterns of the doctors who treated them, the backgrounds of the patients and the nature of their symptoms, and the theories and therapies that shaped medical practices.

The Book focused on Indian subcontinent and it concerned with Psychiatry during the East India Company rule. It deals only with asylums for the European insane in British India before 1858. She devotes much of her study to complicating the idea of a monolithic ruling race in British India. However her examinations of both European and 'native' asylums in the earlier colonial period relied a great deal upon the idea

that asylums could only ever be measures of social control, both at home and in the colonies¹⁴⁹. It paid particular attention to the theories and practices of British psychiatry in relation to Europeans in India. But Ernst's major preoccupations are the intersection of class and race in the Raj and the manner in which psychiatrists and administrators employed social discrimination to maintain white supremacy in India¹⁵⁰. It does however offer the interesting point that even when focusing on the Western population in colonial contexts the psycho-sciences acted to discipline, in this case labelling as mad those likely to tarnish the reputation of the British in order to have them removed from the colony.

As the presence of poor whites in India and other colonies became increasingly problematic over the course of the nineteenth century. *Mad Tales* is most effective at describing the ways class informed diagnoses of insanity, and the ways these diagnoses worked toward the end of preserving white prestige in India. Therefore while Ernst says little about the effects of colonial psychiatry on Indians (who, she acknowledges, constituted the majority of patients), *Mad Tales* deepens our understanding of race in the Indian colonial context by demonstrating the lengths to which Company and later Government officials went to preserve the illusion of white psychological autonomy¹⁵¹.

In this book Ernst describes many of these asylums had started off as private businesses where houses of confinement were managed for profits, often by those who had no medical background or training. Their beginnings in the private sector and their gradual transformation into and replacement by institutions managed by the colonial state mirrored the psychiatric scenario in Britain of the time, where a similar trajectory was followed by asylums. However, the better asylums (most of which happened to be in the Presidency towns) were given over to the care of the Europeans, whereas the ones which were smaller and those located in the *moffusil* were devoted largely to the native Indians. Ernst contends that racial concerns played a major role in modifying this ethos. Europeans cornered most of the medical and administrative

¹⁴⁹ Bhattacharyya Anouska, op.cit, 2013, pp.11-12.

¹⁵⁰ Keller Richard, op.cit, 2001, p. 300.

¹⁵¹ Keller Richard, op.cit, 2001, p. 301.

posts, and where European and Indian patients were interned in the same asylum, they were lodged in different quarters. The European accommodation was distinctly better.¹⁵²

The colonial lunatic asylums were used as a experimental labs for the establishment and evolution of the discipline psychiatry. They were the show cases of the colonial projection of the British rule in India. These asylums were used as detention centres than treatment institutions, through them colonialist operated discipline and punishments. Social and class prejudices had not been except of the lunatic asylums. Author tries to prove that how power was operated through the asylums in raj. In British institutions has been analyzed in relation to colonial ideology, scientific progress and of the 'superior' qualities of Western civilization.

Institutional statistics of course are never indicative of the actual incidence of 'mental illness. Not much has been said about the impact on Westerners of India as a culture. The role of inclusion and exclusion of the native medicine and its effects on the western psychiatry is not mentioned by the author. This book does avoid one important issue-the impact that the strange and stressful environment of India may have had on the emotional health of the British. Ernst acknowledges that "culture shock" may play a role in mental illness, but drops the subject with a shrug, suggesting it is too intangible to explore. By focusing exclusively on the institutional and professional side of the story, Ernst finds herself poorly placed to notice the general environment of psychic pressure that the British inhabited in India.

The result is that Ernst's works leave crucial questions unanswered. Was the British psychiatric network in India really a fait accompli by 1858? Did the shock of the Mutiny, which precipitated so many drastic shifts in colonial policy, also encourage the study of "indigenous mentalities"? How did developments like the foundation of the Indian National Congress alter colonial psychiatrists' perspective, if any? Despite the overall very high quality of her research, the fact that Ernst limits her scope to European psychopaths is regrettable. In any colonial situation, the interaction between colonizer and colonized defines the fundamental social context, and psychiatry is no

¹⁵² Mondal Parthasarathi, op.cit, 2009, pp. 234-35.

exception. But aside from a few notes about early British ethnopsychiatry, Ernst unfortunately relates little detail here. She tells us that psychiatrists thought that Europeans could never overcome the climatic difficulties of life in the Raj, and that Indians were intellectually inferior and developmentally arrested compared to Europeans. She also emphasizes the inherent contradictions in British theory about Indian psychology. According to mid-nineteenth-century psychiatric discourse, pathology marched in step with civilization, but at the same time "primitive Orientals"? who accordingly should have been protected from madness were a fundamentally insane race. But unfortunately for her readers, Ernst never addresses the ways this politically expedient discourse may have changed along with an advancing independence movement.¹⁵³

The theory and practice of the confining the mentally ill designed during the East India Company rule in India. Despite the considerable information these studies have uncovered, the existing scholarship has only scratched the surface of the rich storeis contained in the history of colonial psychiatry. These works are primarily histories of psychiatric discourse, while the social history of these institutions remains largely unexplored. Historians must problematize these issues, especially considering the importance study of the regions in recent colonial studies and works on the history of psychiatry¹⁵⁴.

Although the total number of European mentally distressed were much less than their Indian counterparts, the racial and class considerations were symbolic of the social control function of the asylums. For the Europeans, they were a symbol of control of wayward minds and, for the poorer whites and for Indians, they were a symbol of class and race controls. The intricacies of the workings of this social control and their location in the relevant ideological discourse are examined by Ernst in her article 'Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India'¹⁵⁵.

¹⁵³ Keller Richard, op.cit, pp. 302-303.

¹⁵⁴ Keller Richard, op.cit, pp. 320-321.

¹⁵⁵ Mondal Parthasarathi, op.cit, 2009, pp. 235.

In the 'Establishment of Native Lunatic asylum in early 19th Century British India'¹⁵⁶, she explains about the early methods of treatments which give importance to the diet, Proper infrastructure, adequate building facilities, tender care. However it appears that medical treatment was regarded to be minor importance to the Indian insane. Confinement of mentally ill persons she says "comes to be restricted to cases involving breaches of peace namely violent threats to the European community"¹⁵⁷.

Ernst's research was subsequently followed by James H Mills in his *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900*. Mills's work to alert us of a rich history of the native lunatic asylum in Colonial India, temporally located after European settlement in the subcontinent but before the rise of a professional psychiatry. Throughout this study there is a constant questioning of the nature of this label both in the development of nineteenth century psychiatry and medicine and in the shifting contexts of British India. Mills can also be credited as being the first to suggest that lunatic asylums in India were not as dissimilar from European asylums as the Eurocentric historiography would suggest. He examines the lunatic asylums set up by the British in nineteenth-century India. The author asserts that there was a growth in asylums following the Indian Mutiny, fuelled by the fear of itinerant and dangerous individuals, which existed primarily in the British imagination.

Once established though, these asylums, which were staffed by Indians and populated by Indians, quickly became arenas in which the designs of the British were contested and confronted. However, his predilection for seeing all diagnoses through the lens of cannabis use, while novel, did more to obscure the role played by attendants and other subsidiary staff in the asylum. At no point will this study accept the diagnosis of any of the inmates of the asylums of British India as 'insane'. This would simply be complying with the power relations of the period and colluding with the colonial

¹⁵⁶ Ernst Waltraud, op.cit, 2001, pp. 155-188.

¹⁵⁷ Wujastyk Dominick (eds), *Studies on Indian Medical History*, New Delhi, Motilal Banarasidas, , 2001, p.173.

approach of condemning or ignoring the statements and actions of those incarcerated in the asylums as unworthy of serious consideration¹⁵⁸.

He argues that power is everywhere and is behind every action; colonial power is therefore just another way to assert control over the less powerful. Further he says that colonial asylums in India were meant to control and regulate itinerant and dangerous Indians, they became in reality arenas for contestation and resistance to alien rule. For him, the asylum as a seat of colonial power was also key. "Power is everywhere," he argues, but "attaching too much significance to naming it at any one moment obscures this fact." He deftly asserted that the historical actors in Indian asylums were autonomous individuals whose actions could not be understood by historians simply in terms of prevailing structures of power, whether they were colonial, medical or otherwise. Mills does not really address the question of why so few were locked up as lunatics.

Shridhar Sharma's '*Mental Hospitals in India*' contains a thorough analysis of the historical background of psychiatric care based, until recently, mainly on institutional care in traditional mental hospitals. And it explains the recent initiatives towards integrated and community oriented care, the national mental health programme of 1982 and the mental health Act of 1987. He argues that establish mental hospital were entirely British conception and patronage of these institutions were meant for the convenience of Europeans in colonial India. And he feels that legacy is still continues. He describes the evolutions of mental hospital in six phases of development in India¹⁵⁹. His argument is that mental health services form an integral part of health and social services.

Fabrega Horacio Jr, a practicing American psychiatrist has written extensively on evolutionary psychology, the relationship between psychopathology and human evolution, and the cultural study of medicine. As part of his research interests he wrote book on '*History of Mental Illness in India. A Cultural Psychiatry Retrospective*'. This work makes reader to a serious interest on the history of

¹⁵⁸ Mills James H. op.cit, 2000, p.2.

¹⁵⁹ Shridhar Sharma, *Mental Hospitals in India*, New Delhi: Directorate General of Health Services, New Delhi, 1990., p. 68.

medicine in India and its relation to mental health care. This work is an outcome of a serious thought process on Indian psychology, indigenous Psychiatry. Though he is not a trained historian or linguist he frequently cites Sanskrit sources, such as the early *Ayurvedic* texts. He clearly admires the accomplishments of *Ayurveda*.

This book formulates and provides details about the system of healing of conditions of psychiatric interest that would have been found in ancient traditional and early modern period. It draws on the findings of Indian epidemiologists who have surveyed the prevalence and distribution of psychiatric disorders in modern and traditional settings of contemporary India. In this book Emphasis is placed on how Indian culture, religion, morality, sociology, and philosophical psychology which shape the world view and habit patterns of Indian peoples. He examines what he sees as the social evolution of Indian society, including its worldviews, beliefs, and deep history of ritualizing, in their emergent psychological manifestations. It shaped their form, content and meaning and it provided a basis for approaches to healing. Normal and not so normal conceptions about behavior and well being are discussed based on indigenous systems of meaning. The manner in which psychiatric conditions were and still are formulated in the compilations of Caraka, Susruta, Vagbhata, and Bela are reviewed and compared along with religious and spiritual viewpoints. Discussion of approach to conditions of psychiatric interest rooted in traditional Indian values provides a basis for critique and plea for broadening the scope and depth of the already vibrant and scientifically compelling psychiatry of contemporary India. The book aims to make modern psychiatry more responsive to Indian understanding of the human condition.

He is not dedicated to Freudian psychoanalytic or other popular academic psychological perspectives; indeed, he barely mentions or discusses Freud, Foucault, or Kakar. His views are primarily derived from medical sociology and his own study of Indian history. He rarely cites any secondary literature written after the mid-1990s, and it must be said that the subject of cross-cultural psychiatry has grown immensely since then, especially under the influence of A. Kleinman, G. Littlewood, and others who are rarely, if ever, mentioned here. It is therefore difficult to grasp the center of this massive work except to say that it is loaded with information that displays that India indeed has a long history of cultural psychiatry.

Sudhir Kakar is a Western-trained psychoanalyst, his curious work on '*Shamans, Mystics and Doctors: A Psychological Inquiry into India and its Healing Traditions*'. It provides rich descriptions of the work of a range of practitioners concerned with restoring psychological, moral, and spiritual well-being. His reflection on India's healing traditions from the standpoints of both Indian cultural meaning and comparative analysis using Western psychoanalytic theory. His work gives an insight into various indigenous practices popular to check the mental distress. Kakar argues that Indians have long been involved in constructing explanatory systems for psychic distress and evolving techniques for its alleviation. Kakar's primary intent in *Shaman, Mystics, and Doctors* is appropriately described in his subtitle as a psychological inquiry into India and its healing traditions. The book divides into three sections, they are, First section- is about 'local and folk traditions', Second section is about 'mystical traditions', and Third section is about 'medical traditions'. The focus of Kakar's work, however, is not a study of national character but a study of the manner in which a variety of indigenous healers, healing traditions, and health theories have served to treat characteristic mental illnesses found in northern India. A second objective of the book is a comparative study of 'the form and content of indigenous healing networks with Western assumptions and practices'. He assumes that Indian sacred practices are psychotherapies, and his own expertise with Western psychology appears to rely heavily on psychoanalysis. His another goal is that, one that helps to maintain the delicate balance necessary to compare the two therapeutic modes. Kakar states explicitly that he wishes to understand Indian psychologies on their own ground. In addition, he is conscious of the duality of his own background, his Indian upbringing and his Western training. He considers his work as psychoanalysis of the indigenous psychiatric practices.

His enquiry progress through occultism, faith-healing towards the *Ayurvedic* practices. He addresses *Ayurveda*, India's traditional system of medicine, whose foundations are at once scientific and spiritual. Kakar refers to *Ayurveda* as a principal architect of the Indian view of person and body. Its interpretation of the person presumes the identity of psyche and soma, and health is seen as a state of dynamic equilibrium among factors within the person and between the person and the environment of which she/he is a part. *Ayurveda* has significant implications for the philosophy of medicine and psychology and for clinical practice, a notable one being

its emphasis on physiological therapy for the psyche. Kakar's consideration of issues ranging from the meanings of bodily hygiene to human freedom suggests that various Indian views of body, cosmos, and spirituality substantiate a conception of 'mental health' broader than that of the the West's more specialized psychotherapeutic.

Debjani Das's, *Houses of Madness: Insanity and Asylums of Bengal in Nineteenth-century India*. This is a study on 'insanity and asylums in nineteenth-century Bengal', it takes about four themes. These are 'madness and madhouses of the lower provinces of Bengal'; 'treatment of the insane: conflict between theory and practice'; 'women in the lunatic asylums of Bengal' and 'the role of asylum staff in the treatment of insanity'. It explores these institutions through several phases of their development, which not only involved changes in medical treatment and its interpretation of the mentally challenged, but also in the social composition of and the spatial distribution within mental institutions. By also locating the asylums both socially and geographically, it explains how mental illness was defined within these confines.

In the introduction, the author has claimed that this work 'suggests an alternative way of looking at mental illness and its treatment in asylums', because 'it shows how every aspect of treatment at the asylums was determined by the changing definitions of insanity, and both these aspects were directly associated with the construction and architecture of asylum buildings'. In the chapter 'madness and madhouses of the lower provinces of Bengal', presents detailed discussions on asylums, ranging from European to various 'native' ones, including their building plans, modes of confinement, pays etc.

The chapter on treatment also provides narratives of various methods used and discussions on their efficacy by the doctors. She explains the evolution from the use of mechanical restraints to moral therapy. As she also observed, 'over time, the combination of moral and medical treatment helped the definition of insanity to take shape' and 'insanity began to be known as a medically curable mental disease. This established the supremacy of medical therapy over the moral therapy'. Through a narration of the inmates' daily life inside the asylums of colonial Bengal, she examines the issues of inmate labour in asylums and how male and female insanity were defined differently.

The study on women in the asylums is also full of details with activities, tables and case studies. Though these case studies are only briefly described, yet they reveal the way of looking at gendered illness. The difference with the European situation is also highlighted. The chapter on asylum staff talks about difficulties in recruitment, pay revision issues, training and their performance. This area is described with detail for the first time and the reader gets an idea of how hard the basic asylum staff worked without adequate compensation, however details about native doctors are scanty.

The conclusion is very short and does not provide any clues about the scope for further research and what critical questions evolved from the study. The author notes that, 'asylums and life within those institutions in the twenty-first century, hence is a continuation of how it existed in the nineteenth century and continued to be so even in the twentieth century', and besides giving new names 'nothing much changed beyond this. The book fails to give us a critical view of the knowledge received by the Indians and completely ignores the issue of language. How did colonial practitioners 'know' about their 'native' and non-English-speaking patients? What method of interpretation did they apply to decipher the symptoms expressed verbally? The book sees the colonial intervention in the negative and does not notice the hybrid practices developing from the impact of these interventions and the productive dialogue generated between the two. However, the book has rich details of nineteenth-century asylums in Bengal. Particularly the case studies on women inmates, however short, give an idea of their existential situation, provoking future scholars for further exploration.

O. Somasundaram, *The Government mental hospital, Kilpauk, Madras: Memoirs of the fifties*, is a edited volume. The first edition of 2004 had nearly 80 pages, dealing with the developments during 1950s. In the second edition of 2008, 50 more pages are added as part-II, dealing with various developments from 1957–2007. The author chosen to write about this book is because of a few reasons. Significantly, the hospital is one of the largest in south India, more than 200-years old. It is a recall of the history of this hospital reflects the evolution in the management of mental diseases in South India during the last two centuries. It deals with the early private psychiatric care in Madras Presidency which started from 1794 itself under Surgeon Valentine Connolly

for the European Insane and Eurasians. Private psychiatric practices and madhouses were prevalent in the Presidencies for the care of Europeans, where as native lunatics had tiny accessibility. It also contains with lot of historical information, covering various aspects of an Indian mental hospital from the perspective of its evolution, development, and administration. In a way this books serves as a documentation of the Madras Mental hospital, It through lots of information regarding the how the asylum functioned during the colonial times. But the content of the chapters is insufficient and lacking to provide source, from where they got the information.

The historiography of medicine and public health in India has shown that the origins of Western medicine. It is primarily examined in the context of British colonialism and the role of independent international agencies in setting up of modern health care system. The historiography on medicine and public health under colonial rule has shown how the political, economic, social and ideological considerations have superseded purely medical concerns. Later the historiography on the history of medicine however moved away from such initial concerns and concentrated on the study of disease and medicine as a site of contact, conflict and possible eventual convergence between western rulers and indigenous peoples.

The core argument of this historiography on medicine and public health under colonial rule has been that the colonial medical and public health policies are introduced for the sole benefit of European civilians and the military needs, and not for the benefit of Indians. Though it appears to be true in the eighteenth and the early nineteenth centuries, the colonial administrations gradual shift in extending the medical facilities to the Indian public, for instance, the vaccination, the hospitals and dispensaries has brought about a change in its policy in the early twentieth century. The colonial intervention in public health controlled or reduced the mortality rate of Indians from various diseases. Another argument of the medical historians has been that all the institutions, including education, particularly the medical education were introduced for the colonial commercial and administrative needs and does not give adequate attention to the public health. In the twentieth century there appears to be a marked shift in the preparation of their responsibility or duty to provide medical and health facilities to the whole country.

The histories of colonial medicine, health and disease with environmental, ecological and local themes have attracted the attention of scholars working on nineteenth and twentieth century colonial India. The responses to epidemic diseases both within the colonial administration and among different sections of the indigenous population have been studied by the social historians of modern India.¹⁶⁰

Scholars in British and French colonial history have in the last decade produced important works that revise our understanding of both colonialism and the social history of medicine through their interrogations of colonial psychiatry that is, the establishment, administration, and practice of mental health care for both European and indigenous populations in Asian and African possessions from the early nineteenth century to decolonization¹⁶¹.

The historians of psychiatry and the mind sciences focused almost entirely on Western Europe and North America, until the 1990s. In part this was a legacy from medical history and the historiography of science: science and medicine were by definition a Western endeavour, thus to write a history of either beyond the West was somewhat meaningless. This was certainly true for the history of psychiatry.

The writing of a history on the discipline of colonial psychiatry is derived from recent shifts in emphasis in the historiography of colonialism in nineteenth and twentieth-century India. This is largely because of the paucity of an extensive corpus of historiography on questions of the constitution of insanity and its related institutional and discursive elaboration within the colonial Indian context¹⁶².

Identified gaps in Review and Problem of the Study

The reviews on the existing scholarship on colonial psychiatry have the capacity to engage with distinct historiographies. This research decanters the history of Western

¹⁶⁰ Pati Biswamoy and Harrison Mark (ed.), *Health, Medicine and Empire: Prospective on Colonial India*, Orient Longman, Hyderabad, 2000, p.1.

¹⁶¹ Keller Richard, op.cit, 2001, p. 295.

¹⁶² Sruti Kapila, 2002, pp.13-14.

psychiatry, a field that has grown substantially publication of Foucault's *Madness and Civilization*. Scholars have grappled with this dimension of medical history by examining social, political, technological, and professional aspects of psychiatry since the early modern era, encouraging a polemical debate over questions of progress, power, and professional interest. Foucault's contentions that psychiatric power responded to a wider scientific episteme in the modern era by delineating artificial barriers between reason and madness to protect the former from the latter's incipient threats has sparked wide-ranging criticism. Some argue that Foucault ignores historical truth when he describes a "Great Confinement" beginning in the mid-seventeenth century, as only a tiny fraction of the French population ever experienced psychiatric incarceration. Others agree that Foucault plays fast and loose with the historical record, but agree with his emphasis on the social implications of psychiatric confinement and treatment. It is true that much of the scholarship influenced by the Foucault's work in the context of India also.

Foucaultian accounts of psychiatry as a discourse of control and hegemony merged during the 1980s with the portrayal of medicine and psychiatry in south Asia in terms of its colonial provenance, as 'colonial medicine' and 'tools of empire', as suggested in David Arnold's influential *Colonizing the Body*. Subsequently followed by Ernst seminal writing on mental health has been contributing several books and articles on various aspects of colonial mental health and institutions, among them 'Mad tales from the Raj'. It is an authoritative assessment of Western psychiatry within the context of British colonialism in India in the nineteenth century. It deals only with asylums for the European insane in British India before 1858. The text examines the development of psychiatry, ideological and bureaucratic influences on policies towards the European insane in the three presidencies they are Madras, Bombay, and Calcutta. The role of inclusion and exclusion of the native medicine and its effects on the western psychiatry is not mentioned. The result is that Ernst's works leave crucial questions unanswered. This precipitated so many drastic shifts in colonial policy; also encourage the study of indigenous mentalities. Despite the overall very high quality of her research, the fact that Ernst limits her scope to European psychopaths, this lead to me to think about that, how the natives insane treated in the asylums of Madras presidency. These works are primarily histories of psychiatric discourse, while the

social history of these institutions remains largely unexplored. And Ernst also written about Madras asylum¹⁶³ but it remains its story till nineteenth century.

Ernst's research was subsequently followed by James H Mill's¹⁶⁴ work to alert us of a rich history of the native lunatic asylum in Colonial India. He examines the lunatic asylums set up by the British in nineteenth-century India. However, his predilection for seeing all diagnoses through the lens of cannabis use in the asylum. At no point will this study accept the diagnosis of any of the inmates of the asylums of British India as insane. He argues that colonial asylums in India were meant to control and regulate itinerant and dangerous Indians, they became in reality arenas for contestation and resistance to alien rule. However, Mills does not really address the question of why so few were locked up as lunatics.

Debjani Dass, study on insanity and asylums in nineteenth-century Bengal, explores these institutions through several phases of their development, which not only involved changes in medical treatment and its interpretation of the mentally challenged, but also in the social composition of and the spatial distribution within mental institutions.¹⁶⁵ However, details about native doctors are scanty. The author notes that, 'asylums and life within those institutions in the twenty-first century, hence is a continuation of how it existed in the nineteenth century and continued to be so even in the twentieth century', and besides giving new names 'nothing much changed beyond this. This would prove research future to investigate/ exploration what happened in and around the asylums of Madras Presidency.

The historians of psychiatry and the mind sciences focused mostly on nineteenth century in India. This is partly due to the fact that historians of psychiatry more generally have begun only very recently to shift their focus from the nineteenth to the twentieth century, This is partly due to the fact that historians of psychiatry more generally have begun only very recently to shift their focus from the nineteenth to the twentieth century, with "no narrative in sight which can explain the psychiatry of the

¹⁶³ Ernst Waltraud, op.cit, 1998, pp. 13-30.

¹⁶⁴ Mills, James. op.cit, 2000.

¹⁶⁵ Das Debjani, op.cit, 2015.

20th century, comparable to the authoritative coherence achieved for the 19th century.” The development of psychiatry in British India has been written mainly in reference to nineteenth-century colonial culture¹⁶⁶. Further regional histories of psychiatry need to be done, that is why this study would like to focus History of Mental illness and its institution in the Madras Presidency till first half of the twentieth century. But as good as many of these works are, they focus exclusively on Western developments all over India, it is essential to explore what happened in the different regions of colonial India. Research would like to explore the Indian contribution needed to the field of psychiatry.

The aim of this work is not so much to critique existing work that focuses on the aspect of colonial hegemony as it is to suggest that other important dimensions too had a bearing on the development of psychiatry in British India. The focus on psychiatry as ‘a tool of empire’ is particularly limiting in relation to developments in the early twentieth century. I would like to portray that psychiatric practices in British rule were part of a global, scientific venture rather than deriving its impetus exclusively from the colonial metropolis and British blueprint. And the work will show that institutional psychiatric treatment was also debated and practiced in terms of a citizen’s right and hence colonial people’s entitlement to medical care. Existing scholarship on ‘colonial medicine’ has tended to focus on colonial power and hegemony and the British endeavor to ‘colonize the Indian body’ during the nineteenth century and twentieth Century. It is suggested here that reference to ‘colonial’ medicine and psychiatry tends to reify the ideology of colonialism and neglect other important dimensions such as the role of individual asylums in Madras regions and their locus of care and medicalization.

This work traces the history of psychiatry at Madras Presidency, which, at the micro level, is a mirror to the understanding of the historical trends of psychiatric services in Colonial India. The nature of Psychiatric services as part of colonial administration and their evolution in British India has needed to an extensive enquiry. Specific institutional histories have been fewer. Work will try and trace the early history of the Lunatic Asylums in Madras Presidency. They are Chennai, Vizagapatam and Calicut

¹⁶⁶ Ernst Waltraud, op.cit, 2012, pp. 62-63.

mental hospitals. And also Present work would like to trace the changes in administrative control of the Asylum, the changes in medical practice and some aspects of the social history of the region.

Research Objectives

The present study is proposed to undertake the following objectives:

1. To study how colonial state deal with the problem of mental illness and its intentions behind the care-cure-misuse. Especially, to find out the deeper answers to basic questions such, what role did psychiatry play in the colonial settings? What impacts did the colonial establishment of asylums have on Indian society?
2. To draw the Institutional histories of the three Mental Hospitals in the Madras Presidency and their trajectory of development from 1870 to 1946.
3. And another objective is to document the social history of mental illness, it focus on social lives of inmates and professional practices of staff in the mental hospitals. And it mainly analyse the dynamics of Caste, Region, Religion, Gender and Race through the lens of Social History of Mental Illness and medical practices in Indian perspective.
4. To study Treatment practiced in colonial mental asylums and it explores how natives were treated and it also amylase the theories and Practices of treatments, and describes the evolution, formation and psychiatric practice in the colonial Madras Presidency.

The objective of our historical enquiry is to provide an account of the progress and development of colonial mental science, which has played an important role in the formation and practice of psychiatry and medical care in colonial India. Thus, the history of mental illness constitutes an integral part of the history of Psychiatry, giving an account of Colonial government and the specialists' efforts to deal with Insanity and therapy in specific historical settings. The objective of the study is to provide

contextual analysis of history of mental illness in the Madras Presidency from second half of the nineteenth century to the first half of twentieth century. The questions addresses are:

Research Questions

This thesis primarily tries to understand the motives, nature and outcomes of the colonial policies pertaining to the Mental illness in the colonial Madras Presidency. Particularly (a) how did the British government responded to the malady of mental illness and what were the practices and developments that took place under the colonial rule? (b) What the social background of the mentally disordered people and what their social conditioned effected their lives and What the state had reacted to the different social conditions of the patients? (c) What therapies were introduced to resolve the problem of mental illness in the Madras Presidency?

Significance of the Study

There are about forty-five mental hospitals which were established during the British rule, still they are continuing in treating the mentally sick. These mental asylums were necessarily perceived as an institutional response to individuals with the bondage of mental distress. And there is also as central a part of its ethos as the very obvious element of social control. Therefore, despite all the developments in modern psychiatry and community care, this legacy lingers on and the state and professionals in post-independent India continue to repose their faith in what are now mental hospitals. The decay and neglect in these institutions do not diminish their importance. Modern and Scientific treatment of mental illness have been started in India during the colonial rule, its legacy of shades both good and bad have been continuing in various ways, work would like explore the prevailing situations in the colonial Madras Presidency region.

Basically, this work examines the history mental illness and its Institutions in the Madras Presidency in Colonial India. To know much about the Insanity and its institutions, scholars has to depend on archival data which consisting of Medical history documents of British India especially official asylum records and other mental health collections. They highlight the colonial context of psychiatry in British India

and colonial ideas about the Malady and the therapies. The present would like to have a detailed document about mental illness and mental asylums in colonial Madras Presidency. It attempts to understand the way mental disorders have historically been understood and treated in this region. The major intentions of the present study have been to understand nature of the fascinating history of Mental illness and its Hospitals their prevailing conditions, and developments as part of the formation, and practice of psychiatry from the Indian's perspectives. The present work also explores that, how the natives were treated and understood these institutions. It also traces the policy initiatives and the acts during the colonial time in India. And also the study explores the histories Madras Presidency asylums and their conditions, developments in various aspects. By studying these institutional conditions, the study would like document the social history of mental illness within and around mental asylums. The work explores these institutions through several phases of their development, which not only involved changes in medical treatment and its interpretation of the mentally challenged, but also in the social composition of and the spatial distribution within mental institutions.

By also locating the asylums both socially and geographically, it explains how mental illness was interpreted within these confines. Through a narration of the social history of mental illness inside the asylums of the Presidency, the work would address critical issues such as colonial state perspectives on mental illness and the asylums of this region. It will be focused on how native insane were treated in these institutions and also how female insanity were defined and treated. Every part of the world contributed to the development of the discipline of psychiatry, such a way work would like study whether was the regions of Madras Presidency contributed or borrowed something from the other regions of the world. Which was increasingly dominated the colonial asylum system. Such a way it assumes that Madras Presidency might have contributed its share to the field; if so how far it is happened need to be tested/examined by the present study. The thesis traces the trajectory of treating psychiatry in a colonial context, the changing nature and contents of the emergent regime of the mental science is mapped. By exploring its specific institutional context in Madras Presidency, disciplinary practices, and discursive elaboration of the discipline, the thesis contextualizes colonial psychiatry. In doing so, the tension and interplay between concepts of universal science and its form in different historical

contexts are examined. This work also observes the formation and practice of the discipline of psychiatry in the colonial context.

The present research work broadly covers the period from the 1870 to 1946, the reasons are follows, the year 1870 three lunatic asylums were formally started their services in the colonial Madras Presidency. That is why work has started with the establishment of the three lunatic asylums in Madras Presidency. And work would like to keep its edge point, just before the Indian independence, the health survey and development committee (1946), under the chairmanship of Colonel M. Taylor, surveyed mental hospitals. It is popularly called as “Bhore Committee¹⁶⁷”; this documented existing bad conditions of mental hospitals in all over India, and made recommendations for clinical practices, research, and training. As part of that committee visited Madras asylum only but they did not see and evaluate other two asylum of the Presidency i.e., are Calicut and Visakhapatnam mental asylums. That is why this work would like cover up to 1946. Further, my project takes up the issue of the doctor and patient populations, and the kinds of ideology brought into the asylum by the surrounding community¹⁶⁸.

The psychiatry as ‘a tool of empire’ is particularly limiting our understanding of the developments in the early twentieth century. The work will argue that psychological medicine in British India was part of a global, scientific venture rather than deriving its impetus exclusively from the colonial metropolis and British blueprint. Therefore, we should understand the history of the Mental hospitals not only for the colonial intentions of social control, but the ideas of liberal welfarism shaped the colonial policies pertaining to the Mental hospitals. However, the state’s indifference in allocation of sufficient funds and providing of facilities, led its failure in sufficiently address the lunatic patients. This colonial trajectory was well unveiled when the lunatic asylums were converted into the hospitals as the latter institutions also did not get sufficient funds and medical facilities.

¹⁶⁷ Report of the Health Survey and Development Committee, Volume-III, Government of India Press, Simla, 1946. Col. M. Taylor, the Superintendent of European Mental Hospital at Ranchi as a member of Health Survey and Development Committee, popularly known in India as "Bhore Committee" was asked to survey mental hospitals.

¹⁶⁸ Bhattacharyya Anouska, op.cit, 2013, pp.13-14.

Research Methodology and Period of the Study

To study the mental illness in colonial times in India, it is inevitable to study the lunatic asylums. These asylums have provided the greatest historical record with which to trace the treatment of insanity. However, inherent to conventional histories of the asylum is the notion that psychiatry was the only paradigm practiced inside. Information about patient's illness is available in a range of sources which include case registers, annual reports, official files, journal articles, and monographs written by the superintendents of the mental hospitals. To access the voices of so many non-elite actors, we have to read against the dominant voice of asylum records and official reports. Local and non-imperial voices may also be accessed through the vernacular press, personal correspondence, biographies and memoirs. Reading the asylum reports in parallel with mid-century political documentation, judicial proceedings, and micro histories of a variety of institutions allows us to connect the historiographical traditions detailed earlier to reveal a richer understanding of the colonial asylums in Madras Presidency and British India in the second half of the nineteenth and the first half of the twentieth century. The evidence is derived mainly from colonial government reports, British medical journals, personal correspondence and the institutional records pertaining to the Mental Hospitals in Madras Presidency. The methodology applied to the research is historical in nature, with a strong emphasis on the primary and secondary sources available to date in the field of Colonial Psychiatry. The study is primarily based on colonial archival sources and printed materials in Telugu and English related to the Madras Presidency. While the colonial archival sources are used to show the British policies and their impact on Mental Hospitals and Psychiatric practices, the native language Telugu materials are used to show the public perception of the colonial policies and social intervention. Present work interrogated these sources in a comparative perspective.

The present research work broadly covers the period from the 1870 to 1946, the reasons are follows, from the year 1870 three lunatic asylums were formally started their services in the colonial Madras Presidency. That is why work has started with the establishment of the three lunatic asylums in Madras Presidency. And work would like to keep its edge point, just before the Indian independence, the health survey and development committee (1946), under the chairmanship of Colonel M. Taylor,

surveyed mental hospitals. It is popularly called as “Bhore Committee”; this documented existing bad conditions of mental hospitals in all over India, and made recommendations for clinical practices, research, and training. As part of that committee visited Madras asylum only but they did not see and evaluate other two asylum of the Presidency i.e., are Calicut and Visakhapatnam mental asylums. That is why work would like cover up to 1946.

Chapterization

Based on the available data the work is subsequently classified into five chapters based on the use of primary and secondary sources. To know about the Mental illness in the region of Madras Presidency it is inevitable to study the Psychiatric intuitions, because the existing three mental asylums held responsible for the remedy for the mentally sick inmates in Madras Presidency.

1. Introduction.
2. History of Mental Hospitals in the Madras Presidency.
3. Social History of Mental illness in the Madras Presidency.
4. Treatment Practices in the Madras Presidency Asylums
5. Conclusion.

In the first Introductory chapter explains, in a brief about the concept of mental illness and its trajectory madness to mental illness and evolution of psychiatry both world and Indian context. And it gave an overview about Madness in Pre-colonial time and the origin and development of psychiatry in Colonial India. It dealt with some terms related to mental health, and disease and their meanings. And in the other part the historiography of medicine-public health and Psychiatry in Colonial India explains in a detailed manner. It highlighted various historians’ arguments and multiple points of interrogation of the history of Insanity in the colonial context. It also dealt with Research Methodology and source of the study, period of study, significance of the topic, aims and objectives of research.

The second chapter focused on the institutional history of the mentally ill people established by the British in Madras Presidency. This chapter to provided an outline of the history of the three mental institutions in Madras Presidency; they are, Madras (1871), Vizagapatam (1872) and Calicut Mental hospitals (1872). It evaluated

systematic developments in the field of mental institutions in the Madras Presidency. It also explored the developments in the asylums, and explained the similarities and dissimilarities between these three asylums. There are not many studies available on the history of Mental illness in South India. Among the existed studies O Somasudndaram, Waltraud Ernst, James H Mills, and Saumitra Basu, Santosh Abhram, Bijju Gopal written about the Mental Hospitals in deterrent aspects but these studies were focused mostly on initial establishments, developments in the nineteenth century. But there are less works about both Vishakhapatnam and Calicut mental asylums. Moreover this work took Madras presidency as a geographical entity. The 'The History of Mental institutions in the Madras Presidency' is a useful addition to the field of history of psychiatry in colonial India. It explored vividly on the, political and administrative conditions and policies relating to the Unsound mind in this region in general and Institution histories of the Madras, Vizagapatam and Calicut the mental Asylums in particular. Apart from that, the work portrayed the trajectory of developments in these asylums from 1870 to 1946.

Third chapter Social history of Mental illness in Madras Presidency explains that, the Social history of Medicine and Psychiatry was a major growth in research field among scholars. Existing works on the history of mental hospitals are giving fewer details on the social history of insanity and this literature lead to inquire the social history of mental illness in the context of Madras Presidency from 1870 to 1946. This chapter exclusively focuses on Social history of Mental illness in Madras Presidency such as asylums of Madras, Calicut and Vizagapatam. It briefly discusses social lives of inmates behind the asylum walls. It mainly analyse the inmates and staff of the mental hospitals in Madras Presidency. It would focus on the internal and external histories surrounding the mental asylums of Madras Presidency. This chapter would like to offer an Analysis on the dynamics of Caste, Region, Religion, Gender and Race through the lens of Social History of Mental Illness and medical practices in Indian perspective. These lunatic asylums were extraordinarily permeable spaces and allow us to examine multiple sites, multiple brands of colonial activity, on the ground in Madras Presidency. The investigation into various issues in the asylums and its surrounding the institutional practices helps to construct the social history of Mental illness.

Fourth chapter Treatment Practices in the Madras Presidency Asylums explains that the present chapter would like focus on what happened in these mental institutions in the name of treatment. Treatment practiced in an asylum was directly connected with the understanding of Mental illness. It enquiry about the theories and Practices of treatments in this chapter, this chapter would deal about the Asylum care, the different kinds of treatment practices, and the curative perspectives (their consequences) and their consequences in the Madras Presidency. Historians of colonial medicine and psychiatry tend to focus on the European impact on the outside world and on how the colonial enterprise furthered the expansion of Western scientific knowledge. It is only recently, and largely due to the challenge of social science and literature-based theories of post-colonialism and subaltern studies, that this focus has been widened to look also at indigenous responses and resistance to Western medical and psychiatric blueprints have yet to be investigated. It addresses the question of interaction between psychiatry and indigenous healing traditions. This question is relevant to address the asylum practices in Madras Presidency, which has a rich and diverse tradition of healing. One axiom of Colonial medical discourse in 19th century British India was the presumed superiority of scientific medicine over indigenous medical systems. Scholars observed that psychiatry achieved this superiority through a negotiation between the indigenous tradition and scientific knowledge. And the last chapter Conclusion provides the summary of the study.

Chapter-2

History of Mental Hospitals in Madras Presidency

This thesis focuses on the institutional history of mental hospitals established by the British in colonial India during the 19th to 20th century. It looks at patient numbers and admission policies, the mental health care and the plurality of approaches pursued by different practitioners and asylum staff, and evidence of abuse and kindly treatment and medical regimes, management structures and patient-doctor relationships. These issues were diverse and not always fuelled by the preoccupations of colonial and medical hegemonic power alone. Particularly, this chapter focuses on the history of the mental institutions in Madras Presidency with a particular focus on Madras, Vizagapatam and Calicut Mental hospitals. There are not many studies available on the history of psychiatry in South India. Scholars such as Waltraud Ernst¹⁶⁹, O Somasundaram¹⁷⁰ and Saumitra Basu¹⁷¹, Santhosh Abraham¹⁷² have written about the Madras asylum in deterrent aspects, but these studies were focused mostly on establishments, developments in the nineteenth century and they mentioned very details about twentieth century. But there is almost no works about both Vishakhapatnam and Calicut mental asylums. Due to the paucity of studies of the institutions, it is difficult to understand the nature of colonial policies pertaining to the institutions and the mentally unsound. Therefore, this work would like to take Madras presidency as a geographical entity. It throws vivid light on the, political and administrative conditions and policies relating to the unsound mind in this region in general and institution histories of the Madras, Vizagapatam and Calicut mental asylums in particular.

