The Confinement of the Insane

International Perspectives, 1800–1965

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CAMBRIDGE UNIVERSITY PRESS
Cambridge, New York, Melbourne, Madrid, Cape Town, Singapore, São Paulo

Cambridge University Press
The Edinburgh Building, Cambridge CB2 2RU, United Kingdom

Published in the United States of America by Cambridge University Press, New York

www.cambridge.org

Information on this title: www.cambridge.org/9780521802062

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First published in print format 2003

ISBN-13 978-0-511-07189-8 eBook (EBL)
ISBN-10 0-511-07189-2 eBook (EBL)

ISBN-13 978-0-521-80206-2 hardback
ISBN-10 0-521-80206-7 hardback

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11 Psychiatry and confinement in India

Sanjeev Jain

> The establishment of lunatic asylums is indeed a noble work of charity, and will confer greater honor on the names of our Indian rulers than the achievement of their proudest victories.[1]

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 time. Although there are suggestions that hospitals have been known in the south Asian region[2] from antiquity, there is little documentary proof of their existence. References for institutions for the sick and needy can be found during the reign of Ashoka (268–231 BC).[3] Travellers' accounts of AD 400 mention similar services established by rich merchants and nobility.[4] Mental hospitals had a long history in the Arab world, and the growing Muslim influence in India lead to the establishing of similar hospitals.[5] However, the prevailing social situations have led some authors to suggest that these were seldom used except by 'soldiers and foreigners'.[6] Medical care in medieval India was based on Ayurvedic (derived from the Charak Samhita and other classical Indian and largely pre-Islamic texts, thus predominantly Hindu)[7] and Unani (the Muslim school of medicine), and derivative systems, delivered by

I would like to thank the Wellcome Trust and the Wellcome Institute of History of Medicine, the Commonwealth Trust, and the Department of State Archives, Government of Karnataka for help in preparing this manuscript. I would also like to thank Dr Vivek Benegal, Dr Satish Chandra, Dr Melvin Silva, Mr D. M. Joseph, Mr G. Vidyadhar, and Mr C. C. Silva for help with material and suggestions.

[1] W. Forbes, 'Review of Practical Remarks on Insanity in India', *Psychological Medicine and Mental Pathology* 6 (1853), 356–67.

[2] L. P. Verma, 'History of Psychiatry in India and Pakistan', *Indian Journal of Neurology and Psychiatry* 4 (1953), 138–64.

[3] S. Dhammika, *The Edicts of Ashoka* (Kandy, Sri Lanka, 1993).

[4] Fa Hein, *A Record of Buddhist Kingdoms*, trans. J. Legge (Oxford, 1886).

[5] J. G. Howells (ed.), *World History of Psychiatry* (New York, 1968).

[6] L. P. Verma, 'Psychiatry in Unani Medicine', *Indian Journal of Social Psychiatry* 11 (1995), 10–15.

[7] D. Wujastyk, *The Roots of Ayurveda* (New Delhi, 1998).

professionals trained by study and apprenticeship. These professionals were most often attached to the court, or provided services for a fee. Religious and caste divisions perhaps did not allow a public space for uniform treatment for the ill to exist.

The growing European influence in the second half of the millennium had a profound impact. 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 soldiers. Garcia d'Orta, perhaps one of the earliest European physicians in India, established a herbarium, and was renowned for his medical skills, and published his colloquies in 1563.[8] He interacted with the local Indian physicians and learnt about the Indian pharmacopoeias. However, after his death it was discovered that he was a Jew, and had transgressed existing laws regarding the travel of Jews on Portuguese ships. His body was exhumed and burnt at the stake.[9] It is also suggested that his consorting with the 'heathens' and acknowledging their knowledge systems could have added to his heretical status. It is not known whether the Portuguese hospitals made a specific provision for the mentally ill. 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 success.[10]

The British gained ascendancy over all the other European powers in India by the end of the eighteenth century. 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.[11] 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.[12] Throughout the colonial period, medicine and politics would continue to be linked.

Perhaps the first establishment for treating the mentally ill was the one established by Surgeon George M. Kenderline in Calcutta in 1787. However, it

[8] J. Barros, 'Garcia Da Orta – his Life and Researches in India', in B. V. Subbarayappa and S. R. N. Murthy (eds.), *Scientific Heritage of India, Mythic Society* (Bangalore, 1986).

[9] C. R. Boxer, *Two Pioneers of Tropical Medicine*, Wellcome Historical Medical Library, Lecture Series 1 (London, 1963).

[10] N. Manucci, *A Pepys of Moghul India* (Srishti, 1999).

[11] Lt. Gen. Sir Bennett Hancie, 'The Development and Goal of Western Medicine in the Indian Sub-Continent (Sir George Birdwood Memorial Lecture)', *Journal of the Royal Society of Arts* 25 (1949).

[12] D. G. Crawford, *History of the Indian Medical Service 1600–1913* (London, 1914).

could not be granted 'official recognition' as the surgeon had been previously dismissed from service for neglect of duty. Soon after, William Dick in Calcutta established a private asylum for 'insane officers and men, and civilians of various stations', in 1788. Others in Bombay and Madras followed. The 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 purposes.[13] Assistant Surgeon Valentine Connolly, wrote to the medical board saying that: 'want of an asylum on the coast has been long a matter of regret, and in some instances it has been attended with dreadful consequences'. Suggestions for the asylum included detailed plans for buildings and staff, with a payment from the company for each patient admitted to the asylum. Connolly later 'privatized' this arrangement and began paying a rent of pagodas 825 to the company, and finally sold it to Surgeon James Dalton in 1807 for pagodas 26,000. It was long known as Dalton's madhouse, and is now part of the medical college.[14] By this time the asylum accommodated fifty-four Europeans, and a staff of fifteen keepers. Asylums within Bengal (Murshidabad, Dacca), Madras (Chittoor, Tiruchirapalli and Masulipatanam) and the Bombay (Colaba) presidencies were set up.