¹⁶⁹ Ernst Waltraud, 'The Madras Lunatic Asylum in the Early Nineteenth Century', *Bulletin of Indian Institute of History of Medicine*, Vol-XXVIII-1998, pp. 13-30. & Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, New Delhi, Anthem Press, 2010.

¹⁷⁰ Somasundaram O, (Ed) *The Government Mental Hospital Kilpauk, Madras: Memoirs of the Fifties*, Chennai, Siva Sakhti Printers, 2008. & Somasundaram O, PonnuduraiRatnaraj. 'Kilpauk Mental Hospital: The Bethlehem of South Asia – A recall of its history prior to 1970', *Indian Journal of Psychiatry*, Volume 60 (Supplement 2), February 2018. pp. S183-S191.

¹⁷¹ Basu Saumitra, 'Madras Lunatic Asylum: A Remarkable History in British India', *Indian Journal of History of Science*, 51.3 (2016) 478-493.

¹⁷² Abraham Santhosh , 'Medicine and British Empire in South India: A Study of Psychiatry and Mental Asylums in Colonial Kerala', *Indian Journal of History of Science*, 53.1 (2018) , pp. 125-131.

Since the late eighteenth century, the East India Company (EIC), for the administrative convenience, started various modern institutions in India. Among them Press, Police, Judiciary, Medical institutions such, Hospitals, dispensaries, lunatic asylums are essential services assisted for the smooth running of their administration. Lunatic asylums began to emerge in India towards the end of the eighteenth century¹⁷³. The East India Company's doctors offered their medical services to mentally ill persons by taking the building for the lease to maintain the private lunatic asylums from the support of the company Government¹⁷⁴. Here we should note that prior to English East India Company rule in India, the institution for the 'maladies of the mind' were not present. The practice of sending Unsound Mind employees to these institutions subsequently became a norm and the arrangement was to a certain extent comparable to the then prevailing system in England. Parish officials kept the insane under the care of private mad-house owners for a stipulated rate. Just like the system in England, they were established in India also. These Institutional facilities were mostly intended for soldiers, *sepoys* and civil administration in the colony.

The composition of narratives on the establishments and evolution of institutions is not famous in our country. This work has put forth an unassuming attempt to redress this demeanor by archiving the historical backdrop of this renowned Mental hospital. The Government Mental Hospital, Madras (Chennai), presently called as "the Institute of Mental Health" (IMH), is one of the oldest and largest in our country, nay, in South Asia, rendering psychiatric care to the mentally ill in South India. Its hoary past extends beyond the year 1871 when this hospital was built at the present site and the inmates were also from the neighbouring areas¹⁷⁵ of Tamilnadu, Andhra Pradesh, Karnataka, and Odisha in the days before the state's reorganization on a linguistic basis in 1956. A recall of this Hospital history reflects the evolution, management, mental diseases and their treatments in Southern India during the past two

¹⁷³ Ernst Waltraud, 'Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India', *Comparative Studies in Society and History*, Vol, 39, No.1 (Jan, 1997), pp.153-181, p. 153.

¹⁷⁴ Ernst Waltraud, 'The Rise of the European Lunatic Asylum in Colonial India', *Bulletin of the Indian Institute of the History of Medicine*, 17 (1987), pp. 94-107, pp. 94-95.

¹⁷⁵ Somasundaram, O, op.cit, 2008, p. 17.

centuries¹⁷⁶. Apart from this there were other two Mental Health Care centre in the Madras Presidency, one was at Kozhikode in Malabar district, and on the East Coast of Andhra there was one at Waltair, in Visakhapatnam.

The main feature of the institutions was that the individuals who considered as 'Insane' or 'Lunatic' for a few causes and reasons were placed at High walls around dilapidated building like forsaken stables, barracks and prisons, these places of confinement were transformed into lunatic asylums. The Lunatic asylums, were primarily custodial in nature and mostly catered to the European and the Indian *sepoys* employed by the EIC.¹⁷⁷ The Company's administration concerned itself only with its own countrymen and their Indian staff. The large masses of the local population were mostly left unattended and uncared for.

The elaboration of colonial psychiatric agendas is personally connected to the question of the conduct of colonial hegemonic mentality. In particular, the colonial psychiatry founded its institutional position precisely in the contradictory space that was created by the liberal imperatives for "responsible" governance on the one hand and, on the other, the exercise of coercive power towards affecting a normative public order¹⁷⁸. In commensurability with other colonial spaces, for example, the local jail and native clinic, or accept that all colonial asylums started as devices of realm and of social control. Therefore, the social control and domination were apparently important elements in the colonial policies pertaining to the lunatic asylums. Confinement of Europeans, intra-European class differentiations in internship, dominance of European experts, and isolation and disregard of Indians all show up the asylum as playing out a social control job. Colonialism, in any event on account of asylums, shows up as a story of social control. Obviously, given the more noteworthy prevalence of conventional frameworks of mending of both the brain and the body and the restricted

¹⁷⁶ Somasundaram O, Ponnudurai Ratnaraj, op.cit, 2018. pp. S183-S191.

¹⁷⁷ Sharma S. D, 'Mental Health: The Pre-independence Scenario', in S. P. Agarwal (Ed), *Mental Health an Indian Perspective 1946–2003*, New Delhi, Directorate General of Health Services Ministry of Health and Family Welfare, 2005, p. 26.

¹⁷⁸ Kapila Sruti, *Making of the Colonial Psychiatry in the Bombay Presidency, 1849-1940*, Dissertation submitted in partial fulfillment for the degree of Doctor of Philosophy, School of Oriental and African Studies, University of London, 2002, pp. 8-9.

reach of western clinical and mental asylums, the social control power was more representative than genuine: 'regardless of whether mental constraint makes just restricted commitments from a numerical sense to colonial social control measures, it isn't just the reality yet additionally the possible possibility of repression inside a British asylum that applies a control angle'. Regardless, although symbolic, social control through asylum psychiatry was significant.

The humanism of the asylum was hence embedded in the colonial discourse of social control and domination. The humanism of the asylum was consequently implanted in the pioneer talk of social control and mastery: measures, for example, medical care came to accept a basic philosophical situation in the state. They turned into a way to legitimize pioneer mastery and to persuade the white decision class in India, as much as the general population back home, that the British had (in contrast to the evidently oppressive oriental rulers) not just usurped power however expected it honestly for the sake of human advancement and based on rational scientific knowledge. The asylum was fundamentally seen as an institutional reaction to liberate people from the servitude of mental trouble. This was as focal a piece of its ethos as the conspicuous component of social control.

What this chapter argues is at the turn of the twentieth century, despite the introduction of reforms, based on welfare liberalism, at the institutions to make the lunatic asylums into the Mental hospitals, the colonial state remained focused on the social control and domination. The much-talked liberal welfare reforms did not really alter the nature colonial state with reference to the insane/ mentally unsound. The rot and disregard towards the insane in these organizations had not reduced. To demonstrate my argument, I will first document and analyse the history of lunatic asylums in the late eighteenth and nineteenth centuries and then, I will compare it with the history of the Mental hospitals in the early twentieth century.

Health Profile of the Madras Presidency

In the pre-colonial India, the mentally ill from the general population were taken care of by the local communities and by traditional Indian medicine doctors. As the medical institutions in the Madras Presidency are concerned, an early hospital was

opened by British at Madras in 1664 for the treatment of soldiers in fort. The Madras General Hospital was set up in 1772¹⁷⁹. By this time, the hospital started to provide training to the Europeans and natives in the *Allopathic*¹⁸⁰ branch of diagnosis and treatment and in method of preparing medicines. After completion of training, most of these trained personnel were posted at dispensaries for assisting qualified doctors at district headquarters. These institutions earned the recognition of the model hospital of the East India Company in 1820. Dr. Mortimar made the private medical hall run by him it was regularized as a medical school and then, the Governor of Madras; Sir Fredrick Adams inaugurated the medical school on 2nd February 1835. It was attached to the Madras General Hospital.

The earliest *mofussil* hospitals in the Madras Presidency were set up in 1842, only six civil hospitals were set up in the entire presidency outside of Madras. It seems that, the Madras Medical School and College struck deeper roots and started producing substantial number of graduates and native doctors, in excess to the civil and military demands of the government. The expansion of civil hospitals and dispensaries in the Presidency was supported by the benevolent governors like Lord Napier and other officials. In 1851; the medical school became a college and it was affiliated to the University of Madras in 1877. This medical college was originally an institution for supplying of Assistant Surgeons and Assistants.¹⁸¹

In 1761, the Army Medical Department was established in India for providing services to British troops associated with the East India Company's army. In 1764, the Bengal Medical Service was founded; soon thereafter this organization was replicated in the Madras and Bombay Presidencies. On 29th May 1786, a hospital board was

¹⁷⁹ Kumar Anil, op.cit, 1998, p. 91.

¹⁸⁰ A Greek word *Allopathy* is derived from 'Allas' and 'Pathas', which means 'suffering'. The term "*allopathy*" was coined in 1842 by C.F.S. Hahnemann to designate the usual practice of medicine as opposed to homeopathy. The system of therapy that he founded based on the concept that disease can be treated with drugs (in minute doses) thought capable of producing the same symptoms in healthy people as the disease itself. In concise way it is the treatment of disease by conventional means, i.e. with drugs having effects opposite to the symptoms.

¹⁸¹ The Madras Year Book 1923 With an Official, Commercial and General Directory of the Madras Presidency, First Issue, Madras, the Superintendent, Government Press, 1923, p.134.

created for each presidency.¹⁸²In the category of specialized hospitals, a hospital for lepers of all races and of both the sexes was set up in 1816, which was reported by a Madras public letter dated 26th September 1816, which later developed into the Madras Government Leper Hospital.¹⁸³

Many hospitals and dispensaries were established at district headquarters. The Indian Medical Department was set up in the Madras Presidency on a regular basis in 1786 and Town's Improvement Act of 1871 had given medical relief in towns and municipalities. The Local Funds Act of 1871, made the local boards responsible for opening medical institutions in non-municipal areas of the districts. This act was followed by the legislative enactments of 1884 and 1920.¹⁸⁴ It made many changes in the hospitals. Most of the hospitals were established at the headquarters of the districts in the Madras Presidency. And the development of medical education and the establishment of medical colleges gave inspiration for the growth of hospitals and dispensaries¹⁸⁵.

In the early nineteenth century, several hospitals and dispensaries were established for the benefit of military as well as civilians in the country. A dispensary was established for treatment of the 'Native Poor' and a 'Police hospital' erected to accommodate the patients during the famine and drought years¹⁸⁶. The Local Funds Act of 1871 provided for opening new medical institutions in non-municipal areas of the district. All the dispensaries were maintained by the *Taluk* Boards. Sometimes, these dispensaries were closed due to financial constraints and lack of doctors and medical

¹⁸² Kumar Anil, op.cit, 1998, pp. 91-92.

¹⁸³ *ibid*, pp. 91-92.

¹⁸⁴ Gribble J.D.B, *Andhra Pradesh District Gazetteers: The Manual of the Cuddapah District in the Presidency of Madras*, Madras, the Superintendent, Government Press, First Published in 1875, pp. 649-650.

¹⁸⁵ The Madras Year Book 1923 With an Official, Commercial and General Directory of the Madras Presidency, First Issue, Madras, the Superintendent, Government Press, , 1923, pp.134-137.

¹⁸⁶ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, Delhi, Oxford University Press, 1993, p. 248.

subordinates together.¹⁸⁷ By the beginning of the twentieth century, there were many hospitals and dispensaries were established which played a vital role in the improvement of public health and thousands of people were treated at dispensaries. This was one of the most impressive achievements of colonial health policy in India. And the other associated change noticed was the growing concern of the public about the condition of mental hospitals which resulted not only in the improvement of existing hospital conditions but also in the opening of many more new hospitals¹⁸⁸.

Lunatic Asylums in Madras Presidency

There are some works suggests that hospitals for mentally ill have been existed in the south India region in the pre-colonial times, but there is little documentary proof of their existence. Though the Indigenous therapeutics scattered across this region, but one has to accept that the Institutional care for mentally ill brought by Britishers during the East India Company rule. The British established lunatic asylums in Madras Presidency from the late eighteenth century onwards. These were initially privately run, small-scale institutions, dedicated mainly to the treatment of Europeans. The procedures involving in the disposal of Insane at that period firmly repeated practice in Britain, where private individuals occupied with the entrepreneurial activities about 'unsound mind' offered rooms in their homes to nearby specialists and the expense paying family members of mentally sick individuals. In Madras, similarly, individuals considered 'Lunatics' were shipped off Connolly's private lunatic asylum which came into existence in 1794; it catered mainly for the expatriate community in this region. The quantity of the patients at this period was little. Most of the mentally sick among the Indian populace stayed, as in the past, under the consideration of family members in their networks, while lower-class Europeans, who had a place principally with the military, were all the more ordinarily restricted to regimental jails and hospitals.

¹⁸⁷ Gribble J.D.B, op.cit, 1875, p. 650.

¹⁸⁸ Sharma Shridhar and Varma L P, 'Mental Hospitals in Indian Sub-continent', *Indian Journal of Psychiatry*, 26(4), 1984, pp. 295-300, p. 298.

Actually, the Lunatic asylum at Madras was ordered to be built in 1793, for sixteen patients, and given a generous endowment and land, on the provision that no rent was to be paid as long as the building was devoted to public purposes¹⁸⁹. The EIC, the then administrative authority, for Fort St. George and its surrounding areas, appointed Surgeon Valentine Connolly as in charge of a House for accommodating persons of mentally sick. He entered the Madras Medical Service as Assistant Surgeon on 16th June, 1788, became Surgeon on 24th June, 1796¹⁹⁰. He was Secretary to the Medical Board from 1791 to 1793. It seems he took advantage of his position and pushed his scheme for the establishment of lunatic asylum in 1793¹⁹¹. He received the Madras government's insane employees into his private madhouse in Kilpauk¹⁹². Initially this Asylum was meant for mentally ill Europeans and 'Eurasians'¹⁹³. Connolly lends his house to accommodate persons of unsound mind. There are a few interesting events took place before the asylum came into existence. That is, in 1793 Assistant Surgeon V. Connolly put forward proposal for the establishment of Lunatic Asylum at Madras. On 15th November, 1793, Government sanctioned the project, on 19th November, 1793; Connolly accepted the terms offered, and the establishment of the Asylum on 1st October, 1794, and he is granted 250 pagodas a month for the charge thereof¹⁹⁴. In the same year i.e., 1794, a Lunatic Asylum was established by Valentine Connolly and was within the limits of Purasawalkam (originally it was called as FerozePakkam during the British Period)¹⁹⁵. This hospital premises started as a 'house for accommodating persons of unsound mind by Connolly¹⁹⁶. He was not only become

¹⁸⁹ Subba Reddy, D V. *The Beginning of Modern Medicine in Madras: The Dawn of Modern Medicine in Madras*, Calcutta, Thacker, Spink, 1947.

¹⁹⁰ Crowford, D.G, *A History of Indian Medical Service 1600-1913*, Vol-II, Calcutta, Thacker & Co, 1914 p. 416.

¹⁹¹ Varma L P, 'History Psychiatry in India and Pakistan', Vol-IV, *Indian Journal of Neurology and Psychiatry*, pp. 138-164, 1953, p. 138.

¹⁹² Ernst Waltraud, op.cit, 2010, p. 51.

¹⁹³ Basu Saumitra, op.cit, 2016, p. 484.

¹⁹⁴ Crowford D.G, op.cit, 1914, p. 415.

¹⁹⁵ Somasundaram O, op.cit, 2008, p. 9.

¹⁹⁶ *ibid*, p. 10.

the first Superintendent but also the owner of the Asylum. The erection of this Institution had been sanctioned by the authorities in England and India because of the great advantage anticipated accruing to the town population and to future Patients. The hospital board had recommended the asylum project, pointing out ‘how beneficial the adoption of it would be to the Community at large by affording Security against the perpetration of those Acts of Violence which had been so frequently committed by unrestrained Lunatics’¹⁹⁷.

The accounts prising Connolly’s achievements are similarly divided between mention of personal profit on one the hand and public benevolence on the other. In the standard history of India Medical Service, Connolly is mentioned as the laudable founder of the Madras asylum¹⁹⁸. He was to set in train both a lucrative business and a procedure for the disposal of insane persons, which was regarded as most humane. There two aspects of individual profit and institutional care were to characterize the affairs of the asylum during first half off the nineteenth century¹⁹⁹. It was not surprising then, that Connolly was not denied costly concessions by government (such as the premature extension of the asylum’s lease and the highly over-stated rates granted to him per patient²⁰⁰. The reported cures, Conolly’s reputation as the initiator of benevolent scheme for suffering mankind, and presumably his wealth-based influence contributed to affect the extension of his building’s lease years before the contract’s official termination. The extension of the lease meant that government had contractually bound itself to stipulated terms of payment

A few years later in 1799 the Government obtained the lease of premises and another Surgeon Morris Fitzgerald was appointed as Medical Superintendent and later Dr. Surgeon John Goldie held charge. Goldie must have regarded the purchase as a lucrative venture. He had paid nearly three times the estimated value of the building

¹⁹⁷ Ernst Waltraud, op.cit, 2010, p. 44.

¹⁹⁸ Ernst Waltraud, op.cit, 1998, p. 14.

¹⁹⁹ *ibid*, p. 14.

²⁰⁰ *ibid*, p. 14.

alone²⁰¹. His profit arose from the very high rent that the government paid in addition to grossly inflated rates per patient. And Goldie sold this asylum to another medical practitioner called Dr. Surgeon J. Dalton who was in charge from 1807 to 1815 rebuilt the premises, and the institution came to be called as “Dalton’s Mad House” this hospital was expanded for 54 Europeans inmates and with 15 house keepers, and this is now part of the medical college²⁰². Dalton who again bought the premises for three times their estimated value, soon after Dalton’s take-over, repairs were carried out and shortly before his retirement Dalton considered selling the building for a price as high as the one he had paid some years previously. This time, the government of Madras objected to the sale and transfer of the lease. It was held that ‘the principle of selling not merely the building, but the charge of the patients contained in it, to any individual however qualified, or personally unobjectionable. On retirement to Europe he (Dalton) handed over the medical charge of the institution to a surgeon who was henceforth appointed by government on recommendation from the medical board²⁰³. After legal consultation government consequently resolved that no longer should all in class-specific rates be paid to the superintendent of the asylum. Instead, the superintendent was to receive a fixed monthly allowance; the expenses for the care and treatment of particular patients being henceforth met against detailed bills of expenses; and the medical board was to be solely empowered to admit patients and recommend their proper classification, as well as their treatment²⁰⁴.

The mentally ill from the general population was continued to be neglected or attended by the local communities led by traditional Indian medical experts. Soon, the social reform tendencies and humanitarian concerns of early nineteenth century British India resulted in setting up ‘government asylums’ to provide approved systems of treatment to Indian lunatics. As a result, by 1820, colonial state established government asylums in Madras, Bombay and Calcutta for the exclusive reception of

²⁰¹ *ibid*, pp. 14-15.

²⁰² Basu Saumitra, *op.cit*, 2016, p. 484.

²⁰³ Ernst Waltraud, *op.cit*, 1998, p. 15.

²⁰⁴ *ibid*, p. 17.

Indian patients. However, the character of these lunatic asylums was largely on English model that asylums could only be measures of social control²⁰⁵.

Until the 1820s, asylums existed in Chitoor, Trichinopoly²⁰⁶ (Tiruchchiruppalli), Tellicherri, and Masulipatnam. All these institutions were rather small-scale, with the Madras asylum admitting as few five to ten lunatics annually around the turn of the 18th to 19th century. The recently established provincial asylums were undergoing extensive repair, structural improvement and rearrangement. The court was notified accordingly in March 1822, with the result that the authorities in London re-emphasised that all insane Europeans should immediately be sent to Britain, and demanded reasons for construction and reconstruction of asylums under way in the Madras Presidency. As a result of this, the recently opened provincial asylums were officially abolished in 1822, and patients were soon afterwards transferred to the asylum in Madras.

As revealed from Madras Military Proceedings 1820, in May 1820 the Court of Directors of the East India Company informed the administrative authorities in Madras in respect to European insane. However, 1821 onwards, due to overcrowding of insane, extensive repair, structural improvement and rearrangement of the asylum, European insane were sent to their homeland. The Court had approved the Bengal Government's policy of sending European insane to England and declared the same provision should be made for the Madras Lunatic asylum also. But the situation became reverse for Indian insane. On account of overcrowding the boarding out of Indian patients (sometime designated as 'harmless idiots'), to either the Indian infirmary (the Monegar Choultry) or the jail in the 'Block Town' became a matter of routine from 1824 onwards. Those transferred mainly consisted of what were then called either 'harmless idiots' (for the Monegar Choultry) or – at times – 'mischievous idiots' (for jails). From 1841-1867, 'harmless idiots' were kept separately to avoid overcrowding of the asylum. Due to this the Lunatic Asylum from 1841 onwards it

²⁰⁵ Abraham Santhosh, op.cit, 2018, p.126

²⁰⁶ Code of medical and sanitary regulations for the guidance of medical officers serving in the Madras Presidency, Volume II, 1870, p. 70.

also termed as an 'Idiot Hospital'²⁰⁷. By 1846, the Military Board strongly recommended new construction of asylum due to unsafe condition of the asylum. In spite of this recommendation, several intervening social factors created severe constraints. But the alarming reports of the Madras Military Medical Board 1849–1850, instilled the Madras Government to think over the issue again²⁰⁸. Towards the middle of the century the asylum's reputation as a seemingly receptacle for higher-class European had, however, suffered, as ever-more lower-class Europeans and Eurasians were confined, alongside Indians in derelict premises higher class civilians were consequently no longer admitted at all²⁰⁹.

The situation was even worse in Madras. Here the building had become structurally unsound by the 1840s – only 50 years after it had been constructed as a private enterprise by Conolly. The superintending surgeon described the place in 1846 as being in a 'highly dangerous state,' having originally been built of material of the most inferior quality and 'extremely ill calculated in every way for a Lunatic Asylum'. 'Many of the Cells', he maintained, 'are so inferior in every particular that in England criminals of the worst description would not be confined in them'. Unlike the Beardsmores' asylum in Calcutta, parts of which survived well into the twentieth century, Conolly's madhouse had by the middle of the nineteenth century become 'incapable of restoration'. This was a blow to the Madras authorities, as they had within half a century invested the large sum of three and a half *lakh* of Rupees (Rs 350,000) for the building in rent alone.

Finally in 1851, this recommendation was approved to construct a new building. After the approval, the availability of open and spacious location for the construction of new lunatic asylum became a serious concern. By the middle of the century the Madras asylum had become a receptacle mainly for pauper and low-class lunatics of both European and Indian. Advertisement was published in the Official Gazette and ultimately land was purchased at Locock Garden. The Madras Lunatic Asylum was sanctioned by the then government in G.O. No. 26 Judicial, dated 7th January 1867.

²⁰⁷ Somasundaram. O, 'Psychiatry in Madras at the sunset of the British Raj', *Indian Journal of Psychiatry*, special issue called, Icons of Indian Psychiatry, 2010, Volume: 52, Issue: 6, pp. 114.

²⁰⁸ Basu Saumitra, op.cit, 2016, p. 487.

²⁰⁹ Ernst Waltraud, op.cit, 1998, p. 13.

The asylum was constructed on a 66½-acre site in Locock's Garden outside the Municipal limits. According to the Report on the Administration of the Madras Presidency during the year, 1869-1870, Lunatic Asylum at Madras has been constructing the total cost of the expenditure has reached rupees 1,97,221, and the building as originally laid out, are nearly all completed, and will be ready for the reception of the inmates'²¹⁰. It started functioning on 15th May 1871 with 145 patients²¹¹ and Surgeon John Murray MD as Superintendent with residential quarters inside the premises²¹². Smaller asylums also opened in other sites in Madras State at Waltair, and Calicut in 1871.

A fuller use of the powers conferred under Section 25 of the Lunacy Act of 1890, whereby patients may be sent from mental hospitals to Poor Law infirmaries, should be exercised. Absence on trial and boarding-out, wherever practicable, should be allowed²¹³. In Madras Presidency to avoid crowd in the lunatic asylums up to 1890's the harmless idiots were kept in the jails after that they were sent to the lunatic asylums. The year 1892 saw the transfer in of all "criminal lunatics" from the districts and increase in staff strength was made with additional buildings including cottages for paying patients. Although a small number of those admitted could be sent back to their homes as "recovered," the vast majority had to stay on in the asylum for the rest of their lives, and consequently²¹⁴. It was then; the year 1922 witnessed the change in name of the institution from "Government Lunatic Asylum" to "The Government Mental Hospital." However, it was rechristened in 1977 as the Institute of Mental Health (IMH)²¹⁵.

²¹⁰ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1869-70, the Government Press, Madras, 1870, p. 65.

²¹¹ Srinivasan V, *Mental Hospitals of India*, New Delhi, Director General of Health Services Ministry of Health, 1961, p. 20.

²¹² Basu Saumitra, op.cit, 2016, p. 487.

²¹³ Lunacy and Mental Deficiency. Board Of Control's Report, *The British Medical Journal*, Vol. 2, No. 3330 (Oct. 25, 1924), p. 772 Published by: BMJ Publishing Group Stable URL: <http://www.jstor.org/stable/20438182> .Accessed: 18/09/2013 09:21.

²¹⁴ Somasundaram O, Ponnudurai Ratnaraj. op.cit, 2018. pp. S183-S191.

²¹⁵ ibid, pp.S183-S191.

Since its inception from 1794, provision for the reception of both Europeans and Indians prevailed, though there were separate wards for different races, even in the early nineteenth century, this asylum was not only built by a medical practitioner but it was owned by medics, internal management, cure efficiency and low death rate. These were the three most favourable features of Madras Lunatic Asylum. Besides, growth of Madras Lunatic Asylum was free from all kinds of financial malpractices in comparison with other Asylums even in the early nineteenth century. Now it is imperative to understand the major prerequisite criteria which helped in establishing the Lunatic Asylums in Colonial India and specifically the perceptions of the colonial rulers regarding lunacy²¹⁶.

Visakhapatnam Mental Hospital

It is one of the oldest Mental Hospitals in India and one among the first three mental hospitals which are setup in south India. According to A.W. Wright-Overbeck in his work 'Lunacy in India' he wrote that there are three lunatic asylum located in the Madras Presidency they are, one is located at Madras it is a Central Asylum both for Europeans and Indians; Second is located at Calicut this for Indians; and another is at Vizagapatam this asylum is also for Indians²¹⁷. Vizagapatam Asylum is situated at Waltair, actually it was started as Lunatic Asylum in 1862 with 7 patients²¹⁸. It was developed in a phased manner to accommodate 300 patients²¹⁹. At present this hospital gets around 400-450 patients. In 1971 The Government changed the name "Mental Hospital" as "Government Hospital for Mental Care". In this region Mentally ill people of Telugu were identified with a few local names *Bhuddimandhyam*, *Pichhodu*, *Tikkalodu*, *Mentalodu*, *Burratakkuvodu*, and so on. Present it caters to the needs of the psychiatric patients, from the coastal districts of Andhra Pradesh as well as those from Orissa and Chhattisgarh. Present this hospital provides services to more

²¹⁶Basu Saumitra, op.cit, 2016, p. 481.

²¹⁷ Overbeck-Wright, A.W, *Lunacy in India*, London Bailliere, Tindall and Garden and Cox, 1921.

²¹⁸Krishnarao, Y V. (ed), *Andhra Pradesh Dharshini*, Hyderabad, Vishalandra Publishing House, , 1996.

²¹⁹Vindhya, U, 'Mental Health Care: A Review of Gender Differences', *INT. J. DIAB. DEV. COUNTRIES* (2001), Vol. 21, pp. 86-95, p.88.

than 58,000 patients annually. Compare to other two asylums in the Presidency (Madras & Calicut), Vizagapatam lunatic asylums is smaller, in terms of asylum population, maintenance cost of its lunatics, and in its total expenditure on the asylum also, etc. Its catchment area has consisted of Northern *Circars* of the erstwhile Madras presidency; they are Ganjam; East and West Godavari; Kistna; Vizagapatam districts after some time Anantapur, Bellary, Cuddapah, were also included. Most of the inmate speaks Telugu and *Uriya* language²²⁰. It received both the genders of the male and female patients.

The existing historiography is giving very less information about this hospital; so far its history was not available. But its references only available from few books and Articles like D G Crowford History Indian Medical Service-1600-1914; SD Sharma, Mental Hospital in India; LP Varma's Psychiatry in India and Pakistan; and Gazetteers of Vizagapatam (1907). All these works sited very little information, they mainly dealt with, when it was established, but later historical developments and institutional ups and down is not available, so that, this part of the work tries to document its history during the colonial rule, this hospital known as Vizagapatam Lunatic Asylum or Waltair Lunatic Asylum.

The asylum at Vizagapatam was part of a programme in the 1860s and 1870s that developed a coherent colony-wide approach to those the colonial authorities considered to be "insane". This programme benefited from new legislation, Act XXXVI of 1858, that determined the policy for both the "civil" and the criminally insane. The programme also saw the rapid expansion of the asylum network in India, as 16 of the 26 asylums that operated under the jurisdiction of the Indian Government by 1880 had their origins in the 1860s and 1870s²²¹. According to L P Varma prior to 1867, patients suffering with mental illnesses in Visakhapatnam were housed at the local Jails. For obvious reasons, this practice was found to be objectionable and so a private building at Vizagapatam, situated three miles from this town was rented and

²²⁰ Government of Madras, Public Department, GO-Nos. 734, 735, 6th June 1898, p. 15.

²²¹ James H Mills, 'The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive', *Journal of Medical Humanities*, Vol. 21, No. 3, 2000, pp.141-142.

occupied in 1867. “This Asylum originated in the accidental fact that in 1862 seven non-criminal lunatics had been committed to custody all at once. There being no proper place for them, the District Magistrate was allowed to rent a small house for them. Later, a private house was hired from the Rajah of Vizianagaram. Wherein they lived, guarded by constables and waited on by convicts”²²². Gradually it recognized asylum for the Northern *Circars* of the Madras Presidency and had a regular board of visitors. From then the question of providing *mufassal* asylums was thus raised; and one was sanctioned for Vizagapatam, among other places (Madras, Calicut). The construction of the new build premises started from 1868 at a place known as “Gunner’s Stables” was acquired six cottages and nine single rooms were erected in this area which covered in 20 acres of land. The total expenditure came into being Rupees 43,049 by 1870²²³. The construction was completed by 1871 for the accommodation of 94 patients²²⁴. And other three asylums were also completed by this time and occupied the premises in 1871 from then a proper lunatic asylum was started here it is recognized as District lunatic asylum.

It has been observed that from 1870’s to 1900, the inmates of the asylum on an average of 60 only. And also mortality is high compare to the other asylums in the presidency. Criminal wards very often affected with the repairs the government neglected them rottenly to repair the buildings. The accommodation was again and again found inadequate and numerous criminal lunatics were accordingly confined in jails²²⁵. In the meanwhile temporary confinement in a jail is necessary. With all these reasons lunatics use to transfer to the other asylums and the prisons. In 1892 criminal patients were transferred to Madras and this asylum was reserved solely for non-

²²² Andhra Pradesh District Gazetteers, Vizagapatam District Gazetteer, Volume I, Hyderabad, Published by The State Editor, District Gazetteers, Andhra Pradesh, Originally Published in 1907, p. 159.

²²³ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1869-70, op.cit, p. 65.

²²⁴ Andhra Pradesh District Gazetteers, Vizagapatam District Gazetteer, op.cit, 1907, p. 159.

²²⁵ Report on the Administration of the Madras Presidency, during the year, 1888-89, Madras: Printed by the Superintendent, Government Press, 1889, p. 165.

criminal patients²²⁶, from then the asylum is stance for the civil and native lunatics only.

By the end of 19th Century there was a proposal that asylum at Vizagapatam should be closed and Amalgamation with the Madras Asylum. By 1890's the reception of the patients were low compare to the other asylums. And asylum building was in a bad position and it was observed that the mortality was very heavy in the Waltair Asylum compare to the other two asylums in the presidency. Combined with the other unknown reasons, in 1896 there was proposal by the Government of India that 'the amalgamation of the Calicut and Vizagapatam lunatic asylums with the Madras asylum'²²⁷. And increase in the pay of the Superintendent of the Asylum at Madras. The objections are raised to the abolition of the smaller asylums. The Governor Council Express strong disapproval to the proposal of the Government, they said that asylum at Vizagapatam should not be closed. The Governor General in Council is in agreement with the Government of Madras in thinking that it is not desirable to confine together very large numbers of lunatics at Madras asylum, and that the patients are likely to be happier and to have a better chance of recovery if they are confined in a portion of their country, the customs and vernacular of which resemble their own homes²²⁸. And also they put forward various reasons in respect to many differences with Climate, Customs, Language, and Distance.

A new building for sick among the male patients and six cells for the noisy and filthy patients are under construction in Waltair Hospital in 1924²²⁹. Accommodation has been increased to 164 patients by the year 1925. From the year 1921 onwards the India Psychiatrist became Superintend Lieut.-Col. M.N. Chaudhuri, I.M.S., for this

²²⁶ Varma L P, op.cit, 1953, p. 143.

²²⁷ Government of Madras, Public Department, GO-Nos. 734, 735, 6th June 1898, p.14.

²²⁸ *ibid*, p.14.

²²⁹ Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 1122, 5th August, 1924, p.2.

hospital²³⁰. Improvements in the accommodation of this hospital was took place, the hospital had an accommodation for 234 males and 19 females in 1931. And His Highness the Maharaja of Jeypore presented a motor bus to the hospital. The hospital had an accommodation for 239 males and 42 females in 1945. And gradually various cross-cultural influences took place in Administration and treatments in the asylum.

History of Calicut Mental Hospital

Mental Health services in Kerala had its beginning from colonial times, Kerala has three Mental Hospitals. The one at Thiruvananthapuram [Trivandrum] in 1870, second one is originated at Kozhikode [Calicut] in 1872²³¹ and third one is established at Thrissur [Trichur] in 1889²³². James T. Anthony identified various categories and themes on the asylum practice in nineteenth and early twentieth century in Kerala. The Archival documents are rare in number about Travancore and Thrissur asylum. But properly documented detailed reports available on Calicut mental asylum which was under Madras Presidency in colonial India. These geographically connected, but administratively different institutions for insane in a single vernacular region in Kerala. There are different words used in Malayalam to express the word ‘madness’. The common words are found to be *Bhranth*, *Vattu*, *PE*, *Ulan*, *Cittabhramam*, *Ilakkam* and *Unmadam*. These are reviewed and analyzed a few dictionaries and historical textbooks to trace the evolution of the word ‘madness’. Exploring the meaning of these words has helped us to arrive at and deal with the cultural intricacies of the word ‘madness’²³³.

Government Mental Health Center (GMHC), at Kuthiravattom near Kozhikode is a renowned and premier center of treatment, care and rehabilitation in the South India. It

²³⁰ Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 909, 27th May, 1926, p. 3. & Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 1122, 5th August, 1924, p. 5.

²³¹ Menon A Sreedhara, *Kerala District Gazetteers-Kozhikode*, Trivandrum, the Superintendent of Government Press, 1962, p. 690.

²³² James T. Anthony, Icons of Kerala Psychiatry, *Indian Journal of Psychiatry*, 2010, p. Volume 52, Issue-6, pp: 117-118, p. 117.

²³³ Baiju Gopal, op.cit, p.115.

has its long and unique history from colonial times, According to Annual report of Lunatic Asylum 1873 the Calicut Lunatic Asylum opened in the year 1872. This was located at a distance of one mile from the town. It was the decision of colonial government to introduce asylums in its various presidencies²³⁴. The detailed report of the asylum is available only from the year 1873. According to the report of 1873 it has been found that 75 patients were treated in the year 1873²³⁵. Among this 75 patients 48 were admitted in the year 1873 and the rest were remained from the previous year. Among the newly admitted 48 patients 37 were males and 11 were females. The number of total treated Europeans and Eurasians were 4²³⁶. The analysis of the later years prove the fact that the number of admissions are increasing in Lunatic Asylum in the first few years thereafter there is no much increase in the number of new admissions. It catered then for both the criminal and non-criminal patients but since 1893 when the criminal patients were transferred to Madras it serves only the non-criminal patients²³⁷. In 1886, there were facilities to accommodate 84 patients²³⁸. It had an accommodation for 200 males and 72 females in 1926²³⁹. The patient strength increased to about 350 in 1935, 500 in 1940, 700 in 1970 and 800 in 1990. Thereafter the patient strength declined to the existing level of about 600 in 2008²⁴⁰.

Those days it is known as Calicut Lunatic Asylum where as the local people called it the “*Bharanthan Jail*” (Lunatic Jail), due to spatial identity Kuthiravattom is a name synonymous with Mental Health Care for more than a century unfortunately. This asylum is one among the three lunatic asylums in the erstwhile Madras Presidency. Initially this asylum catered to isolate the mentally deranged British soldiers, in

²³⁴ *ibid*, p. 230.

²³⁵ Annual Report of the Lunatic Asylum in the Madras presidency, 1873, p. 12.

²³⁶ Bijiugopal, p.230.

²³⁷ Varma L P, *op.cit*, 1953, pp. 142-143.

²³⁸ *ibid*, pp. 142-143.

²³⁹ *ibid*, pp. 142-143.

²⁴⁰ Government Mental Health Centre, Kozhikode official web page, <http://gmhckkd.com/> .

course of time it extended the services to civilians and native Insane also. It receives civil mental patients from the districts of Malabar, South Kenara, Coimboitore, Nilgris and Anjengo²⁴¹.

In the case of Calicut asylum the superintendents, doctors, nurses and asylum administrators were English up to 1912 and medical reports have noted the recruitment of native doctors and nurses after 1920 due to increased Indianisation in the colonial provinces. Apart from these, most of the other staffs employed in the asylum were recruited from the local community, like hospital assistants, attenders, cooks and other servants. The daily care of the patients were managed and carried out by local attendants and they have exercised a significant influence over the patients²⁴². It was under the Jail department in the pre independent India and was referred to as lunatic jail by the people. It continued to be under the jail department for 2 more years even after independence and Inspector General of Jails was in charge of the hospital. It was in 1950 that the hospital was transferred under the Department of Health.

Psychiatry and its developments in the first half off the twentieth century

The early parts of the Twentieth Century characterized by a more humane handling of mental health issues, leading to significant legislative, administrative and clinical modifications. In spite of these changes, mental health services were confined to lunatic asylums, and these asylums were managed by physicians assigned to the posts of superintendents. Mental health services till then did not have formally trained manpower and most of the qualified psychiatrists were British living in India. In such a colonial set up, during the beginning of the twentieth century when Swadeshi fragrance was blooming in the air, the distressed condition of these asylums drew attention of the Indian intelligentsia. They made severe protest against this malady through press which in turn reflected even in the British Parliament²⁴³. Due to the adverse publicity in the press the conditions of lunatic asylums were reflected both in

²⁴¹ Abraham Santhosh, op.cit, 2018, p. 125.

²⁴² ibid, p. 130.

²⁴³ Basu Saumitra, op.cit, 2016, p. 488.

India and abroad. Soon gathered a more humanistic concern of the Government, this propaganda leads to wide a discussion among society, which consequently paved a way to significant administrative, clinical and legislative modifications in the field of Psychiatry. This deterioration in the state of mental hospitals was a cause of great concern both in India and abroad. This heralded the third phase of development of mental hospitals lasting the first quarter of the 20th century. All asylums that were hitherto under the charge of the inspector general of Police were put under the charge of civil surgeons²⁴⁴. The next most important change was the recognition of the role of specialists in the treatment of psychiatric patients. It was also acknowledged that specialists in psychiatry and medical doctors were appointed as full-time officers in lunatic asylums²⁴⁵. And the third significant addition was the intent of Government to have a central supervision of all lunatic asylums which was contemplated in 1906 and was brought out in the form of India Lunacy Act 1912. The year 1912 is significant as the capital of India was shifted from Calcutta to Delhi²⁴⁶. These administrative changes were reflected all over India.

Major R. Bryson was an officer for the Indian Medical Service, who was employed as Principal of the Medical College at Madras and as Senior Medical Officer of the General Hospital. Having been superintendent of the Calicut Asylum for two years, he mysteriously took leave from the IMS for nine months, only to return and publish one of the most widely ready lunacy texts in India at the time. Bryson was first published *The Indian Lunacy Manual (ILM)* in 1909 at Madras²⁴⁷ “to place within handy reach of all Medical Officers a Summary of the Rules and Regulations referring to lunatics.” The *British Medical Journal (BMJ)* criticized the first edition for focusing only on the Madras Presidency and suggested that “with some alterations and additions, it might

²⁴⁴ Muktesh Daund, Sushma Sonavane, Amresh Shrivastava, Avinash Desousa, and Sanjay Kumawat, op.cit, 2018, p. 241.

²⁴⁵ Banerjee Gouranga, ‘Mental Hospitals and Healing Practices in Colonial India’, *Mental Health Reviews*, 2001, p. 5.

²⁴⁶ Muktesh Daund, Sushma Sonavane, Amresh Shrivastava, Avinash Desousa, and Sanjay Kumawat, op.cit, 2018, p. 241.

²⁴⁷ Major R. Bryson, *The Indian Lunacy Manual for Medical officers and the General Public*, Thacker, Spink & Co, Calcutta, (Third Edition revised by Captain P. Heffernan). 1913, p. 2.

be made applicable to other parts of the Indian Empire.” The *Indian Medical Gazette (IMG)* also critiqued the Manual for being “not as a rule available to District Officers when called upon in an emergency”, and encouraged Bryson to produce a version that could be distributed to District Officers and the public alike. The second edition was published only a year later, in March 1910, “in response to the appreciation, by the general public, of the intention of the compiler to supply a handbook of information in aid of those who have a relative inflicted with insanity sufficiently pronounced to require admission into an asylum.” And the third edition was revised by Captain P. Heffernan, Superintendents of Madras Lunatic Asylum, published only a year later, in May 1913. This Manual provides the information for required persons such as Psychiatric Professionals, legal personals, and the general public of India. And this text specifically provides the steps to be taken for the admissions into the lunatic asylums, treatment for the sufferers from mental illness, transfer of the insane and discharge procedures. This is one of recognizable contribution of Madras Presidency to the field of psychiatry in Colonial India.

By the early years of the twentieth century, the native asylum had transformed into an institution that were more similar to its European counterparts than before, and more akin to the archetype of colonial power with which we are familiar. This transformation was underlined by a second set of lunacy laws in 1912, which represented a confident top-down colonial intervention into the care and treatment of Indian insane under British rule²⁴⁸.

Lunacy Act IV of 1912

However, in this scenario ended in the Vice regal Lodge of Simla on Monday the 18th September 1911 with Baron Hardinge of Penshurst presiding over the Council of the Governor General of India. The Hon’ble Mr. Jenkins introduced a Bill to consolidate and amend the law relating to lunacy. The intention was to consolidate the various lunacy laws in India and to introduce certain amendments and especially to bring the law in certain important particulars in line with the modern English law i.e. the Lunacy Act 1891. After a careful consideration by the Council, with Hon’ble Sir

²⁴⁸ Anouska Bhattacharyya, op.cit, 2013, p. 4.

Guy Fleertwood Wilson as President, the Bill was passed as the Indian Lunacy Act 1912. This act contains the Act of 1858 and it stay in force until the Act of 1912, was passed. It Act enumerated the procedures in Sections 5 to 11 and 18 to 20, replacing Section 7 of the Lunatic Asylum Act 1858. But the same fear of false detention of insane people was reflected in the passage. Here the role of the then Madras Government was really praiseworthy²⁴⁹. It should be said to the credit of the then Governor of Madras, Sir Thomas David Gibson Carmichael brought to the notice of the Governor-General that an additional category of patients- voluntary boarders- should be included in the Act. The Government further considers that advantage may be taken of the present opportunity to incorporate the provision of the Scottish law section 15 of 29 and 30 Vict. Chapter 51, which allows admission of uncertified cases as voluntary boarders in asylums²⁵⁰.

The Lunacy Act of 1912 had a very significance in the history of Psychiatry in India. It addressed issues regarding reception, care, treatment of the mentally ill, discharge and management of the asylums. The act also covered and emphasized on establishing lunatic asylums. That act had provisions to admit patients as voluntary boarders, due to which admissions were classified into two categories again, i.e., compulsory admissions and voluntary admissions²⁵¹. As it is introduced a concept called 'Voluntary Boarders' According to the "The Lunacy Act of 1912, Section. IV (1 & 2) -A patient who desires admission to a Lunatic Asylum for treatment as a Voluntary Boarder must apply in Person to the Superintendent. If the Superintendent of the Asylum considers the case a suitable one for admission, the Prospective Boarder must then make a written application for admission, which application must be countersigned by two Official Visitors of the Asylum in token of their approval. In the Madras Asylum a special form may be obtained from the Superintendent for this purpose. The form is filled up and signed by the Voluntary Boarder"²⁵². From then

²⁴⁹Basu Saumitra, op.cit, 2016, p. 488.

²⁵⁰ Somasundaram, O, "The Indian Lunacy Act, 1912: A Historical Background." *Indian Journal of Psychiatry* 29, 1 (January 1987): pp. 3-14, p. 9.

²⁵¹ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1912, Printed by the Superintendent, Government Press, Madras, 1913, p. 12.

²⁵² Major R. Bryson, op.cit, 1913, p. 2.

Madras Government started admitting the voluntary boarders. There were six voluntary admissions took place in 1912-13 took place in Madras lunatic asylum, but there are no admissions in Vizagapatam and Calicut²⁵³, and in 1913-14 Seventeen in Madras Presidency^{254, 255}. Vizagapatam lunatic asylum also received two voluntary admissions in the year 1913-14²⁵⁶. During the consequent years voluntary admissions have increased considerably. Here we should pay tribute to the foresight of the Governor of the Madras when we remember that the voluntary admissions were made possible in England and Wales only in 1930 by the Mental Treatment Act²⁵⁷. The 1912 Act was to remain the backbone of the legal apparatus for dealing with those considered 'insane' until 1987²⁵⁸.

The enactment of Indian Lunacy Act 1912 can be symbolized as historical trajectory which in turn drastically altered the whole system of Mental Health Services and administration even in British India. With the 1858 Lunacy Acts, native lunatic asylums occupied an uneven position between medical and judicial dichotomy of this colonial government. After this Act, mental health supervision was released from the grip of the Inspector General of Police and Psychiatrists were appointed as fulltime officers in mental hospitals. Therefore, it is relevant to mention that by the enactment of the 1912 Act, these asylums transformed into exemplary colonial institutions, guided by psychiatric doctrine and were filled with Western-trained Indian doctors who did not entertained much of other alternative belief systems in this colonial space. Provision of this Act paid more attention to increase the legal safeguard against

²⁵³ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1912, op.cit, p. 12.

²⁵⁴ Report on the Administration of the Madras Presidency, during the year, 1912-13, Madras: Printed by the Superintendent, Government Press, 1913, p.89.

²⁵⁵ Report on the Administration of the Madras Presidency, during the year, 1913-14, p. 83.

²⁵⁶ Statistical returns Of the Lunatic asylums in the Madras presidency for the year 1913, p. 12.

²⁵⁷ Somasundaram, O, op.cit, 1987, p. 9.

²⁵⁸ Mills, James H, Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947, *International Review of Psychiatry*, August 2006; 18(4): 333–343, p.234.

wrongful imprisonment and proposed rigorous criteria for certification of the mentally ill²⁵⁹.

This act suggested improvement of improvement and establishment of new asylums. A gradual increase in the number of patients led to additional wards being constructed. Under the legislation of Indian Lunacy Act 1912 a Central lunatic asylum was established in Berhampur for European patients, which was later closed after the establishment of Central European Hospital at Ranchi on 17th May, 1918, (now known as Central Institute of Psychiatry). This was mainly due to its exclusive character it was meant almost entirely for European patients and was staffed by British Army doctors²⁶⁰. Mental institutions had been under provincial control since 1919, but responsibility for any Indian Medical Service staff associated with them lay with the central government²⁶¹. For the next few decades the Ranchi hospital became a symbol of excellence in India. In 1922, it was put under the control of a Board of Trustees with various participating state governments represented in the Board. The notable fact was that from 1922 onwards this Institution was affiliated to the University of London for the Diploma in Psychological Medicine examination. It was a unique phenomenon since the postgraduate training in Psychiatry was nonexistent in India during those days.²⁶² Superintendent Lt. Col. Owen A.R. Berkeley Hill (1919 to 1934) made the Ranchi institution the foremost institution in India at that time. He was deeply concerned about mental hospitals in those days²⁶³.

²⁵⁹ Basu Saumitra, op.cit, 2016, p. 488-489.

²⁶⁰ M.A.M. Khan, "Indian Psychiatry: The British Connection" ", in S. P. Agarwal (Ed), *Mental Health an Indian Perspective 1946–2003*, Directorate General of Health Services Ministry of Health and Family Welfare, New Delhi, 2005, p. 62.

²⁶¹ Ernst Waltraud, The Indianization of Colonial Medicine The Case of Psychiatry in Early-Twentieth-Century British India, N.T.M. 20 (2012) 61–89, 0036-6978/12/020061-29, DOI 10.1007/s00048-012-0068-7, Published online: 4 May 2012, p. 72.

²⁶² Ernst Waltraud, op.cit, 2011, p. 536–537.

²⁶³ Sharma S.D, "Mental Health: The Pre-independence Scenario", in S. P. Agarwal (Ed), *Mental Health an Indian Perspective 1946–2003*, Directorate General of Health Services Ministry of Health and Family Welfare, New Delhi, 2005, p.28.

Lunatic Asylums to Mental Hospitals

Steps are being taken to bring the Lunatic Asylums into line with the mental hospitals in the United Kingdom. However, the standard of medical treatment, nursing, accommodation and the opportunities for recreation of convalescents are greatly below those in the Asylums of Great Britain. This movement reflected in India also A.W, Overbeck-Wright explains in his work *Lunacy in India* “To whichever class the visitor belongs, I think he leaves us with his views very considerably altered. In fact, one such visitor, well-educated and intelligent, remarked, when taking his departure: "An asylum! This is not an asylum! It is a hospital where sick people are treated! Why is it not called a hospital, and its true nature spread among the community?"²⁶⁴. Let the title "asylum" be discarded. It will take longer to strip it of the old erroneous prejudices attached to it than to vest in a new title a proper belief in all the relief and benefits derivable from such an institution. "Mental Hospital" is not so much longer, nor so much more difficult to pronounce, and gives at once a true idea of the intention of such institutions, and one which can readily be grasped by the most ignorant ryot. They know the benefits to be obtained at a hospital, and its purpose, and at once we attain two objects: we do away with the old ideas and prejudices attached to the term "asylum," and at the same time instil a dim perception of the fact that if it is a hospital then its inmates must be ill, and as all illness is not incurable why should not some of these invalids also recover? To still further carry out this view would be to start out-patient departments in connection with such institutions. Here incipient cases might be brought for advice and consultation cases who have had previous attacks, relatives seeking advice, would all have the benefit of expert opinion. Such dispensaries would be found to afford many opportunities for the application of preventive measures and the dissemination of knowledge²⁶⁵.”

There seems to be still far too great a tendency to be satisfied in India with an asylum that partakes of the nature of a medical prison rather than of treatment in a “hospital

²⁶⁴Overbeck-Wright, A.W, *Lunacy in India*, London Bailliere, Tindall and Garden and Cox, 1921, p. 137.

²⁶⁵ Overbeck-Wright, op.cit, 1921, p.138.

for mental disease”²⁶⁶. There has been a distinct attempt made to pass from the state of the lunatic asylum to that of a hospital for patients suffering from mental diseases²⁶⁷. The sustained efforts of Dr. Berkeley Hills and many of his colleagues persuaded the government to change the term ‘asylum’ to ‘hospital’ in 1920²⁶⁸. “The Indian Lunacy Act was specially amended in last year (1922), in order to allow of the asylums being styled “Mental Hospitals,” with a view to emphasizing the fact that these institutions are intended to serve as hospitals where modern scientific treatment can be afforded to mental patients, rather than as prisons where lunatic can be interned. The Government has accordingly directed the change of the designation of the lunatic asylums in the Madras Presidency into “Mental Hospitals”²⁶⁹. The purpose of the asylum shifted from refuge to hospital. More specialist staff is employed and ‘lunatics’ become ‘patients’. While talking about Kerala scenario Santhosh Abraham says “The change of terminology of the asylum from Lunatic asylum to Mental hospital soon after the Indian Lunacy Act 1912, also indicated the clear shift towards professional and scientific psychiatry in 20th century”²⁷⁰. It was the effort of Berkeley Hill that not only raised the standard of treatment and care in the mental hospital at Ranchi but it was his persuasion with the Government that the names of all mental asylums in India were changed to mental hospitals”²⁷¹.

There are several developments took place in the field of Colonial Indian psychiatry during first half of the twentieth century. They are, psychopathology has been

²⁶⁶ Triennial Report on the Working of the Lunatic Asylums in the Madras Presidency for the Period 1918-1920, Printed by the Superintendent, Government Press, Madras, 1921, p. 5.

²⁶⁷ *ibid*, p. 6.

²⁶⁸ Haque Nizamie S and Nishant Goyal, History of psychiatry in India, *Indian Journal of Psychiatry*. 2010 Jan; 52(Suppl1): S7–S12.

²⁶⁹ Report on the Administration of the Madras Presidency, during the year, 1922-23, p. 88. & G.O. No. 1427, Local Self-Government (Public Health) Department, dated the 27th August 1923; Statistics of British India, Vol. III, Public Health-Lunatic Asylums. & Somasundaram O, (Ed) op.cit, 2008, p. 25.

²⁷⁰ Abraham Santhosh , op.cit, 2018, p. 129.

²⁷¹ Muktesh Daund, Sushma Sonavane, Amresh Shrivastava, Avinash Desousa, and Sanjay Kumawat, op.cit, 2018, p. 241.

elucidated and psychological treatment given ever widening scope and sanction²⁷², with the invention and application of psychoanalysis by Sigmund Freud²⁷³. There were other significant changes that took place during this period. This Period saw growing appreciation of need for Occupational therapy was recognized as a part of the treatment given, in addition to other rehabilitative measures, during the third decade of the century. The need of associating social scientists, mainly psychologists in the diagnosis and management of psychiatric patients, was also gradually realized and practiced for the first time in 1920–1930 at Ranchi. The first efforts to train psychiatrists and psychiatric nursing personnel were made during this period at Ranchi. And made first efforts to educate psychiatrists and psychiatric nurses, and establish links with families of patients through family units in hospitals as a part of the social awareness. The origin of psychiatric rehabilitation in India can be traced to innovative service programs which were initiated at the Central Institute of Psychiatry (CIP) in 1922 when Occupational Therapy Unit started at this place²⁷⁴. Girindra Shekhar Bose founded the Indian Psychoanalytical Association (IPA) in 1922 in Calcutta and Berkeley-Hill started the Indian Association for Mental Hygiene (IAMH) at Ranchi (1924)²⁷⁵. In 1930, an Association of the Medical Superintendents of Mental Hospitals (AMSMH) was established²⁷⁶. All of these emphases mirror what was happening in contemporary Western psychiatry²⁷⁷.

²⁷² Roy Porter, *Madness a Brief History*, Oxford University Press, New York 2002, p. 5.

²⁷³ Psychoanalysis means a set of techniques for exploring underlying motives and a method of treating various mental disorders; based on the theories of Sigmund Freud. / A system of psychological theory and therapy which aims to treat mental disorders by investigating the interaction of conscious and unconscious elements in the mind and bringing repressed fears and conflicts into the conscious mind.

²⁷⁴ Nizamie SH, Goyal N, Haq MZ, Akhtar S, op.cit, 2008, p. 144-8.

²⁷⁵ Basu Saumitra, op.cit, 2016, p. 480.

²⁷⁶ Sharma S. D, op.cit, 2005, p. 28.

²⁷⁷ Fabrega Horacio, Jr .*History of mental illness in India: A cultural psychiatric retrospective*. Delhi: India: Motilal Banarsidass; 2009, p. 554.

The Indianization of the colonial medical service

Following the hegemonic premises of colonial rule, the upper positions of the colonial medical service in India were, during the vast majority of the time frame, involved by Europeans as it were. Notwithstanding, the association among colonizer and colonized changed significantly in the first quarter of the twentieth century. Historians of colonial medicine in India have rarely explored how developments such as the decentralization of some of the colonial services in 1919; the establishment of local self-government in the various provinces in 1935; and in particular the “Indianization” of the colonial services affected western-trained Indian doctors and the nature of medical service provision²⁷⁸. In relation to this few interesting advancements took place in the field of Colonial psychiatric practices in India too.

During the 1920s and 1930s, the Indianization of the colonial medical service was in full swing and Indians increasingly came to occupy senior appointments in the Indian Medical Service and in the other medical service organizations in India. Some of the issues related to the position of indigenous agency in the field of psychiatry are explored, and the personal and professional experiences resulting from it. Rather, it explores how colonial subjects in senior positions in India negotiated the changing parameters of colonial rule just a couple of decades prior to Independence. Such subjects at times successfully cut across the boundaries of colonial preferentialism in some respects, while being simultaneously caught up in professional competition and subject to social prejudice rife among the different segments of European and Indian society. The evidence is derived mainly from colonial government reports, British medical journals, personal correspondence and the institutional records pertaining to the Indian Mental Hospitals²⁷⁹.

Clearly, while the medical services were being “Indianized,” the new brand of Indian colonial servant was not to take the initiative to Indianize or reform medical policy. There were persistent financial problems and policies of self-help and decentralization

²⁷⁸ Ernst Waltraud, *op.cit*, 2012, p. 62.

²⁷⁹ *ibid*, p. 63.

were championed. Moreover, during the 1920s and early 1930s the Independence movement in its various manifestations as political agitation, non-cooperation and armed rebellion had been particularly strong throughout India²⁸⁰. By 1933, the language of “nation-building” and reference to the needs and problems of different communities was particularly contentious²⁸¹. The case of Indianization discussed above highlights issues relevant to the history of British colonialism in South Asia and the history of medicine during the early twentieth century. It has been shown that Psychiatrist or Doctor’s professional career and personal life choices reflected the new opportunities opened up during this period by the colonial government in response to nationalist demands for Indian self-government²⁸². It also exacerbated competition among Indian doctors for key positions in the customarily supreme Indian Medical Service. Despite formal equity, there was continued discrimination. How the latter manifested itself and stamped the experience of senior Indian staff depended on the medical qualifications they had gained, their specific service affiliation, and local parameters. All of these factors require attention, not least in order to avoid a medical history that focuses on official policies and homogenizing proclamations rather than the continuities (as well as changes) and the multifaceted experiences and contradictory trends concomitant on the “constitution of a new imperial order” in varied localities during the period of Indianisation²⁸³.

However, it appears from the official sources that regime of psychiatry in the early years of twentieth century has become more accommodative to Indian conditions as scholars identified more of official Indianisation tendencies in the form of incorporating Indians into the structures of British government. However, the reason for Indianisation was also identified as due to the contemporary decolonization tendencies as well as due to the press for self- government in India²⁸⁴. In the case of Calicut asylum the superintendents, doctors, nurses and asylum administrators were

²⁸⁰ *ibid*, p. 74.

²⁸¹ *ibid*, p. 74-75.

²⁸² *ibid*, p. 83.

²⁸³ *ibid*, p. 84.

²⁸⁴ Abraham Santhosh, *op.cit*, 2018, p. 127.

English up to 1912 and medical reports have noted the recruitment of native doctors and nurses after 1912 due to increased Indianisation in the colonial provinces. Apart from these, most of the other staffs employed in the asylum were recruited from the local community, like hospital assistants, attenders, cooks and other servants²⁸⁵.

The first efforts to train psychiatrists and psychiatric nursing personnel were made during this period, “They (The Government of Madras) have also recently sanctioned the deputation of a selected Assistant Surgeon to England for special training in mental diseases in order to provide expert medical treatment in the mental hospital”²⁸⁶. The appointment of Superintendent of the Mental Hospital, Madras, has been reserved for a member of the Madras Medical Service, and in order that a specially trained medical officer may be available to take charge of the appointment, the Government have deputed Dr. Henry Samuerez. Hensman, an officer of the Madras Medical Service (MMS), to England for a period of one year for training in the treatment of mental diseases²⁸⁷. He was the first Indian Medical Superintendent; He hailed from Jaffna and trained in Psychiatry in the United Kingdom. He served as the Deputy Superintendent for a considerable time under various senior I.M.S officers. He took charge as Superintendent in 1924. He appears to have been the first doctor to hold that post without the fear of unusual transfer, a feature of Government service. Since he had additional training in psychological medicine he could hope to continue to work in the specialty till retirement and he set in motion changes affecting the hospital²⁸⁸.

Psychiatric Clinic in a General Hospital in India

For the first time, the emphasis shifted from custodial care to a curative approach in some of these hospitals. This attitudinal change also led to another significant

²⁸⁵ Abraham Santhosh, op.cit, 2018, p. 130.

²⁸⁶ Government of Madras Local Self-Government (Public Health) Department, G.O. No. 1427-P.H., 27th August 1923, Mental Hospitals, Statistical returns for 1922-recorded with remarks, p. 1.

²⁸⁷ Triennial Report on the Working of the Mental Hospitals in the Madras Presidency for the year 1921, 1922 & 1923, p. 5.

²⁸⁸ Somasundaram. O, op.cit, 2010, pp. 113-114.

development. Growth of general hospital psychiatry in our country a revolution in the history of modern psychiatry, this progressive trend is also called psychiatric outpatient service. It is generally agreed that the establishment of psychiatry units in general hospitals has done more to advance psychiatry than any single diagnostic or therapeutic discovery could do. These units have become easily accessible to the general population and were instrumental in reducing the stigma attached to mental disorders. There was been long story behind the establishment of the psychiatric clinic in general hospital in the world and Indian context.

During the early decades of the 20th century a movement was initiated, first in the USA and then in the UK to improve the quality of care for mental illness and to disseminate knowledge about mental health amongst the masses. In order to organize this movement a National Committee for Mental Hygiene (NCMH) was established in the USA in 1909. This was followed by the formation of a Mental Hygiene Council (MHC) in the UK in 1923. The educated and the enlightened people of all walks of life were enrolled as members of these organizations. The impact of their activities was felt on the shores of India very soon. On active encouragement from the MHC of UK, the IAMH came into being at Simla on 23rd August 1928. The membership of the association was open to all who subscribed to its aims and objectives and participated in all activities towards their implementation. Lt. Col. Owen Berkeley – Hill was elected as its first President. The aims and objectives of the association, as attributed by its President, were as follows –

- 1). To disseminate the knowledge about mental hygiene amongst masses
- 2). To organize meetings, seminars and popular lectures on mental health and mental illnesses
- 3). To establish a library for storing and distributing books on mental health and allied disciplines.
- 4). Publication of a quarterly Bulletin of the Association
- 5). Establishment of treatment centres for mental illnesses.

The Calcutta Chapter of the Association was opened sometime in late 1929. Dr. Girindra Sekhar Bose, who was the Founder President of Indian Psychoanalytical Society (established in 1922) and the then head of Department of Psychology, Calcutta University was a leading member of the Association at Kolkata. The Calcutta Chapter, under the leadership of Dr. Bose, took an active part in implementing the

rather ambitious plan of the Association. From a small beginning (with five founder members) this subcommittee of the Association grew in size rapidly. In course of less than four years, by the beginning of 1933, its membership rose to 264²⁸⁹. The Association decided to establish a home for the Mentally Retarded for their custody, care, and training. Support in the form of money, land and voluntary expert service came readily and the Home was established on 24th April, 1932. The name of the Home *Bodhana Niketan* was coined by the Nobel Laureate poet Rabindranath Tagore.

The next step taken by the Association was the opening of a psychiatric outpatient clinic in a general hospital, under the leadership of Dr. Girindra Sekhar Bose, persuaded the authority of Carmichael Medical College (CMC), Calcutta and then run by a non-profit-making private organization to allow it to open a psychiatric outpatient clinic in the college premises. It was agreed that the Association would pay for the expenses of the clinic. Thus the stage was set for opening the doors of the first psychiatric outpatient clinic in a general hospital in India. This is the precursor to the present-day general hospital psychiatric units in India.

Though the OPD (Out Patient Department) clinic was opened on 1st May, 1933 the first patient was registered on the following day i.e. 2nd May, 1933. The original case record of this patient is still preserved and displayed on the wall of the chamber of the Head of the Dept. of Psychiatry of R.G. Kar Medical College. It is on record that 174 new cases attended the clinic during the first year of its existence²⁹⁰. The second such unit was organized by Dr K.R. Masani at the J. J. Hospital, Bombay in 1938²⁹¹. This progressive trend, however, remained confined to the two major metropolitan centers and mental hospitals continued to constitute the backbone of the system. And a department of Neurology and Psychiatry was established in the Calcutta Medical College in 1939 by an order of the Government of Bengal.

²⁸⁹ Banerjee Gauranga, First Psychiatric Clinic in A General Hospital in India, [Www.Psyplexus.com](http://www.Psyplexus.com)., pp. 1-2.

²⁹⁰ Banerjee Gauranga, op.cit, p. 2.

²⁹¹ Sharma S. D., op.cit, 2005, p.29.

In Madras initially 'There was no separate outpatient department but a Senior Medical Officer would take the responsibility of seeing all the new patients, record their names and addresses, maintaining a register'²⁹². In 1940 as an experimental measure 'On the recommendation of the Surgeon-General, the Government have sanctioned the opening of an out-patient Clinic in the King George Hospital (KGH), Vizagapatam. It is hoped that with suitable publicity of the facilities afforded, the clinic will become popular and very useful'²⁹³. The general hospital psychiatry units are able to carry on the delivery of psychiatric services to the surrounding localities and reduce the strain on the main Mental Hospital. Dr. A.S. Johnson started the psychiatric clinic at the Government General Hospital (GGH), Madras in 1949 for out-patients only; open 3 days a week. He was assisted by 2 or 3 Medical Officers from the Government Mental Hospital (GMH)²⁹⁴.

An old ward opposite the Superintendent's original office was vacated to accommodate the Out-patient Department. Staff, furniture and equipment were organized as also arrangements for Electroconvulsive therapy (ECT); a small area was reserved for 'Day Hospital' treatment. New cases registered and records were maintained. One Senior Medical Officer, Dr. A. Venkoba Rao who was an MD in General Medicine and already experienced, took charge of the out Out-patient Department. Patients were examined, thoroughly screened and admitted only if necessary. This Outpatient and Day Hospital arrangement worked very well and proved very effective in reducing the strength of the hospital and the new Outpatient building and departments in improving awareness of the advantage of treatment among the family members. Since the temporary arrangement of running an OPD. in a small ward was found inadequate, it was decided that a separate out-patient Block should be constructed for the exclusive management of outpatients. In 1966, a new Out-patient Block was therefore opened up in the land adjoining the hospital²⁹⁵.

²⁹² Somasundaram O, op.cit, 2008; p. 85.

²⁹³ Government of Madras, Education and Public Health Department, (Public Health), G.O. No. 1427, 3rd April 1941, Report-Administration Report on Mental Hospitals, 1940- Reviewed, p. 4.

²⁹⁴ Somasundaram O, op.cit, 2008, p. 21

²⁹⁵ *ibid*, pp. 85-86.

Apart from the above developments in the field of Mental illness in Madras Presidency, This field of psychiatry have produced committed and psychiatrists their contributions are discussed respectively. Lt. Col. Dr. G.R. Parasuram, an alumnus of Eduinburgh was to join as Deputy Superintendent several years before Dr.Hensman retaired in 1937. The two of them were responsible for instruction on ‘Mental diseases’ to the undergraduate medical students who visited the hospital for the two weeks during their final year of studies²⁹⁶. He could not assume the Superintendant post in 1937, as he had to join the Army in the Second World War²⁹⁷ and also acted as Interim superintendent of the Kalipauk Mental Hospital²⁹⁸. He was a dynamic person and one of the earliest psychiatrists to start and run a large private psychiatric facility successfully at Palghat, Kerala after retirement. It attracted numerous patients from Tamilnadu and Kerala, not to mention the other states of India²⁹⁹.

Dr. J. Dhairyam took charge as Superintendent and, during his stewardship, the system of admission as ‘voluntary boarders’ gained increasing popularity. Indigenous medicines were tried on a large scale. Particular mention has to be made of the introduction of ‘convulsive therapy’ and insulin coma therapy, as well as modified Intermediate Care Team (ICT)³⁰⁰.

Dr.Hensman was succeeded by Dr.S. Venkatasubbarao, he had been holding appointments as Physician in teaching institutions for several years, even after taking the Diploma in Psychological Medicine (DPM). He has made a special study of Psychiatry, has been the Superintendent of the Government Mental Hospital, Madras, for about four-and-a-half years, he retires from service in March 1941³⁰¹. He

²⁹⁶ Ibid, p. 25.

²⁹⁷ Somasundaram. O, op.cit, 2010, pp-114 & 115.

²⁹⁸ Somasundaram O, (Ed) op.cit, 2008, p. 114.

²⁹⁹ Somasundaram. O, op.cit, 2010, pp. 114 & 115.

³⁰⁰ Somasundaram O, (Ed) op.cit, 2008, p. 26.

³⁰¹ Government of Madras, Education and Public Health Department, (Public Health), G.O. No. 1427, 3rd April 1941, Report-Administration Report on Mental Hospitals, 1940- Reviewed, p. 4.

remembered by the excellent Doctor-patient relationship, which is unique and memorable³⁰².

The World War II (1939-1945) saw a separation of military psychiatry from psychiatry in general. It is at this juncture of time the history of modern psychiatry in India seemed to have returned to its origin. The Ranchi European Hospital was one of the first to begin these radical practices and thus became a symbol of excellence. Later in the 1940s, the emphasis was on improving the conditions of existing mental healthcare and the treatment programmes. Systematic efforts for using physical treatment methods like Electro-Convulsive Therapy (ECT), insulin-coma treatment and psychosurgery began in the late thirties. Electroencephalography (EEG) was introduced for diagnosis

The Asylum bore the appearance more of a prison than of an Asylum for Lunatics. However, accommodation at asylum itself was without doubt very insufficient. Overcrowding in the Lunatic Asylums had again become a serious problem³⁰³. The asylum population then confined in the asylums of Madras Presidency was in excess of the accommodation. In the Indian Medical Review (IMR) of 1938 noted that there are 17 mental hospitals in British India with an accommodation for 8425 patients, but the number of patients actually confined in the hospitals in 1936 was 11,792. There was overcrowding in almost all the hospitals, but it was more acute in Madras, Bombay and United Provinces³⁰⁴. It is evidenced in the official reports of Madras Presidency that there is longstanding complaint of overcrowding in the Mental Hospital, Madras, the population of which had steadily increased from the average of 1,285 in 1935 to 1,611 in 1940³⁰⁵. In the same way the existing accommodation for

³⁰² Somasundaram O, (Ed) op.cit, 2008, p. 10.

³⁰³ Government of Madras, Education and Public Health Department, (Public Health), G.O. No. 1310, 27th April 1946, Report - Mental Hospitals- Administration Report for 1945- Reviewed, p. 1.

³⁰⁴ Srinivasa Murthy, R. *Development of Mental Health Care in India 1947-1995*, Voluntary Health Association of India, New Delhi, 2000, p.4.

³⁰⁵ Government of Madras, Education and Public Health Department, (Public Health), G.O. No. 1427, 3rd April 1941, Report-Administration Report on Mental Hospitals, 1940- Reviewed, p. 1.

patients in the Mental Hospitals at Waltair and Calicut continues to be inadequate and there is a tendency for the population to increase still further in these hospitals.

Bhore Committee Report

It was against this background that the Government of India in 1946 appointed a high level Health Survey and Development Committee, headed by Sir Joseph Bhore, to review the entire public health sector in the country, including the 19 mental hospitals which, together, accounted for 10, 181 beds. The monumental report produced by this committee, generally referred to as the Bhore Committee Report, and became indispensable for health planners in independent India and merits attention even today³⁰⁶. By the end of colonial rule in India worst conditions were prevailed in the asylums, this was it reflected in the Committee report. In 1946, Col. M. Taylor, the Superintendent of European Mental Hospital at Ranchi as a member of Health Survey and Development Committee, was asked to survey mental hospitals. He visited Madras Mental Hospital also³⁰⁷, According to his report, he observed that majority of mental hospitals in India were quite out of date and are designed for detention in safe custody without regard for curative treatments. Worst at that, Punjab hospitals, Thana hospital, Nagpur, Bombay, Agra hospitals savour of the work house at prison and should be rebuilt. The remainder should be improved and modernized, interestingly, the three cities of Bombay, Calcutta and Madras which had the distinction of having 13 mental hospitals in the country, the two cities of Bombay and Calcutta ceased to have any mental hospital to meet the needs of the community. It was also observed by him that there was a gross inadequacy of medical personnel in all mental hospitals both numerically and in specialized qualifications. Similarly, there was an acute inadequacy of the nursing staff and other attendants³⁰⁸.

³⁰⁶ Sharma S. D, op.cit, 2005, p.29.

³⁰⁷ Annual Report on The Working of the Mental Hospitals in the Madras Presidency for the year 1945, p. 2.

³⁰⁸ Bhore Sir Joseph, Report of the Health Survey and Development Committee, Government of India Press, Simla, Volume-III, 1946, p.49.

He visited Madras Mental hospital, his observations are follows, the hospital is built over a large area approximately 60 acres, and there is ample ground space and plying fields, the buildings are good and are kept in a good state of repair. The hospital is grossly overcrowded, and only a small percentage of the patients have cots. He observed that the custodial care is of a reasonably good standard, accordingly he defined the term “Custodial Care” as the orderly and systematic-methods by which physical, recreational, and hygienic activities are regularly carried on. The Medical Superintendent holds the degree of M.B.B.S. (Madras), he had no Post-Graduate courses of instruction, and has been on the staff of the hospital for 14 years; the members of the medical staff are temporary and belong to the General Service cadre, and are not highly qualified. The ratio percent of admissions, recoveries, discharge, figures are indicate that detention rather than therapy is the main function of this institution. He expressed an opinion that the “responsibilities are too heavy for Superintendent, who has had no clinical or Post-Graduate experience at side the Madras Mental Hospital. I understand t he Madras Government proposes to press for the release of the permanent Superintendent at present serving as Psychiatrist in the Army, and I consider is an urgent necessity”. There are no Outdoor Psychiatric Clinics at any of the Madras and this well, for there are no officers with the qualifications and experience to conduct such clinics.

The Medical Superintendent is responsible for the training of Under-Graduates from the Madras, Stanley and Missionary Medical Colleges. At that point of time, there are no facilities in Madras for the Post-Graduate training in Psychiatry. The Lt.-Col. G. R. McRobert, I.M.S., Professor of Medicine Madras, has delivered before the Council of Post-Graduate Medical Education of the University of Madras “For disease of Mind we have not in the whole Madras Presidency with its teeming millions, and vast amount of mental disorder and Pay-choneuroses, a single a single Mental Expert, technically qualified to teach even up to the pass M.B. standard, far loss to instruct Specialists”. He observed that “The Social Services which I was invited to visit in Madras are the pioneering stage. There will be no co-ordination in Social Services until Madras has an organized Mental Health Efficiency is not possible until an

adequate number of trained Psychiatric back-and-Psychologist is available”³⁰⁹. The Committee did not reflect the conditions of Calicut and Waltair Mental Hospitals.

Besides other recommendations, he stated that the Indian Lunacy Act of 1912 has outlived its usefulness. Similarly, to improve the conditions he suggested that there was a need of a Directorate Central Health level as well as in Provinces³¹⁰. As a follow up of the recommendations of this committee ‘the Indian Psychiatric Society’ (IPS) appointed in 1949, an ad hoc Committee of three distinguished psychiatrists, namely, Dr. J. Roy of Nagpur, Dr. R. B. Davis and Dr. Hasib of Ranchi. They prepared a draft of ‘Indian Mental Health Act (IMHA)’³¹¹.

The Indian Psychiatric Society (IPS)

Berkley Hill of Ranchi was able to organize the Indian Association for Mental Hygiene (IAMH) 1929. This association was affiliated to the National Council for Mental Hygiene (NCMH) in Great Britain. The first meeting of the superintendents of mental hospitals in India took place under the auspicious of the Indian Division of the Royal Medico psychological Association (RMPA) on January 24, 1939. It was attended by 20 psychiatrists under the chairmanship of Lodge Patch. The Indian Psychiatric Society (IPS) which was founded in January 1947. The Aim and objectives of the IPS at time of foundation are, Promotion of mental health, prevention, control, and treatment of mental disabilities, advising on the standard of education and training of medical and paramedical personnel in psychiatry, promotion of research in psychiatry and mental health, cooperation with other professional bodies, advising the government and other bodies on various aspects of psychiatry and mental health and to publish papers or periodicals. The Institute of Mental Health (IMH), Chennai, psychiatrists played an important role in the IPS from its inception. The first meeting held in the Delhi University Campus on 7th January, 1947. It was attended by the former Superintendent Dr. A.S. Johnson, he was one among the thirteen psychiatrists attended the first meeting. Since then the psychiatrists and

³⁰⁹ *ibid*, op.cit, 1946, pp. 49-50.

³¹⁰ *Ibid*, op.cit, 1946, pp. 49-50.

³¹¹ Shridhar Sharma, op.cit, 1990, p.68.

faculty members of this region actively associated and held prominent portfolio in the Indian Psychiatric Society³¹².

Summary

This chapter made us to understand the history of three mental hospitals in Madras Presidency, by studying them; it allows us evaluated the quality of asylum care and exiting conditions under British rule from 1870 to 1946. Among the three hospitals, Madras Mental Hospital is considered as Central asylum as it accommodates both Europeans and Indians, where as other two asylums accommodate Indians that is why they considered as native asylums³¹³. The standard of comfort in the Madras Asylum is greater than that at Calicut and much greater than that at Vizagapatam³¹⁴. This region contributed much to the field of Indian psychiatry. The Lunacy Act of 1912 had played a very significance in the history of Psychiatry in India. That act classified admissions into the lunatic asylum as two categories, i.e., compulsory admissions and voluntary admissions³¹⁵. This innovative a concept of ‘Voluntary Boarders’, is a unique contribution to the Indian psychiatry from the Madras Presidency. Bhore committee reports that there is not outdoor patient clinic in Madras³¹⁶; where as in 1940 as an experimental measure opened an out-patient Clinic at the King George Hospital in Vizagapatam, this facility becomes popular and very useful³¹⁷. Dr. Parasuram Superintendent of Madras Mental Hospital was also responsible for the establishing a private psychiatric nursing home at Palghat, Kerala after retirement. It attracted numerous patients from Tamilnadu and Kerala, not to mention the other states of India.

³¹²Somasundaram O, (Ed) op.cit, 2008, p. 124.

³¹³ Overbeck-Wright, op.cit, 1921, p. 395.

³¹⁴ Triennial Report on the Working of the Lunatic Asylums in the Madras Presidency for the Period 1918-1920, p. 5.

³¹⁵ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1912, p.12.

³¹⁶ Bhore Sir Joseph, op.cit, 1946, p.50.

³¹⁷ Government of Madras, Education and Public Health Department, (Public Health), G.O. No. 1427, 3rd April 1941, Report-Administration Report on Mental Hospitals, 1940- Reviewed, p.4.

Other side of these professional advancements there are some bad conditions too prevailed in this Presidency; they are, the Mental Hospitals in the Madras Presidency would more or less give a true picture of the conditions and progress of the other hospitals. The high walls all around and the ill-lit ventilated blocks of building and bad sanitary arrangements giving the appearance and atmosphere of a jail; the lack of accommodations, the legal difficulties in the admission of patients. The indifferent role of the visitors, inadequacy of staff untrained, illiterate bullying subordinate staff, poor quality and bad arrangements for the feeding of patients, the miserable arrangements for washing and bathing, the meagre clothing, insufficient or no bedding and entire absence of furniture which prevailed in the early days were graphically dealt with. The superintendents and their deputies had such a lot of extra professional duties that they had very little time to attend to the therapeutic needs of the patients. Treatment, not deliberately, but all unconsciously was not individual but mass treatment.