Prior to this, patients, especially those whose symptoms lasted for more than a year, were to be transported to England. John Reading, a doctor in Chingleput near Madras, writing to George McCartney,[15] recommends that one Mr Porter, who has been suffering from a maniacal complaint, be sent home. He also mentions that several such patients now live in Madras. 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 already being made.[16] Financial irregularities, and overcharging the company (expenses are proportionate to the number of surgeons, rather than the number of sick) for the care of the ill was a frequent concern, as were poor maintenance and misuse. Prompted by this, the East India Company in 1802 ordered asylums to be built for the wandering insane in all its territories. Indian kingdoms were not very encouraging. However, Hoenigberger, a German doctor, who travelled overland and lived in Punjab, did establish a small asylum in Lahore early in the nineteenth century.[17] This was paid for by the court at Lahore, but had been ordered by the British Commissioner. It existed for a few years, and was staffed by European doctors, but it fell into disuse once Hoenigberger returned to Europe.

[13] H. D. Love, *Vestiges of Old Madras 1640–1800* (Madras, 1996).
[14] D. V. S. Reddy, *The Beginnings of Modern Medicine in Madras* (Calcutta, 1947).
[15] George McCartney 1737–1806, First Earl McCartney, Governor and President of Fort St George, Madras. Correspondence and papers concerning medical services at Madras 1782–7. MS 5746, Wellcome Library, London.
[16] *Ibid.* James Hodges to McCartney, 17 April 1783.
[17] J. M. Hoenigberger, *Thirty Five Years in the East* (London, 1852).

In this period, before the Indian Mutiny (which occurred in May 1857), approximately thirteen asylums had been established in various parts of the company's dominions. By this time, the British directly controlled several large portions (the Calcutta, Madras and Bombay presidencies) and had administrative control over other areas through bilateral agreements between them and the rulers of independent states. The sub-continent was thus broadly divided between princely or native kingdoms, and the British possessions. The contrasting outcomes in the various asylums, and differences in the cost of maintaining them, led to one of the first official enquiries in 1818, and has been summarized earlier.[18] The select committee had raised similar issues in the United Kingdom in 1815/16. The concept of the asylum was defined as a 'retreat, providing for the tender care and recovery of a class of innocent persons suffering from the severest of afflictions to which humanity is exposed'.[19] Gross deviations from this noble aim were observed. Most asylums were seen to be a cluster of ill-constructed and poorly maintained buildings, resembling gaols rather than asylums. Conditions within were deplorable, with indifferent staff, unwholesome food, inadequate clinical classification and care.

The native clientele of the asylums

While most asylums were established as distinct establishments, in Bangalore in southern India, a somewhat different approach was taken. The city of Bangalore, lying almost in the centre of peninsular India, was of considerable strategic importance. It was also noted for its 'salubrious climate' and was used as a convalescent base for the Crimean, Afghan, the First and Second World Wars. It was felt that 'the climate is particularly congenial to the European constitution; sores quickly take on a healthy action, and convalescence from acute diseases is rapid, often in a remarkable degree; and the protracted convalescence and low chronic state of disease, seen in other parts of India, are seldom met with at this station'.[20] The British had moved the Mysore division of the Madras army here from Seringapatanam, after the 'White mutiny' of 1809, and also because of the high rates of fevers at that place. A large cantonment was built, which had elaborate hospitals. Dragoons (cavalry), European infantry, Indian soldiers and civilians were provided with separate hospitals. The Garrison hospital, which had both European and Indian soldiers, was considered the 'best'.

[18] W. Ernst, 'The Establishment of "Native Lunatic Asylums" in Early 19th Century British India', in G. J. Meulenbeld, D. Wujastyk and E. Forsten (eds.), *Studies on Indian Medical History* (Groningen, 1987).

[19] *Ibid*.

[20] 'McPherson Report on the Medical Topography and Statistics of the Provinces of Malabar and Canara' (Madras, 1844).

The city was administered between 1831 and 1881 by appointed Commissioners, one of whom was Sir Mark Cubbon. A man of considerable foresight, he initiated a number of; public-health services. At the time of rendition[21] in 1881, when the administration reverted to the Maharaja of Mysore, a total of three general hospitals, seventeen dispensaries, two maternity hospitals, eight gaol dispensaries, ten railway hospitals and two special asylums (leper and lunatic) had been established in the kingdom.[22] Rates of various diseases were quite high. Dysentery, hepatitis and delirium tremens were frequent causes of illness in European soldiers. Between 1829 and 1838, in the 15,590 European soldiers, the commonest diseases were syphilis (25 per cent), wounds and injuries, dysentery, fever, hepatitis and chest diseases. The Indian troops (70,000) had much lower rates of illness. Fever, diarrhoea, wounds, chest diseases, rheumatism and syphilis (2.1 per cent) were recorded, but not at the high rates as were noted for the European soldiers. Excessive drinking and 'wanton' behaviour were often blamed for the high rates of hepatitis. Ebrietas (drunkenness) was recorded as a diagnosis for more than a hundred European soldiers every year between 1834 and 1838, but not even once for an Indian soldier.[23]

Dr Smith, who appears to have been a physician to Sir Mark Cubbon, in addition to being a public doctor, began his diary in 1833. He provides one of the first detailed case notes of psychiatric diseases, and suspects that a large proportion of them are caused by organic factors.[24] He describes patients who show depressive symptoms, progress to dementia and after death are discovered to have inflammatory changes in the brain, or spicules surrounded by inflammation.[25] These provide the first descriptions of neurocysticercosis, which was formally described only several years later.

Dr Smith's casebook has several case histories. One patient became suspicious of European and native officials and shot dead a native in order to force attention upon himself. Another maintained an exemplary life in the office for fourteen years, but was otherwise 'eccentric to the point of madness' and suddenly became acutely disturbed and Dr Smith was 'obliged to put him in a straitjacket'. Of the 138 patients with mania treated by Dr Smith, thirty-eight

[21] *Rendition*: the kingdom of Mysore was under direct British rule through a commissioner between 1831 and 1881. At the time of taking control in 1831, Britain had contracted that the kingdom would revert to native rule in fifty years. As a result, the administration reverted to the Maharaja of Mysore in that year (1881), but the British retained control of large tracts of land, and part of the city of Bangalore (the cantonment).