Chapter - 3

Social History of Mental illness in Madras Presidency

The social history of insanity is a recent growth area within medical history, before the 1970s historians and social scientists showed relatively little interest in the history of psychiatry or the institutions where their patients were housed³¹⁸. The existing scholarship has only scratched the surface of the rich stores contained in the history of colonial psychiatry. These works are primarily histories of psychiatric discourse, while the social history of these institutions remains largely unexplored. Only Ernst³¹⁹ engages gender as an analytical category: the others limit their discussions to sex, addressing male-female ratios without delving into the significance of gender in colonial madness. The historians must problematize this issue, especially considering the importance of gender in recent colonial studies and works on the history of psychiatry. Except Ernst and Debjani Das³²⁰, scholars have confined themselves to the nineteenth century, by getting inspiration from them; this chapter would like to extend further this study to the twentieth century and native women perspective.

Existing works on the history of mental hospitals are giving fewer details on the social history of insanity and this literature lead to inquire the social history of mental illness in the context of Madras Presidency from 1871 to 1947. This chapter exclusively focuses on Social history of Mental illness in Madras Presidency such as asylums of Madras, Calicut and Vizagapatam. It briefly discusses social lives of inmates behind the asylum walls. It mainly analyse the inmates and staff of the mental hospitals in Madras Presidency. It also focuses on the internal and external histories surrounding the mental asylums of Madras Presidency. This chapter would like to offer an Analysis on the dynamics of Caste, Region, Religion, Gender and Race through the

³¹⁸ Joseph Melling and Bill Forsythe (ed), *The Politics of Madness The State, Insanity and Society in England, 1845-1914*, London and New York: Routledge Taylor & Francis Group 2006, p.1.

³¹⁹ Ernst, Waltraud, "European Madness and Gender in Nineteenth- Century British India", *The Social History of Medicine*, 1996, pp. 357-382.

³²⁰ Debjani Das, "Is Insanity a 'Female Malady'? Lunatic Women in the Asylums of Bengal in the Nineteenth Century", *Social Scientist*, Vol. 39, No. 5/6 (May-June 2011), pp. 23-47.

lens of Social History of Mental Illness and medical practices in Indian perspective. These lunatic asylums were extraordinarily permeable spaces and allow us to examine multiple sites, multiple brands of colonial activity, on the ground in Madras Presidency. The investigation into various issues in the asylums and its surrounding the institutional practices helps to construct the social history of Mental illness.

Social history of the Mental illness is about the background of patient history. Such as Their age, gender, caste, religion, marital status, employment status etc. The Social background and Mental Status are the most important diagnostic tools a psychiatrist has to obtain information to make an accurate diagnosis. Although these important tools have been standardized in their own right, they remain primarily subjective measures that begin the moment the patient enters the Hospitals. By documenting the specific histories of the Institutions and positions of patients of in an asylum can thus help us to understand the evolution of the physical and the intellectual growth of psychiatry in Madras Presidency.

The routine life of the inmates revolved around the treatment employment and amusement, diet and space, as part of the administration reform and reward and patients and bureaucrat's resistance and adjustment. As part of the treatment work was emphasized for its therapeutic value but it looks profits were central in order to make asylums self-sufficient. Work, in fact, became the yardstick on which a patient's recovery was measured, and insanity was conceptualized as curable or incurable. The complex temporal and spatial materialities of everyday lives inside the asylum are studied here in order to comprehend the role played by various actors and discern how authority was constantly reordered and redefined. The investigation into various issues surrounding the asylum practices helps to construct the social history of Mental illness in Madras Presidency.

Inmates of the Mental Asylums

Colonial medical policies and practices in British India are often combined with the characteristics of both the police state and a liberal state in the colony. As part of the making of psychiatry in colonial India, the British enumerative practices in the lunatic asylum led to the classification, categorization, and construction of a different and

peculiar image of the colonial subject in the colony³²¹. Various institutional reports and correspondences of the colonial lunatic asylums in India provide statistical and qualitative information on insane.

The patients in the asylums were categorized according to their, caste, religion, private and public and also within the colonial judicial sphere of criminal lunacy³²². While classifications of patients' gender, age, occupation, etc., were in tone with the institutional base of asylums, and most importantly the 'criminal lunatics' were more problematic. In accordance with the Foucauldian thinking, these categories were new structures of social control and through these types of classification, the colonial psychiatry created the knowledge of the other, mostly for its scientific credentials and for justification.

It is in this juncture; this study brings, first, the importance of the new scribal practices in the institutional history of colonial medicine, more particularly in the case of psychiatry in India. The second focus emerged in the evidence of deeper colonial observation of the demographic trends from these quantitative notes. In this context, this study argues that the making and institutionalization of psychiatry and the colonial governmentality in India are inseparable. Many of the colonial scribal practices in Indian asylums particularly, the day-to day activities and routines in the asylums, procedures of admission of patients, introduction and prescription of medicines and the appointment of staff and nursing, etc., were always linked to the larger ideological, surveillance and law and order terrain of colonial governance in India³²³. This demographic knowledge shows that it was an attempt to classify and segregate the mentally ill. I would like to argue that the asylum reports and medical notes were seen as techniques of medical governance with a special objective of governing and controlling the 'insane' in a colonial setting. Statistical representations of the lunatic patients were indeed an attempt to construct a suitable ground for enacting interventions in social, physical and natural processes.

³²¹ Abraham Santhosh , 'Medicine and British Empire in South India: A Study of Psychiatry and Mental Asylums in Colonial Kerala', *Indian Journal of History of Science*, 53.1 (2018) , pp. 125-131.

³²² *ibid* p.130.

³²³ *ibid* p.128.

Since the time, the foundation of the lunatic asylums in Colonial India, there started several process of classification of inmates very early from the admission itself. Mental asylums received both male and female patients. Generally the patients were divided into two categories they are Civil and Criminal patients, again these two were classified into three categories, 1) Military lunatics 2) Civil lunatics and 3) Criminal lunatics³²⁴. All these categories were again divided on the basis of the class, race, caste and gender, within this, again the inmates of the asylum classified into following categories respectively; Europeans and Eurasians (East Indians), and the Natives were classified into Hindus, Mahomedans, Buddhist, Native Christians and Other Castes. The whole of the civil male and female lunatics have been maintained by the various Municipal and Local Fund Boards of the districts, and where as the criminal insane were funded by Government only³²⁵&³²⁶.

Admissions of Insane were categorised into Europeans and East Indians; Hindus; Mahomedans; Native Christians; Other Castes³²⁷. “Lunatics (According to the law in India) are either: Private Patients (who have friends or relatives willing to sign an admission order) or Public Patients (who are brought up by the police). Public Patients may be Civil (who are wandering at large, dangerous, etc., but have not committed themselves in any way before removal through the magistracy to an asylum) or Criminal (who have done some act which is against the law of the country)³²⁸.” The documents relating to patients incarcerated because they were considered ‘dangerous’ that is why they use to caught by Police and sent to the asylums. Besides these admissions from the civilian population, a considerable proportion of the patients were classified as criminal. During this period the number

³²⁴ Criminal lunatic means any person for whose detention in, or removal to an asylum, jail or other place of safe custody, an order has been made in accordance with the provisions of the Code of Criminal Procedure, of section 30 of the Prisoners Act, 1900, or of section 103A of the Indian Army Act, 1911.

³²⁵ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p.9.

³²⁶ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1883-84, the Government Press, Madras, 1884, p. 17.

³²⁷ *ibid*, p.4.

³²⁸ Major R. Bryson, *The Indian Lunacy Manual for Medical officers and the General Public*, Calcutta: Thacker, Spink & Co, (Third Edition revised by Captain P. Heffernan).1913, p.iii.

of community admissions was very small. However, there are examples which show that the Indian population did use these institutions despite the fact that they were based on alien notions of mental health and of correct treatment to restore this. Self-admissions all seem to have been vagrants and beggars who identified the asylums as places of refuge from their harsh life³²⁹. Medical Officers have Classification of Mental Patients to deal with two classes of insane, those who want treatment at the hospital or in their homes. Asylum patients were primarily from a poor social background, and of a low caste. Statistics and returns in the reports show gender, race, class, occupation and ethnicity of those admitted. The majority of Indian asylum inmates were made up of mendicants and beggars picked up from streets and bazaars by police for threatening the public peace and order.

Apart from the family members sometimes, other members of the community could be involved in admission procedure, one of the reason is that they (the local community) gradually began to realise that there was an opportunity presented by the British institutions to pass on the costs involved in providing for non-productive members of their families³³⁰. Formal procedure after the admission in the asylum, on the arrival of a new patient, he/she is to be washed, have his hair cut or shaved, and receives asylum dress. He/she will then be left for a short time under observation, until his habits, disposition have been ascertained, so as to admit of his being placed in the appropriate class³³¹.

There were native patients and British doctors in every 'native' asylum. Each asylum was assigned a superintendent, and there were also Official Visitors, men or women from the government who – along with their other responsibilities to the Crown – visited a particular asylum up to four times a year to check on its functioning. In contrast to the official visitors, there were native medical assistants, who had no official training, but received a small wage to assist the British doctors. Beyond these

³²⁹ Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p.336.

³³⁰ Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p.336.

³³¹ Code of medical and sanitary regulations for the guidance of medical officers serving in the madras presidency, Section XVII, Lunatic Asylums, Volume-II, 1870, p.86.

official members, the asylum employed many non-medical personnel. These included cooks, cleaners, laundry men (dhobis), janitors, security men, and male and female attendants. These actors did not live on site in the asylum (although some of them may have slept overnight when acting as night attendants), but would have lived in the surrounding village or town, within close walking distance. On top of these regularly employed natives, the asylum embraced more disparate groups: tea sellers, for example, who visited on an ad hoc basis, and missionaries or religious gurus, all of whom had their own schedule, and payment of some type was expected afterwards. Finally, there were the patients' families, whose frequency of visitation depended on the nature of the familial relationship. Some patients had very concerned families and relatives in the asylum's immediate vicinity, who visited them almost daily, with food, gossip and care. Other patients, having been picked up, wandering the countryside, with little recorded family history, never received guests at all, unless mistakenly³³². an ecological perspective of the asylum allows us to see these people and those who were not the direct recipients of asylum care, including doctors, attendants, villagers and families, all of whom participated in life within and without the institution.

Criminal Patients

The basic criterion for the admission of Indians was to become their danger to the community at large rather than their state of mind. The criminal lunacy laws therefore did much to bring out into the open one major aspect inherent in lunacy policy towards Indians, namely its double function as a means of guaranteeing public peace and order, and of controlling and disciplining socially harmful misfits. The oft-proclaimed humanitarian ambition of governments in India to provide a refuge or retreat for those amongst its subjects who were afflicted by insanity and idiocy (regardless of whether they be violent) had fallen prey to the necessities of cost-effective institutional management and considerations for the safety of the public and particularly the expatriate community³³³.

³³² Anouska Bhattacharyya, 'Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858-1912', PhD theses, The Department for the History of Science, Harvard University Cambridge, Massachusetts, 2013, p.23-24.

³³³ Ernst Waltraud, *Mad tales from the Raj: the Colonial Psychiatry in South Asia, 1800-1858*, New Delhi: Anthem Press, 2010, p. 37.

Prior to the momentous enactments of 1858, legal provision had been made in 1849 and 1851 for a special group among the insane – ‘criminal’ lunatics: those amongst the mentally ill who had committed a violent act that would under ordinary circumstances have been punishable under the penal law. The association between states of ‘unsoundness of mind’ and the law was not peculiar to colonial rule alone, nor was it typical only of Anglo-Saxon legislation. Irrespective of the state of the law, ‘criminal lunatics’ had been subject to greater public apprehension than the mentally ill in general. This was not only due to the often reasonable fear that they might repeat a violent action, but also because it was frequently in question whether a verdict of ‘unsoundness of mind’ was legitimate. Shamming was after all suspected to be common practice among military servants. Insanity in particular was feigned as a last recourse by soldiers tired of military duty in the East and unable to buy themselves out of the service. The common view was that lunatics could not be held responsible for their actions and that they should be released once their mental derangement had subsided. From 1849 onwards, and even more so from 1851 when the legal situation was clearly circumscribed, early discharge would however no longer be guaranteed, as criminal lunatics had to be transferred to the jail in order to serve the full sentence in case they recovered from the mental affliction prior to the end of their term³³⁴.

The revolt of 1857 marked a major break as power was transferred from the East India Company to the Queen in 1858, which led to increasing legal management of the insane. The Queen’s proclamation brought with it the Lunacy Acts of 1858. While the laws proclaimed ethical treatment of the mad and suggested use of restraints only in extreme cases, they also legalized the process further by giving magistrates control over detaining anyone who had been examined by a medical practitioner³³⁵. This was the first act specifically designed to provide a legal framework for incarcerating those Indians considered mad by the British who had not come to the attention of the authorities through criminal behaviour. The legal provisions for criminal lunatics of

³³⁴ *ibid*, p.33-34.

³³⁵ Dhar Ayurdhi, *Madness and Subjectivity A Cross-Cultural Examination of Psychosis in the West and India*, Routledge Taylor & Francis Group, London and New York , 2020, p. 91.

the various administrations of India were also standardized in Chapter XXVII of the Criminal Procedure Code which was passed in 1861”³³⁶.

The distinction between the criminal lunatic and the lunatic admitted as neglected, dangerous or wandering is one that was central in asylum administration. Criminal male lunatics sentenced to rigorous imprisonment will wear a light iron ring on the left leg, and will be locked up at night.’ Dr Corbyn at the Bareilly asylum mentioned that ‘Criminal Lunatics are of course kept apart from the others, and have a yard and ward exclusively their own.’ It is not always clear that distinguishing dress, leg irons and spatial separation were enforced in other asylums³³⁷. A small but significant group of those admitted to the asylums has yet to be mentioned though. The number of criminal lunatics in the asylums is often difficult to calculate as the information available is patchy. However, it seems that by the end of the 1860s they made up almost a quarter of the population residing in the asylums³³⁸. However it is certainly the case that by the 1860s the criminal lunatic as a separate subgroup of the asylum population was recognized throughout the asylums of British India. It was not clear if the category of Criminal Lunatic was usurped by the Indian Penal Code of 1860 (where the label of criminality cannot be put upon a legally defined insane person), and this may have added to the confusion between medical and legal jurisdiction at the administrative level³³⁹. This is shown in the annually published reports supplied by the superintendents of each asylum in which a count of the criminal lunatics was routinely provided for each asylum, often with further statistics regarding their crimes, their marital status and so on. This division, between the criminal and the non-criminal, will initially be followed here³⁴⁰.

Perhaps the most significant set of figures though is those which show the proportion of the population incarcerated by the British in this period as criminals who were

³³⁶ Mills, James. *Madness, Cannabis and Colonialism: The ‘Native-Only’ Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p.12.

³³⁷ *ibid*, p.67.

³³⁸ *ibid*, pp.80-81.

³³⁹ Anouska Bhattacharyya, *op.cit*, 2013, p.78.

³⁴⁰ Mills, James. *Madness, Cannabis and Colonialism: The ‘Native-Only’ Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 67.

confined in the asylums as opposed to the lock-ups and prisons. Only in Bengal and the Central Provinces was more than 1 per cent of the total incarcerated criminal population resident in an asylum at the end of a year by the end of the 1870s. Figures available for the other provinces suggest in most cases a rise in the proportion of those confined being so in an asylum over the period (Bombay being a notable exception) but the figures remain extremely small. Quite simply then only a tiny percentage of those that the British had incarcerated across India because they had been convicted of a crime ended up in asylums while the overwhelming majority of these passed their sentences in prison. The question remains then of what was so distinctive about those individuals which were singled out among those incarcerated for crime which made the authorities segregate them in a separate institution³⁴¹.

The criminal lunatic means any person for whose confinement in, or removal to an asylum, jail or other place of safe custody an order has been made in accordance with the provisions of section 466 or section 471 of the Code of Criminal Procedure, 1898, or of section 30 of the Prisoners Act, 1900³⁴². In Indian asylums the so-called criminal lunatics are divided into three classes: (A) Those unfit to stand their trial owing to their mental condition rendering them unfit to make their defence (Section 466, Criminal Procedure Code). (B) Those who have stood their trial and been found to have committed the crime while labouring under mental disease (Section 471, C.P.C.). (C) Those who have been tried and sentenced, and while undergoing their term of imprisonment have become mentally affected and had to be sent to the asylum (Section 30, Act III. of 1900).

Class A are detained, as a rule, until fit to make their defence, though the magistrate has it in his power to hand them over to relatives on their security if he deem it fit to do so. When fit to make their defence such cases are sent to stand their trial, and then either handed over to relatives or returned to the asylum as Class B patients according to the circumstances of the case (Sections 467, 468, and 473 C.P.C.). Under this class are included persons who, though not technically insane, are through the loss of some special sense, such as being deaf and dumb, deprived of the power to make their

³⁴¹ *ibid*, pp.80-81.

³⁴² Major R. Bryson, *op.cit*, 1913, p. 42.

defence. Class B have to spend a probationary period in the asylum without showing any signs of insanity, and then the cases are reported to the Local Government, which passes orders as to whether they may be released or not, and whether security must be taken from their relatives for their proper supervision and control (Sections 474 and 475 C.P.C.). Act IV. of 1912 has repealed Sections 471 (2) and (3) and 472 C.P.C., and the period of probation in gaols prior to the release of Class B criminal lunatics is no longer necessary. Class C, if they recover before the expiry of their sentence, are returned to gaol ; if sane when the sentence expires, they are discharged as cured to their homes; otherwise they are transferred from the criminal to the non-criminal sections, and treated as ordinary lunatics admitted under Section 14, Act IV. of 1912³⁴³.

Therefore, any person charged with a crime and considered mentally ill had to be put forward by magistrates and jail officials for admission to the region's general mental hospital. These institutions were seen to be the most appropriate place of confinement for mentally deranged people who had committed a crime. Indian Lunatic Asylums Act of 1858, the Indian Lunacy Act of 1912 and subsequent amendments in conjunction with the code of criminal procedure of 1898, amended in 1923, and the Prisoners Act of 1900 provided for the detention of violent and dangerous mentally ill persons. These provisions were based largely on similar legislation in England and Wales³⁴⁴.

As for as the Position of Criminal Patients in Madras Presidency concerned that, The Reports from the 19th century onwards also refer to the better care that could be provided for this group, as 'criminal lunatics' were seen to require a distinct vigilance (no violence or punishment encouraged as far as the official documentations are concerned) from staff, by early 20th century the need for medical treatment increasingly predominated. This division, between the criminal and the non-criminal is followed in mental asylums. "Criminal lunatics were kept separate from other asylum inmates and were not usually allowed to partake in the few amusements and

³⁴³ Overbeck-Wright, A.W, *Lunacy in India*, London: Bailliere, Tindall and Garden and Cox, 1921, p.48.

³⁴⁴ Ernst, Waltraud, *Colonialism and Transnational Psychiatry: The case of the Ranchi Indian Mental Hospital in British India, c. 1920-1940*. London: Anthem Press, 2013, p. 35.

privileges granted to them”³⁴⁵. Patients who found themselves admitted were usually single black males who were criminal lunatics or had no community assistance.

The Annual reports attributing that both the physical and the moral causes of insanity among the criminal insane, the principal causes of insanity among the criminal populations of the asylum are given as follows. The hot season is the time when dangerous patients are usually admitted³⁴⁶. A large number of people sent to Madras Presidency Asylum as public patients had committed some kind of crime, most commonly murder, and grievous bodily harm³⁴⁷. Unlike any other feature, the reception of this group determined the treatment that could be pursued by hospital staff.

According to the G.O. No. 34, Judicial, of 13th January, 1890, all criminal lunatics in the Madras Presidency shall be concentrated in the Madras Asylum³⁴⁸. An enclosure for criminal insane as completed in 1892 when criminal lunatics were accommodated Madras asylum³⁴⁹. In 1892 criminal patients were transferred to Madras Waltair lunatic asylum and this asylum was reserved solely for non-criminal patients³⁵⁰, from then the asylum is stance for the civil and native lunatics only. The Calicut lunatic asylum transferred its criminal patients to Madras in 1893, from then it serves only non-criminal patients³⁵¹. When the Bhoire Committee mentioned that no criminal

³⁴⁵ Waltraud Ernst, *Mad tales from the Raj: the Colonial Psychiatry in South Asia, 1800-1858*, New Delhi: Anthem Press, p.35.

³⁴⁶ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 13.

³⁴⁷ Ernst, Waltraud, *Colonialism and Transnational Psychiatry: The case of the Ranchi Indian Mental Hospital in British India, 1920-1940*. London: Anthem Press, 2013, p.35.

³⁴⁸ Major R. Bryson, *op.cit*, 1913, p.19.

³⁴⁹ Varma L P, ‘History Psychiatry in India and Pakistan’, Vol-IV, *Indian Journal of Neurology and Psychiatry*, 1953, pp.138-164.

³⁵⁰ *ibid*. p.143.

³⁵¹ *ibid*, p.142.

patients were there in Madras asylum³⁵². Criminal lunatics are kept confined in the Mental Jail at Cuddalore³⁵³.

In the nineteenth century, the records of the lunatic asylums were more likely to be collected with the judicial/legal records than they were with the medical records, especially due to the high number of criminal lunatics being transferred between prisons and asylums. Criminal lunatics were confined in jails³⁵⁴. However, confinement at Madras Presidency asylums were not restored to for all criminal lunatics; on account of persistent accommodation problems, some were continued to be detained in jails³⁵⁵. With all these reasons lunatics use to transfer to the other asylums and the prisons. The Mental asylums and the prison were the few such sites, where the British had unlimited access to the Indian body. Persons under Act III of 1900, who have become insane while undergoing imprisonment in jail and are confined under warrant from Government; or in case of a capital sentence, prisoners who have become insane before the sentence can be carried out, and have had their sentence commuted³⁵⁶. The number of those certified as criminal insane confined at Madras Presidency asylums and the provincial jails was indeed very small in relation to overall population. Criminalisation of mentally ill people who had committed minor acts of nuisance such as pilfering. The gradual decrease in the number of criminal patients was partly due to the fact that several patients charged with petty offences were subsequently transferred to the non-criminal class with sanction of the government concerned³⁵⁷.

³⁵² Bhore Sir Joseph, Report of the Health Survey and Development Committee, Government of India Press, Simla, Volume-III, 1946, p. 53.

³⁵³ *ibid*, p.79.

³⁵⁴ Report on the Administration of the Madras Presidency, during the year, 1888-89, Madras: Printed by the Superintendent, Government Press, 1889, p.165.

³⁵⁵ Ernst, Waltraud, *Colonialism and Transnational Psychiatry: The case of the Ranchi Indian Mental Hospital in British India, c. 1920-1940*. London: Anthem Press, 2013, p.35.

³⁵⁶ Major R. Bryson, *op.cit*, 1913, p.17.

³⁵⁷ Ernst, Waltraud, *Colonialism and Transnational Psychiatry: The case of the Ranchi Indian Mental Hospital in British India, c. 1920-1940*. London: Anthem Press, 2013, p.37.

The role of Superintendents and Doctors

Every medical superintendent is probably in a position to raise the efficiency of the hospital in his charge provided he can get plenty of good ideas to work with. The Superintendents of asylums in the Presidency were in charge of providing the necessary information regarding mental illness to the government. And in those days the information about patients is available in a range of sources which include case registers, annual reports, official files, journal articles, and monographs written by the superintendents of the mental hospitals³⁵⁸.

The Superintendents of asylums were regularly updated with news on insanity and its treatment in England and Europe³⁵⁹. With this evidence of superintendents in many cases taking a keen interest in the medical theories of the day concerning their charges in the lunatic asylums it is possible to trace discursive circumstances in which the emphasis on physical information in the case notes can be understood³⁶⁰. However, the most interesting part of the survey is the visibility it gives to asylum superintendents. Colonial asylums were not considered prestigious spaces, yet they had to be managed by some representative of the colonial government. The survey reveals these undistinguished men who ran rather undistinguished institutions, with very little support from their government, and very few tools to organize themselves into a profession³⁶¹. Very often there is a scarcity of resources or lack of Govt interest and negligent attitude is prevailed in the asylums. The nursing of all the asylums and the attendance is far below, both in quality and in numbers that which is considered necessary in a European mental hospital. The Superintendent is not³⁶² provided with a

³⁵⁸ Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p.31.

³⁵⁹ Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, New Delhi: Oxford University Press, 2015, p.19.

³⁶⁰ Mills, James. Op.cit. 2000, p.31.

³⁶¹ Anouska Bhattacharyya, op.cit, 2013, p.32.

³⁶² Triennial Report on the Working of the Lunatic Asylums in the Madras Presidency for the Period 1918-1920, Printed by the Superintendent, Government Press, Madras, 1921, pp.5-6.

laboratory or the assistance which is necessary for detailed clinical investigation of each case³⁶³.

In the late eighteenth century, this cautious and even hostile attitude can partially be accounted for by the fact that madhouse superintendents rarely possessed any formal medical qualification. They not uncommonly included clergymen and ‘quacks’, as well as the medically qualified³⁶⁴. The impression that emerges from an examination of various asylum superintendents’ careers over the first half of the nineteenth century is not only one of increasing professionalization, but also of a process of the medicalization of madness³⁶⁵.

Those who cared for the mentally ill in British India were not always medical doctors. When medical practitioners became professionalized and distanced themselves from the trade in sickness, medically trained asylum superintendents lagged behind, as they failed to convince government and medical authorities of their special professional skills. By mid-century, however, the medicalization of madness in India was all but complete, as Western expertise in the care of the sick in mind joined that of the sick in body as a significant component of the apparatus for imposing the enlightened nostrums of European civilization upon colonial India – at the expense of indigenous skills³⁶⁶.

There was no lunacy board; army medical officers with no particular training in psychiatry administered the asylums, medical practitioners who were referred to as ‘alienists’ in the nineteenth century³⁶⁷. The lunatic asylum superintendent was no specialist in mental illness during early 19th century in British India. In other words, the Civil Surgeon who found himself charged with the superintendence of the local

³⁶³ *ibid*, 1921, p.5.

³⁶⁴ Waltraud Ernst, *op.cit*, 2010, p.69.

³⁶⁵ Mills, James. *Op.cit*, 2000, p.77.

³⁶⁶ Waltraud Ernst, *op.cit*, p.86.

³⁶⁷ Kapila Sruti, *Making of the Colonial Psychiatry in the Bombay Presidency, 1849-1940*, Dissertation submitted in partial fulfillment for the degree of Doctor of Philosophy, School of Oriental and African Studies, University of London, 2002, p.7.

asylum was trained as a physician and a surgeon, not as a psychiatrist. His field of expertise was the body and its workings and his day-to-day business in running the dispensaries would require him to routinely observe record and treat features of the body. It is observed that the case notes are dominated by information on the patient's body rather than on his/her mental state³⁶⁸.

By mid 19th century, on completion of their medical training in Britain, medical practitioners were sent to India to practice. In case individual was departing to join as a physician in one of the asylums in India, then additional training from Bethlem, St. Luke's Hospital, or other hospital of a similar measure in England was considered the most necessary. If the doctor wanted to apply for the position of superintendent, he was required to receive training and experience as practitioner in any of asylums in India for a considerable period of time before joining the office. The medical Board considered this training mandatory for 'judicious and skilful superintendence of lunatics in India. It was expected that their training back home would prepare them for dealing with 'difficult and obstinate' cases in India. The thorough instructions received there were meant to guide them in dealing with different modes of coercion and restraint practised for the 'protection and recovery' of 'lunatics' in India³⁶⁹. According to the Medical Board, which was composed of European physicians, the qualifications required of a superintendent of an asylum were: first, intellectual prowess of the highest order; second, expertise in general medical service; third, intimate acquaintance with the philosophy of human minds and its sound functioning; fourth, possession of qualities to distinguish among the different types of insanity; fifth, skill to prescribe necessary remedies; sixth, judgement to direct the moral and physical regimen suited to each case; and finally, possession of sound discretion for the general management of the institution³⁷⁰.

³⁶⁸ James H Mills, The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive, *Journal of Medical Humanities*, Vol. 21, No. 3, 2000, p.142.

³⁶⁹ Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, New Delhi: Oxford University Press, 2015, pp.15-16.

³⁷⁰ Das Debjani, op.cit, 2015, p.16.

The official of the Medical Board did not want asylum superintendents to change their locations from one asylum to another as the latter might lack the knowledge and expertise to deal with certain cases which might be specific to a particular asylum. This materially impact upon the treatment and management of the insane³⁷¹. Superintendents and physicians followed the contemporary medical literature of England and Europe they tried to put into practice. This transformation of practices ranged from the duties and qualification of a Superintendent to the changing perceptions, understanding and definitions of insanity³⁷². The role and responsibilities of the superintendents are having gained control of the inmate the next problem for the superintendent was how to get the patient to 'recover', that is, as was mentioned above, how to make of the patient an ordered, productive individual. A potent indication of the ambitions of the asylum superintendents is in their conceptualization of the asylum and the inmate³⁷³.

The superintendent had been using extreme violence in his treatment of those in his charge in order to impose his own notions of correct behaviour. In other words the violence visited upon the Indians at the asylum was state sanctioned. In the asylums of British India in the 1870s the colonial government seems to have established sites where its officers could intervene in the lives of those that the state had chosen to incarcerate in an attempt to reorder their psyches by altering not just what they did but what they wanted to do³⁷⁴. It could be possible to see this continued defiance of the doctor's painful attempts to impose his moral order as heroic, the resort to 'weapons of the weak on the part of the subjected. These inmates may have lost their freedom as they were incarcerated in a colonial institution but they were determined to resist the imposition of an alien order on their bodies³⁷⁵.

³⁷¹ *ibid*, p.17.

³⁷² *ibid*, p. 17.

³⁷³ Mills, James, *op.cit*, 2000, p.118.

³⁷⁴ *ibid*, p.2.

³⁷⁵ Mills, James, *op.cit*, 2000, p.2.

The European doctor's moral power over his patients Hierarchy and social discrimination were central characteristics of nineteenth-century asylums. The opinion of a Company doctor that it was of the utmost importance for the superintendent to maintain moral power over his patients. Asylum management reflected and flourished on ubiquitous social prejudice, cultural ignorance, and indifference. Moreover, it reconstituted within the confines of the mental hospital the contemporary colonial pecking order from superintendent down to keepers, patients, cleaners, and servants. As within any other colonial bureaucratic structure, a European medical officer had to be in charge of both European and native asylums³⁷⁶.

Work at the Lunatic Asylum was involved many difficulties and frequently encountered problems. Doctors Service and the their timings the poor well meaning superintendant and their deputies had such a lot of extra professional duties that they had very little time to attend to the therapeutic needs of the patients³⁷⁷. Almost all asylum superintendents, however diverse in actual clinical practice, could therefore to some extent lay claim to them³⁷⁸. Sometimes distance also a matter for the doctors who works in the asylum, because often the asylums were located away from the living spaces³⁷⁹. Sometimes for the superintendents it was difficult to complete rounds of all the establishments, as he was also in charge of the general hospitals. In addition, he was also expected to see European and Eurasian patients at home³⁸⁰.

To avoid such issues Madras Government have been pleased to sanction an upper storey to the Superintendent's quarters, which, it is hoped, will be erected as early as possible after the commencement of the official year³⁸¹. However, from different

³⁷⁶ Ernst, Waltraud, 'op.cit, (Jan, 1997), p.160.

³⁷⁷ Somasundaram , O., 'Psychiatry in Madras at the sunset of the British Raj', *Indian Journal of Psychiatry*, 2010, p.2.

³⁷⁸ Ernst, Waltraud, op.cit. (Jan, 1997), p.156.

³⁷⁹ Mills, James H, 'Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947', *International Review of Psychiatry*, August 2006; 18(4): 333–343, p.281.

³⁸⁰ Sanjeev Jain, 'Psychiatry and confinement in India', Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, New York: Cambridge University Press, 2003, p.281.

³⁸¹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878, p.13.

Medical Reports of British India, it is clearly revealed that, European Surgeons did not spend much of their working time in the respective asylum rather they spent more time on private practice. Thus the management of the asylum and execution of the superintendents' guidelines were almost shouldered by the Indian sub assistants³⁸². It is important to note that these doctors came to treat madness in India without much acquaintance with Indian society and its cultural environment³⁸³.

British Superintends use to depend on local staff in the mental asylums. The doctor–patient contact would often have to be through interpreters³⁸⁴. The fact is, this British superintendent could not differentiate between the many Indian faces before him. He was thus reliant upon attendants who, being local, could assist him in managing his charges. This reliance upon local knowledge, upon subsidiary actors, was not something that could have occurred in a representative colonial asylum elsewhere³⁸⁵.

The official positions of the asylum witnessed significant changes in the pattern of appointment in the mental hospitals. As was shown earlier, in the period 1858 to 1914 asylums tended to be staffed mainly by Indians. But the senior position of Superintendent was always reserved for a European, usually the local Government Civil Surgeon. The period 1914 to 1947 saw the Indianisation of the senior positions of the asylum. The first reason for this Indianisation was the circumstances created by First World War. European Indian Medical Service (IMS) officers were all expected to serve with active units, many of which were sent overseas. Thus a series of temporary vacancies arose in India. Indian medical officers, usually restricted to subordinate positions such as Assistant Civil Surgeon, were therefore called upon to

³⁸² Basu Saumitra, 'Madras Lunatic Asylum: A Remarkable History in British India', *Indian Journal of History of Science*, 51.3 (2016) 486.

³⁸³ Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, New Delhi: Oxford University Press, 2015, p.16.

³⁸⁴ Sanjeev Jain, "Psychiatry and confinement in India" Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, New York: Cambridge University Press, 2003, p. 282.

³⁸⁵ Anouska Bhattacharyya, op.cit, 2013, pp.1-2.

take up the senior positions³⁸⁶. Over work burden to the European medical officers was also one of the reasons to extend the senior positions to the Indians. And for European superintends colonial government need to pay many allowances apart from their salaries. Apart from these reasons, inadequate number of staff was a frequent complaint regarding the Indian mental hospitals. Moreover, as Sanjeev Jain says, by the end of the nineteenth century, Indian medical students were beginning to engage with English writings on psychiatry, which established points of contact between Indian and Western systems of madness. Some of these students later rose to become superintendents of asylums in the early twentieth century³⁸⁷.

SUPERINTENDENTS OF THE MADRAS MENTAL HOSPITAL

Surgeon G. Bidie -	1869.
Surgeon John Murray, M.D. -	1870.
L.C. Nanney -	1875.
A. H. Leapingwell -	1880.
S. L. Dobie -	1881.
Henry Armstrong -	1885.
Major C. Adams -	1891.
Lt. Col. S. L. Dobie -	1892.
Capt. C. H. Leet Palk -	1895.
Capt. C. B. Harrison -	1901.
Capt. R. Bryson, I.M.S. -	1903.
Capt. P. Heffernan, I.M.S. -	1909.
Major C. H. Leet Palk, I.M.S. -	1915.
Major A. Chalmers, I.M.S. -	1917.
H. W. McCaulley Hayes -	1919.
Lt, Col. D. S. Rai, I.M.S. -	1922.
Dr. H.S. Hensmen -	1924.
Dr. S. Venkata Subba Rao -	1936.
Dr. J. Dhairyam -	1939.
Dr. A. S. Johnson -	1949-1957 ³⁸⁸ .

³⁸⁶ Mills, James H, Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947, *International Review of Psychiatry*, August 2006; 18(4): 333–343, p.342.

³⁸⁷ Anouska Bhattacharyya, op.cit, 2013, pp.14.

³⁸⁸ Somasundaram, *The Government Mental Hospital Kilpauk, Madras: Memories of the Fifties*, Chennai: Siva Sakhti Printers, 2008, pp.35.

Staff of the Mental Asylums

Mental hospital staffs were considered by protagonists of ‘moral therapy’ to be ‘most essential instruments’. The British Superintends depends on local staff in the asylum and the superintendents were primarily concerned with establishing that expert medical management dominated the treatment of the insane. Medical officers would, of course, insist (albeit mostly unsuccessfully) that they be authorized to employ a sufficient number of staff in order to guarantee the security and day-to-day care of patients. At the same time they preferred to pass on orders to European and Eurasian staff of inferior abilities and of doubtful character, rather than supervising Indian employees³⁸⁹. While the native doctor managed the day-to-day affairs of the place, the European superintendent acted as the figurehead and representative of British rule. This system of dual management was intended to increase discipline and to establish a social hierarchy within the asylum which was congruent with the reality of colonial rule. Consequently, it was the European who supervised and asserted the institutional hierarchy, organized periodic roll calls for his Eurasian and native staff, carried out sporadic inspections on the wards, laid down rules, and enforced hierarchical forms of deference and address. These measures were designed in a way and articulated in a language that aimed at deterring breaks in ranks and at impressing staff and patients³⁹⁰.

The opinion of a Company doctor that it was of the utmost importance for the superintendent to maintain moral power over his patients³⁹¹. Superintendents, on admission of new patients, had often to rely on hearsay from the attendants³⁹². Superintendents relied on their subordinate staff that was recruited from the communities that surrounded each asylum³⁹³. He was thus reliant upon attendants

³⁸⁹ Waltraud Ernst, *Mad tales from the Raj: the Colonial Psychiatry in South Asia, 1800-1858*, New Delhi: Anthem Press, p.82.

³⁹⁰ Ernst, Waltraud, op.cit. (Jan, 1997), pp.8-9.

³⁹¹ ibid, p.9.

³⁹² Waltraud Ernst, op.cit. 2010, p.111.

³⁹³ Anouska Bhattacharyya, op.cit, 2013, p.iii.

who, being local, could assist him in managing his charges³⁹⁴. The Indian asylums were staffed by both Europeans and natives. As in Britain, asylum work was unpopular. Despite the difficulty in finding people willing to work in the asylums, Indians were excluded from all but the lowest of posts. The records contain praise for the native staffs, as well as complaints, most often about the inefficiency of the wards – accompanied, however, by recognition that the pay for these already undesirable positions was so low as to provide no motivation for a good work ethic.

Staff shortage was a frequent complaint in the entire history of colonial mental hospitals. We can observe in most of the asylum report and other colonial records about the requirements of staff. The staff as a whole had little formal training in psychiatry, and psychiatry itself was still in the early stages of understanding mental illness. Again these staff had no specialist qualifications and it seems that often the issuing of instructions was the only way in which they received an idea as to how to work with the patients³⁹⁵.

The European doctor's moral power over his patients, hierarchy and social discrimination were central characteristics of nineteenth-century asylums. The opinion of a Company doctor that it was of the utmost importance for the superintendent to maintain moral power over his patients. Asylum management reflected and flourished on ubiquitous social prejudice, cultural ignorance, and indifference. Moreover, it reconstituted within the confines of the mental hospital the contemporary colonial pecking order from superintendent down to keepers, patients, cleaners, and servants. As within any other colonial bureaucratic structure, a European medical officer had to be in charge of both European and native asylums³⁹⁶.

The European Overseer, the Native Doctor, and Servants male and female, are strictly enjoined invariably to treat the patients with the greatest kindness; to abstain from harsh language, threats, abuse, all acts of oppression, blows or any other acts. The

³⁹⁴ *ibid*, p.2.

³⁹⁵ James H. Mills, Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947, *International Review of Psychiatry*, August 2006; 18(4): p.339.

³⁹⁶ Ernst Waltraud, Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India, p.160.

medical officers however were not always so fortunate in their choice of staff and some had to describe poor performance in their employees. Several keepers have been fined or dismissed for carelessness or harsh treatment of the lunatics under their charge. The medical officers with no particular training in psychiatry administered the asylums, there were frequent changes of staff, and the pay was deficient, work irksome and full of petty detail.

However, these superintendents were also the civil surgeons for the entire area. They had a range of other duties to attend to, with the day-to-day running of the asylum in the hands of mainly Indian subordinates. Each superintendent would have relied on his Indian staff for details when completing the case notes, but it seems likely that he and these doctors were always male during the 19th century—actually wrote up these documents³⁹⁷.

Ever since the establishment of lunatic asylums in India it had been difficult to attract reliable European employees. In consequence of the new, race-specific regulation, asylum superintendents found it even more difficult to enlist, for example, apothecaries who were racially acceptable as well as suitable for their task in terms of their character, qualification and experience. Subordinate staff and in particular asylum keepers or attendants were extremely poorly paid and work in a *pagal-khana* or madhouse did not appeal to many³⁹⁸.

Subordinate staff continued to work in asylums for monetary gain and ascent in social status. Most of the subordinate staff in Bombay's asylums came from the *Mahar* and *Madras*i communities. Indian society considered the *Mahars* 'dalit' or 'untouchable' during colonial times; they were a community who 'ran errands for the villages'. While pay, promotions, and accommodation were good incentives for the subordinate staff, service in the asylum gave them a means to break free from economic and psychological subservience to existing village structures. Employment in the 'colonial apparatus' provided them with an opportunity to repudiate the 'stranglehold of caste'. Their service in colonial institutions also raised their status in the colonial social

³⁹⁷ James H Mills, The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive, *Journal of Medical Humanities*, Vol. 21, No. 3, 2000, p. 142.

³⁹⁸ Waltraud Ernst, op.cit, 2010, pp.81-82.

hierarchy. Colonial observers called them ‘warm friends of the British government’ who were ‘not to be pitted by us against other classes of society, but to be upheld in their just rights and privileges’. Historians have traditionally placed the responsibility of colonial domination of India on the British and the Indian bourgeoisie. Loyalty to the British government, however, superseded class lines. In the case of the lunatic asylum, the staff came from the lower classes and castes who acted as colonial agents. Since their agency was indispensable to the functioning of the colonial asylum system, superintendents were willing to negotiate with them. Superintendents did not restrict their negotiations merely to Indian staff. They permitted some negotiations with patients and their relatives as well³⁹⁹.

Alongside staff and patients, the asylums were populated by tea sellers, local visitors, janitors, cooks and holy men, all of whom presented alternate and complementary ideas about the treatment and care of Indian insanes⁴⁰⁰.

Racial and Regional Discrimination

The British approach to racial relations during the nineteenth century and succinctly expressed the growing belief that Indian society was intrinsically inferior and had to be subordinated to European guidance – a view that culminated in the Victorians’ ideology of their civilizing mission. Concomitant on sharpened racial discrimination, the maintenance of the rulers’ prestige became a central theme of government policy and of the conduct of the affairs of daily life. Indians were, for example, excluded from higher government offices⁴⁰¹.

Within the three main asylums of British India, except some intra institutional variation, the major determinants of room allocation were racial background, social class and gender. Similarly, the dietary arrangements, provision of general services, cure and mortality rate also depended on the patients’ class and race. No effective recommendations were thus made by the Presidency Medical Boards to ensure a full

³⁹⁹ Sarah Ann Pinto, *Lunatic Asylums in Colonial Bombay Shackled Bodies Unchained Minds*, UK: Palgrave Macmillan, 2018, p.85.

⁴⁰⁰ Anouska Bhattacharyya, op.cit, 2013, pp.iii.

⁴⁰¹ Waltraud Ernst, op.cit, 2010, pp.7-8.

direct regime for lower class inmates. Patients' involvement in work and recreational activities, which were the main constituent of the contemporary system of 'moral treatment' again, depended on patients' social class and race. In terms of daily routine of the inmates, European Lunatic asylums were not at all free from controversy. European inmates enjoyed some freedom to move about their wards, to find amusement in reading books, newspaper, playing cards etc. and Madras asylum was no exception to this phenomenon. Till 1840s, European insanes who were admitted to the Madras lunatic asylum could enjoy considerable entertainment. The spatial constraints made possible greater freedom of contact between inmates of different cultural background. In the Madras Lunatic asylum class specific confinement among Europeans was also enforced during earlier decades of the 19th century⁴⁰².

While there were many more divisions of race and skin colour in colonial India, and the significant presence of multiple generations of Anglo-Indians prevented any absolute association between colour and behaviour, racial predisposition diffusely underpinned diagnoses and attitudes towards insanity in the 'native' asylum of India. The science of phrenology was influential enough to imagine some inherent difference between Indians and Britons: skull shape and personal ability were thought to be correlated, and this association did not disappear entirely with the demise of phrenology⁴⁰³ as a 'real' science⁴⁰⁴.

The importance of racial difference to colonial psychiatric theory and practice means that the dominant accounts of psychiatric history fail to explain developments. Racial segregation was consequently sustained inter-institutionally and separate lunatic asylums for Indians and lower-class Eurasians were to be found from the beginning of the nineteenth century in the major districts: Benares, Bareilly, Patna, Dacca and near Calcutta, and, towards the middle of the century, in Delhi. Although the superintendents in the Calcutta asylum at Bhowanipore escaped the task of separating Indians and Europeans, they were still careful to make appropriate provision for Europeans and Eurasians of different gender and social backgrounds. By the late

⁴⁰² Basu Saumitra, Madras Lunatic Asylum: A Remarkable History in British India, *Indian Journal of History of Science*, 51.3 (2016) 486.

⁴⁰³ A now abandoned study of the shape of skull as indicative of the strengths of different faculties

⁴⁰⁴ Anouska Bhattacharyya, op.cit, 2013, pp.14-16.

1850s the asylum consisted of ‘two divisions’: one for male, the other for female patients⁴⁰⁵.

In particular in terms of social precedence and class-consciousness, the European community in Calcutta was first to develop and last to give up hardened attitudes bordering on snobbery and bigotry. The climate of racial and social intolerance inevitably permeated the lunatic asylum. The European asylum in Calcutta had an advantage over the institutions in Madras and Bombay in that its superintendents needed to take no pains to create social distance and racial segregation⁴⁰⁶.

Race prejudice had become the most important fact in the social state of India. Indian staff have been fined or dismissed with the allegations of their carelessness or harsh treatment of the lunatics under their charge, had to describe poor performance in their employees⁴⁰⁷. After all, the responsibility for European patients had always been with a European superintendent. Only in ‘native lunatic asylums’ were Indian assistants customarily entrusted with the day-to-day care of Indian and lower-class Eurasian patients. But even there a European had always been authorized to control the treatment of the Indian insane. During the nineteenth century Indians were referred to in a derogatory way as ‘blacks’, ‘natives’ and ‘brutes’⁴⁰⁸. However, the important factors which used to be taken into account while treating the insane were race as evident in the colour of skin, social class and gender in Madras lunatic asylums⁴⁰⁹.

The new government policy of Indianization of the colonial service did not do away instantly with discriminatory practices and ingrained adverse attitudes among European practitioners. Issues of race and class, and professional competition within the context of job shortages were rife. Structural inequalities that had affected staff in

⁴⁰⁵ Ernst Waltraud, op.cit, 2010, p.61.

⁴⁰⁶ Ibid, p.60.

⁴⁰⁷ Mills, James H, ‘Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947’, *International Review of Psychiatry*, August 2006; 18(4): 333–343, p.339.

⁴⁰⁸ Ernst Waltraud, op.cit, 2010, p.9.

⁴⁰⁹ Basu Saumitra, ‘Madras Lunatic Asylum: A Remarkable History in British India’, *Indian Journal of History of Science*, 51.3 (2016) 486.

earlier decades persisted, ensuring the continuation of an employment hierarchy favourable to Europeans⁴¹⁰.

Menial job done by Indians, the number of night watchmen was reduced from eight to six, as a system of night rounds which has proved successful, so that with six night watchmen thus supervised, the work is more effectually carried out than with the eight as formerly⁴¹¹. The night watchmen work fairly well. They require constant supervision. The native warders are, on the whole, a very indifferent set of men. A few work well, but very little reliance can be placed in them generally, they require constant looking after⁴¹². However, it is clear that the some officials expressed satisfactory on the work of subordinate staff⁴¹³ and some not⁴¹⁴.

However, since 1799 to 1850, steady increase was thus observed in the asylum population. In comparison with the European insanes, the number of Eurasian and Indian patients increased drastically. In case of upper class Europeans social distance between the races were maintained. Even the mad members of the Europeans used to keep a distance from Indians and lower class Europeans. But the maintenance was inferior among the Eurasians or Indians⁴¹⁵. Asylums in India were segregated. Hospital regulations were altered several times to favor the mentally ill Europeans in India. The environment of the asylums and hospitals for Europeans were significantly better than their Indian counterparts. Accordingly, the medical professionals treating Europeans had received better training than those serving in Native-Only asylums.

⁴¹⁰ Ernst Waltraud, *The Indianization of Colonial Medicine The Case of Psychiatry in Early-Twentieth-Century British India*, *N.T.M.* 4 May (2012) 61–89, p.65.

⁴¹¹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878, p.20.

⁴¹² Nanney, L. C., Surgeon-Major, Superintendent, Lunatic Asylum. MADRAS, 1st April 1878; Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 22.

⁴¹³ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 11.

⁴¹⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 11.

⁴¹⁵ Basu Saumitra, 'Madras Lunatic Asylum: A Remarkable History in British India', *Indian Journal of History of Science*, 51.3 (2016) 486.

Throughout the medical facilities of India, changes were enforced to ensure British superiority in every aspect of hospital care⁴¹⁶.

Racial prejudices were too powerful in colonial India lunatic asylums. This is important, as western hospitals, and doctors in general, were viewed Indians as unclean under orthodox beliefs. Until 1855 no “natives” were supposed to be in senior positions in British India. Subsequently, Indians were allowed to occupy higher-level roles. However, public proclamations and official regulations did not always adequately affect or mirror British officials’ sentiments and unofficial practices. In addition to persistent racial prejudice, medical degrees acquired at medical colleges in India were not recognized for appointments in the senior medical service until 1892⁴¹⁷.

Stigmatic perspective of Mental illness

Historically, people with mental illnesses were mistreated, stigmatized, and neglected, and, in many cases, they still are. One of the chief barriers to treatment of mental illnesses is Stigma; it leads to discrimination, which often leads to a mentally ill individual being unable to obtain gainful employment or being fired. Many people with mental disorders feel too ashamed or embarrassed to seek treatment because public perceptions and distorted ideas. There was a social stigma attached to the use of the asylum. This issue of stigma associated with the mental asylums have largely neglected area of research in colonial India. Some scholars argued that there was ‘no evidence of stigma’ associated with the asylum. The asylum reports show very little evidence of stigma, neither by the local community nor the British staff. How the colonial asylum power went beyond the physical structure, and into the everyday social and cultural lives of British Indians. Moreover, as the government linked asylum committal to the criminal justice system, it further stigmatized asylum use⁴¹⁸.

⁴¹⁶ Kymberly C. Brumlik, ‘Lunacy for Profit: The Economic Gains of ‘Native-Only’ Lunatic Asylums in the Bengal Presidency, 1850s-1870s’, *Journal of South Asian Studies*, 02 (01) 2014. Pp.1-10.

⁴¹⁷ Ernst Waltraud, op.cit, 2012, pp.63-64.

⁴¹⁸ Sarah Ann Pinto, op.cit, 2018, p.190.

In many cases the men and women those who were held against their will in institutions or with their supports also under gone with the stigmatization with the label of mental illness even after the process of de-institutionalization. At stake for these the inmates were the issues of the deprivation of the inalienable rights such as life, liberty and equality. These activists spoke out against institutional abuses and the construct of mental illness was seen by them as by-products of imperialism, patriarchy and capitalism.

Religion and Caste

The interaction between religion and psychiatry can be at several levels. Psychiatric patients may have religious beliefs that may need to be taken into consideration when planning any management. They may also seek help from religion and religious healers, using different models of distress. The interaction of the therapist's religious views and the patient's religious views may cause conflict. The patient's religious values may affect acceptance of psychotherapy and other treatments⁴¹⁹. The disciplinary functions of the psycho-sciences were first highlighted by Michel Foucault in his classic work on insanity in Western culture, *Madness and Civilization*. This account has it that the origins of the asylum were as an institution where errant individuals identified as such by bourgeois morality could be confined as punishment and be reformed. The walls of confinement enclosed 'fortresses of moral order . . . in which were taught religion and whatever was necessary to the peace of the state'⁴²⁰. As has already been stated, for Foucault the asylum was 'A religious domain without religion, a domain of pure morality, of ethical uniformity an instrument of moral uniformity and of social denunciation.' The frustration of the asylum regime by the Indian staff and the resistance offered by the patients shows that while the asylum may have been established and intended as an instrument of 'moral uniformity', in reality it rarely functioned as such⁴²¹.

⁴¹⁹ Bhugra, Dinesh (ed), *Psychiatry and Religion Context, Consensus and Controversies*, New York: Routledge London and 1996, p.3.

⁴²⁰ Mills, James. op.cit, 2000, pp.6-7.

⁴²¹ Ibid, p.181.

A very insignificant fraction of the insane population of Madras Presidency reaches the existing asylums. It is observed that many native asylum patients were primarily from a poor social background, and of a low caste. Caste and religious prejudices are as yet too powerful⁴²². And also Statistics of lunatics were classified into the religious basis in the asylum reports. Details of religious backgrounds are collected, revealing how the colonists felt religion affected body and mind: 'Hindus being of weaker physique and worse nourished than Mahomedans or Christians'⁴²³. According to this report Musalmans and Christians are more liable to insanity than Hindus'. A reason which has been suggested for the position of the Musalmans is that, they marry within closer degrees of consanguinity than members of other religions. The high percentage among Christians is entirely due to the prevalence of insanity among Eurasians, the number of lunatics among whom is between six and seven times as high as among any of the other castes. One of the striking points about the figures of insanity in subsidiary tables is that, next to the Eurasians, the Brahmans, who constitute most of the priest class in the occupational groups in each linguistic division shows a higher proportion of lunatics than any other castes. Then Brahmans were the highest affected persons of insanity in the presidency, after them traditional or hereditary occupational groups like, commercial castes, Artisans, Weavers, are the most liable to insanity, if put it in simple words the liability to insanity varies roughly with social position-the highest castes suffer most and the lowest castes least of all (because of accessibility of asylum by upper caste population is high). Then the smallest percentage of insanity is found among the polluting castes. The lower castes and the labouring classes are much more subject to exposure and want and are much fonder of strong drink and other intoxicants. The attendance was small, but it is to be regretted that the humanising effect of divine service with music, which would attract and soothe, should not be afforded to those who are debarred from so many of the pleasures and consolations of life. It seems most fitting that religion should hold some place in so large an institution⁴²⁴.

⁴²² Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, Madras: The Government Press, 1878, p. 4.

⁴²³ Report on the Lunatic Asylums in the Central Provinces for the Year 1877. Nagpur & Allahabad, 1878, p.2.

⁴²⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, Madras: The Government Press, 1878., p.19.

Gender

The gendered aspects of mental health and delivery of mental health care services has been an evolving area of research and practice in the last three decades elsewhere in the world, as well as in India. The area of research began with the understanding that men and women occupy different status in all societies and that this difference is bound to affect their health, mental health as well as their experiences with the mental health services. The differences in enjoyment of social status may relate to various socio-economic dimensions, such as access to basic needs, education, housing, social security, employment and a good standard of life⁴²⁵. Despite the considerable information these studies have uncovered, the existing scholarship has only scratched the surface of the rich stores contained in the history of colonial psychiatry. These works are primarily histories of psychiatric discourse, while the social history of these institutions remains largely unexplored. Only Waltraud Ernst engages gender as an analytical category, the others limit their discussions to sex, addressing male-female ratios without delving into the significance of gender in colonial madness. Historians must problematize this issue, especially considering the importance of gender in recent colonial studies and works on the history of psychiatry⁴²⁶. Especially femininity is not covered in any of the Indian works in the 20th Century.

It is one thing to find that mad women in British India were seen in a significant number of cases to have suffered from a, typical female, career-sequence of marriage husband's death-insanity. It seems that a loss in the family could easily be linked up by the male certifying doctors with the onset of madness. Was not a widow, after all, only a women without her man, an anomalous state which could not but be understood as a factor in mental derangement, especially within a colonial context such as nineteenth-century India where female Europeans had a legitimate identity only as wives and daughters and, in exceptional cases, as spinster, teacher, servant, and missionary'. In regard to many other cases where loss, grief, and disappointments

⁴²⁵ Chavan BS, Gupta Niting & Arun Priti, (Ed), *Community Mental Health in India*, Bhargavi v Davar's chapter "Gender and community mental, Health: sharing experiences from our service program", Jaypee Brothers Medical Publishers, New Delhi, 2012, p.136.

⁴²⁶ Richard Keller, 'Madness and Colonization: Psychiatry in The British and French Empire, 1800-1962', *Journal of Social History*, Vol.XX1, No. 7, winter 2001, pp.295-326.

were presented as having played a crucial role, a gendered division emerges again in regard to the men's and women's personal histories prior to psychiatric treatment: women tended to grieve the loss of relatives whilst men, especially those belonging to or aspiring to belong to the middle class, were more likely to bemoan some loss of fortune, or career problems⁴²⁷. Such gender-specificity owes much to the relatively restricted options open to European women in the East; mainly that of wife or mother⁴²⁸. Otherwise, they would be expected to live with their families rather than pursuing any independent trade or profession⁴²⁹.

A critical analysis of the literature reveals that firstly, a large amount of mental distress among women remains unrecognised and untreated. Secondly, a number of mental disorders which disproportionately affect women are related to their work and position in society, rather than to biological factors alone. Thirdly, due to social and gender inequity, women receive less than their share of benefits of mental health services. The causes for these disorders are located in the psychosocial context of women's lives rather than in biological/ organic factors alone.

If we observe some tales about women from reports, which can always be questionable, because these stories are based on reports drawn up by male medical professionals, guided and restrained by the standard administrative requirements typical of the time and specific to colonial context. The accounts are therefore, of course, not women's but a perspective which not only incorporates a male stance, but is also embedded in contemporary assumptions on mental illness by the medical professional, and administrative views of a women's mental predicament.

Part of this difference is to be attributed to concealment, part to the fact that women lead a more secluded if monotonous life, are less subject to exposure and anxiety, and are less liable to indulge in excesses of various kinds. The age curves (which in the case of that for females should be transposed to a greater height to allow for concealment) show this clearly, as that for females reaches a point much near its

⁴²⁷ Ernst Waltraud, *European Madness and Gender in Nineteenth-Century British India*, *The Social History of Medicine*, 1996, p.364.

⁴²⁸ Ernst Waltraud, op.cit, 2010, p.94.

⁴²⁹ Ibid, p.94.

maximum at 15 to 20 years than that for males, and is without the 25-35 peak. This relatively earlier rise in the figures among females is to be attributed to the strain of premature and excessive maternity, while the later rise in the male figures corresponds to the entry into life with family and working cares.

While it is important always to incorporate a gender perspective into accounts of socially constructed phenomena such as health and illness, we may lose sight of the complexity of reality by over-focusing on one factor. Intension of this part of the chapter is to draw some generalization of women with mentally ill and their conditions in the madras presidency. It had been observed that women were lower than men in number in the entire period. It had been observed that between the ages of 20-40 years the rate of Insanity among the women is high⁴³⁰. The proportion of cures is smaller. Whether men or women self interpretation of the malady is missing, on behalf of them their relatives, parents, those who were carrying them to the asylums were given their symptoms of madness. Most of the times reasons were ignored for the depressions for the female maladies, reasons for them may medical professionals (mostly male), ignoring them by putting them in the category of stereotypes.

Among Inmates of the mental institutions males were usually afflicted in greater numbers than females. And females the incidence at all ages are less than among males. The number of women patients confined in madras lunatic asylums was very small in any period in relation to overall population up to 1946. In Madras Presidency however, the health care services are marked by gender-based inequity of access to asylum care. In such a case, drawing conclusions about the comparative prevalence of madness in men and women based upon utilisation data from hospital samples is therefore both questionable and misleading. And the subsidiary tables showing that large number of the persons both men and women were effected insanity between 20-40 years of age⁴³¹.

⁴³⁰ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1878-79, Printed by the Superintendent, Madras: Government Press, 1879, p.6.

⁴³¹ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1877-78, Printed by the Superintendent, Madras: Government Press, 1878, p.5.

Female activities in asylums in the name of treatment are following, even therapy paid less attention to gender than to factors like class and educational background. An average of 235 males and 32 females were employed on manufacture; several others were usefully employed in asylum work⁴³². Notably, there was a gendered division of the work in the asylums – female patients performed gardening tasks while buildings were maintained by men. Treatment of male and female asylum patients was also gendered, as women were permitted to occupy themselves with what could be seen as female activities, such as sweeping, cooking and sewing, while men were allowed to engage in male pursuits. Patients gender as well as their educational and social background played a role in regard to the recreational pursuits offered. However, there was gender specific therapies were available in the asylums.

In regard to many other cases where loss, grief, and disappointments were presented as having played a crucial role, a gendered division emerges again in regard to the men's and women's personal histories prior to psychiatric treatment: women tended to grieve the loss of relatives whilst men, especially those belonging to or aspiring to belong to the middle class, were more likely to bemoan some loss of fortune, or career problems⁴³³.

Shared the features of grief, depression and occasional violence, and although these features might seemingly fit in with female constructions of madness, the madness of the men was not explained simply as a manifestation feminine. The certifying surgeons were required by medical etiquette to comment on the factors which may have brought on a person's deranged state and to elaborate on the behaviour and events that were seen as indicators of madness symptoms. They consequently reported any incidents prior to admission which appeared to make the mad behaviour understandable as a seemingly necessary consequence of certain factors. In the case of women, reference to their family and children was seen to suffice.

Sometimes women was sexually abused in mental asylums of Madras Presidency in Waltair Lunatic Asylums "One birth occurred during the year; the mother, an insane

⁴³² Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1918, Printed by the Superintendent, Madras: Government Press, 1919, p.1.

⁴³³ Ernst Waltraud, op.cit, 1996, p.364.

named Nuki, was admitted into the asylum on the 20th November 1874 and was found to be pregnant on the 17th July 1877. Searching inquiry was at once instituted regarding the paternity by the Assistant Magistrate and subsequently by the official visitors, Deputy Surgeon-General, District Judge, and District Magistrate, but nothing was discovered regarding it. After the woman had become enceinte her mental condition improved rapidly, and she was discharged cured on the 19th January 1878, two months after the birth of her child. The female cottage is enclosed by a henna hedge which practically is no fence at all as it is full of gaps. The official visitors are of opinion that the females should be removed into the criminal enclosure, the male criminals being transferred elsewhere”⁴³⁴.

Most of the admissions stories revolve around male patients; women are found less often in these asylums, and their presence is rarely accompanied by familial support⁴³⁵. Large number of the women were don’t approach modern lunatic asylum, because of poverty, most of them were cared by the native healers and doctors and rest of them were under the family care, because of stigma attached to madness. It is likely that these women were discharged at the request of their relatives. In the minority of cases, usually women, were referred to the asylum by family members, any objection to the asylum's regime was equally unlikely because the usual motivation for voluntary referral was apparently the desire to be relieved of the burden of care of an unwanted family member⁴³⁶.

Most of the times even the Superintendents do not have post-graduate experience or training in Psychological medicine, and yet these men have been barged with the supervision of large hospitals. And sub-ordinate Medical Staff are more or less a temporary nature, utterly untrained in Psychiatry. In these circumstances how can one expect women specialists in this field for the better treatment? The Asylums reports were expressing its defects following way “If the work of a mental hospital is to advance along the right lines, it is very necessary that the medical and the nursing staff should be both permanent and contented. From my experience of over six years

⁴³⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, Madras: The Government Press, 1878, p.24.

⁴³⁵ Anouska Bhattacharyya, op.cit, 2013, p.78.

⁴³⁶ Ernst Waltraud, op.cit, p.160.

in this hospital, I have found that the present conditions of service are not financially attractive enough to draw and retain the best men and women in this kind of work which is not only considered unpleasant and risky but also requires special knowledge and experience. It is therefore necessary that a special cadre for mental hospitals should be introduced as soon as possible. Only such medical officers and nurses as have an aptitude and are willing to volunteer for this branch of service should be posted to such hospitals, and when once found satisfactory, should not be transferred elsewhere⁴³⁷". If British officers were sensitive to caste taboos and local concerns over women in public spaces, they also recruited high-caste or even female medical staff to encourage families to enter these colonial medical spaces. Kumari Jayawardena has argued this was a strategic maneuver, exploiting traditional norms to strong-arm Indian communities into participating with the colonial regime⁴³⁸.

Summary

This chapter drawn good amount of analysis on social history of mental illness in the Madras presidency, for that it has taken the following categories, Race, Stigma of mental illness, Religion, Caste, Gender. The study identified that prior to 1920, the patients in the asylums were categorized according to their caste, religion, private and public and also within the colonial judicial sphere of criminal lunacy⁴³⁹. To know about the unsound minds in the region of Madras Presidency it is inevitable to study the Psychiatric intuitions, because the existing three mental asylums held responsible for the remedy for the mentally sick inmates in Madras Presidency. So far this chapter discoursed the social history mental illness in this presidency, later part would be discussed the treatments that were practiced in the three mental hospital in Madras Presidency.

⁴³⁷ Annual report on the working of the mental hospitals in the madras presidency for the year 1930, printed by the superintendent, government press, Madras, 1931, p.5.

⁴³⁸ Anouska Bhattacharyya, op.cit, 2013, p.74.

⁴³⁹ Abraham Santhosh , 'op.cit, 2018, p.30.

Chapter-4

Treatment Practices in the Madras Presidency Asylums

So far we studied History of Mental institutions and their developments in Madras Presidency in the earlier chapter, in elaboration to this, the present chapter would like focus on what happened in these mental institutions in the name of treatment. Treatment practiced in an asylum was directly connected with the understanding of Mental illness. It enquiry about the theories and Practices of treatments in this chapter, this chapter would deal about the Asylum care, the different kinds of treatment practices, and the curative perspectives (their consequences) and their consequences in the Madras Presidency. Historians of colonial medicine and psychiatry tend to focus on the European impact on the outside world and on how the colonial enterprise furthered the expansion of Western scientific knowledge. It is only recently, and largely due to the challenge of social science and literature-based theories of post-colonialism and subaltern studies, that this focus has been widened to look also at indigenous responses and resistance to Western medical and psychiatric blueprints have yet to be investigated. It addresses the question of interaction between psychiatry and indigenous healing traditions. This question is relevant to address the asylum practices in Madras Presidency, which has a rich and diverse tradition of healing. One axiom of Colonial medical discourse in 19th century British India was the presumed superiority of scientific medicine over indigenous medical systems. Scholars observed that psychiatry achieved this superiority through a negotiation between the indigenous tradition and scientific knowledge.

Mental illness is a fascinating field of historical investigation namely the evolving discourse about the understanding and treatment of mental illness in the colonial Indian context deriving from both European understandings and indigenous perspective. Mental illness and treatments have been mentioned and documented in the contemporary psychiatric institutions in the colonial Madras Presidency. In a way it is a biography of Psychiatry in this historical region of Madras Presidency. In the asylums of the colonial period, the vast majority of the treatment and therapeutic practices were obtained from the European asylums. Seemingly, a considerable lot of the practices and thoughts in the mental health clinics today are a continuation of those started by the British. During their colonial phase the institutions show up

additional as instruments of control, since they were ridden with racial discrimination, class distinctions, gender orientation, religious-caste prejudices, and the clinical facilities and general conditions came up short.

The therapeutic means adopted in the asylum by the medical officers could be broadly divided into three categories: mechanical, moral, and medical. The moral treatment could further be divided into two: occupational and recreational. Since the turn of the nineteenth century, mechanical restraint, applied with chains, waist coasts, leather jackets, and in many other harsh ways, were questioned in France and elsewhere in Europe by the advocates of moral treatment of insanity such as Pinel, William Tuke, John Haslam, Robert Gardiner, and later John Conolly. Instead of such coercive practices, they put forth notions of moral and humane treatment. In this new method of treatment, mechanical restraint was abolished and shackles were expected to be removed from the patients: a humane mode of treatment was expected to replace the inhumane one. Attendants and medical officers were directly engaged in the treatment. This application of moral therapy involved an engagement with the bodies of the patients as attendants were employed to take physical care of the ‘lunatic’ for twenty-four hours. Attends were employed for caring and guarding the patients. Moral therapy was meant to discipline the inmates without any application of force or coercion. European medical officers made an effort to put an end to the use of chains, waistcoats, leather jackets, and so on, but mechanical restraint could never be completely abolished. The asylum authorities justified the practice of mechanical restraint in certain cases, particularly while dealing with violent and maniac patients. This explained that using any method of coercion in treating the insane was considered easier than medical or moral therapies. Regardless of the attempt to implement moral methods of treatment, restraint continued to be practised in the mental asylums. Moral therapy therefore, did not completely replace the mechanical restraints⁴⁴⁰.

Both West and Indian context during this period the condition of mentally ill patients in these institutions were one of the neglect, restraint and abuse with poor clothing, unhygienic conditions, poor nutrition, restricted movements due to chaining of hands,

⁴⁴⁰Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, Oxford University Press, New Delhi, 2015, pp.76-77.

feet and lack of interest among the ruling aristocracy and over-crowding of mental hospitals⁴⁴¹. Humanitarian effort put an end to the abuses, inaugurated an era of kindness and medical care, which prepared the way for a rational, humane approach to the mastery of mental illness. In the nineteenth century the pathology of insanity was investigated, its clinical forms described and classified its kinship with physical disease and the psychoneuroses recognized⁴⁴².

This chapter demonstrates how far restraint, non-restraint, and medical practices were used in the treatment of the mental illness was understood in the nineteenth century. For instance, when insanity was understood as a physical disease, medical treatment was practiced, but when it was understood as a disease of the mind, then moral treatment was implemented. Physicians, who looked at insanity as both a disease of the mind and body, practised both kinds of treatment⁴⁴³.

The Types of Mental illness and the Causes of insanity

It attempts to answer some queries such as, the types of mental illness, and the colonial perception of the causes of insanity and how was insanity understood and constructed in the medical record? And who were these patients? How were they certified, diagnosed? This part is dealing with these issues. The epidemiology of mental illness during the British Raj can be mapped in the extensive statistical tables which attempt to identify and categorise mental illness. This classification of patients also indicates according to their rank in and kind of degree of sanity. The statistics and comments show clearly 'how insanity had been transformed... into a condition which could be authoritatively diagnosed, certified and dealt with by a group of legally recognised experts.'

The patients were admitted in this Asylum with various types of insanity they are acute mania; Chronic mania; mania epileptic insanity; Acute dementia; insanity due to

⁴⁴¹ Nizamie S.Haque, Goyal Nishant, 'History of Psychiatry in India', *Indian Journal of Psychiatry* 52, Supplement, January 2010, p. 7.

⁴⁴² Roy Porter, *Madness a Brief History*, Oxford University Press, New York 2002, p. 5.

⁴⁴³ Das Debjani, op.cit, 2015, p.77.

alcohol; confusional insanity; insanity due to cannabis indica; delusional insanity; circular insanity; Melancholia; Idiocy. Taking the whole asylum population, the most common form of insanity was fell under the headings of acute mania, and next to that chronic mania and chronic dementia⁴⁴⁴, Idiocy, Toxic insanity, morbid changes in brain, consecutive insanity from fevers & visceral inflammation and other forms of insanity. But these were ‘the most common forms of insanity in the three asylums were mania, dementia, and melancholia⁴⁴⁵. ‘These results are in harmony with the teaching of experience in the treatment of insanity in England and elsewhere, which goes to prove that dementia is the most intractable and fatal of all mental derangements; next after it melancholia gives the smallest number of recoveries and highest mortality. In cases of mania the number of recoveries is higher and the mortality less than in other forms⁴⁴⁶. It was recorded in Reports of Mental hospitals that ‘the principal types of insanity in their order of frequency were, Schizophrenia including Dementia, Mania, Toxic Psychosis, Mental Deficiency Arteriopathic and Senile Psychosis⁴⁴⁷. And other types, cannabis indica, imbecility, secondary or terminal dementia, epilepsy, delusional insanity, circular insanity, and melancholia other forms⁴⁴⁸.Despite the growing political and social importance of hereditary and narrowly medical concepts of madness and mental capacity, classificatory and diagnostic categories did not change to any great extent. This listing, though idiosyncratic and by no means exhaustive, contained the most distinct diagnostic categories then used in England and British India⁴⁴⁹.

The symptoms of insanity have been documented in the Indian asylums in some form or other from the beginning of nineteenth century. The patient had become suddenly insane from causes which have never been explained. The alleged causes of insanity

⁴⁴⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1880-81, the Government Press, Madras, 1881., p. 25.

⁴⁴⁵ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1880-81, p. 5.

⁴⁴⁶ *ibid*, p. 5.

⁴⁴⁷ Education and Public Health Department,(Public Health) Government of Madras, G.O.No.1427, 3rdApril, 1941, Report- Mental Hospitals-1940 - Reviewed, p. 2.

⁴⁴⁸ Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 1380, 6th June, 1935, Report- Mental Hospitals-1934 - Recorded with remarks, p. 1.

⁴⁴⁹ Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p.108.

are attributed to admission was broadly divided into two categories 1) Physical Causes of insanity and 2) Moral Causes of insanity⁴⁵⁰. These alleged causes are not always to be implicitly accepted, but roughly they seem to show that in this country insanity is more often produced by physical than moral causes. Dr. Nanney superintendent of Madras asylums “opinion that insanity is more frequently the result of depraved bodily conditions than of overstrained mind”⁴⁵¹. The regular addition to physical causes of insanity such as small-pox, venereal disease and typhoid up to the early 1900s demonstrates that, as some historians have argued, there was more focus on physical conditions than mental. The 1882- 83 report on sexual excess during the immature and adolescent period of life; and, to a small, but appreciable extent, the abuse of alcohol⁴⁵². Broadly the causes of insanity of the cases admitted in the Indian asylums were found to be epilepsy, hereditary factors, *bhang* or *ganjah*⁴⁵³ smoking, congenital, suppression of menses, religion, privation and starvation, puberty and adolescence, mental stress and previous attacks.

Madras shows the split between alleged physical and moral causes, with physical causes including epilepsy, fever, sunstroke, over-study and moral causes given as grief, fear, confinement in jail and infidelity. Masturbation and witchcraft are also commonly documented as physical causes of insanity. Their inclusion may have provided the rationale that the deviant, dangerous indigenous population required ‘civilising’ by western methods. The differences in opinion among colonial staff about the physical causes of insanity and the moral causes of insanity are seen in 1881: When we come into the domain of “the physical causes of insanity”, the abuse of narcotic drugs, intemperance, epilepsy and hereditary seem to be the most common. Of the moral causes grief, misfortune, and anxiety⁴⁵⁴. Epilepsy is common

⁴⁵⁰ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, p. 23.

⁴⁵¹ *ibid*, p. 9.

⁴⁵² Chartres Molony J. The Census of India-1911, Vol.XII, Madras Presidency, Part-I, Madras: Government Press, 1912, p. 145.

⁴⁵³ The most commonly used illicit drug; considered a soft drug, it consists of the dried leaves of the hemp plant; smoked or chewed for euphoric effect.

⁴⁵⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, *op.cit*, p.5.

among insane Natives⁴⁵⁵. The causes of insanity among the criminal women populations of the asylum are Puerperal causes (Physical)⁴⁵⁶.

The following abstract shows the several ascertained causes which were believed to have caused madness⁴⁵⁷&⁴⁵⁸&⁴⁵⁹.

Moral Causes	Physical Causes
Grief	Congenital
Family quarrels	Concussion of brain
Domestic trouble	Epilepsy
Religion	Narcotic drugs
Infidelity	Intemperance
Love and jealousy	Puerperal state
Loss of property	Privation
Overstudy	Syphilis
Dissipation	Fever
Satyriasis	Confinement in jail
Foreign service	Hereditary influence
Fright or shock	Masturbation
Mental anxiety	Injury to head
Disappointment	Ill-treatment
Disgrace	Phthisis
Desertion of husband or wife	Starvation
False belief	Previous attack
Fear	Old age
Anger	Irregular habits
Vicious habits	Other diseases
Misfortune	Intemperance
	Disease of brain
	Sunstroke
	Fall
	Nymphomania

⁴⁵⁵ *ibid*, p. 6.

⁴⁵⁶ *ibid*, p. 7.

⁴⁵⁷ *ibid*, p. 6.

⁴⁵⁸ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1880-81, p. 5.

⁴⁵⁹ *ibid*, p. 5.

Little is stated about the actual mental disorders of the patients apart from the intake rosters. The patient lists give one-word summaries of the disease and its cause for each patient; most were described as unknown. Out of the patients that had a cause listed, the common diseases included chronic mania and dementia with the most common causes being “*ganja* smoking” and intemperance from alcoholic consumption⁴⁶⁰. In entering the alleged causes of insanity Superintendents of Asylums and Magistrates are largely dependent on the statements of ignorant friends or relatives, or often of Police Officers, who are total strangers to the habits of the lunatic⁴⁶¹.

The epidemiology of mental illness during the British rule of India can be mapped in the statistical tables which identify and categories mental illness. The regular addition to physical causes of insanity such as small-pox, venereal disease and typhoid up to the early 1900s demonstrates that, as some historians have argued, there was more focus on physical conditions than mental. The inclusion of masturbation, syphilis and witchcraft as causes of insanity in the Bengal reports uncovers some of the British cultural and social perceptions of madness and of their colonial subjects. From the 1860s until 1912, types of insanity appear as various forms of mania and dementia, melancholia and imbecility. From 1912 types and causes were merged, but retained many physical categories, and still listed alcohol and cannabis as causes of mental illness.

However, as these causes were attributed by the Medical and District officers I have included them in this Statement. An 1871 report shows some alleged reasons for insanity as being bitten by a jackal, a peculiar view on religion and ‘got sick with fever and suddenly turned out as mad.’ The transition to specialized medical definitions is seen in 1946 when mental illnesses are listed as schizophrenia, manic depressive psychosis, mania, paranoia, mental deficiency. Furthermore, examining

⁴⁶⁰ Kymberly C. Brumlik, ‘Lunacy for Profit: The Economic Gains Of ‘Native-Only’ Lunatic Asylums In The Bengal Presidency, 1850s-1870s’, *Journal of South Asian Studies*, 02 (01) 2014. 01-10, p. 4-5.

⁴⁶¹ Annual Report on the Lunatic Asylums in the Punjab for the Year 1894, 1.

causes and types of insanity in these reports reveals changing British cultural and social perceptions of not only their colonial subjects but of madness itself⁴⁶².

With regard to the causes of insanity, hereditary predisposition, in India as in Europe, seems to play an important part. It is intensified by the frequency of consanguineous marriage⁴⁶³. Musalmans and Christians are more liable to insanity than Hindus', reason which has been suggested for the position of the Musalmans is the fact that they marry within closer degrees of consanguinity than members of other religions⁴⁶⁴. Of the social precedence groups,, the Brahmins, who constitute most of the priest class in the occupational groups,, have the largest proportion of insanes. The most striking point about the figures of insanity in subsidiary tables - is that, next to the Eurasians, the Brahmins in each linguistic division show a higher proportion of lunatics than any other castes⁴⁶⁵. The smallest percentage is found among the polluting castes. The lower castes and the labouring classes are much more subject to exposure and want and are much more fond of strong drink and other intoxicants than those higher up the social ladder and it does; not therefore seem likely that either a hard life or too much alcohol have a marked: effect in producing insanity⁴⁶⁶. Generally speaking insanity is an affliction of the adult period, unlike deaf muteness, which is one of the young or blindness, which is severest in old age⁴⁶⁷. Age factor also a factor for causes of the madness, the tendency to insanity is most distinctly marked in the third and fourth decennia of life; it is less marked between the 40th and 60th years of age, still less marked under 20 years of age, and reaches its minimum as old age advances⁴⁶⁸. It was observed that as in the previous years the incidence of insanity was large between the ages of 20 and 40, i.e., during the active period of

⁴⁶² Francine Millard, *Lunatic Asylums of British India: A National Library of Scotland Collection*, p. 4.

⁴⁶³ Chartres Molony J. op.cit, 1912, p. 145.

⁴⁶⁴ Francis W, *The Census of India*, 1901, Vol-XV, Madras, Part-I, Printed by the Superintendent, Government Press, Madras, P. 112.

⁴⁶⁵ *ibid*,p. 112.

⁴⁶⁶ *ibid*, p. 112.

⁴⁶⁷ Hutton J W. op.cit, 1933, p. 257.