[22] B. L. Rice, 'Mysore: A Gazetteer Compiled for Government' (London, 1887).

[23] 'McPherson Report on the Medical Topography and Statistics of the Provinces of Malabar and Canara', 20.

[24] S. Jain, P. Murthy and S. K. Shankar, 'Neuropsychiatric Perspectives from 19th Century India: The Diaries of Charles Smith', *History of Psychiatry* (forthcoming).

[25] Charles Irving Smith, commonplace book, containing medical notes, MS 7367, Wellcome Library, London.

died, putting these symptoms at par with ascites and paralysis in terms of prognosis. Given the number of mentally ill patients that he treated at the Hospital for Peons, Paupers and Soldiers, he was able to convince Sir Mark Cubbon about the need to establish a ward for the mentally ill at this hospital in 1847, and eventually an asylum.[26] In 1850, the asylum was moved out of the hospital into the gaol, and subsequently a new building was constructed on an elevation near a large lake. This facility, and its successors, would have an important role in the growth of psychiatry in India. He was not averse to using native medicines. He prescribed limejuice and pepper for an attack of rheumatism to Mark Cubbon, and strongly recommended coconut water as a blood purifier.

Asylum reports form the bulk of historical sources of psychiatry in India. The asylum in Delhi, as the report pointed out in 1870,[27] was situated just outside the ramparts, close to the gaol and Feroze Shah's tomb. This asylum lay in the path of the mutineers marching towards Delhi from Meerut, and on 11 May 1857, all 110 inmates escaped.[28] After the mutiny, the asylum was reorganized and lasted until 1861, when it was moved to Lahore. Bad conditions, and the 'barbarous practice of using jails' as asylums was often a cause for complaint. Chemical and bacteriological examination of the water supply in 1867 revealed that the water was unfit, and new sources were identified. In the 1850s, G. Paton introduced a very strict discipline in the Delhi Asylum. Servants could be dismissed if the wards were dirty. Tobacco was to be given only when patients performed active work. Food was diversified, so that those who worked got better food than those who did not. The patients were employed in laying out and maintaining extensive gardens. Economic incentives could also be offered. Medical treatment consisted of blistering the head and neck, cold and warm baths, and tonic and aperient medicines (both native and European). In 1873, the superintendent of the Delhi Asylum opines that the 'insane lose all caste prejudices', and thus could be housed in common wards. This is important, as western hospitals, and doctors in general, were viewed as unclean under orthodox beliefs. The superintendent, however, lamented that there was one *baniya* (a member of the merchant caste), who was very rigid and refused to accept food from his hand (being British). Some of the other Hindu patients refused meat, but accepted chapattis (bread) from everyone. In 1873, Mr and Mrs Gilson, a British couple, lived with the patients, and shared the food. They got glowing tributes by successive superintendents, and much regret was expressed upon their transfer to Agra.

It was felt that 'amusement helps to cure lunacy as [much as] anything else, besides having a humanising effect on the violent patients'. An orchestra by the patients was organized, with a sitar, tabla, etc. and there was 'much singing in

[26] *Ibid*.
[27] Annual Report of the asylum at Delhi,1867, V/24/1718, India Office Library, London.
[28] Annual Report of the asylum at Delhi, 1872, V/24/1719, India Office Library, London.

the wards'.[29] Pets were a particular passion, and the patients maintained cats, pigeons and monkeys in the wards. On prominent festival days like Dussehra, the patients were dressed up in fine clothes, several bullock carts were hired, and they were all taken to the fair in front of the Red Fort. It was felt that contact with the wider community would be effective in reducing the prejudice against the insane. By 1877, it was reported that there was a gradual improvement in the quality of the deputy superintendents, and in time, it would be possible to bring the asylum as near to the English standard as the circumstances of the country permit. There seems to have been some attention to administrative probity, as some of the British staff was suspended for laxity in discipline, or stealing money from patients.

Clinical descriptions are also quite illuminating. In 1877, an Irish soldier claimed that he was a general and alleged that the government had stolen his pay and spent it on oranges.[30] He converted to Islam and announced at the Jama Masjid (the main mosque of Delhi where the Mughal emperors offered prayers) that the Russians were on their way, and that all Muslims should get ready to help them. He was admitted to the asylum, but there was a public outcry, as it was felt that he was being considered insane for converting to Islam, while conversions to Christianity were not similarly viewed. Faced with an uncomfortable situation, and with the population of Delhi 'excitable', Mr H. was quickly transferred to Colaba in Bombay, where there was a holding asylum for Europeans while they were on their way to the Ealing Asylum in England. Another instance is of a Sikh soldier, who was admitted in 1883 after being caught eating the dead body of a child. The soldier explained that he belonged to a particular sect, that forbade him to work or beg for food, and he was supposed to eat whatever providence brought his way. Walking along the riverside, he saw some jackals eating the body, and after chasing them away, he did the same. It was decided that he was not insane, and he was set free. Other clinical vignettes describe behaviour in some detail, suggesting a close interaction between the doctors and the patients.

Elsewhere in northern India, for instance, in the Punjab, asylums had a chequered history.[31] After the annexation of Punjab in 1848–9, the twelve patients in the asylum set up by Hoenigberger were handed over to the British. After much debate, disused barracks in Anarkali in Lahore were converted into an asylum. Faced with huge costs, some people were of the opinion that the cost should be spread over twenty-five years to get a true estimate, and the running of asylums should 'reflect the highest credit upon the Government for work of such great importance'. As Lahore became the 'Paris of the east' the suburb

[29] Annual Report of the asylum at Delhi, 1883, V/24/1720, India Office Library, London.

[30] Annual Report of the asylum at Delhi,1876–77, V/24/1720, India Office Library, London.