⁴⁶⁸ Annual Report on the Lunatic asylums in the Madras Presidency, during the year 1877-78, p. 5.

life⁴⁶⁹. Acute mania is the form of insanity most amenable to treatment, particularly when it occurs in young persons and is early detected⁴⁷⁰.

The most frequently listed physical cause was the abuse of intoxicating drugs – specifically hemp, as J C Penny, Superintendent of the Delhi lunatic asylum, stated in 1872, insanity or permanent disorder of the mind is a result of the evil habit of over-indulgence in this narcotic. And particularly of *ganja* or Indian hemp, accounts for the largest number of admissions⁴⁷¹. “A few years ago it was the fashion to put the blame on *ganja*- and opium-smoking, but since the Indian Hemp Drugs Commission (IHDC) 1893/1894, exposed the fallaciousness of this attitude, diagnoses of the causes of insanity have 'become more cautious. *Ganja* and opium smoking, constitutes the main cause of the insanity in the native army in the Madras Presidency, particularly in from Vizagapatam area. In 1895, 27 of the cases admitted into the Government Lunatic Asylums were declared to be due to the excessive use of *ganja* and opium, but since that year the number of attacks, attributed to this cause has steadily declined, and in 1900 it was only four. Probably more opium is consumed in the Agency Division than in any two others, as it is greatly used there as a prophylactic against malaria, but insanity is not more prevalent in this Division than in the others⁴⁷²”. The information which the reports contain as to the causation of insanity; as heretofore, physical greatly preponderate over moral causes. In natives of India, insanity is invariably brought on by those causes of physical diseases to which the lower orders are chiefly exposed abuse of *ganja* and opium, over-work of body, and insufficient food⁴⁷³.

There were two stages by which cannabis use and cannabis users became categorized as a social problem in the asylums of colonial India. First, medical officers at the asylums came to believe that cannabis use was linked to insanity and violence in Indians. Second, the officers used the asylum as a site where they could observe

⁴⁶⁹ Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 1380, 6th June, 1935, Report- Mental Hospitals-1934 - Recorded with remarks, p. 2.

⁴⁷⁰ Annual Report on the Lunatic asylums in the Madras Presidency, during the year 1877-78, p. 5.

⁴⁷¹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1881-82, p. 5.

⁴⁷² *ibid*, p. 111.

⁴⁷³ General Report, No 6, on the Lunatic Asylums, Vaccination, and Dispensaries in the Bengal Presidency, Calcutta: Office of Superintendent of Government Printing, 1876, p. 9.

cannabis users and establish the distinguishing signs which marked them off as a distinct human type to be watched out for because of their dangerous potential. The British superintendents of the asylums came to believe that cannabis was linked to insanity and violence as they were told by the Indian policemen who had picked the inmates up that many of the people that they brought to the asylum were there because of excessive use of hemp. Perhaps more importantly the doctors who received this police information had reasons not to dismiss this information and to note it in their records⁴⁷⁴. However, the tendency to pinpoint cannabis as the main cause of insanity in Indian asylums was later revealed as flawed. The Indian Hemp Drugs Commission ruled that asylums statistics were unreliable, with drug abuse being used as the default cause of insanity by persons usually policemen unqualified in psychiatry.

According to the Census reports it is observed that Causes of Insanity are follows i.e., Of the cases admitted in asylum was found that insanity of epilepsy, hereditary, *bhang* or *ganjah* smoking, conjenital, suppression of menses, religion, privation and starvation, puberty and adolescence, mental stress, previous attacks.

Most of the cases admitted in Vizagapatam asylum were found the insanity of epilepsy, hereditary, bhang or ganjah smoking, conjenital, suppression of menses, religion, privation and starvation, puberty and adolescence, mental stress, previous attacks. Ganja and opium smoking, constitutes the main cause of the insanity in the native army in the Madras Presidency, particularly in from Vizagapatam area. There is little difference in the amount of insanity found in the various natural divisions of the presidency. Madras contains largest proportion of the insane in the presidency, after that Krishna and Godavari districts contains a large proportion of insane, Krishna districts occupied the same in 1881 and 1891 also, but the reasons were not available⁴⁷⁵.

⁴⁷⁴ Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 50.

⁴⁷⁵ Francis W, Census of India, 1901, Vol-XV, Madras, Part-I, Report by W. Francis, Printed by the Superintendent, Government Press, Madras.

To summarize then, information supplied to the superintendents at the asylums linked the use of a variety of hemp preparations to insanity and to unpredictable and violent behaviour. Despite the often dubious nature of this information, many of the superintendents believed it as it corresponded with their general misgivings about intoxicants like opium and alcohol and fitted in with their beliefs about the physiological origin of madness. As the only hemp users that were encountered by these superintendents were those who were under their charge at the asylum because of their disordered or violent behaviour, those medical officers based their opinions of all in India who used cannabis substances on that small and unrepresentative sample⁴⁷⁶.

Within this context the mental state of higher-class European women and men would tend to be described and understood in a language akin to that of modern neurotic complaints, namely in terms of ‘temporary weakness’ or ‘lowness of spirits’ which were due to ‘sudden loss of fortune’, ‘overexertion’, or ‘domestic trouble’. The condition of lower-class Europeans was in contrast seen primarily as a necessary consequence and manifestation of lack of will power and of potentially immoral living conditions and pursuits, such as barracks life, drinking, fornication, or vagrancy⁴⁷⁷. Rates of various diseases were quite high. Dysentery, hepatitis and delirium tremens were frequent causes of illness in European soldiers⁴⁷⁸. The hot tropical climate was often to blame, and a voyage home held out the promise of a cure. Allegations of exorbitant charges and corruption in contracting private hospitals were being made. Financial irregularities and overcharging the company for the care of the ill was a frequent concern, as were poor maintenance and misuse.

It was also during this period that ideas of addiction developed and became medicalised – for example, ‘Cannabis Indica Psychosis’ is listed as a mental disease from the late 1920s until 1951. Furthermore, the asylum reports show that cannabis

⁴⁷⁶ Mills, James. op.cit, 2000, p. 55.

⁴⁷⁷ Ernst Waltraud, *Idioms of Madness and Colonial Boundaries: The Case of the European and "Native" Mentally Ill in Early Nineteenth-Century British India*, 1997, p. 164.

⁴⁷⁸ Sanjeev Jain, “Psychiatry and confinement in India” Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, Cambridge University Press, New York 2003., p. 277.

and opium were actually used on occasion in the asylums for the purpose of calming patients. The causes of insanity are hereditary predisposition, in Madras Presidency seems to play an important part. It is intensified by the frequency of consanguineous marriage; sexual excess during the immature and adolescent period of life. According to the Census reports it is observed that Causes of Insanity are follows i.e., Of the cases admitted in asylum was found that insanity of epilepsy, congenital, suppression of menses, religion, privation and starvation, puberty and adolescence, mental stress, previous attacks. Sexual victimization whether through brutal stressors like rape, battering, or other forms of violence against women. By 1940's the chief cause of insanity were domestic worry, hereditary pre-disposition, business worry, epilepsy, syphilis, body illness, other toxins, other infections⁴⁷⁹. The primary causes of mental illness are mystery even today that is why; the study interested to know more about it. The search for the cure for madness is also the search for a reason to be optimistic that the mad can be cured⁴⁸⁰.

And last but not least, mental illness among Indians was explained in terms of sweeping generalizations about their alleged innate racial inferiority and savage customs. In British India, the Old World principle that 'the rich and poor suffered different insanities' still prevailed, although the new colonial species of the 'native insane, emerged as yet another discrete variety. In the East, too, the categories of medical psychology were 'shot-through with sociological allusions'⁴⁸¹.

The treatment of insanity, was take into consideration the two-fold nature of the disease: first, as a malady of the mind, whether from injury to the cerebral substance, or from a vitiated condition of the blood affecting the brain directly, or from exhaustion of the mental powers through worry, grief or excessive strain of any kind; secondly, as a physical disease of the nerve centres thereby the mental functions become deranged. In the one case we may conceive of the mind as acting on the body, in the other we see the reaction of the body in the mind. There are those who would

⁴⁷⁹Education and Public Health Department,(Public Health) Government of Madras, G.O.No.1427, 3rdApril, 1941, Report- Mental Hospitals-1940 - Reviewed, p. 2.

⁴⁸⁰ Mary de Young, *Madness an American History of Mental illness and its Treatment*, Mcfarland & company, inc., publishers, Jefferson, North Carolina, London, 2010.

⁴⁸¹Ernst Waltraud, op.cit, 1997, p. 164.

explain mind as a mere attribute of the brain, and Maudsley defines insanity “as a disorder of the supreme nerve centres of the brain, the special organs of mind producing derangement of thought, feeling and action, together or separately⁴⁸².”

Diagnostic Practices

Some highly trained psychiatrists dispute the very existence of mental illness and declare, therefore, that diagnosis and treatment are nothing but a farce; others call psychiatry a pseudoscience because it diagnoses mental illnesses when there is no concrete, definitive, scientific diagnostic method by which to do so; still others deem that treatment of any kind is detrimental, dangerous, and damaging; yet others maintain that psychiatry as an industry largely diagnoses individuals who display certain behavioral traits or nonconformist attitudes as being mentally ill and uses that diagnosis as either a means of social or political control⁴⁸³. Systematic study of the different scientific journals, medical records and public health reports of Colonial India reveals that with the progression and reinvention of scientific discourse, late eighteenth and early nineteenth century witnessed billowy wave in the field of medicine and scientific discoveries. Many scientific observations and speculations were made over the causes of mental disorders particularly in the Western Medical Community. At that time, the major lacuna in the treatment of the mentally ill was a lack of training in diagnosis and treatment of mental diseases even in the West⁴⁸⁴.

From today’s point of view the kinds of classifications may well appear to have been based on quite diverse terms if not different concepts. They would not conform to criteria such as those now laid down in the various versions of *the Diagnostic and Statistical Manual of Mental Disorders* (DSM) developed and marketed by the American Psychiatric Association, and *the Manual of the International Statistical*

⁴⁸²British officials outside the immediate purveyance of the asylum read such texts as Henry Maudsley’s *Natural Causes and Supernatural Seemings* (London: K. Paul, Trench & Co., 1886), and William James Moore’s *A Manual of Family Medicine and Hygiene for India* (London: J. & A. Churchill, 1883), both of which suggested that lunacy had environmental as well as hereditary causes.

⁴⁸³Thompson, Marie L, *Mental Illness*, Greenwood Press, Westport, Connecticut, London, 2007, p. xiii.

⁴⁸⁴Basu Saumitra, Madras Lunatic Asylum: A Remarkable History in British India, *Indian Journal of History of Science*, 51.3 (2016) 478-493, p. 479.

Classification of Diseases, Injuries, and Causes of Death (ICD) produced by the World Health Organization. Modern mainstream psychologists and psychiatrists who have been reared on the principle that any therapeutic measure ought to be based on sound diagnostics might doubt the extent to which the treatment applied in the various asylums in nineteenth-century British India could have been efficacious. Dr. A.W. Overbeck-Wright a prominent practising psychiatrist in colonial India, a influential scholar in mental sciences, he served more than a decade as superintendent of the Agra Asylum, he authored *Mental Derangements in India* (1912), and *Lunacy in India* (1921). In his work he offers some explanations of the diagnostics procedures. For that purpose the Observation of Patient and his Emotions plays a prominent role he suggested that “Ascertain all you can about your patient as regards heredity, temperament, habits, and his behaviour generally. Go into his medical history carefully; find out how he has changed from formerly; what his delusions are, whether he is morbidly suspicious, or suicidal or homicidal. In fact, get a clear, concise history of the case, noting especially the manner of its onset and its general course”. Further he suggests that test of patient’s mind plays essential “Test his mental faculties, his memory, power of cognition, his reasoning power, judgment, self-control, volition, etc., and look out for hallucinations and delusions, depression, stupor, or excitement, and altered feelings towards his relatives.

In general, doctors possessed some inkling about who among their patients would be likely to remain under medical care for prolonged or intermittent periods. This knowledge stemmed more from longstanding practical medical experience and the continued observation of an individual patient’s state of mind than from recognition of any specific feature in a patient’s previous history⁴⁸⁵. On the basis of the little knowledge doctors had been able to accumulate on the aetiology of madness, they were not usually in a position to ameliorate the condition of those patients who suffered from mental problems brought on by infections, malnutrition, neurological diseases, or the like⁴⁸⁶. The categories such as ‘mania’ and ‘dementia’ as descriptive rather than generic terms. ‘Mania’ basically was how a person behaved and appeared to another. It was the term used to describe the symptoms rather than the disease

⁴⁸⁵Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p. 110.

⁴⁸⁶Ibid, pp. 109-110.

itself: the disease a patient suffered from was ‘insanity’; the way it manifested itself was through ‘mania’ or other ‘forms of the disease’. Consequently, a patient might have been categorized as a ‘maniac’ at one time and as ‘imbecile’ or suffering from ‘moral insanity’ at another. Not only would the diagnostic label vary with **the patient’s symptoms**, but the treatment, too, would follow suit⁴⁸⁷.

Observation of the **body** helps psychiatrists to determine the cause and treatment of mental illness. Bodies are fascinating. They are functional and biological entities, yet at the same time bodies depict aspects of the emotional self. It seems as if a person’s experiences are contained within the physicality of their bodies⁴⁸⁸. The body is fundamentally relevant to mental health practice. British psychiatry has historically approached the cause and treatment of mental illness through observation of the body. This tradition continues within current psychiatric and allied mental health practice in the case of mental health assessment. To form a diagnosis, practitioners routinely conduct detailed observations of patients’ appearance, posture, gesture and gait, thereby using the body as a diagnostic index. However, within the biomedical framework of routine mental health practice, there is little scope for considering how the bodily presentation of patients may reflect aspects of their lived experience⁴⁸⁹. L. C. Nanney, Superintendent of Madras Lunatic Asylum, has said ‘It may be observed that insanity is more frequently the result of depraved bodily condition than of overstrained mind’. Instances occur of a mind of high order failing from too great mental exertion; it the majority of cases are instances of degeneration of race which nature thus extinguishes⁴⁹⁰.

The first step involved bathing and examining the patient. Madness provided unrestricted access to the body of the patient. Asylum doctors examined the ‘native body’ for the ‘purposes of knowledge’. Mental illness became a legitimate excuse to

⁴⁸⁷Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p. 109.

⁴⁸⁸ Louise Phillips, *Mental Illness and the Body beyond diagnosis*, Routledge Taylor & Francis Group, London and New York, 2005, p.2.

⁴⁸⁹*Ibid*, p.3.

⁴⁹⁰ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878, p. 15.

survey, examine, and classify Indian bodies, since to ‘unclothe was to uncover the truth about the native’. On the pretext of examination or treatment, asylum staff undressed and observed patients several times. The observation of the Indian body was part of the diagnostic process. In colonial asylums, Mills argued that the body was the omphalos of the diagnostic process. Examination of patient bodies included examining genitalia⁴⁹¹. Dr. A.W. Overbeck-Wright suggested to study the Patients Body language, in his book he said “Note carefully his speech, manners, and behaviour, how he enters the room, his bearing, gestures, etc., as all these constantly give us indications of the mental condition we have to deal with, and what tone to adopt to derive most information”⁴⁹². And take the pulse and temperature, and examine into the condition of all the bodily functions. This is an important point to note, for, in my own experience, I have known a patient certified by a medical practitioner and sent in the usual way for admission into my asylum when the poor fellow was really suffering from enteric fever. Find out how he sleeps, and if he dreams, and the character of the dreams. Examine into the motor and sensory functions of the brain and cord, asking about headaches and neuralgic pains⁴⁹³. And Valuable aids to diagnosis are “Silence, obstinacy, stupidity, and other negative symptoms should be noted, and are valuable aids to diagnosis and treatment”⁴⁹⁴.

The information included in the **case records** is not the result of purely scientific observation. Diagnostic patterns reflect professional interests, institutional strategies and medical improvisations. Perhaps the cultural assumptions of the white doctors about the mentalities of the black patients influenced the diagnostic decisions recorded on case notes. The colonial doctors thought that their black patients were fundamentally different from whites and that their mental experiences would reflect

⁴⁹¹Sarah Ann Pinto, *Lunatic Asylums in Colonial Bombay Shackled Bodies Unchained Minds*, Palgrave Macmillan, 2018, p. 98.

⁴⁹²Overbeck-Wright, A.W, *Lunacy in India*, London Bailliere, Tindall and Garden and Cox, 1921, p.187.

⁴⁹³ Ibid, p.187.

⁴⁹⁴ Ibid, p.187.

this and this was decisive in assessments of the experience of depression among black patients⁴⁹⁵.

Overbeck-Wright suggested to asylum staff to Speak and Listen to Patient for the Diagnostic purpose “In interviews with your patient be fearless, frank, honest, and a good sympathetic listener, behaving outwardly as if your patient were sane and you were treating him for some physical ailment. Do not be afraid to lead up to his weak points and delusions after you have gained his confidence. Unless you wish to test his self-control, never contradict or irritate him, and, if possible, avoid any sign of deceiving him. Having made sure he is ill, try and convince him of the fact too. Above all things take plenty of time, and never seem to be in a hurry; you will only frustrate your object by doing so, and far from doing yourself good may do yourself incalculable harm”⁴⁹⁶. **Patients’ voices** were an important part of the asylum soundscape. It examines the management of patients’ voices and their significance to the asylum soundscape. Within asylum walls, the staff evaluated, interpreted, and manipulated patients’ voices for their diagnostic and evidential value. The manipulation and interpretation of patients’ voices were essential to managing the soundscape, because the ‘mad both articulated their condition and were defined as such by others, through interpretive hearing’. Patients’ voices were thus extremely important in identifying their insanity. Most patients in Indian asylums came from the poorest section of the society.

It was difficult for superintendents to gain information about patients since they found patients’ relatives difficult to trace or they were ‘ignorant and uneducated’. This lack of information meant that doctors had to depend on the descriptive roll on the medical certificate. Police constables filled in these descriptive rolls on the lunacy certificates based on ‘the statement of the lunatic while still insane’, and interestingly, these descriptions provided ‘not only the history and habits but also the cause of his insanity’. A patient’s speech, then, was decisive evidence of his own insanity. On

⁴⁹⁵Mills, James. *Madness, Cannabis and Colonialism: The ‘Native-Only’ Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 25.

⁴⁹⁶Overbeck-Wright, A.W, *Lunacy in India*, London Bailliere, Tindall and Garden and Cox, 1921, p.187.

committal to the asylum, a patient's speech and silence were evaluated, interpreted, and manipulated to serve the diagnostic process.

Dr. Overbeck-Wright highlighted the importance of the patient's speech in the diagnostic process "Speech ... is closely connected with all the mental processes that it is unusually implicated in the course of insanity.... the mental condition is often indicated by the character of speech"⁴⁹⁷. Superintendents commonly used a list of set phrases to evaluate a patient's silence or speech. They used these phrases in the diagnostic process to define symptoms of a patient's insanity. 'Incoherence of speech' or talking 'nonsense' were common signs of insanity. While **patients' voices** were significant to the diagnostic process, they also served other purposes in the asylum⁴⁹⁸. While asylum agencies permitted patients to 'shout to [their] heart's content', their voices and silences were evaluated, interpreted, and manipulated. Patients' voices were significant because they had both diagnostic and evidential value. Asylum staff interpreted patients' voices within and beyond asylum walls. The manipulation and censoring of these voices protected the asylum staff from coming under government censure. The government ignored the complaints of patients, choosing the narratives of the superintendents over those of the patients⁴⁹⁹.

Socio-cultural norms underpinned diagnostic practices outside the asylum, particularly in the arena of state politics, in the form of a highly codified idea of masculinity and sexuality. To know the social background and the details about Insane could be helpful in diagnosis "Make sure of your patient's caste and station in life, and learn all you can about his caste prejudices and customs, his religious beliefs, superstitions, etc. This may seem unnecessary detail perhaps, but the following experience of mine gives point to it. A lady was certified and sent to an asylum as insane on the grounds of "facts narrated by her husband and his relatives," and this one fact noted by the certifying doctor, "Suffers from the delusion that some saint gave her baby." Needless to say the matter was speedily rectified, but it taught me a

⁴⁹⁷Sarah Ann Pinto, *Lunatic Asylums in Colonial Bombay Shackled Bodies Unchained Minds*, Palgrave Macmillan, 2018, p. 144.

⁴⁹⁸*ibid*, p. 147.

⁴⁹⁹*Ibid*, p. 151.

lesson I shall never forget”⁵⁰⁰. However, apart from increasing a practitioner’s knowledge and perhaps his understanding of a patient’s personal circumstances, awareness of preceding events had little influence on either diagnosis or treatment⁵⁰¹. And the decision when to declare a patient as ‘cured’, ‘relieved’, or ‘uncured’ was based more on guess-work and wishful thinking than on accurate diagnostics⁵⁰².

The rules for the determining of diagnosis that he laid down stressed the observing of the "bearing", "gestures" and "expression" of the lunatic-patient. Further, the physical aspects of both the malady and its manifestation were sought to be invoked via the diagnostic procedure. Overbeck-Wright stressed the need to assess the patient's physiology in terms of nutrition, pulse and also disease indicators and his physiognomy as the critical indicators for assessing the mental state of the patient⁵⁰³.

Method of Treatment

The treatments of the mental patients in the colonial mental hospitals were directly connected with the understanding and accurate diagnostics of mental maladies. This part studies, the treatment of the madness in the mental institutions of the Madras Presidency. Especially the kinds of treatment practiced in hospitals and how natives were treated, as part of that, it describes ideas and practices that made up a heterogeneous environment in asylums. It also describes the evolution of psychiatric practice in the colonial Madras Presidency. Medical practice differed from practitioner to practitioner and changed over the course of the nineteenth century⁵⁰⁴. The therapeutic measures were applied on a basis of trial and error and whilst in some cases this method proved most successful, it could be fatal, or at least ineffective, in

⁵⁰⁰Overbeck-Wright, A.W, *Lunacy in India*, London Bailliere, Tindall and Garden and Cox, 1921, p.186.

⁵⁰¹Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p. 110.

⁵⁰²Ibid, p. 64.

⁵⁰³Kapila Sruti, *Making of the Colonial Psychiatry in the Bombay Presidency, 1849-1940*, Dissertation submitted in partial fulfillment for the degree of Doctor of Philosophy, School of Oriental and African Studies, University of London, 2002, p. 125.

⁵⁰⁴Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p. 112.

others⁵⁰⁵. Colonial psychiatry had little to offer as far as treatment of the insane was concerned. Liberal diet, occupational therapy and amusement were considered to be pillars for treatment⁵⁰⁶. Generally the treatments in the colonial lunatic asylum in India can be divided into three categories; they are mechanical, medical and moral categories. Moral therapy was meant to discipline the inmates without any application of force or coercion. The moral treatment could further be divided into two: occupational and recreational. Since the turn of the nineteenth century, mechanical restraint, applied with chains, waistcoats leather jackets, and in many other harsh ways⁵⁰⁷.

One explanation may lie in the limited prestige enjoyed by psychiatrists within a medical profession which had been greatly expanded by the growth of welfare states but which had devoted few resources to mental health provision. As numerous scholars have noted, physicians who claimed a professional expertise in healing the insane were limited by the weakness of their scientific credentials and the evidence that large numbers of incurable patients were languishing in asylum care for decades⁵⁰⁸. Little specific value is attached to the curative properties of medicines. Medicines were classified into two types Europe medicines and Bazaar medicines⁵⁰⁹. The system of modern medicine characterised as “scientific western medicine” was introduced in India as early as the seventeenth century.⁵¹⁰ Little specific value is attached to the curative properties of medicines. Medical and public opinion had come to believe that madness could be cured and that confinement in an institution could

⁵⁰⁵Ibid, p. 110.

⁵⁰⁶Shilpi Rajpal, “Colonial Psychiatry in mid-nineteenth century India: The James Clark enquiry”, *South Asia Research* Vol. 35(1): 61–80, 2015, p. 71.

⁵⁰⁷ Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, Oxford University Press, New Delhi, 2015, p. 76.

⁵⁰⁸ Joseph Melling and Bill Forsythe (ed), *The Politics of Madness The State, Insanity and Society in England, 1845-1914*, Routledge Taylor & Francis Group London and New York, 2006, p. 1.

⁵⁰⁹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1884-85, the Government Press, Madras, 1885., p.18 .

⁵¹⁰ J.R. John Hume, “Colonialism and Sanitary Medicine: The Development of Preventive Health Policy in the Punjab, 1860 to 1900” in *Modern Asian Studies*, Vol. XX, 1986, p.703.

not fail to be beneficial both for Europeans and Indians⁵¹¹. As regards the treatment of insane in those days superintends of the institutions, believed that exercise and occupation, kindness in discipline, recreation, and, appropriate diet, with plenty of fresh air are the chief remedies for promoting recovery.

According to James H Mills, the ‘early’ forms of drug treatment for psychiatric conditions were also introduced into India in this period. These were largely aimed at controlling patient behaviour and also of allowing the patient some respite from his/her condition through sleep⁵¹². In the earlier decades the use of mercury concoctions was widespread, as was the bleeding of patients. These remedies were increasingly regarded as non-effective and even detrimental in a climate such as that of British India. This was particularly so for insane Europeans. Purgatives and tonics, emetics and douches became the main favoured remedies⁵¹³. In Calicut Lunatic Asylum “the treatment has consisted in subduing great mental excitement by large cases of bromide of potassium, hydrate of chloral, morphia, and lately tincture digitalis has been tried”⁵¹⁴. The treatment has consisted in subduing great mental excitement by large cases of bromide of potassium; hydrate of chloral, morphia, and lately tincture digitalis has been tried⁵¹⁵. Of the medicinal remedies we may mention morphia used hypodermically and hydrate of chloral as hypnotics and sedatives, and bromide of potassium in epilepsy, now looked upon as a remedy of established value. Mild counter-irritation is often attended with most marked benefit⁵¹⁶. The hospital needed a large quantity of bromide of potassium, essential for epileptic and other cases, and opium for those suffering from diarrhoea⁵¹⁷. Officers decided to devise

⁵¹¹ Waltraud Ernst, “Idioms of Madness and Colonial Boundaries: The Case of the European and “Native” Mentally Ill in Early Nineteenth-Century British India”, *Comparative Studies in Society and History*, Vol. 39, No. 1 (Jan., 1997), p. 153.

⁵¹² Mills, James H, Modern psychiatry in India: The British role in establishing an Asian system, 1858–1947, *International Review of Psychiatry*, August 2006; 18(4): 333–343, p. 338.

⁵¹³ Ernst, Waltraud, *Mad tales from Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, New Delhi, 2010, p. 112.

⁵¹⁴ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 27.

⁵¹⁵ Ibid, p. 27.

⁵¹⁶ Ibid, p. 17.

⁵¹⁷ Ibid, p. 21.

alternative ways of achieving control over the excited patient's behaviour and in effecting desired changes in the inmate's conduct.

In the case of noisy and excitable, sleepless, and epileptic patients, some medicinal agents have been administered, such as opium and its derivatives, Cannabis Indica, bromide of potassium; Ammonium, hydrate of chloral, and other sedatives were used. Together with counter-irritation with blisters and the cold and tepid baths, are all remedies that have proved of distinct service in the treatment of the various mental affections. It has been observed that benefit from the use of morphia internally and hypodermically, mild counter-irritation to the back of the neck, cold douche, shower-bath, warm and tepid bathing have been used⁵¹⁸.

As regards the treatment of insane in those days superintends of the institutions, believed that exercise and occupation, kindness in discipline, recreation, and, appropriatediet, with plenty of fresh air are the chief remedies for promoting recovery. "Dr. Nanney dwells on the importance of mental as well as of bodily treatment, placing great stress on moral influences, gentle discipline, firmness united with kindness, exercise and interesting occupation in restoring mental power and in making life more endurable. The system adopted is the non-restraint system in which great attention is paid to diet, to regular exercise in the open air, to suitable employment and to occasional amusement. Referring to the " boarding-out system " suggested in my last report Dr. Nanney thinks that there will be great difficulty in bringing the system into operation in Madras in consequence of the want of suitable persons to whom such responsibility could be entrusted, and he thinks that the existing arrangements of the asylum with its spacious grounds, cottages and warders render the adoption of the proposed system unnecessary until the asylum becomes overpopulated. The point however has been missed in these remarks. A lunatic asylum like that at Madras is an expensive institution, established for the *cure* of the insane not for the *detention* of harmless incurables"⁵¹⁹.

⁵¹⁸ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1878-79, the Government Press, Madras, 1879., p. 25.

⁵¹⁹Ibid, p. 9.

Ever since the establishment of Calicut Lunatic Asylum in 1872, there were attempts to implement more humane treatments to the patients. Since 1877, it is reported that European doctors made an effort to put an end to the use of chains, waistcoats and jackets on the patients, instead preference was given to moral and occupational therapies. The Superintendent of Lunatic Asylum has reported in the year 1880 that, 'the greatest reliance must be placed on moral and hygienic measures and drugs used sparingly'. Doctors in the asylum used purgatives, sedatives and tonics to control at the initial level of treatment⁵²⁰.

In the Madras Presidency institutional care for the mentally ill was very less. Even though it was doubt that how far it was sufficient to the institution to the mentally ill people in the presidency. Lunatics were placed in the Three lunatic asylums and some criminals were placed in the jails also due to the over crowd in the asylums in the presidency. James Mills, in his study of colonial lunatic asylums in north India has pointed out the 'disciplinary functions of the asylums' and argued that 'medicine functioned to drill and produce bodies that could prove useful in a colonial system'⁵²¹.

On the so-called moral treatment Dr. Bucknell observes, "the emotional repose and intellectual diversion which are now sought to be obtained well-conducted establishments for the treatment of the insane are not, strictly speaking, moral agencies; they constitute physiological measures taken to procure functional repose for an irritated and diseased organ."⁵²². In Madras Asylum in many cases of insomnia a little wine or arrack at bed time induces quiet sleep, and I(Superindent) do not consider the use of opiates desirable where simple means can be employed to effect the desired result (I think this must be in practice)⁵²³. The humouring method of treatment which some condemn as calculated to feed the original delusion. Although it is a method of treatment requiring tact and personal observation of the individual

⁵²⁰ Abraham Santhosh , 'Medicine and British Empire in South India: A Study of Psychiatry and Mental Asylums in Colonial Kerala', *Indian Journal of History of Science*, 53.1 (2018) , pp. 125-131, p.129.

⁵²¹ *ibid*, p.127.

⁵²² *Ibid*, p. 5.

⁵²³ *Ibid*, p. 18.

case (superintendent condemned this method)⁵²⁴. Of hygienic measures cold douche, warm baths, tepid sponging to the weak and feeble, and shower baths for those who are violent and troublesome. These are valuable aids when judiciously administered, care being taken that they should never assume a punitive character⁵²⁵.

British efforts and motivation to provide asylum care based on the increasingly popular, more humane 'moral management' system can be examined in the Mental Health collection reports. Authors of reports emphasise the need to treat patients kindly, to maintain cleanliness and to provide a good diet alongside occupational therapy. Treatment within the asylums represented the norms and values of 19th and early 20th-century Britain and the desire to transplant these into colonial India.

In the case of Calicut asylum the superintendents, doctors, nurses and asylum administrators were English up to 1912 and medical reports have noted the recruitment of native doctors and nurses after 1912 due to increased indianisation in the colonial provinces. Apart from these, most of the other staffs employed in the asylum were recruited from the local community, like hospital assistants, attenders, cooks and other servants. The daily care of the patients were managed and carried out by local attendants and they have exercised a significant influence over the patients⁵²⁶. Mental health services for rural population is a very serious issue of concern, organising mental health services for this predominantly rural population is indeed a daunting task. Compounding this problem are low budgetary resources, the presence of competing and conflicting healing systems, scarcity of mental health personnel, brain drain, and the stigma of seeking help for problems related to the mind⁵²⁷.

It was after the Indian Lunacy Act of 1912, the Calicut lunatic asylum has developed into a permeable space with transparent avenues of care. 1912 act opened the asylum

⁵²⁴Ibid, p. 18.

⁵²⁵Ibid, p. 17.

⁵²⁶ibid, p. 130.

⁵²⁷Thara R, Padmavati R and Srinivasan T N, "Focus on Psychiatry in India", *The British Journal of Psychiatry* (2004)184: p. 366-373, p.366.

doors to the public, for a wide range of actors to cross the asylum walls. In this context one can argue that by the act of 1912, psychiatry had been subsumed to by the mainstream medicine as a respected profession. The change of terminology of the asylum from Lunatic asylum to Mental hospital soon after the Indian Lunacy Act 1912 also indicated the clear shift towards professional and scientific psychiatry in 20th century. It is noted in the British colonial medical reports that both medical and moral treatments and therapies were practiced in Calicut Lunatic Asylum⁵²⁸. Ever since the establishment of Calicut Lunatic Asylum in 1872, there were attempts to implement more humane treatments to the patients. The Superintendent of Lunatic Asylum has reported in the year 1880 that, ‘the greatest reliance must be placed on moral and hygienic measures and drugs used sparingly’. Doctors in the asylum used purgatives, sedatives and tonics to control at the initial level of treatment. However, soon the other options included engagement in various types of asylum labour and certain kinds of amusements were also used. It is reported that since 1920, occupational therapy had become a standard term for patient work in the asylums. The ranges of activities were: weaving, carpentry, book binding, brickworks, rope making, tailoring, mattress making, etc. Similarly, sports and leisure activities were also offered. Along with moral therapies, the Calicut Lunatic asylum also reported to engage the patients in various kinds of games as part of their recreational therapy. Patients frequently amused themselves with games that involved light physical exertions. Other activities like singing competition, listening to radio, badminton, dancing, card games and use of native musical instruments were used to amuse patients as part of recreational therapy⁵²⁹.

Histories of colonial psychiatry have largely placed the cases of lunatic asylums as archetypes of colonial power with strict doctrines that went beyond the ‘medical gaze’ to discipline natives in the imperial world. An attempt is made here to examine the specific case of Calicut lunatic asylum as a ‘hybridized’ psychiatric space where a variety of actors interacted and negotiated the meaning of insanity and also a medical setting which showcased the presence of a hybridized system of treatment that borrowed from local, religious, state, colonial and European beliefs about madness.

⁵²⁸Abraham Santhosh , op.cit, p.129.

⁵²⁹ibid, p.129.

The term 'hybridized' is used here in a similar sense as 'the creation of new transcultural forms within the contact zone produced by colonialism'⁵³⁰.

New hybrid modernity was visible by progressively adapting and blending of local practices with those of the West. By focusing on the case of psychiatry in these regions, this research suggest a very different 'hybrid' nature of lunatic asylum practices in colonial India, compared to other British asylums in India, which was exemplified as a heterogeneous place of care and treatment for the insane. This study used the colonial medical reports to examine the hybrid psychiatric space particularly to understand the everyday life of the asylum. It is found that psychiatric care in Madras Presidency have been shaped and reformed by local and foreign actors around the asylums and also by successfully blending the local belief systems that were specific to the regions with that modern biomedical practices. "The system followed of opening the asylum at proper times to the inspection of the public is one calculated to secure public confidence in the working of the institution and 'to dispel erroneous ideas touching the treatment' to which the afflicted inmates are subjected"⁵³¹.

The above must, however, be regarded as there accessories and the greatest attention paid to diet, which should be light and nutritious, to exercise in the open air, which should be sufficient to induce repose, without causing over-fatigue to a quiet routine of occupation varied with amusement. The non-restraint system is rigidly adhered to in this asylum, and no patient restricted to his ward without superintendents sanction, nor is it often found necessary to resort even to this mild form of restraint, A kind word and a little encouragement is generally sufficient to induce most of the inmates to engage in any work to which they are suited, and when a patient is noisy and troublesome adopt the plan of having him taken for a long walk or removed to another portion of the asylum, when they usually quiet down without the need of more stringent measure⁵³².

⁵³⁰Ibid, pp. 125-131, pp.129-130.

⁵³¹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 10.

⁵³² Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 17.

The long walks round the extensive grounds of the asylum in which all patients not actively employed throughout the day are induced to join tend to improve their bodily health, work off their superfluous energies, and prepare them for the night's repose; in fact it proves one of the best hypnotics as well as a most healthy and innocuous one. I may instance the case of one who formerly loitered about and was on several occasions very violent and always an uncertain and troublesome patient. Since, by order of superintend, he accompanied the others in their walks, he has become quiet, tranquil, and well behaved⁵³³.

Descriptions of 'nitrogen gas inhalation' and 'prolonged continuous sleep treatment', which were in vogue in Canada and America respectively, allow analysis of the spread and success of emerging therapies. By 1939 Electric Convulsion Therapy (ECT) from Italy was viewed as a cheaper replacement for cardiazol convulsion therapy in India, around the same time as it was in Britain.

There are also those who believed treatment should be administered by the court order when an individual diagnosed as seriously mentally ill refuses treatment or is too ill to either realize the need for treatment or cannot regulate his or her own treatment regimen⁵³⁴. This point comes under the discipline and punishment also in often and sometime it was misused by the concerned authorities. In the asylum the superintendent exposed how medical officers could overcome the restrictions on restraint and devise acceptable ways of punishing errant behaviour in patients, mechanical restraint is adopted in the treatment of violent or unruly patients⁵³⁵. During the early period of the growth of colonial asylums, various types of mechanical shackles, which was considered as coercive such as chains, waistcoats were used on patients restricting their movements and freedom. Colonial authorities justified the practice of mechanical restraint in certain cases, particularly while dealing with violent and maniac patients. Using mechanical method of treating the insane was considered easier than medical or moral therapies. It is only during the later years of colonialism that proper medical therapies and the moral therapies like recreational and

⁵³³Ibid, p. 18.

⁵³⁴Thompson Marie L, *Mental illness*, Greenwood Press, Westport, Connecticut. London, 2007. p.xiii.

⁵³⁵Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 113-114.

occupational therapies were introduced into the asylum regime in India⁵³⁶. Such patients are placed in one of the dark, boarded cells, or merely shut up for a few hours in an ordinary room until the excitement subsides.’ In this example then exclusion and isolation rather than direct physical contact were adopted to chastise and frighten the inmate⁵³⁷.

And There is system of isolation from the other patients, when the patient harmful to other, they were confined in an isolated place in the asylum.No distinction was made between the mentally ill and the criminally insane, and thousands of mentally ill—particularly the poor—were locked up in prisons with violent criminals in dark, dank cells, often unmercifully chained to the walls. Thousands more were sent to government welfare poorhouses (lunatic asylums), which were being established to house them⁵³⁸.Superintendents used the padded room for violent patients rather than noisy ones. They used the ‘dark boarded cell’ for treating ‘violent and unruly patients’ who were kept there ‘until the excitement subside[d]’⁵³⁹.The padded room, crucial to noise control in nineteenth-century asylums elsewhere, failed to occupy a significant place in asylums. In other parts of the world, asylum staff isolated patients in darkened or quiet rooms to maintain effective sound control. Padded rooms became increasingly popular in the second half of the nineteenth century as a replacement for mechanical restraint. Asylum staff used ‘violence’ rather than ‘noise’ as the criterion for incarceration in a padded room. They believed that such rooms served to manage patients with ‘destructive habits’ or patients who were ‘refractory’, ‘uproarious’, or ‘dangerous’. Superintendents in India acknowledged that the poor regulation of noise was peculiar to Indian asylums⁵⁴⁰.

Dr. A.W. Overbeck-Wright, Superintendent of the lunatic asylum at Agra, discussed the lack of control over noise in the colonial asylum soundscape. In his book *Mental*

⁵³⁶ Abraham Santhosh , ‘op.cit, p.129.

⁵³⁷ Mills, James. *Madness, Cannabis and Colonialism: The ‘Native-Only’ Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 113-114.

⁵³⁸ Thompson, Marie L, *Mental Illness*, Greenwood Press,Westport, Connecticut, London, 2007, p. 11.

⁵³⁹ Sarah Ann Pinto, *Lunatic Asylums in Colonial Bombay Shackled Bodies Unchained Minds*, Palgrave Macmillan, 2018, p.131.

⁵⁴⁰ *ibid*p.131.

Derangements in India, he elaborated on the lack of regulation on the sensory environment in Indian lunatic asylums by comparing the use of the padded room in English and Indian asylums. In Britain, he explained, staff considered a noisy patient ‘to upset the whole place’. In order to control such patients they were ‘shut up in the padded room, where he can shout certainly, but no one hears the music but himself’⁵⁴¹. In contrast, he observed that in Indian asylums, ‘if a patient shouts he is left alone, or at most a sedative is given if he requires it, and [the patients is] allowed to shout to his heart’s content without the other patients in any way being affected’. In the twentieth century, superintendents felt that padded rooms were not required in India, since a tiny dose of ‘suphanol or other sedatives was sufficient to tame and quiet the most unruly’. Superintendents used the padded cell only occasionally and under the ‘strictest supervision’⁵⁴².

In Madras Presidency also the Mental hospitals aware about Padded cells The annual reports of the Calicut Mental hospital mentioned in its reports “An industrial workshop was completed during the year. The construction of a self-contained block for better class of patients, the separation of acute, chronic, epileptic and recovering cases, the provision of special baths for hydrotherapy in the male and female hospitals and the construction of padded cells for violent cases and a ward for dysentery and tuberculosis patients should be taken up as funds permit”⁵⁴³. The Waltair Mental hospital annual reports also mention as “Special wards for well-to-do patients and a padded cell for female epileptics are necessary. The present buildings are of a very old type and unsuitable for use as a mental hospital. Plans for remodelling this hospital are under consideration”⁵⁴⁴. By these references we got to know about the usage padded cells in the region.

⁵⁴¹ A.W. Overbeck-Wright, *Mental Derangements in India: Its Symptoms and Treatment* (Calcutta and Simla: Thacker, Spink and Co., 1912), p. 326.

⁵⁴² Sarah Ann Pintoop.cit, p.132.

⁵⁴³ Annual report on the working of the mental hospitals in the madras presidency for the year 1927, printed by the superintendent, government press, madras, 1928, p. 2.

⁵⁴⁴ Annual report on the working of the mental hospitals in the madras presidency for the year 1927, printed by the superintendent, government press, madras, 1928, p. 2.

The treatment must also be of a double character and whilst we may rely on medicinal agents to improve the bodily health, regulate the secretions, give tone to the system or soothe excited or irritated conditions of the nerves, we must endeavor by careful hygienic measures, attention to dietetics and the moral influence of gentle discipline, firmness united with kindness, exercise, interesting occupation, to restore the mental capacity, and, where a complete cure cannot be effected, to alleviate the symptoms, divert the thoughts from brooding on their own sad condition, and render life endurable to those thus afflicted⁵⁴⁵.

Moral treatment

As medical director of the Asylum de Bicêtre and later of the Salpêtrière Hospital, both in Paris, France, Philippe Pinel ordered that the chains be struck off the mad patients. His carefully conducted analytic observations showed that restraint and brutal treatment did nothing to restore the minds of the mad, so in their place he introduced *le traitement moral*, or moral treatment, that included work, recreation, and intellectual and religious activities to occupy the minds of the patients and to prepare them for return to a society that had been disrupted by the French Revolution and the Restoration government⁵⁴⁶. As for Pinel, whose unchaining of the insane was a myth created decades after the event – what some have called a ‘fairy tale’. Nevertheless, it was Pinel who ‘theorized’ the changes, and provided the first systematic published account of the French version of moral treatment, and in the process helped to institutionalize the new approach. And it was the utopian optimism that moral treatment gave rise to – the sense that a new, more humane and effective form of therapy had been found, one inextricably linked to a reformed version of the madhouse – that gave birth to the age of asylumdom⁵⁴⁷.

⁵⁴⁵Ibid, p. 17.

⁵⁴⁶Mary de Young, *Madness An American History of Mental Illness and its Treatment*, McFarland & Company, Inc., Jefferson, North Carolina, and London, 2010, p. 82.

⁵⁴⁷Scull Andrew T, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine*, Princeton University Press, Princeton and Oxford, 2015, p.161.

And a handful of small, charitable asylums were created, heavily influenced by parallel developments in Europe, particularly in England, where the moral treatment practised by the Quakers at the York Retreat had begun to attract international attention. These handful of so called corporate asylums provided no scandals to match those uncovered by the European reformers, but that did not stop their most notable North American counterpart, the remarkable moral entrepreneur Dorothea Dix (1802–87), from creating a parallel set of exemplary tales of horror to advance her chosen cause of lunacy reform⁵⁴⁸. Here was the true Great Confinement of the insane, one that materialized in the nineteenth century all across Europe and the North American continent, and eventually spread, through the imperial efforts of the European powers, to other countries and continents as well⁵⁴⁹. Moral treatment was born out of religious and social concerns for the well-being of asylum patients, and its central premise was to afford them the rights that they had lost with their diagnoses of insanity. Rather than using physical restraints and punishments, as in a prison, the patients were to be treated as morally accountable humans. In practice, many asylum superintendents could not provide such a service for inmates in their overcrowded institutions⁵⁵⁰.

Developments in the treatment of the mad in Europe had a profound influence on Colonial Indian Asylums and physicians. Intention of Moral therapy is “Instead of such coercive practices, put forth notions of moral and human treatment. In this new method of treatment, mechanical restraint was abolished and shackles were expected to be removed from the patients: a human mode of treatment was expected to replace the inhumane one. Attendants and medical officers were directly engaged in the treatment. This application of moral therapy involved an engagement with the bodies of the patient as attendants were employed to take physical care of the ‘lunatics’ for twenty-four hours. Attendants were employed for caring and guarding the patients. Moral therapy was meant to discipline the inmates, without any application of force or

⁵⁴⁸Scull Andrew T, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine*, Princeton University Press, Princeton and Oxford, 2015, p.196.

⁵⁴⁹*Ibid*, p.161.

⁵⁵⁰Anouska Bhattacharyya, *Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858-1912*, PhD theses, The Department for the History of Science, Harvard University Cambridge, Massachusetts, 2013, pp.64-65.

coercion”⁵⁵¹. The Moral treatment also called as Moral management it is further divided into two occupational and recreational, these activities played prominent role in Moral treatment. It was expected that engagement with such activities would have a positive effect on the inmates and help to cure their illness⁵⁵².

In Europe of the time, it was the predominant thinking that mental distress can be treated better by care than by mere confinement. 'Moral treatment' occupied an important position in this ethos. Moral treatment was an eclectic mix of medical theory with the guiding politico-moral ideology of the time (that is, order, discipline, and work as morality, importance of family, respect for established social hierarchies, etc.). The doctor in the asylum was the chief persona of this framework, though, as the debate on wrongful confinement shows, his authority was often not supreme. Care, therefore, in this context consisted of medicine and certain methods such as 'talk of kindness and humanity, moral management, industriousness, segregation, classification, and non-restraint'; the mentally distressed were 'to be brought 'out of themselves and into contact with all in nature or art or social arrangements that is pleasurable and pure and good'. In addition, patients were given opportunities for reading, physical exercise, and monitored interactions with outsiders. The asylums were the space for this reform in treatment⁵⁵³.

With the emergence of 'moral treatment' around the turn to the nineteenth century, patient work became, as Andrew Scull put it, a 'major cornerstone' of treatment, with emphasis on the development of the patient's self-control, as distinct from control established by a therapist⁵⁵⁴. Colonial authorities justified the practice of mechanical restraint in certain cases, particularly while dealing with violent and maniac patients. Using mechanical method of treating the insane was considered easier than medical or moral therapies. It is only during the later years of colonialism that proper medical

⁵⁵¹Das Debjani, *Houses of Madness Insanity and Asylums of Bengal in Nineteenth-Century India*, Oxford University Press, New Delhi, 2015, pp. 76-77.

⁵⁵²Ibid, pp. 76-77.

⁵⁵³ Parthasarathi Mondal, "Freedom in the Imperial Imagination: Mental Asylums, Ideology, and Political Economy in Colonial India", *Sociological Bulletin*, Vol. 58, No. 2 (May - August 2009), pp. 235.

⁵⁵⁴Ernst, Waltraud (ed). *Work, Psychiatry and Society c. 1750–2015*. Manchester, Manchester University Press 2016, p. 7.

therapies and the moral therapies like recreational and occupational therapies were introduced into the asylum regime in India⁵⁵⁵.

The colonial state expected superintendents to maintain a productive patient class. Employing patients in manual work would ensure the inexpensive expansion and maintenance of asylums. Superintendents increasingly emphasized moral therapy over the nineteenth century. Occupation was the chief means of moral therapy and they used it conveniently to justify the employment of patients on the pretext of therapy⁵⁵⁶. In these asylums doctors insisted on classification among white and black and coloured patients, since doctors perceived coloured and black patients as people with 'ingovernable passions' who were 'savage' in their habits. They therefore advocated moral management as a method of treatment to 'civilise' the 'native'. Despite advocating moral management, the government managed these asylums ineffectively⁵⁵⁷.

The British medical reports inform that both medical and moral treatments and therapies were practiced in the Asylums of Madras Presidency. Ever since the establishment of Calicut Lunatic Asylum in 1872, there were attempts to implement more humane treatments to the patients. Since 1877, it is reported that European doctors made an effort to put an end to the use of chains, waistcoats and jackets on the patients, instead preference was given to moral and occupational therapies. The Superintendent of Lunatic Asylum has reported in the year 1880 that, 'the greatest reliance must be placed on moral and hygienic measures and drugs used sparingly'⁵⁵⁸. However, towards the end of nineteenth century, though the location of the asylum was not changed, the attitude towards the insanity and treatment was changing in the case of Calicut Lunatic asylum. This showed that insanity was beginning to be considered as a medically curable disease. At this stage, what is noted in the case of Calicut Lunatic Asylum is the aspect of moral, occupational and amusement therapies. It replaced the old horror tales of the asylum as a place of severe torture and

⁵⁵⁵Abraham Santhosh , *op.cit*, p. 129.

⁵⁵⁶Sarah Ann Pinto, *op.cit* pp.80-81.

⁵⁵⁷*Ibid*, p.16.

⁵⁵⁸Abraham Santhosh , 'op.cit, p. 129.

physical coercion to as a place where the humane treatment⁵⁵⁹. The asylum reports by the superintendents of Calicut Lunatic Asylum after 1920 stated that the patients were provided with all types of benefits and cures inside the asylum. Moral and occupational and amusement therapies were considered as a successful way of treating the patients⁵⁶⁰.

Work as a therapy in Asylums

On their arrival in the asylum, the insane were kept under observation and then were classed into different categories: (i) curable or incurable; (ii) violent and/or dangerous; (iii) harmless; and (iv) epileptic and/or idiots. This kind of classification, certainly subject to manipulation, helped in the management of the insane. The idea of curability meant change in the patient's attitudes to fit the doctor's or white man's expectations. The idea was also related to one's ability to participate in the asylum's work. The 'incurable' were, of course, the idle and disorderly. The 'violent' and 'dangerous' were typically the criminal insane. Confined in separate cells, they were segregated from the rest. The harmless were the most productive class, as they were put to work and performed the majority of the asylum's daily chores⁵⁶¹.

There was a provision of work therapy to the mentally ill in the British lunatic asylums, which is considered much useful to the patients as well as the state in the colonial rulers. According to that labour should be part of the therapy in the asylums. The origins of work therapy have commonly been linked with the advent of moral therapy or moral management during the early nineteenth century⁵⁶². British Psychiatrists in India and England were actively support and propagated work as a means of moral therapy of mental illness. The British believed honest work was the only cure. The British idea of a sane, healthy, functioning person was one that involved submissiveness, obedience, self-regulation, and productivity. Occupational

⁵⁵⁹Ibid, pp. 125-131, p. 130.

⁵⁶⁰Abraham Santhosh , 'op.cit, (2018) , p. 131.

⁵⁶¹ Shilpi Rajpal, "Colonial Psychiatry in mid-nineteenth century India: The James Clark enquiry", *South Asia Research* Vol. 35(1): 61–80, 2015, P. 65.

⁵⁶² Ernst, Waltraud (ed). *Op.cit*, 2016, p.10.

therapy introduced a 'normal' working routine to the patients and was the primary method of trying to improve the patients' wellbeing. Each patient is encouraged to engage in some occupation and employment activities. Much attention has been paid to suitable and regular occupation for the patients, and great assistance has been rendered by them in various menial duties connected with the management of the asylum⁵⁶³.

The main treatment regimens would consist of cleanliness, Victorian morality and a work ethic. The British stated repeatedly that they frowned upon coercion; instead it was thought that peer pressure would help build a moral foundation leading to a strong work ethic⁵⁶⁴. During the early nineteenth century, work tended to be firmly embedded in the rhetoric of 'moral therapy', with emphasis on kind and humane treatment of the insane. While still part of the wider framework of moral treatment, from the late nineteenth century, the prevention of 'idleness' was accentuated⁵⁶⁵. Patient work was a major feature of lunatic asylums or mental hospitals during the modern period. It was considered not only therapeutic but also to contribute to the upkeep of institutions. Although many other aspects of psychiatric treatment have been focused on by historians, patient work has not received any in-depth, systematic assessment⁵⁶⁶.

Few asylums had separate airing yards, which at times were converted into work sheds⁵⁶⁷. Asylum architecture aimed to isolate males from females, the curable from the incurable and the harmless from the dangerous. Another component of architectural design was to avail the facility of specialised spaces for occupation and amusement. As noted, occupational therapy was a significant element of treatment.

⁵⁶³Sanjeev Jain, "Psychiatry and confinement in India" Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, Cambridge University Press, New York 2003., p. 278.

⁵⁶⁴Kymberly C. Brumlik, "Lunacy for Profit: The Economic Gains Of 'Native-Only' Lunatic Asylums In The Bengal Presidency, 1850s-1870s", *Journal of South Asian Studies*, 02 (01) 2014. 01-10, p. 3.

⁵⁶⁵ Ernst, Waltraud (ed). *Work, Psychiatry and Society c. 1750–2015*. Manchester, Manchester University Press, 2016, p.15.

⁵⁶⁶*Ibid*, p.1.

⁵⁶⁷ Shilpi Rajpal, "Colonial Psychiatry in mid-nineteenth century India: The James Clark enquiry", *South Asia Research* Vol. 35(1): 61–80, 2015, p. 73.

The official's also emphasised separate work sheds in asylums, while the question related to distinct spaces for amusement was evaded by most superintendents⁵⁶⁸.

Occupational therapy was officially an important part of the moral management system. It is noteworthy, however, that by the mid-nineteenth century, the annual reports of the lunatic asylums had separate columns showing 'profits' earned during the year. In the colonial context, then, occupational therapy was reduced to labour, as the insane had to work hard in the institutions in order to help run them⁵⁶⁹. "The Superintendent has been successful in introducing useful and remunerative occupations among the inmates of the asylum; such occupations are remedial agents of great value and, from an economical point of view, are of considerable pecuniary importance to Government. In future the bedding as well as the clothing of the asylum will be made by the inmates. Dr. Nanney's efforts in this direction are most praiseworthy"⁵⁷⁰.

There was a large measure to the careful sanitary arrangements enforced by the Superintendent. "The insanes are occupied morning and evening in watering the young trees, cleaning the grounds of weeds, litter and decayed leaves and in drawing water; their recreation apparently consists principally if not entirely of music and singing. It would be well were other useful and varied occupations introduced and the recreations made somewhat more varied than those detailed in the report; rope-making, mat-making, pottery, weaving and other simple manual occupations might be introduced with advantage by the Surgeon Smith the Superintendent of Vizagapatam Lunatic Asylum"⁵⁷¹.

This idea that the labour of the inmates should be remunerative and contribute towards the cost of running the asylum was formalized in the tables which had to be returned with the annual reports, so that the superintendents included comments in

⁵⁶⁸Ibid, pp. 73-74.

⁵⁶⁹Ibid, p. 71.

⁵⁷⁰ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 10.

⁵⁷¹Ibid, p. 10.

their narratives like the following (Find such example in Madras Presidency) Statement No. 10 – This statement shows the profits of the labour of the lunatics which amount to Rs 781-9-4 for the year. As soon as I came here I introduced the manufacture of bon mooj matting in the Asylum, and during the six months the lunatics have worked at it they have made by this alone a clear profit of Rs 220-3-3⁵⁷².

Ernst explores the changing and plural meanings of work in relation to prevalent medical ideas and practices in different institutional settings in British-held territories from the early nineteenth to the middle of the twentieth centuries. Different aspects of work are discussed, such as work as therapy; means to combat idleness; patients' empowerment; institutional profit; and forced labour. The incentives used by staff to induce patients to engage in physical labour and the punishments employed in cases of non-compliance will be scrutinised. It will be shown that gender, social and caste prejudices and sentiments affected the types of activity patients were expected to engage in, and how, with the emergence of professionalised occupational therapy (OT) from the early twentieth-century patient, work became increasingly acceptable also with regard to European patients⁵⁷³. In the early twentieth century, patient work became part of a medical paradigm that conceived of it as beneficial if not curative, alongside an array of other practices (such as hydrotherapy, sedation, tonics, and shock treatments). It was reconceptualised in the scientific terms of the period and, with the emergence of newly professionalised auxiliary medical disciplines, refashioned as 'occupational therapy'⁵⁷⁴.

The asylum reports by the superintendents of Calicut Lunatic Asylum after 1920 stated that the patients were provided with all types of benefits and cures inside the asylum. Moral and occupational and amusement therapies were considered as a successful way of treating the patients.⁵⁷⁵ Doctors in the asylum used purgatives, sedatives and tonics to control at the initial level of treatment. However, soon the

⁵⁷² Mills, James. *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India*. London; New York: Macmillan, 2000, p. 124.

⁵⁷³ Ernst, Waltraud (ed). *Work, Psychiatry and Society c. 1750–2015*. Manchester, Manchester University Press, 2016, p.117.

⁵⁷⁴ Ibid, p.15.

⁵⁷⁵ Abraham Santhosh, 'op.cit, p131.

other options included engagement in various types of asylum labour and certain kinds of amusements were also used. It is reported that since 1920, occupational therapy had become a standard term for patient work in the asylums. The Calicut Lunatic asylum also reported to engage the patients in various kinds of works as part of the occupational therapy, the range of activities were: weaving, carpentry, book binding, brickworks, rope making, tailoring, mattress making, etc⁵⁷⁶.

Alas, another wave of therapeutic pessimism in the wake of changes within the mind sciences, economic depression and the silting up of hospitals with chronic patients characterised institutional regimes from the 1920s onwards, with unpaid patient work coexisting alongside a variety of practices subsumed under the newly emerging specialism of occupational therapy (OT). The therapeutic value of patient work remained elusive well into the middle of twentieth century, when, as Harris points out, female patients, for example, ‘may have worked as maids and janitors for much of their day with no therapeutic rationale, and then attended a brief OT class’⁵⁷⁷.

Lunatic asylums reports termed it as ‘Industries and employments’ under this title they classified the occupational therapy as “Gardening, growing of vegetables, basket making, mat making, rope making, coir twisting, dhall cleaning, rice pounding, weaving of cotton articles, sewing and knitting form the chief remunerative employments of the insanes. Selected patients are also utilized for assisting the carpenter, blacksmith, mason, tailor, dhoby, cook and storekeeper”⁵⁷⁸. Not only did the British see these **gardens** as a way to give the patients an outdoor job considered as part of their treatment regimen, but they also hoped to sell the excess produce for profit. A satisfactory profit made on these gardens, there might be governmental retribution. It did not matter that the patients were well fed with an ample supply of garden fresh fruits and vegetables; what concerned those in charge of the asylums as well as colonial administrators was profit margins⁵⁷⁹. In Madras Mental Hospital

⁵⁷⁶Ibid , pp. 125-131, p, 129.

⁵⁷⁷ Ernst, Waltraud (ed). *Op.cit*, 2016, pp.11-12.

⁵⁷⁸ Triennial Report on the Working of the Lunatic Asylums in the Madras Presidency for the Period 1918-1920, Printed by the Superintendent, Government Press, Madras, 1921, p. 3.

⁵⁷⁹Kymberly C. Brumlik, “Lunacy for Profit: The Economic Gains Of ‘Native-Only’ Lunatic Asylums In The Bengal Presidency, 1850s-1870s”,*Journal of South Asian Studies*, 02 (01) 2014. 01-10, p.6.

forty-three percent of the patients were engaged in various occupations during the year of whom 18 percent worked in the manufacturing department, i.e., oil mill, mat-making, weaving and knitting. The remaining 25 percent were employed in unskilled labour, such as gardening, sweeping, cleaning of food stuffs, etc. selected patients were also utilized for assisting the carpenter, dhobis, blacksmith, mason, tailors, cooks, etc⁵⁸⁰. In 20th Century small monthly rewards to buy articles from shops and some patients send money to family. “as usual these patients were rewarded with small presents on the occasions of the Christmas tree and the annual sports held during the year and also by indulgence in small luxuries such as cheroots, tobacco snuff, betel-nut, cinema shows motor drives, etc”⁵⁸¹. The employment of suitable patients helping in the domestic duties (such as cooking and sweeping, etc.) connected with the mental hospitals continued as usual⁵⁸².

The original European ideology of work as therapy, in these institutions it was held that Europeans should not work (because of harsh climatic conditions, it seems), whereas Indian patients were made to labour on the basis of the same European ideology. Moreover, whereas the physical restraint of violent patients was considered to be barbaric by reformers in Britain, in India, it was advocated on the grounds that it was a better option than facing the humiliation of being physically controlled by subject native staff. And psychiatric ideology of the time held that mental distress was related to climatic conditions and levels of civilization, in the case of Indians, it was held that they were a fundamentally mentally distressed race. Racial considerations were intersected by class considerations. There were two distinct classes of treatment and care: one for well-off Europeans and the other for working-class Europeans and soldiers. The former received 'first-class' treatment, whereas the latter were categorized as 'second-class'. As the majority of the European mentally distressed came from the second category, the East India Company, and later the British

⁵⁸⁰Education and Public Health Department,(Public Health) Government of Madras, G.O.No.1380, 6th June, 1935, Report- Mental Hospitals-1934 – Recorded with Remarks, p. 2.

⁵⁸¹Ibid, p. 2.

⁵⁸²Ibid, p. 3.

Parliament, was concerned that their ungainly sight would reduce the image and prestige of the British as a supreme race in the eyes of the natives⁵⁸³.

The noted shifts largely echoed dominant psychiatric discourses prevalent in the West, but, as Ernst shows, the colonial context led to modifications in the ways in which particular work, as well as leisure, activities were employed highly selectively to fit the perceived needs and predispositions of different genders, races, castes and social classes. What is more, individual superintendents accentuated different aspects of patient work, employing it as therapy, to empower patients, as a means to combat idleness, to create institutional profit, and as forced labour. Patient work meant a number of different things and was implemented in varied ways⁵⁸⁴. Psychiatrists in Britain advocated work as a means of “moral management” of mental illness, on the other hand British psychiatrists in India designated hard labour “impracticable, to Europeans” because of the harsh climate. This kind of view demarcated the social class in a very crude way. Physicians prescribed that soldiers and working-class Europeans should not work in asylums, while in the same institutions Indian patients were forced into exhaustive labour as part of their therapy. Thus psychiatrists in Britain and India differed on the issue of controlling violent patients. British psychiatrist viewed handcuffs and leg irons as barbaric symbols of the asylum’s dubious past, but they differed in their views regarding Indian patients⁵⁸⁵.

In the early 19th Century asylum management ought to practice moral therapy, as part of that work therapy was considered as reclaim patients to the engagement and exercise of reason. Work therapy to discourage idleness and malingering in Hospital, suitable employment for the purpose of combating idleness. Work therapy: In 20th century asylum practices considered work is a pleasant pastime and undoubtedly curative. The next expect was that always benefit for the state, staff and community of the asylum is the main emphasis is really comes forth. There was also the profit share for the staff of the asylum, in order to increase the production. Work therapy keeps

⁵⁸³ Parthasarathi Mondal, “Freedom in the Imperial Imagination: Mental Asylums, Ideology, and Political Economy in Colonial India”, *Sociological Bulletin*, Vol. 58, No. 2 (May - August 2009), pp. 234-35.

⁵⁸⁴ Ernst, Waltraud (ed). *Op.cit*, 2016, pp.15-16.

⁵⁸⁵ Basu Saumitra, *op.cit*, 2016, p. 482.

the institution self-sufficient. In British Indian asylums, those who hard they get incentives, motivation, inducement, whereas those who unable to work did get less food. The sick and old actually excluded from work, because of this reason the mortality rates high in the asylums.

Upon examination of reports pertaining to asylums supervised by the British, it became evident that these facilities were no more than forced labour houses producing goods for the British Empire. In reality, the asylums had little to do with the rehabilitation of mentally ill patients. In reality, the asylums had little to do with the rehabilitation of mentally ill patients. By researching the yearly reports from the asylums, which were veiled in Victorian morality, it became apparent that the reports of medical treatment had evolved into profit margin data. As a result of ‘occupation’ as a cure, the goods produced by these patients in the asylums created a new significant avenue of profit for the British⁵⁸⁶. In an era where the discipline of psychiatry was becoming popular and new treatments were being developed, the focus of the Native-Only Asylums concentrated on employment and profits. Treatment is not represented as a priority in these annual reports⁵⁸⁷.

The limited medical knowledge available about the field of psychiatry is evident in the documents, but the lack of medical concern for the patients is also apparent. The goal of these facilities was not to ‘cure’ the patients, but to profit off of their work instead⁵⁸⁸, and disciplining the society. The work therapy demonstrates that Colonial lunatic asylums in the Madras Presidency resulted in a profit motive. The ethos of increase of indigenous populations was used to manipulate the diagnoses of those who were not truly mentally ill. The brunt of ‘work therapy’ resulting in financial remuneration for the British Empire. The funds realized from these facilities were not reinvested for the benefit of the asylums⁵⁸⁹.

Recreation or Amusement

⁵⁸⁶Kymerly C. Brumlik, op.cit, 2014, p.1.

⁵⁸⁷Ibid, p. 7.

⁵⁸⁸Ibid, p.8.

⁵⁸⁹Ibid, p. 9.

In 1853, Dr. Campbell described asylum treatment practices in two broad categories: hygiene and moral treatment. Hygiene treatment included ‘airing, clothing, bathing and feeding’ and moral treatment included ‘amusement and exercise’ (labour)⁵⁹⁰. The Superintendent of Waltair Lunatic Asylum Surgeon, J. Smith, opinions that ‘Occupation and recreation with good diet and kind treatment are the means used for promoting recovery; I have noticed that those insanes who work cheerfully and willingly keep the best health. All the deaths, without exception, occurred among the non-working insanes’⁵⁹¹. Amusement was an essential part of the moral management system and therefore it was considered to be a part of the treatment regimen. Entertainment was provided to the inmates along the lines of race and class. In the nineteenth century, European patients were provided with amenities of superior quality, whereas Indian patients were provided inferior facilities. By the turn of the century, superior facilities were being provided to those Indian inmates who could pay for them⁵⁹². Amusement, along with physical activities, hygienic food was measured to be beneficial treatments, as different forms of entertainment ruined the dullness of the patients and enabled the inmates to relax. Entertainment and amusement offer to selected inmates normal experiences of the outside world and within the mental asylum.

An enquiry into recreation patterns helps to understand the social history of mental illness in colonial madras presidency. It is to be regretted that the humanising effect of divine service with music, which would attract and soothe, should not be afforded to those who are debarred from so many of the pleasures and consolations of life⁵⁹³. The warders’ work with the patients and their friends visit them weekly. Nearly allied to this subject is the occasional mingling of the two sexes, which, from its associations

⁵⁹⁰S. A. PINTO, p.95..

⁵⁹¹ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p. 24.

⁵⁹²Shilpi Rajpal, “Quotidian Madness: Time, Management and Asylums in Colonial North India, c. 1850–1947”, *Studies in History*, 31(2) 206–234, 2015, p. 222.

⁵⁹³ Annual Report on the Lunatic Asylums in the Madras Presidency during the Year 1877-78, the Government Press, Madras, 1878., p.19.

with home life, proves valuable and beneficial⁵⁹⁴. Along with moral therapies, the Calicut Lunatic asylum also reported to engage the patients in various kinds of games as part of their recreational therapy. Patients frequently amused themselves with games that involved light physical exertions. Other activities like singing competition, listening to radio, badminton, dancing, card games and use of native musical instruments were used to amuse patients as part of recreational therapy⁵⁹⁵.

Involvement of Philanthropists had changed the aspects and perspectives of mentally ill people of in this region. The asylum inmates are well looked after in this respect; and the records of the institutions show that real sympathy is felt by the educated public for their afflicted brethren. Several persons gave books and money for monthly treats. Rao Bahadur M. Natesa Ayyar, District Registrar of Madras, left a legacy of Rs. 580-4-0 to the Madras Asylum, the interest on which sum is to be used towards the help of needy inmates. In 1914 the Madras Asylum put a cricket team into the field. Being apparently the first asylum in India to do so—and played matches with Newington College, Doveton College, the St. Thomas' Mount, and the Eastern Telegraphs. The band of the Madras and Southern Mahratta Railway Rifles, by kind permission of Lieut.-Colonel Porteous and the officers of the corps played selections of music for the Madras Asylum patients in the Asylum on many occasions., and books and periodicals for the Asylum library were received from His Excellency the Governor of Madras, Mrs. Porteous and several others⁵⁹⁶.

These were various; chief among them were treats during festival occasions, such as Christmas, Pongal time, etc. Football, cricket, tennis and badminton are being now regularly played in the Madras Asylum and several matches were played with outside teams, the asylum teams winning in some of them. Some of the patients compete for the Park Fair sports for events specially reserved for them. By kind permission of the proprietors of the Globe, Wellington and Elphinstone Cinema Companies, some of the patients were allowed to attend free of charge. By the kindness of Messrs. Oakes & Co., and the Madras Engineering Company batches of patients were taken for

⁵⁹⁴Ibid, p. 18.

⁵⁹⁵Abraham Santhosh , op.cit, 2018, p. 129.

⁵⁹⁶Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1914, Printed by the Superintendent, Government Press, Madras, 1915, p. 8.

picnics in busses and these were much appreciated by the patients. In Calicut also well behaved patients were sent to witness dramas, bioscopes, sports, etc. In Calicut a special feature of this year was the experiment made by employing a keeper to teach the three "R's " to a selected number of patients, and some were made to learn by heart passages in English poetry and also poems in Malayalam. " This method of training," says the Superintendent of the Calicut Asylum, " appears to be very commendable inasmuch as it affords both work and recreation to the patients and requires encouragement⁵⁹⁷."

Various kinds of amusements are, as usual, provided for the patients. In the Mental Hospital, Madras, several concerts and entertainments were organized during the year and several ladies and gentlemen from outside associated themselves with these. The patients still enjoy the privilege of attending cinemas free of charge. The class for the training of patients in the three R.'s which engaged some of literary patients in reading and writing had to be discontinued in the Mental Hospital, Calicut, as the keeper employed for the purpose had to be sent away owing to the reduction of establishment ordered in G.O. No. 1753 P.H., dated 28th November 1924. The Honorary Secretary of the Indian Red Cross Society (Madras Branch) was kind enough to supply some very useful gifts consisting of hospital requirements, shirts, toilet requisites and games for the use of the patients in the Mental Hospital, Calicut⁵⁹⁸.

Various kinds of amusements were provided for the patients in all the hospitals. The Red Cross Society besides supplying magazines, illustrated papers, books and sporting materials made a very generous gift of Rs. 388 towards the annual Christmas treat to the patients of the Mental Hospital, Madras. The late Sri Sitabai, Rani Saheba of Wadhwan, Vizagapatam, gave a sumptuous treat to the inmates of the Mental Hospital, Waltair, on 12th December 1927. The thanks of the administration are due to the ladies and gentlemen who have interested themselves in these hospitals⁵⁹⁹.

⁵⁹⁷Triennial Report on the Working of the Lunatic Asylums in the Madras Presidency for the Period 1918-1920, Printed by the Superintendent, Government Press, Madras, 1921, p. 3.

⁵⁹⁸Ibid, p. 2.

⁵⁹⁹Ibid, p. 3.

The patients in all the three mental hospitals were as usual provided with various kinds of amusements. **Madras.**—To promote a greater sense of freedom, some selected patients were allowed to go out daily for evening walks outside the hospital either by themselves or accompanied by attendants. The privilege of allowing a certain number of the patients to attend the Wellington Cinema in the evenings has been continued through the kind courtesy of the proprietor and is much appreciated. The Red Cross Society kindly continued their supply of magazines, illustrated papers and books, etc. This society also made a very generous donation of Rs. 535 towards the annual treat to the patients. The editors of the *Madras Mail* the *Hindu* and two other vernacular journals continued the free supply of their papers to this hospital. The band of His Excellency the Governor of Madras very kindly played once a month in the hospital as in previous years. The band of the Madras Guards, which was hitherto playing once a month in the hospital, was disbanded and a private orchestra was engaged to play once a month on payment of a fixed monthly contribution of Rs. 15 from October 1930. The committee of voluntary lady visitors continued their good work in the female enclosure of this hospital.

The patients were entertained to a feast by the Zamindar of Chemudu on 21st December 1930. A new gramophone with plates was presented to the hospital by the Indian Red Cross Society, Madras, and spinning wheels and other accessories by M.R.Ry. Sree Vikrama Deo Varma Garu for the occupation of female patients. The editors of the *Hindu*, the *Āndhra Patrika*, *Illustrated Weekly*, Bombay, the *Trilinga* kindly continued the free supply of their papers to this hospital. Bi-weekly bhajana (concert of worship) with Indian drum and cymbals, was also arranged for, for the entertainment of the patients.

Through the kindness of the proprietors of the Radha Picture Palace a dozen patients were allowed to witness their show free of charge every Saturday as in the previous year. The teaching class here also goes a great way in improving the mental condition of the inmates. The Red Cross Society has kindly supplied the hospital with requisites for games and also other useful articles. The daily issues of the *Hindu* and the *Mitavadi* are supplied to this hospital gratis by the editors of the respective papers.

The thanks of the administration are due to the ladies and gentlemen who have interested themselves in these hospitals⁶⁰⁰.

Patients Waltair took part in games like football, badminton, etc., and other amusements like cards and chess. Music was provided systematically by a gramophone and also by concerts given by patients with talent for music. The patients were also amused occasionally with feats by professional jugglers and acrobats and they were regularly sent on excursion trips. The motor bus was freely utilized for taking patients to fairs and festivals in surrounding places and to bi-weekly shows of the local "Sree Krishna⁶⁰¹" Cinema. The editors of the newspapers continued their supply of papers. The nucleus for a hospital library was found with Telugu books presented by Messrs. V. Ramaswami Sastrulu & Sons, Madras. The *Calicut* patients were provided with various kinds of amusements. The editors of the papers continued the free supply of their papers⁶⁰².

In the Asylum at Calicut the Music class and the class for training the patients in the three R's are still continued with beneficial results. A drama "Benefits of the British Rule in India" composed by M.R.Ry. Rao Sahib A. Gopalan, Deputy Superintendent, was staged by some of the keepers and insanes to the great amusement of all. European patients had dances arranged in the Recreation Hall. Dr. S. Venkata Subba Rao introduced carom boards and other play things, Harmonium, Tabla, Mridangam and radio for each section. Along with escorts, he sent patients out for walks up to Purasawakkam, a nearby market place. Later some patients were allowed to go out for walks even without attendants. Two European patients worked outside as mechanics and deposited their earnings in the hospital office.

The dilemma of treatment versus non-treatment is huge:

Most people who know they have a mental illness remain untreated for various reasons. They are psychological, physical, emotional, and financial burden of

⁶⁰⁰Annual report on the working of the mental hospitals in the madras presidency for the year 1930, printed by the superintendent, government press, madras, 1931, p. 3.

⁶⁰¹Annual report on the working of the Mental Hospitals in the Madras Presidency for the year 1932, printed by the superintendent, government press, madras, 1933, p. 2.

⁶⁰²Ibid, p. 3.

untreated mental illness to those who have it, to their families, and to society⁶⁰³. The primary reason for the non-treatment is the stigma that surrounds mentally illness. Stigma leads to discrimination, which often leads to a mentally ill individual being unable to obtain gainful employment, and denied the respect in the society. Another reason for non-treatment is cost: treatment of any kind is expensive. There are no clinical tests to definitively diagnose mental illness. Diagnosis is determined by a clinician who asks a patient for a history and listens to a description of the patient's feelings and how those feelings affect thoughts, actions, relationships, and life overall⁶⁰⁴. One of the reasons that the asylum system was felt as a burden to government in this period was that the new institutions established after 1858 quickly silted up with chronic cases⁶⁰⁵.

Native and Indigenous Treatment Practices

Studies in ethno psychiatry offset the discourse of Western psychiatry to some extent, but like their Eurocentric counterparts, they ignore the role of contact between Western and alternative psychiatric medicine. By their very nature histories of colonial psychiatry disrupt these accounts, elucidating the ways in which Western medicine's alliance to colonial authority encouraged a return to traditional practices in Asian and African colonies.⁶⁰⁶ Historians of colonial medicine and psychiatry tend to focus on the European impact on the outside world and on how the colonial enterprise furthered the expansion of Western scientific knowledge. It is only recently, and largely due to the challenge of social science and literature-based theories of post-colonialism and subaltern studies, that this focus has been widened to look also at indigenous responses and resistance to Western medical and psychiatric blueprints have yet to be investigated. One axiom of Colonial medical discourse in 19th century British India was the presumed superiority of scientific medicine over indigenous

⁶⁰³Thompson Marie L, *Mental illness*, Greenwood Press, Westport, Connecticut. London, 2007. p.xiii.

⁶⁰⁴Ibid, p.22.

⁶⁰⁵James H Mills, *Modern Psychiatry in India*, p. 335.

⁶⁰⁶Richard Keller, *Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962*, p. 295-96.

medical systems. Scholars observed that psychiatry achieved this superiority through a negotiation between the indigenous tradition and scientific knowledge⁶⁰⁷.

It addresses the question of interaction between psychiatry and indigenous healing traditions. This question is relevant to address the asylum practices in Madras Presidency, which has a rich and diverse tradition of healing. Since time immemorial concern with mental health has been a part of Indian culture. Like very few others, Indians have long been involved in constructing explanatory techniques for its alleviation. There are traditional physicians like the Vaid, the Hakims – many of whom also practice what we today call ‘psychological medicine’. In addition there are palmists, a variety of shamans, whose therapeutic efforts combine elements from classical Indian astrology, medicine, alchemy and magic with beliefs and practices from folk and popular traditions⁶⁰⁸. The Madras presidency offers a relatively little-researched field for the investigation of colonial/indigenous relationships articulated through mutual engagement with the medical, legal and social implications of a severe endemic disease⁶⁰⁹.

A number of religious healers and ascertain their views on mental illness. The healers-Hindu, Muslim and Christian-were share a part at length. Various religious rituals observed. The shrines are virtually spec in dealing with specific psychiatric problems. The indigenous healing practices for managing mental illness in the Madras Presidency. It is further sub divided into **a)** family based practices, **b)** religious centre based practices and **c)** ritual art forms. Various Indigenous healing traditions were prevailed in Madras Presidency: various systems of medicine sought survival through professionalization and they are: ‘Allopathy, Homeopathy, Ayurveda, Siddha and Unani systems, the later four of these came to be known as the ‘indigenous system of medicine’ in India. Naturopathy and Yoga have also attracted the medical practioners for their therapeutic values. The Telugu periodicals like Arogya Prabodini, Arogya

⁶⁰⁷Basu Saumitra, Madras Lunatic Asylum: A Remarkable History in British India, *Indian Journal of History of Science*, 51.3 (2016) 478-493.

⁶⁰⁸Mills, James. The History of Modern Psychiatry in India: 1858 – 1947, *Journal of the History of Psychiatry*, 12 (2001): 431 – 458

⁶⁰⁹ Leprosy in south India, p.4.

Suda, Arogya Prakasika, and Andhra Vaidya Sammelana Patrika provide detailed information on the history of indigenous medical systems.

The Places of worship for Hindu, Muslim and Christian are still important centres for the treatment of mental illness. Here the locus of control is placed outside the sufferer and problems may be attributed to black magic, a curse, divine wrath, or karma (determinism) of a previous life. The explanatory model therefore largely influences the type of help sought. Treatments at religious centres range from performing a series of rituals such as bathing in the temple tank and circumambulating the temple, to prayers at specified times. Physical restraint by chaining patients to a pole or a tree is not uncommon. Belief in the efficacy of religious treatment has led to the growth of unauthorised shelters housing mentally ill patients around such centres of worship⁶¹⁰.