[31] W. Lodge Patch, *A Critical Review of the Punjab Mental Hospitals 1840–1930*, Punjab Record Office, Monograph 13, V/27/858/9, India Office Library, London.

of Anarkali became fashionable and the asylum had to be moved away. By the end of the nineteenth century, financial prudence was strictly enforced. In 1896, it was ordered that only two meals per day were to be served, salaries were reduced and it was regretted that a 'secretary had compared the cost of mental health care across India and decided that it was too expensive'. As early as 1867, an opinion was expressed that large central asylums were a mistake and the separation from the family was not good. It was also suggested that admission to an asylum was necessary for a brief period to establish diagnosis, after which patients could be sent back to 'village colonies'. Though sceptical of home and family care, there was some merit seen by now in emulating the Italian reforms of 1905 that recorded cases of insanity and monitored their care in the community.[32] These and other instances across India perhaps show some of the earliest thoughts about adapting community care for the mentally ill.

Reports from the asylums in the Madras presidency (1877–80) suggest that up to 20 per cent of the inmates were Europeans or Eurasians. Unlike Delhi, it was reported that caste and religious prejudices were as yet too powerful. A number of patients suffered from an acute mania, which had an excellent prognosis, with almost a third recovering entirely. It was again pointed out that 'insanity more often [arose] out of depraved bodily condition, rather than overstrained mind'. In proportion to moral causes, twice as many patients with physical causes were admitted in Madras (289:100), as compared to rates in Europe (129:100). It was suggested that the 'European . . . is subject to restless mental activity, keen sensibility and susceptibility to emotion . . . to which [the Hindu] . . . is a stranger'.[33] It was also suggested that 'asylums should be for cure, and harmless imbeciles and lunatics can be cared for in huts, attached to mofussil [district] dispensaries, and under medical supervision'. Drugs used by now included bromide of potassium, hydrate of chloral, morphia, digitalis tincture, etc, but it was also mentioned 'that wine or a little arrack often proves to be a good hypnotic, and avoids use of opiates'.[34] The sameness of mental symptoms was emphasized, and the point made that different classes and different nations have identical symptoms. Depression was found to be very common, especially with respect to moral causes. Entertainment at the asylum included a fortnightly band and 'open house' where patients mingled with the public; cricket twice a week for Europeans and once a week for Indians, and the occasional circus. It was commented that the native warders were generally indifferent, and on occasion some were suspended for striking a patient. The guiding principle was provided by a quote from Maudsley that 'the true treatment of the insane lies in still further increase in their liberty'.

[32] *Ibid*.
[33] Records of the Madras Asylum, V/24/1704/Madras, India Office Library, London.
[34] *Ibid*.

On the west coast, asylums in the Bombay presidency[35] also had diverse experiences. Inmates of the asylum in Ahmedabad showed significant evidence of caste prejudice, and never entered each other's rooms. The asylum in Poona was 'utterly devoid of the most evident requirements of a medical institution'; the condition in Dharwar 'no credit to Surgeon Major MacKenzie'; while in Haiderbad (Sind) there was an increase in population after 'having seen for themselves how kindly and carefully the patients are treated, to the credit of Dr Holmstead'. Costs in the asylums in Bombay itself reflected the differences in care. Europeans were budgeted at Rs 400 per annum, Parsis and Jews at Rs 263, while the Hindus and Muslims at Rs 213. Annual diet costs were Rs 64 for Hindus and Muslims, but Rs 200 for Europeans. These were the holding asylums, earlier described by Ernst.[36] A superintendent here was to report that 'the Europeans are not inclined to work . . . and it would be difficult and not without danger to employ them in the same shed as natives . . . as insane people are almost always full of prejudices and conceits, and are possessed of irritable and hasty tempers'.[37]

The annual reports of the asylum in Bangalore[38] during the same period show a gradual increase in the number of admissions, and the size of the asylum. It ultimately offered accommodation for 260 patients, at approximately 50 feet per person. The buildings were described as being 'simple, but airy'. The asylum was at an elevation, close to a lake; and adequate water supply and dry earth conservancy were provided. The annual reports repeatedly emphasize the importance of 'moral influence', and the 'dreary misery enlivened by amusements suited to their condition and capacity'. Work was emphasized, and a number of opportunities like gardening, rope weaving and domestic work were offered. The asylum was administered by doctors of the Indian Medical Service, with a number of Indian assistants. After the transfer of power to the kingdom of Mysore, in 1881, it became the only asylum that was supported by a native kingdom.

Work at the Bangalore Asylum was given enough prominence by the administration. Difficulties were frequently encountered. The *pettah* (old city) hospital and the asylum were three miles from the cantonment, and Dr Henderson, the superintendent of the asylum, complained in 1871[39] that it was difficult to complete rounds of all the establishments, as he was also in charge of the general hospital. In addition, he was also expected to see European and Eurasian patients at home. The chief commissioner ordered that 'since duties at the asylum

[35] Records of asylums in the Bombay presidency V/24/1708, India Office Library, London.
[36] W. Ernst, *Mad Tales from the Raj: The European Insane in British India* (London, 1991).
[37] Records of asylums in the Bombay presidency V/24/1708, India Office Library, London.
[38] Annual Report of Special Hospitals in Mysore (1877).
[39] Medical 1870, 1/1870 1–17, Reorganization of Civil Medical Establishment at Bangalore, Karnataka State Archives, Bangalore.

are of a very different nature – moral and disciplinary to a much larger extent than purely medical, Dr Henderson could decide on his own time for rounds'. This was a significant departure from rules, as morning and evening rounds by the doctor, were compulsory. It was suggested that the arrangement 'was practicable without in any way compromising the interests of the lunatics'.[40]

Overcrowding became evident very soon. In 1868, the number of lunatics in the Asylum had reached one hundred, against a projected maximum at that time of 150. Staff shortages was a frequent complaint. Dr Oswald complained in a letter to the government in April 1868 that though the Madras Presidency Asylum had one peon for every three to five lunatics, the Bangalore Asylum had five permanent and two temporary peons for one hundred patients. The seriousness with which this complaint was viewed is reflected in the speed of decision-making. The Viceroy in faraway Calcutta sanctioned more posts in June 1868. It was also observed in 1872 that a large number of paupers were being admitted for humane reasons. Going through the records reveals the famous diversity of India. Patient's religious and national identities were recorded, and Armenians, European Catholics, Italians, Irish, English and people from all parts of India were represented in the patient register. Although it 'may be advisable to provide additional accommodation for caste patients . . . [it] should be done without prejudicing the interests of those who look of European mind', suggested one official communication.[41] While cognizant of local social mores, the administrators were also becoming aware of the changes occurring in Indian society by the advent of western medicine. The diagnoses were very varied, but were consistent with those in use in asylums in the UK at this time. Although the bulk of the patients were classified as having one form of mania or the other, there were a few diagnosed as morally insane (mainly Europeans). Alcohol and cannabis (ganja) are listed as common physical causes.

Academic responses

Although the East India Company doctors were supposed to have some knowledge of Indian languages,[42] the doctor–patient contact would often have to be through interpreters. The official recognition of Indian languages, and by extension, indigenous knowledge, was still evolving.[43] Administrative records could be faulted for not paying enough attention to the voices of the mentally ill, especially those of the 'native'. However, since there are no known first-person accounts from the nineteenth century, these records provide at least some insight

[40] *Ibid*.

[41] Medical 1870, 1–17, letter from secretary to chief commissioner, 29 February 1872; Karnataka State Archives, Bangalore.

[42] D. G. Crawford, *History of the Indian Medical Service 1600–1913* (London, 1914).

[43] B. S. Cohn, *Colonialism and its Forms of Knowledge* (Delhi, 1997).

into the workings of institutional psychiatry in India. Given this handicap, it is quite interesting that the details of the diagnosis and the clinical vignettes contain psychopathological material at all.

Doctors who were to serve in India, had been asked by the company to 'produce a certificate of having diligently attended, for at least three months, the practical instructions given at one of the asylums for the treatment of the insane', as well as to acquire a knowledge of Hindustani before coming over.[44] By 1855, accounts of insanity in India began to be published.[45] This account, written by the superintendent of the Dacca Asylum, was replete with case notes, and suggestions about the etiology. It was also to set the tone for subsequent discussions. One of the aims of psychiatry was 'to determine whether the dark races of man are susceptible to the mental and moral influences necessary to the production of various forms of insanity . . . and cured by the same plan of treatment as in Europe'. Excessive studying, and a rapid change from a 'less civilized' state, were attributed as causes. It was also observed that, contrary to expectation, significantly smaller numbers of the mentally ill were seen in a 'country where the mental faculties were so less cultivated'. A preliminary attempt at calculating rates was also made, and the total of 157 lunatics under treatment in the Dacca circle (population 9.8 million) was much smaller than the 13,400 under treatment in England and Wales (population 17.9 million). The much higher incidence in Europe was caused by the spread of education and the generally more nervous temperament. Winslow Forbes, the editor of *Psychological Medicine and Mental Pathology*, acerbically pointed out 'many of the facts presented are interesting, but full of error . . . views that are unsubstantiated'.[46] Forbes disagrees with Wise that 'the Hindoos [*sic*] are perhaps in a lower state of mental development than even the rudest savages'. He found this untenable, as evinced by the literary and architectural achievements in India. Indeed, he was critical of the major role mercantile and military interests were playing in India, and the neglecting of the development of the liberal perspective.[47]

Case reports and reviews in the nineteenth century also began discussing issues related to psychiatry in India. Organic causes were often identified, as in the case of a chronic mania who recovered after developing symptoms of effusion of the brain,[48] and a soldier who developed symptoms of paranoia after developing an ischio-rectal abscess.[49] A soldier who drove a nail into his head

44 Crawford, *History of the Indian Medical Service*.
45 T. A. Wise, *On Insanity in Bengal* (Edinburgh, 1852).
46 Forbes, 'Review of Practical Remarks on Insanity in India'.
47 W. Forbes, 'Moral Sanitary Economics', *Psychological Medicine and Mental Pathology* 6 (1853).
48 *Indian Medical Gazette* 13 (1878), 140.
49 D. M. Moir, 'Mental Depression, Hallucinations and Delusions Associated with Ischiorectal Abscess', *Indian Medical Gazette* 26 (1891), 7–9.

while intoxicated with cannabis, and died after a delirium lasting two weeks, was found to have a clot on post mortem.[50] Case reports, for example, the one by C. K. Swaminath Iyer[51] of an acutely ill twenty-year-old male, who recovered after passing a roundworm, suggests that Indian medical personnel were also beginning to contribute to the scientific literature.

Psychological issues were also described, as in the case of a man who developed a brief psychosis after watching a float that had actors masquerading as being decapitated during a Moharram procession.[52] Chetan Shah, an Indian assistant surgeon, gave an account of hysteria in a fourteen-year-old boy, who could not walk and complained of pain at regular times everyday.[53] Since the boy seemed to be devout, 'an attempt was made during an intermission to produce a deep impression and to invoke the Guru's help'. Dr Shah opined that hysteria in young men was not as rare as mentioned in the textbooks, and felt that faith had a significant role in its cure. Another Indian,[54] Dr Pandurang, reported a case of hysteria that was helped by deva-rishis (native faith healers, but 'sorcerers' in the original report) after his treatment with various drugs and a wine-and-egg mixture had failed. Dr Ram C. Mitter, at the Arrah Charitable Dispensary, treated a case of acute mania in a fourteen-year-old married girl with blistering of the head, purgatives, and cold baths with complete recovery over a week.[55]

The emphasis was on physiological and organic causes of insanity. This was in keeping with the tenor of psychiatry in England in the nineteenth century.[56] There was an ambiguous approach to neurology, but simultaneously an unwillingness to view mental disorders other than manifestations of a brain disease. There was a reluctance to explore psychological models, and thus the absence of much of this in writings from India is not surprising. Emphasis was placed on moral therapy, and that is the predominant theme in the asylums in India.