It also shows how permeable the asylum could be, both physically and figuratively to people and ideas. The permeability of the native asylum in India permitted a hybrid practice of care within. Mid-century psychiatry had not yet formed coherent disciplinary boundaries that could be applied in the Indian asylum with any rigor. Its practitioners had limited tools for treatment and care at their disposal. Local ideas could therefore enter the asylum and intermingle with the variable skill set of the British superintendents in charge to produce a heterogeneous or hybrid practice of care. This hybridity was specific to the characteristics of its locale every native lunatic asylum was permeable to its surrounding community, but that the level of intermingling, of interaction between different kinds of historical actors, represented the particular characteristics and belief systems of the community in which the asylum was embedded⁶¹¹.

Lunatic Asylums in Madras Presidency were a permeable space, with fluid peripheries and a hybridized practice of care within. The treatments investigated include varying combinations of drugs, herbal extracts, dietary regulations, physical

⁶¹⁰ R. Thara, R. Padmavati and T. N. Srinivasan, 'Focus On Psychiatry In India', *British Journal Of Psychiatry* (2004), 184, pp. 366-373. P.367.

⁶¹¹ Anouska Bhattacharyya, op.cit, p. 2.

exercises and lifestyle modifications.⁶¹² For instance healers prescribed limejuice and pepper for an attack of rheumatism to patient, and strongly recommended coconut water as a blood purifier⁶¹³. During Dr. John Dhairyam period, Indigenous medicines were tried on a large scale. His involvement with the Indian systems of medicine Ayurveda and Siddha is vividly recalled by his son Desaraj. He had intimate contact with various sadhus who helped him in the preparation of 'Podoms' and 'Baspams'. The whole root preparation of *Rawolfia Serpentina* was widely used⁶¹⁴. Snake venom in minute doses is also being tried in cases of epilepsy in the Mental Hospital, Waltair⁶¹⁵. The vast majority of the rural population had no opportunity to reach Mental hospitals due to various legal medical administrative structures.

Theories and Practice of treatment in the Asylum

There was always a huge gap between theory and practices of mental health practices in the mental hospitals of Madras Presidency. For instance, in diagnosing the mental illness, doctors do not take the patients voice or testimony into consideration; most of the times, they depend on states made by police and relatives who brought the patient to the hospital. Another observation is that according to the moral therapy patient has to treat with much kindness in theory, whereas in practice patient assigned with hard labour in the name of work as a therapy, patients have been exploited by the staff of the asylums, those who do not meet work deadline get punishment whereas those who works hard use to get small rewards.

Summary

⁶¹² R. Thara, R. Padmavati and T. N. Srinivasan, 'Focus On Psychiatry In India', *British Journal Of Psychiatry* (2004), 184, pp. 366-373. P.367.

⁶¹³ Sanjeev Jain, "Psychiatry and confinement in India" Roy Porter and David Wright (Ed), *The Confinement of the Insane International Perspectives, 1800–1965*, Cambridge University Press, New York 2003., p. 278.

⁶¹⁴ Somasundaram. O, "Psychiatry in Madras at the sunset of the British Raj", *Indian Journal of Psychiatry*, special issue called, Icons of Indian Psychiatry, p.3. Year.....?.

⁶¹⁵ Local Self-Government (Public Health) Department, Government of Madras, G.O. No. 1380, 6th June, 1935, Report- Mental Hospitals-1934 - Recorded with remarks, p. 1.

This chapter explained Treatment practices in the Madras Presidency, the types of mental illness and colonial perceptions of the causes of insanity, diagnostic procedures and various treatment practices in the three mental hospitals of Madras Presidency are discussed here. Treatment practiced in an asylum was directly connected with the understanding of Mental illness. By the end of the nineteenth century causes of the mental illness was broadly categorized into two they are Moral causes and Physical causes, whereas, social factor that contributes the mental illness had been noted at the census reports from the early parts of the twentieth century. The diagnostic practices involve mostly on observation of patient's behaviour, body language and speech expressions, which were observed by staff of the asylum, police case reports and relatives testimonies about the patients. And patients voice is ignored by staff and doctors, which is unscientific according to the medical science, that is why most of the researches say that psychiatric diagnosis are unscientific and it is also called as pseudoscience. The treatment practices in the Madras mental asylums were classified as mechanical, medical and moral therapies. In the Madras mental hospitals work therapy or occupational therapy was given prime importance, it is believed that in the contemporary asylum practices the work and exercises are beneficiary methods in curing the mental illness. In other side of the coin to the work therapy was, in the name of the moral treatments the inmates were bound to work, to serve the purpose of institutional cleanliness and benefits of the individual as well as, it was exploitive in nature. Another important aspect of the moral treatment is recreation or amusements, it is observed that inmates occasionally involved and encouraged to participate the recreational practices but criminal patient excluded. In Madras presidency various philanthropist, concerned individual and officials were offered delicious feasts, newspapers, magazines, free cinema shows and encouragement and small prizes to the inmate of the three mental hospitals of this region. Among the moral therapies occupational therapy is beneficial to the institutions that are why the practice of occupational therapy is encouraged. Whereas recreations were offered by philanthropist state has no state in it except managerial operations. It is observed that reasons for the causes of the mental illness are not diagnosed properly, in most of the cases colonial perceptions on mental illness were documented.

And also the chapter addressed the question of interaction between psychiatry and indigenous healing traditions. In these traditions *SiddhaAyurveda* and *Unani* and

others were prevailed in this region, most of the poor who were not in a position to availed modern psychiatric institutions they approached indigenous healing traditions in madras presidency. Superintendent role is very important in management of asylum and treatment of the Insanity and it depends on him whether to adopt Indigenous healing traditions or not. The theory and practice in treating the mental illness is very huge in these three institutions and it is observed that psychiatry achieved this superiority through a negotiation between the indigenous tradition and scientific knowledge. The study of the mental illness in Madras Presidency also helped to construct the formation and practice of psychiatric sciences in India by studying the various issues relating to the mental illness. And the last chapter Conclusion provides the summary of the study.

Chapter-5

Conclusion

This chapter deals with the summary, the finding and concluding remarks on the study. The first research objective engaged about how colonial states dealt with mental illness. In this sequence brief explanation to construct the concept of mental illness, trajectory of mental illness and the evolution of psychiatry in both the world and Indian context were focused. Moreover, it gave an overview of Madness in Pre-colonial time and the origin and development of psychiatry in Colonial India. It dealt with some terms related to mental health and disease and their meanings. Furthermore, in the other part, the historiography of medicine-public health and Psychiatry in Colonial India were explained in a detailed manner. It highlighted various historians' arguments and multiple points of interrogation of the history of Mental illness in the colonial context. It also dealt with the research methodology, periodization of the study and the aims and objectives of the research.

It is understood that the malady of Mental illness is the most significant health problem today in the world. Moreover, mental disorder causes a great deal of suffering to the patients, their family members and society. Throughout the time and space Psychiatrist, researchers have been struggling continuously to understand the nature, causes and consequences around this malady. The illness to the mind is a universal phenomenon; all regions and cultures have been familiar with this sickness. Irrespective of class, race, and gender everyone have been affected. But the reasons and causes of the mental illness are yet to be discovered accurate manner. Mental illness has a unique history in all the societies and cultures. Every region of the world has their forms of treatment procedures and institutional practices. Though it seems to be a single identity called as mental illness, it has contained and loaded with much history of human suffering and exploitation, and empowerment somehow involves around this Malady of Mental illness. To know and understand much about mental illness in an Indian context, it is inevitable to study the lunatic asylums in colonial India. Because the modern practices of institutionalization for mental illness in India are transplanted for the convenience of the European expatriate community in India during the East India Company's rule.

Asylums thus existed with the EIC's approval in the major presidencies of Madras, Bombay, and Calcutta after arrival of significant number of soldiers and civilian colonialists. The lunatic asylums served Europeans patients primarily. Psychiatry in India also reflect the practices in England. The early mental institutions in the Indian sub-continent were greatly influenced by the idea and concept prevalent in England and Europe during those days. Primarily the asylums were created to protect the pride and prestige of the white race in India because of some European vagrants' created tensions to white superiority. Essentially colonial psychiatry was permanently and intrinsically linked with the British civilizing mission. Thus British had control over India. Mental hospitals were constructed in isolated areas to segregate those who, by reasons of insanity, were considered troublesome and dangerous to the neighbours. The overriding concern was to protect the citizens without regard for appropriate care and the cure of the patients. The advancement of imperial power in colonial India motivated the development of psychiatric infrastructure in India. In the early nineteenth century, asylums had begun as a private business, which the British administration gradually took over. Early asylum's proprietors were set to train both lucrative business and follow procedure for the disposal of insane persons, which was regarded as most humane. The aspects of individual profit and institutional care characterize the affairs of the asylum during the first half of the nineteenth century in EIC rule. Indians from the better class and poorer sections started to avail of this facility over time.

Today there are about forty-five mental hospitals, out of which about thirty-one were established during the British colonial rule. Still, they are continuing in treating mentally ill people. Mental health care in government mental institutions in India are still based on colonial model. The legacy of psychiatric and its treatment continued even today in India after independence. Thus it is essential to know the background story of mental hospitals and their developments in colonial settings.

The second research objective focused on the institutional history of the mentally ill people in the Madras Presidency. There are three mental hospitals in Madras Presidency; they are, Madras (1871), Vizagapatam (1872) and Calicut Mental hospitals (1872). Moreover, the research objective also evaluated systematic developments in the field of mental institutions in the Madras Presidency. It also

explored the developments in the asylums and explained the similarities and dissimilarities between these three asylums. It is observed that there are fewer works available about both Vishakhapatnam and Calicut mental asylums.

Moreover, this work took Madras presidency as a geographical entity and documented the regional histories on mental illness and its institutions. It is a valuable addition to the field of history of psychiatry in colonial India. It explored vividly the political and administrative conditions and policies relating to the unsound mind in this region in general and institution histories of the Madras, Vizagapatam and Calicut, the mental Asylums in particular.

Among the three hospitals, Madras Mental Hospital was considered as the ‘central asylum’. It accommodated both Europeans and Indians, whereas the other two were domestic asylums to accommodate Indians. As a result, they considered as native asylums. The usual comfort in the Madras Asylum is more significant than the one at Calicut; further much greater than the one at Vizagapatam. From the inception of the institutions, there were frequent complaints about insufficiency of accommodation. They were always overcrowded with the mentally sick in the asylum. To deal with such situations, the Madras government kept insane in the jails. Mainly the accommodation was found inadequate to numerous criminal lunatics. As a result, they were confined in jails. In 1892 criminal patients were transferred to Madras, and this asylum was reserved solely for non-criminal patients. From then, Calicut and Vizagapatam asylum were reserved for the civil and native lunatics’ treatment.

The Colonial state introduced numerous policies and acted in that period. In this regard, The Lunacy Act of 1912 can be observed, which had significance in the history of psychiatry in India. The enactment of these laws created a new vista in the asylum history of British India and drastically altered the concept of lunacy to a great extent. Here the role of the then Madras Government is undeniable. The Madras Government first raised the issue of the admission of uncertified voluntary borders in the asylum. Due to time, it was incorporated in the Indian Lunacy Act of 1912 of Section IV. That act classified admissions into the lunatic asylum into two categories, i.e., compulsory admissions and voluntary admissions. This innovative concept of

'voluntary boarders' is a unique contribution to Indian psychiatry from the Madras Presidency.

The introduction of the 'voluntary' system of admission adds a new phase to the future development of lunatic asylums. Captain Heffernan, I.M.S., in his report on the Madras Asylum for 1912, remarks: "The year 1912 will be remembered for the introduction into the region of practical therapeutics of Psycho-analysis and Psychotherapy... The recognition that many forms of mental disorder are of psychical origin, and can be treated successfully by psychical means, is the greatest step psychiatric science has made for fifty years. Unfortunately, however, the cases for which such treatment methods are applicable do not come to the Lunatic Asylums until too late. To treat such forms of mental disorder successfully, the patient must be caught early in the disease. The innovation in India of the ' Voluntary Boarder ' by Act IV of 1912 will, it was hoped, help in ensuring that many such cases may henceforth be treated before irreparable harm is done."⁶¹⁶

In the History of Psychiatry, a significant shift took place during 1920 due to the contemporary reflections from Europe and the consistent efforts of committed psychiatrists like Dr. Berkeley Hills. As a result, lunatic asylums got transformed into mental hospitals. The importance of the scientific treatment of persons suffering from mental diseases was beginning to be recognized in the country. And steps were taken to bring the asylums in the Madras Presidency in line with the mental hospitals in the United Kingdom. The Indian Lunacy Act was significantly amended in 1922 in order to allow the asylums to be styled 'mental hospitals' to emphasize the fact that these institutions are intended to serve as hospitals where modern scientific treatment can be afforded to people with a mental health condition, rather than as prisons where lunatics can be interned. The government has accordingly directed change of the designation of the asylums in the Madras Presidency as 'mental hospitals'.⁶¹⁷

⁶¹⁶ Statistical Returns of the Lunatic Asylums in the Madras Presidency for the year 1914, Printed by the Superintendent, Government Press, Madras, 1915, p. 5.

⁶¹⁷ Government of Madras, Local self-government (public health) department, G.O. No. 1427, P.H., 27th August 1923, Mental hospitals, Statistical Returns for 1922—recorded with remarks, p. 1.

Several developments took place in colonial psychiatry in the Madras Presidency during the first half of the twentieth century. This period saw growing appreciation for Occupational therapy and it was recognized as Occupational Treatment part of the treatment procedures. The need for associating social scientists, mainly psychologists, in diagnosing and managing psychiatric patients was also gradually realized and practised. Moreover, it made efforts to educate psychiatrists and psychiatric nurses and established links with families of patients through family units in hospitals as a part of social awareness.

The colonial government's attitude towards Indians was visible in the allotment of superior positions in Psychiatric institutions in the Madras Presidency. It explains the racial discrimination in the hegemonic premises of colonial rule. The Europeans and the deputies enjoyed higher positions in the medical service. But, subordinate and menial positions were given to Indians, which was clearly visible in the annual reports of mental hospitals. It was observed that after 1920s, senior positions in mental hospitals were given to Indians; it reflected in Calicut mental asylum and Madras mental hospital documents. It was because of a few reasons, like the personal and professional experiences resulted competition. The new brand of Indian colonial servant was not to take the initiative to Indianize or reform medical policy. There were persistent financial problems, and policies of self-help. However, decentralization was championed. Moreover, during this period, the national movement got manifested as political agitation. As part of this movement, non-cooperation and armed rebellion had been powerful throughout India. New opportunities were opened during this period by the colonial government in response to the nationalist demands of self governance.

After 1922 the first effort to train psychiatrists and psychiatric nursing personnel were made. The Government of Madras has sanctioned the deputation of a selected Assistant Surgeon to England for special training in mental diseases to provide expert medical treatment in the mental hospital. Dr H.S. Hensman, an officer of the Madras Medical Service, went to England for one year for training in the treatment of mental diseases. After that, he occupied the Superintendent position in the Madras mental hospital in 1924, and he was the first Indian Medical Superintendent. He appears to

have been the first doctor to hold that post. Late on, Dr S. Venkatasubba Rao and Dr J. Dhairyam held these superior positions in the Madras Presidency.

After return of Dr Venkata Subba Rao from his special training in Europe and America, he incited for the forming a psychiatric clinic at the general hospital in Madras. His vision was to use it for officers' in services and wished to establish a school for defective children. A conference was held at Ranchi in March 1929 between the Superintendents of the three mental hospitals of Madras Presidency, the Consulting Architect to Government and Lt.-Col. O. Berkeley-Hill, for the discussion of schemes relating to the improvement and development of the hospitals on up-to-date lines.⁶¹⁸

The Bhore Committee (1946) visited Madras mental hospital and observed that though the building of mental hospital was in dilapidated condition it was well maintained. The hospital was grossly overcrowded, and only a tiny percentage of the patients had cots-dressed. Further the Committee observed that the custodial care was at reasonably good standard. This Committee defined the term 'custodial care' as based on orderly and systematic methods by which physical, recreational, and hygienic activities were to be regularly carried. The medical staff members were temporary and belonged to the general service cadre. But, they were not highly qualified. The ratio percent of admissions, recoveries and discharge figures indicate that detention rather than therapy was the primary function of this institution. Bhore expressed an opinion that the responsibilities were too heavy for Superintendent, who had no clinical or Post-Graduate experience at the Madras mental hospital. There were no Outdoor Psychiatric Clinics anywhere in Madras. And there were no qualified officers and experienced doctors to conduct such clinics. The Committee did not reflect the conditions of Calicut and Waltair Mental Hospitals. The Committee reported that there were no outdoor patient clinics at Madras. But, in 1940 on an experimental measure an out-patient Clinic was opened at the King George Hospital, Vizagapatam. This facility became popular and useful. Bhore observed that the Social Services in Madras are the pioneering stage. There will be no coordination in Social Services until Madras has an organized Mental Health Efficiency.

⁶¹⁸ Government of Madras, Local self-government (public health) department, G.O. No. 1372, P.H., 2nd June 1930, Mental hospitals Report for 1929—recorded with remarks, p. 1.

There were a few interesting observations found by the study concerning the mental hospital in Madras Presidency. Colonial government was little concerned about the mental hospitals. Even after 1922, asylum features continued where it carried social prejudices. The three hospitals acted as custodial care centres rather than curative centres. Asylum figures indicate that detention rather than therapy was the primary function of these institutions. It is observed that Madras, Waltair and Calicut mental hospitals are maintained an inferior standards and they functioned as routine custodial cares rather than curative hospitals for the mentally ill patients.

The third chapter mainly focused on the social history of mental illness, it explained the social lives of inmates and professional practices of staff in the mental hospitals, and it mainly analyzed the dynamics of caste, region, religion, gender and race through the lens of social history of mental illness in the Indian context. Mental asylums received both male and female patients. Generally, the patients were divided into two categories: Civil and Criminal patients, again these two were classified into three categories, 1) military lunatics, 2) civil lunatics, and 3) criminal lunatics. All these categories were again divided based on class, race, caste and gender. Again the inmates of the asylum were classified into; Europeans and Eurasians (East Indians), and the Natives were classified into Hindus, Muslims, Buddhist, Native Christians and Other Castes. The whole of the civil male and female lunatics have been maintained by various Municipal and local fund boards of the districts. But, the criminally insane were funded by the government.

According to Lunacy Act 1912, admissions were classified into two categories; as compulsory admissions and voluntary admissions. Again, they were categorized into: Europeans and East Indians; Hindus; Muslims Native Christians; Other Castes. Lunatics, according to the law in India, are either: private patients (who have friends or relatives willing to sign an admission order) or public patients (who are brought up by the police). Public patients may be civil (who are wandering at large, dangerous, etc., but have not committed themselves in any way before removal through the magistracy to an asylum) or criminal (who had done some act which is against the law of the country). Self-admissions seem to have been vagrants and beggars who wished to join the asylums as refugees. Asylum patients were primarily from poor social

background and of a low caste. Statistics in the reports revealed gender, race, class, occupation and ethnicity of the admitted patients. Majority of Indian asylum inmates were mendicants and beggars picked up from streets and bazaars by police, who usually threatened public peace and order. The colonial archives revealed that the socially well to do sections were able to get into the asylums. They included sections like; nurses or compounders, teachers, religious mendicants, sheep breeders, potters, and both higher and other lower caste women better and sufficiently articulate class of the Presidency.

The legal provisions for criminal lunatics of various administrations in India were standardized in Chapter 27 of the Criminal Procedure Code, which was adopted in 1861. The distinction between the criminal lunatics and the lunatics admitted as neglected, dangerous or wandering was central in the asylum administration. Criminal male lunatics, who were sentenced to rigorous imprisonment used to wear a light iron ring on the left leg and were locked up at night. The certified criminal insane was confined at the Madras Presidency asylums. But, the provincial jails were very small concerning the overall population. Criminal lunatics were kept separate from other asylum inmates and were not usually allowed to partake in few amusements and privileges. Patients who found themselves admitted were usually single black males who were criminal lunatics or had no community assistance.

According to the G.O. No. 34 of the judicial department released on 13 January 1890, all criminal lunatics in the Madras Presidency shall be concentrated in the Madras asylum. An enclosure for criminal insane was completed in 1892 when criminal lunatics were accommodated at Madras asylum. In 1892 criminal patients were transferred to Madras. As a result, the Waltair lunatic asylum and Calicut asylum were reserved solely for non-criminal patients. From then onwards, these lunatic asylums were accommodated for civil and natives lunatics of the Madras Presidency. The Calicut lunatic asylum transferred its criminal patients to Madras in 1893. From then it serves only non-criminal patients. When the Bhoze Committee mentioned that no criminal patients were there at Madras asylum; the criminal lunatics were kept confined in the mental jail at Cuddalore.

The inexperience of asylums in India constrained the British officers to be effective superintendents and impose coherent psychiatry. The Superintendent used extreme violence to treat those in his charge to impose his notions of correcting the patient's behaviour. Every medical Superintendent was probably in a position to raise the efficiency of the hospital in his charge, provided he can get plenty of good ideas. The Superintendents of asylums in the Presidency were in charge of providing the government's necessary information regarding mental illness. Moreover, in those days, the information about patients was available in various sources, including case registers, annual reports, official files, journal articles, and monographs written by the superintendents of the mental hospitals. The Superintendents of asylums were regularly updated with news on insanity and its treatment in England and Europe. Medically trained asylum superintendents lagged as they failed to convince government and medical authorities about their special professional skills. The lunatic asylum superintendent was no specialist in mental illness during this Period in British India in the 19th century. His field of expertise was the body, and it was observed that the case notes were dominated by information on the patient's body rather than on one's mental state.

The European doctor's moral power over his patients' hierarchy and social discrimination were central characteristics of the asylums. Doctor's service had such a lot of extra professional duties that they had very little time to attend to the therapeutic needs of the patients. However diverse in actual clinical practice, almost all asylum superintendents could lay claim to them to some extent. Sometimes distance was also a matter of concern for the doctors who work in the asylum, as they were located far away from living spaces. In addition, he was also expected to see European and Eurasian patients at home. That is why, these English doctors assigned the asylum maintenance to Indian subordinates.

It is important to note that these doctors came to treat madness in India without much acquaintance with Indian society and its cultural environment. Thus the management of asylum and execution of the superintendents' guidelines were almost shouldered by the Indian sub assistants. Therefore, local ideas could enter the asylum and intermingle with the variable skill set of the British superintendents in charge to produce a heterogeneous or hybrid practice of care. The Period 1920 to 1947 saw the

Indianisation of the senior positions of the asylum. The first reason for this Indianisation was the circumstances created by First World War. European IMS officers were all expected to serve with active units, many of which were sent to France and Mesopotamia. Though there was “no Post-Graduate experience or training in Psychological Medicine, and yet these Indians have been charged with the supervision of large hospitals. And it is observed that, the Deputy Superintendents and subordinate medical staffs were more or less of temporary in nature, utterly untrained in Psychiatry in the Madras Presidency.

The study identified that most of the beds were in urban areas. As a result, vast majority of the rural population were excluded from easy access to mental health facilities. The second focus that emerged is the evidence of more profound colonial observation of the demographic trends from these quantitative notes. In this context, this study argues that the making and institutionalization of psychiatry and the colonial governmentality in India are inseparable. Many of the colonial scribal practices in Indian asylums mainly, the day-to-day activities and routines in the asylums, procedures of admission of patients, introduction and prescription of medicines and the appointment of staff and nursing, etc., were always linked to the more extensive ideological, surveillance and law and order terrain of colonial governance in India. This demographic knowledge was a colonial attempt to classify and segregate the mentally ill.

The study found racial prejudices were too powerful in colonial Indian lunatic asylums. This is important, as western hospitals and doctors, in general, viewed Indians as unclean under orthodox beliefs. It is observed that many native asylum patients were primarily from a poor social background and of a low caste. The study found that caste and religious prejudices were practiced in the three asylums of this region. For example separate kitchens and chef were maintained for Brahmans. Moreover, statistics related to lunatics were classified on religious basis in the asylum reports. Details of religious backgrounds were collected, revealing how the colonists felt religion affected body and mind. Hindus were considered as weaker in physique and worse nourished than Mahomedans or Christians. The study identified that Musalmans and Christians were more liable to insanity than Hindus. Consanguinity

marriages were considered as a prime reason for the Mental illness among the Muslims than other religious people.

The fourth chapter is titled as 'Treatment Practices in the Madras Presidency Asylums'. It focused on what happened in these mental institutions in the name of treatment. Treatment practised in an asylum was directly connected with the understanding of mental illness. It enquired about the theories and practices of treatments. This chapter also dealt about the asylum care, the different kinds of treatment practices, and the curative perspectives (their consequences) and their consequences in the Madras Presidency. Historians of colonial medicine and psychiatry tend to focus on the European impact on the outside world and how the colonial enterprise furthered the expansion of western scientific knowledge. It is only recently, and mainly due to the challenge of social science and literature-based theories of post-colonialism and subaltern studies, that this focus has been widened to look at indigenous responses and resistance to western medical and psychiatric blueprints have emerged. It addresses the question of interaction between psychiatry and indigenous healing traditions. This question is relevant to address the asylum practices in the Madras Presidency, which has a rich and diverse healing tradition. One axiom of colonial medical discourse in 19th century British India was the presumed superiority of scientific medicine over indigenous medical systems. Scholars observed that psychiatry achieved this superiority through a negotiation between the indigenous tradition and scientific knowledge.

The medical officers' treatment practised in an asylum could be broadly divided into three categories: mechanical, moral, and medical in Madras Presidency. The moral treatment could further be divided into two: occupational and recreational or amusements. Till the early parts of the twentieth century Madras asylums reports reflected their opinion that insanity is more frequently the result of depraved bodily conditions than of overstrained mind. The patient had become suddenly insane from different causes, which have never been explained most during colonial times. The alleged causes of attributed insanity were broadly divided into two categories 1) physical causes of insanity and 2) moral causes of insanity till 19th century. Over time, social factors were identified as important in the Reports of 20th century. By 1946 there were three major categories of mental illness: psychological factors of mental

illness and Social factors of mental illness were reflected in the documents of mental hospitals in the Madras Presidency. It was observed that throughout the period of study, the incidence of insanity was large between the ages of 20 and 40, i.e., during the active period of life.

Some highly trained psychiatrists dispute the very existence of mental illness and declare that diagnosis and treatment were nothing but a farce. However, others call psychiatry a pseudoscience because it diagnoses mental illnesses when there is no concrete, definitive, scientific diagnostic method. Still, others deem that treatment of any kind is detrimental, dangerous, and damaging. However, others maintain that psychiatry as an industry largely diagnoses individuals who display certain behavioural traits or nonconformist attitudes as mentally ill and uses that diagnosis to be either a means of social or political control.

Systematic study of different scientific journals, medical records and public health reports of colonial India reveal that with the progression and reinvention of scientific discourse, the late eighteenth and early nineteenth century witnessed a billowy wave in the field of medicine and scientific discoveries. Many scientific observations and speculations were made over the causes of mental disorders, particularly in the western medical community. At that time, the major lacuna in the treatment was a lack of training in the diagnosis and treatment.

According to Dr A.W. Overbeck, diagnostic methods are as; 1) Patients' voices/speech – (patients expressions not considered); 2) Patients' body; 3) Patients' behaviour (temperament habits, suicidal). Medical history was one of the essential aspects to diagnosis the mental illness. The body is fundamentally relevant to mental health practice. British psychiatry has historically approached the cause and treatment of mental illness through observation of the body. This lack of information meant that doctors had to depend on the description on the medical certificate. Police constables filled in these descriptions on the lunacy certificates based on the statement of the lunatic while still insane. And interestingly, these descriptions provided not only the history and habits but also the cause of insanity.

Little specific value was attached to the curative properties of medicines. Medicines were classified into two types, as European and Bazaar medicines. Medical and public opinion had come to believe that madness could be cured and that confinement in an institution could not fail to be beneficial both for Europeans and Indians. Regarding the treatment of the insane in those days, superintends of the institutions suggested to have; exercise and work, kindness in discipline, recreation, and appropriate diet, with plenty of fresh air, as best remedies for recovery.

Moral therapy was meant to discipline the inmates without any application of force or coercion. Moral treatment was also called moral management. It was further divided into two; occupational and recreational. After 1920 the patients were provided with all types of benefits and cures inside the asylum in Calicut. Towards this end, moral, occupational and amusement therapies were considered a successful way of treating the patients.

Work as a therapy in asylums explains that the harmless was the most productive class, as they worked and performed most of the asylum's daily chores. The work therapy demonstrates that colonial lunatic asylums in the Madras Presidency worked with profit motive. Occupational therapy introduced a 'normal' working routine to the patients and was the primary method of improving the patients' wellbeing. Each patient was encouraged to engage in some occupation and employment activities. Much attention was paid for suitable and regular occupation for the patients. And they have rendered great assistance in various menial duties connected with the management of the asylum.

The Superintendent has successfully introduced useful and remunerative occupations among the asylum inmates; such occupations acted as remedial agents of great value. And, from an economic point of view, they were of considerable pecuniary importance to the government. Works such as watering the young trees, cleaning the grounds of weeds (*Kalupu*), litter decayed leaves and drawing water, were some as part of the occupational therapy. The other activities included; weaving, carpentry, bookbinding, brickworks, rope making, tailoring, mattress making, etc. Additionally, useful and varied occupations were introduced and recreations were made more varied than those detailed in the report.

In the 20th century, small monthly rewards were offered to buy articles from shops. Patients were also granted an option to send money to their families. As usual these patients were rewarded with small presents on the occasions of Christmas and annual sports were also held. In the name of occupation therapy, patients were exploited with assignment of works. To encourage with exploitative tendencies, authorities offered small rewards. Employment of suitable patients helping in domestic duties (such as cooking and sweeping, etc.) was connected with the mental hospitals, continued.

Ernst explored the changing plural meanings of work in the early 19th and 20th centuries. Different aspects of work were discussed, such as; therapy, combat idleness, patients' empowerment, institutional profit, and forced labour. The incentives used by staff to induce patients to engage in physical labour and the punishments employed in cases of non-compliance were discussed. It will be shown that gender, social, and caste prejudices and sentiments affected the types of activity patients were expected to engage. And with the emergence of professionalized occupational therapy (OT) from the early twentieth-century patient work became increasingly acceptable concerning European patients. It was reconceptualised in the scientific terms of the period and, with the emergence of newly professionalized auxiliary medical disciplines, refashioned as 'occupational therapy'. In British Indian asylums, those who work hard get incentives, motivation, inducement, whereas those who cannot work did get less food. The sick and old were excluded from work. Thus, the mortality rates were high in the asylums.

Recreation or amusement is another treatment which includes singing, dancing, playing games, playing the *tabla* and other musical instruments, taking to watch movies (by kind permission of the proprietors of the Globe, Wellington and Elphinstone Cinema Companies, some of the patients were allowed to attend free of charge) and social functions added to their comfort and happiness. Singing competition, listening to the radio, badminton, dancing, card games, and native musical instruments were used to amuse patients as part of recreational therapy. Football, cricket, tennis and badminton were regularly played in the Madras Asylum, and several matches were played with outside teams. On a few occasions, the asylum teams won. Surgeon J. Smith, Superintendent of Waltair Lunatic Asylum, opined that

'Occupation and recreation with a good diet and kind treatment are the means used for promoting recovery; I have noticed that those insane who work cheerfully and willingly keep the best health. All the deaths, without exception, occurred among the non-working insane'.

The involvement of philanthropists had changed the aspects and perspectives of mentally ill people. The Committee of voluntary lady visitors, Red Cross society, complimentary newspaper subscripsts, etc, provided feasts during occasions like Christmas and Pongal. In the asylum at Calicut, the Music class and the class for training the patients in the three R's were continued with beneficial results. A drama 'Benefits of the British Rule in India' composed by M.R.Ry. Rao Sahib A. Gopalan, Deputy Superintendent, was staged by some of the keepers and insane to the great amusement. European patients had dances arranged in the recreation hall. Dr S. Venkata Subba Rao introduced carom boards and other playthings, Harmonium, Tabla, Mridangam and radio for each section. Along with escorts, he sent patients out for walks up to Purasawakkam, a nearby market place. Later some patients were allowed to go out for walks even without attendants. Two European patients worked outside as mechanics and deposited their earnings in the hospital office.

Religious treatment (Missionaries-Temples) was also a kind of treatment in the colonial period. The thesis further examined the work of medical missionaries amongst some of the poorest and most disadvantaged of peoples in mental asylums in the Madras Presidency. Local healers had previously been the only significant providers of health care amongst them. However, from the late-nineteenth century onwards, missionaries began to carry out medical work to gain legitimacy with a view to religious conversion. This process at times gave rise to tension and social conflict. Native and indigenous treatment practices were another kind of treatment in this region. There were few methods of indigenous heals practiced in the Madras Presidency; they were family-based practices, religious centre based practices and ritual art forms. Various systems of medicine sought survival through professionalization, they were: '*Allopathy, Homeopathy, Ayurveda, Siddha and Unani* systems. These four came to be known as the 'indigenous system of medicine' in India. *Naturopathy* and *Yoga* have also attracted medical practitioners for their therapeutic values. The Superintendent of Madras mental hospital, Dr John Dhairyam

(1939-1949), believed in indigenous medicines and tried on a large scale. Due to his involvement in Indian systems of medicine like *Ayurveda* and *Siddha*, he had intimate contacts with various *sadhus*.

The emphasis was on physiological and organic causes of insanity. Except the rich and influential, other people preferred to move to the native healers. The native healers used to advise lime juice and pepper for an attack of rheumatism, as a prescription. Moreover, the native healers strongly recommended coconut water as a blood purifier. Snake venom in minute doses was also tried in cases of epilepsy in the mental hospital at Waltair, during 1940s.

The history of medical systems is meant to throw light on the decline of the 'indigenous system' of medicine, particularly '*Unani*' and *Ayurveda*', in India's colonial rule. Indian society had a good relationship with an indigenous system of medicine from times immemorial. Nevertheless, the introduction of western medicine and its dominance changed the attitude and mindset of the people. This resistance to western medicine was complemented by spirited defences of indigenous approaches to disease and healing techniques and sustained efforts often directly linked to the nationalist political agenda to revitalize Indian medicine.

There was always a huge gap between theory and practices of mental health in the mental hospitals of Madras Presidency. For instance, in diagnosing the mental illness, doctors did not take the patients voice as testimony into consideration. Most of the times, doctors depend on statements made by police and relatives who brought the patient to hospital. Another observation was that according to the moral therapy patient has to treat with much kindness in theory. But in practice patients were assigned hard labour as therapy. Thus, patients were exploited by the staff. Moreover, the staff used to assign work deadlines for accomplishment of tasks. And, if the assigned tasks were not completed in time then punishments were given. On the other, for those who met deadlines were rewarded.

Even though the thesis has dealt with numerous concepts and issues, the study's central argument was to provide a contextual analysis of the history of mental illness in the Madras Presidency from the second half of the nineteenth century to the first

half of the twentieth century. This historical inquiry's central focus was to provide an account of the progress and development of colonial mental science, which has played an important role in the formation and practice of psychiatry and mental health care in the regions of Madras, Visakhapatnam and Calicut mental hospitals in Madras Presidency. Thus, the history of mental illness in the Madras Presidency constitutes an integral part of the history of psychiatry. This study gave an account of the role of the colonial state in the establishment of psychiatric institutions and the specialists' efforts to deal with insanity. An account of the social history of mental illness and treatment practices in colonial mental hospitals in Madras Presidency is succinctly provided.

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Early History of Madras Lunatic Asylums, 1794-1871

— Sudarsanarao Ithadi

Introduction:

The meaning of Lunatic Asylum is Mental Hospital. For a researcher who works in the field of the History of Psychiatry, Michel Foucault is an unavoidable name. Foucault had suggested that in Western Europe the first houses of confinement appeared in the most industrialized parts. Psychiatry in India during most of the nineteenth century has been represented and perceived in most recent publications as essentially colonial psychiatry and as permanently and intrinsically linked with the British civilizing mission and British control over India.

However, it was obvious that the initial siting of asylums was to do with the needs of the rulers and not those of the ruled.

The history of mental hospitals, as they evolved, is valuable in understanding the growth of psychiatry. The history of modern psychiatry in the Indian subcontinent is the story of the establishment of mental hospitals in India. The early establishment of mental hospitals in the Indian sub-continent reflected the needs and demands of European patients in India during the period. British colonialists established lunatic asylums in India for the treatment of insane Europeans and Indians modeled on

HISTORY OF VISAKHAPATNAM MENTAL ASYLUM

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Introduction

During the colonial period those who suffered from mentally illness were called as Insane, Unsound mind people, lunatics and mad people. These people were kept in a place called lunatic asylums¹ or mental hospitals. By the end of the eighteenth century, these hospitals were established during the East India Company rule for the expatriate community in India. These were runned by the surgeons as a private practice. In course of time they were patronized by the company rulers. In 1858, the Crown took over the political administration of British India; it was also to take charge of public institutions previously established by the East India Company. As part of that several lunatic asylums were also taken over by the British Government². As part of the developments in the field of the psychiatry whatever developments took place in the England and other European Countries, they use to implement in the India too. Like the way in the Lunacy Act 1858-XXXVI was passed to set some rules and regulations for the admissions of the lunatics and the conceptualized the madness³. Along with these, it suggested the increase of the psychiatric infrastructure in the colonies also; accordingly lunatic asylums were set up in many parts of the colonial India. As part of that in the Madras Presidency also three lunatic asylums were constructed in 1871, they are Madras, Calicut and Visakhapatnam. Each asylum has its distinctive history in its establishment and the evolution. There are only few works that provides passing references to these institutions. This paper would provide a brief historical account of the Visakhapatnam mental asylum. The present paper tries to study history this asylum from its inception to Independence period.

Visakhapatnam mental hospital is one of the oldest mental hospitals in India and one among the first three mental hospitals which are setup in south India. It is situated at Waltair an area of Visakhapatnam in the north coastal region of Andhra Pradesh. In 1971 The Government changed the

name "Mental Hospital" as "Government Hospital for Mental Care". Present it caters to the needs of the psychiatric patients, from the coastal districts of Andhra Pradesh as well as those from Orissa and Chhattisgarh. At present this hospital gets around 400-450 patients and also this hospital provides services to more than 58,000 patients annually⁴.

The existing historiography is giving very less information about this Visakhapatnam Asylum, so far its history was not available. But its references only available from few books and Articles like D G Crawford, *History Indian Medical Service-1600-1913*; SD Sharma, *Mental Hospital in India*; LP Varma, *History of Psychiatry in India and Pakistan*; and Francis W, *Gazetteers of Visakhapatnam*. All these works sited very little information, they mainly dealt with, when it was established, but later historical developments and institutional ups and downs are not available, so that, this paper tries to document its history during the colonial rule in India.

A Brief History of the Visakapatanam lunatic asylum

The lunatic asylums in colonial India as distinct stories of their own, like the way lunatic asylum in Visakhapatnam has its separate story behind its establishment. During this period it was known as Visakhapatnam lunatic asylum or Waltair lunatic asylum. Prior to 1867, patients suffering with mental illnesses in Visakhapatnam were housed at the local Jails. Actually it was originated in the accidental fact that in 1862 seven non-criminal lunatics had been committed to custody all at once. There being no proper place for them, the District Magistrate was allowed to rent a small house for them⁵. Later, a private house was hired from the Rajah of Vizianagaram⁶. Wherein they lived, guarded by constables and waited on by convicts'. Gradually it recognized asylum for the Northern Circars of the Madras Presidency and had a regular board of visitors. From then the question of providing mufassal asylums was thus raised; and one was sanctioned for Visakhapatnam, among other places (Madras and



WOMEN'S WORLDS CONGRESS



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ASYLUM PROVISION IN COLONIAL MADRAS PRESIDENCY, in the Women's Worlds Congress on
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Gender in a Changing World held on August 17- 22, 2014.

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on 7th & 8th January, 2012.

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History of Mental Illness in Madras Presidency, 1870-1946

by Sudarsanarao Ithadi

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