All these anecdotes, and administrative reports notwithstanding, the initial impetus for providing services was not maintained. Discussing the possibility of employing native staff, an editorial comment in the *Journal of Mental Science* regretfully observed that the 'race prejudice had become the most important fact in the social state of India . . . a conquered country, ruled by a dominant race', not unlike the relation between the races in the citizens of America.[57] The imperial expansion, and wars in the Crimea, Afghanistan and various parts of India needed large amounts of money. There was also widespread famine in

[50] *Indian Medical Gazette* 15 (1880), 71.
[51] *Indian Medical Gazette* 19 (1884), 78.
[52] Dr B. L. Rice, *Indian Medical Gazette* 13 (1878), 112.
[53] Chetan Shah, *Indian Medical Gazette* 23 (1888), 302.
[54] Dr Pandurang, *Indian Medical Gazette* 4 (1869), 55–6.
[55] R. C. Mitter, *Indian Medical Gazette* 2 (1867), 225.
[56] W. F. Bynum, 'Theory and Practice in British Psychiatry from J. C. Prichard (1786–1848) to Henry Maudsley (1835–1918)', in Teizo Ogawa (ed.), *History of Psychiatry* (Tokyo, 1979).
[57] 'Reports on East Indian Asylums', *Journal of Mental Science* 5 (1859), 218–22.

the 1870s. In an order in 1879, it was stated that financial exigencies forced the government to cut back on non-essential expenses.[58]

By the end of the century, things were not in a good shape. An effort to tabulate the services revealed that there were 3,246 insane patients in British India, in twenty-one asylums, and conditions were apparently somewhat better than earlier.[59] The presidential address by T. W. McDowall[60] to the fifty-ninth meeting of the Medico-Psychological association focused on the insane in India and their treatment. Dr McDowall regrets that only 4,311 places for patients exist in the asylums of British India, for a population of 23 million. Even more disturbingly, apart from Mysore, none of the other native states, with a total population of 75 million, had an asylum. Rather than a low rate of insanity, he feels it is neglect of patients and want of services that are revealed in these figures. There was no lunacy board; army medical officers with no particular training in psychiatry administered the asylums, there were frequent changes of staff, the pay was deficient, work irksome and full of petty detail. In general, there was a systemic failure of the administration, annual reports had become worthless and there was no attempt to develop an efficient policy for treatment.

Census reports – early attempts at developing an epidemiology of psychiatry

The Indian census, one of the largest demographic exercises in the world, was initiated in 1872, and conducted every ten years, with the exception of the war years. It was meant to assist the government in planning services and provide insight into social conditions all over India.

Since 1881, the census listed the mentally ill as a separate category, and a statement of number of persons of unsound mind by religion, age and sex (form XIV, census 1881) was to be provided by the returning officers. The governor general of India had requested in 1867, that the number of insane in the provinces be counted.[61] Between 1881 and 1951, the census reports included estimates of the number of mentally ill. Doubts were frequently raised about the quality of information, as, for example, by Dr Deakin of the North-West Province who felt that non-professional enumeration might not identify mild or periodic forms of insanity.[62] However, despite these drawbacks, it still provides a window into the status of services available. Huge variations were seen within India, and between India and the UK. In the 1881 census, more than 80,000 insane were identified in British India.[63] Consanguinity, brain disease and 'disappropriate ambition'

[58] 'The Punjab Reference Book for Civil Officers', 14 (1879), 42–5.
[59] H. C. Burdett, *Asylums – History and Management* vol. I: *Hospitals and Asylums of the World* 4 volumes (London, 1891).
[60] T. W. McDowall, 'The Insane in India and their Treatment', *Journal of Mental Science* 53 (1897).
[61] Patch, *A Critical Review of the Punjab Mental Hospitals 1840–1930*.
[62] 'Census of British India, 1881' (London, 1883). [63] *Ibid*.

and 'intense application to study' were listed as causes. At the same time, the fact that rates were a sixth of those in England and Wales (but almost the same as Italy, a less developed European country) was consequential to the fact that 'mental work (and) intense competition of an active civilization is completely unknown'. In 1881, the census officer of Mysore suggested that some amount of insanity could be attributed to the habit of marrying with relatives, 'which was a compulsory obligation in certain classes and castes'.[64] Addressing this question, the census officer of Assam in 1921 reported that this was not likely, as rates of insanity were the same in exogamous and endogamous tribes.

Geographical, religious and cultural differences were explored in several subsequent census reports, and a ten-fold difference in rates between Coorg in southern India and Burma was observed. By 1921, it was evident that the role of these factors was not substantiated. More importantly, as per estimate, 14 per cent of the insane were already housed in twenty-three asylums of British India. This was important, as it was felt that in the community 'the lunatics' [lives are] not happy . . . [they] receive little sympathy . . . [are] bound hand and foot or [have] a heavy log fastened to the ankle'.[65] Till this point, mental hospitals were to be the mainstay of psychiatric care in India. No data was available for the native states and it was feared that most mentally ill were confined to gaols.

These census reports provide very crude data, but at the same time reflect a concern for establishing the nature of the burden of mental illness, and matching the provision of services to the numbers expected to utilize them. Several epidemiological studies were conducted after Independence, to establish the same issues, with equally disparate results.

Increasing amounts of admissions to the asylums was now causing significant overcrowding. A significant development was the establishing of the hospital for the European insane in 1918 in Ranchi. Though the most modern, its superintendent, Colonel Berkely-Hill noted 'that those responsible for the original design were obsessed with its custodial function so as to sacrifice most, if not all, of its remedial potentialities . . . it has anything but an agreeable appearance'.[66] Occupational therapy, psychoanalysis, amusements, organotherapy and, rarely, hypnotics were used. A follow-up study of discharged patients was attempted, and some effort made to study whether patients recovered sufficiently. One of the best accounts of the state of institutional care in India in the early part of the twentieth century can be found in the reviews of Mapother (1938)[67] and Moore Taylor (1946).[68]

[64] B. L. Rice: 'Census of Mysore'.
[65] 'Census of British India, vol.1, 1921' (Calcutta, 1921).
[66] O. Berkely-Hill, 'The Ranchi European Mental Hospital', *Journal of Mental Science* 52 (1924).
[67] Report of Professor Edwin Mapother to Sir John Migaw, the president, medical board, India Office, 1938; Archives of the Bethlem Hospital.
[68] Summarized in 'Quality Assurance in Mental Health, National Human Rights Commission', 1999.

Mapother report

Professor Edwin Mapother, was requested to visit Ceylon in 1937 and suggest reform of the psychiatric services. For this, he visited India, and submitted a report, which the medical board of the India House decided was not to be published but used exclusively as a background to suggestions for improving services in Ceylon. In the years before this, he had been instrumental in establishing the Institute of Psychiatry at the Maudsley Hospital in London, one of the principal responsibilities of which was to develop services in the British Empire.

'It would be difficult to affirm that with respect to psychiatry, the bearing of the white man's burden has been adequate', notes Professor Mapother at the beginning of his report.[69] In London, there was a psychiatric bed for every 200 individuals, while in India there was one bed for 30,000. Within British India, while in Bombay presidency there was one bed for every 12,000, in the Bengal, Bihar and Orissa region, there was only one bed for every 57,000 individuals. While there were five psychiatric beds for every eight beds for 'physical disease' in London, there was only one bed for psychiatry to every seven in India. There was overcrowding in almost every asylum, and a general shortage of staff. The 'inadequacy was increased by the ignorance and indifference of most medical men' and a 'tactful reticence . . . about defects that cruder persons might publicly call scandalous' he remarked. The asylum buildings, Professor Mapother caustically notes, 'were a permanent monument to brutal stupidity', perhaps 'guided by a PWD[70] concept of a lunatic . . . (one ward) a replica of the accommodation for tigers at the Regent's park Zoo' and some a 'desolate waste, based on the assumption that the insane are indifferent to discomfort and ugliness, and are destructive'. He rated the asylums on a grade of 'badness', with only the Asylums of Ranchi (for Europeans) in British India, and the one in Bangalore in the Kingdom of Mysore having anything to commend them. However, he wondered at the waste of money on an asylum for Europeans, recently established by Berkely-Hill with much triumph, 'based on a concept of race that in practice is unreal, and does not correspond to education, mode of life or any valid claim'. On the other hand, the asylum in Bangalore, he told Sir Sikander Mirza, the dewan of Mysore, was a 'monument to the vision and wisdom of all those responsible for the mental defectives in the East. The Institution is almost unique among mental Hospitals in India . . . it is quite evident that modern methods of diagnosis and treatment are available and freely used'.[71] The impending transfer of power into India hands was of no great concern, indeed many British psychiatrists stated that it was easier to obtain money

[69] Report of Mapother to Migaw.
[70] The Public Works Department (PWD) that was responsible for the design, construction and maintenance of government buildings.
[71] Sir Mirza Ismail, *My Public Life: Recollections and Reminiscences* (London, 1950).

from provincial governments than when the health services were under direct British control. In most places, Indian doctors were managing the asylums, and several had received training in England or the USA.

Professor Mapother[72] was also well aware of the complexity of the Indian social and political situation. While admitting the need for more trained specialists, he was sceptical about the possibility of bringing adequate numbers of Indians to train in the UK or USA in view of the colour prejudices. There was therefore an urgent need to develop a school in India, and the asylum 'at Bangalore was [is] structurally the only center which yet exists that is fit to house a post-graduate school'. In addition to its professional capabilities, it had the benefit of an enlightened native administration, religious harmony and an appeal to nationalism by being established in a native kingdom, Mapother said. Another asylum could be established in Delhi in the future, under British control. The post-graduate school could serve the entire region for training specialists. He also suggested reforms for psychiatric services in India. Easier access, reduction of legal procedures, setting up of visitors' committees and an urgent need to increase the number of beds, irrespective of all pressures, were the major recommendations. He also suggested that psychiatric wards be provided in all general hospitals, and only chronic cases be sent to the asylums. The quality of undergraduate education needed to be improved, and training in psychiatric social work and rehabilitation was to be introduced.

These suggestions, unfortunately, could not be executed at it was felt that 'other needs must have priority and that economic reasons forbade these defects being rectified'.[73] Mapother regretted that any criticism of the system was countered with the need for financial prudence, and the need to maintain the security and prestige of the British Raj. As an example of misplaced priorities, he wonders how an expense of £18 million (of a total budget for India of £60 million) can be justified for building New Delhi for 'ceremonial entertainment'. It was quite evident by now that reform and improvement would not be carried out in British India.

The case of Mysore native asylum in the British Empire

The kingdom of Mysore was administered directly by the British between 1831 and 1881, after which rule reverted to the maharaja of Mysore. At the time of rendition, a policy paper was prepared concerning medical services under the new administration. 'The future medical arrangements must partake of a European character, because there is no native system to fall back upon... the Principal charges are the Civil Hospital, Lunatic Asylum and Medical

[72] Report of Mapother to Migaw.
[73] *Ibid*.; Conversation between Mapother and Megaw.

Stores, and experienced and well-trained men be placed'[74] was the considered advice.

The asylum continued to provide services to the Indian population and the British residents of the army cantonment of Bangalore. Until the early part of the twentieth century, Indian and European women were housed together, but the overcrowding of female European lunatics necessitated the setting up of separate wards for European women in 1913. A gradual increase in the number of patients led to additional wards being constructed, but by 1914 no further expansion was possible. It now accommodated 200 patients, including twenty-seven Europeans and Eurasians. The number of people being admitted every year continued to increase, so that by the second decade of the twentieth century, more than a hundred admissions were made every year.[75] Exclusively Indian staff managed the asylum by now. By 1920, it was evident that 'a new building for the Lunatic Asylum is absolutely necessary . . . there will have to be specialists in nervous diseases'.[76] Dr Francis Noronha had recently been deputed to train in England, where he worked at the Maudsley Hospital with Dr Mott, from where he returned in 1921. Work was deferred for almost a decade because of lack of funds, but a new building was ready by 1932 in a sprawling campus on the outskirts of the city. Modelled on the plans of the Bethlem Asylum at the Lambeth site, it had four large pavilions, an interior courtyard garden and extensive lawns.

Dr M. V. Govindswamy, a medical graduate from the Mysore Medical College also began working at the mental hospital, and was also sent abroad – to the USA and to the Maudsley Hospital, for further training in psychiatry. In London, he met Professor Willi Mayer Gross, who had been brought over from Germany under the Rockefeller programme. The two shared common interests in philosophy and medicine, and this acquaintance was to guide the development of academic psychiatry in India. Upon his return to India, Dr Govindswamy was an active researcher. He began using cardiazol induced convulsions,[77] insulin coma,[78] and later, psychosurgery,[79] almost as soon as these were available in Europe. A scholar of Sanskrit and English, he also taught himself some German to read the original texts. He was instrumental in maintaining high standards of care, and systematic notes and medical evaluations became a routine at the hospital. Laboratories, rehabilitation services and psychological testing was also

[74] Medical 1880–1, file 1, series 1–2, Karnataka State Archives, Bangalore.

[75] Report of the Mysore State Asylum, Bangalore, 1916; medical 49/17/2 3452–3453 (December 1917), Karnataka State Archives, Bangalore.

[76] Medical 42/22, serial 1–5, 1922, Karnataka State Archives, Bangalore.

[77] M. V. Govindswamy, 'Cardiazol Treatment in Schizophrenia', *Lancet* (1939), 506.

[78] M. V. Govindswamy, 'Insulin Shock and Convulsion Therapy in the Tropics', *Lancet* (1939), 1232.

[79] M. V. Govindswamy, 'Rao BN Bilateral Frontal Leucotomy in Indian Patients', *Lancet* (1944), 466.

introduced. He also felt the need to apply concepts of Indian philosophy to the description of psychopathology, over and above the practice of ayurvedic and other traditional forms of medicine.[80] After Independence, the recommendations of the Sir Joseph Bhore committee in the preceding years to establish a centre for post-graduate education were to be executed.

The only centres thought adequate were the ones at Bangalore and the erstwhile European Asylum in Ranchi. Professor Mayer Gross, who had recently retired in the UK, was invited as a visiting Professor, to Bangalore. Here he helped develop a curriculum for post-graduate training. Dr Govindswamy was convinced that basic neurosciences were crucial to understanding disorders of the brain and mind. He developed a programme that included clinical services in neurology and neurosurgery (in addition to psychiatry, psychology and psychiatric social work), and basic sciences. This hospital was designated as the All India Institute for Mental Health, and began training students for a diploma in psychological medicine, and in clinical psychology in 1956. Unlike the western, especially American experience, psychoanalytical viewpoints were not reflected in the development of psychiatry. Dr Govindswamy himself felt that psychoanalysis was 'a strain on one's credulity',[81] as did Edwin Mapother, who said of a certain analyst that 'he represented the greatest danger to the development of psychiatry in India'.[82] This Institute was redesignated as the National Institute of Mental Health and Neurosciences in 1974. It was indeed ironical, and a tribute to Sir Mapother's perspicacity, that a native-administered asylum, rather than one of the colonial establishments, proved to be the most adept at synthesizing western and Indian approaches, and developing a comprehensive approach to neurosciences and psychiatry.

Case notes at the Bangalore Mental Hospital

Records at this hospital in Bangalore extend to the beginning of the twentieth century. We have tabulated these registers, and have tried to profile the clinical details. In 1903, the asylum had 258 patients (201 males, fifty-seven females) who had been there for an average of seven years. While a few were there from 1865, most had been admitted in the decade after 1895. *Mania acuta* and *Mania longa* were the commonest diagnosis and accounted for almost 60 per cent of the patients. Melancholia was also frequently diagnosed. Organic causes such as epilepsy, and acute and chronic dementias accounted for sixty-two admissions, almost 25 per cent of the total cases. Rarer diagnoses included chronic mania, chronic delusional states and idiocy. Seven individuals were declared not insane,

[80] M. V. Govindswamy, 'Need for Research in Systems of Indian Philosophy and Ayurveda with Special Reference to Psychological Medicine', *Journal of the Indian Medical Association* 18 (1949), 281–6.

[81] *Ibid*. [82] Report of Mapother to Migaw.

but not before they had spent an average of fourteen months in the asylum. Following the records of these patients, it was seen that eighty-seven (34 per cent) died. More than half of those admitted with idiocy, chronic dementia or epileptic dementia died. A significant number of those with mania recovered entirely, although a fourth of these patients also died over the next seven years. Of all the individuals admitted between 1895 and 1903, at the end of 1910 only thirty-five were still in the asylum. Eighty-eight had been discharged as cured or improved, while fifty-five had died.

We also analysed records of the new patients admitted in the years 1903–4. Relatively small numbers were admitted afresh – forty-two in 1903, and thirty-seven in 1904. This had remained relatively static for several years, for instance there had been thirty-eight admissions in 1878. Their average age was in the early thirties and a significant number had sought treatment earlier from the asylum. We could chart the outcome of these new cases through the casebooks of the successive years. *Mania acuta* and *Mania longa* were still the most common diagnoses. The large majority of these recovered or were discharged to the care of the family, and only five patients stayed on till 1910. Half of the new admissions stayed in the asylum between six and seven months, and *mania acuta* had the best recovery rate. Some died soon after admission, but most of these were suffering from epilepsy or idiocy.

Religion, caste and social background were recorded, and were representative of the population of Bangalore. Hindus accounted for 70 per cent of admissions, Muslims 21 per cent and Christians 8 per cent (including Europeans and native Christians). While most new cases who were discharged were from the city of Bangalore, a larger proportion of those who stayed in the asylum for longer periods were from more distant places in the kingdom.

In 1878, there were only eight diagnostic categories, but by 1904, nineteen diagnostic categories were in use. The case notes were reviewed, and quite often the diagnosis would be changed a few months after admission. New categories in 1904 included hypochondriac melancholia, and several categories of dementia. This probably reflected a better understanding of the causes of dementia by this time in medicine.

Changes in diagnostic practice are quite evident in cannabis-related psychosis. In 1879, ganja was identified as a cause in 75 per cent of the admissions.[83] Of the patients resident in 1903, ganja use was a factor in ten cases of mania, and a few of dementia. However, after 1900, ganja-induced psychosis as a diagnosis decreases substantially in the records. The closing years of the nineteenth century had seen a huge interest in cannabis. From the initial curiosity regarding its possible use in treatment,[84] there had been growing concern about its

[83] Annual Report on special hospitals in the province of Mysore for 1879.
[84] W. B. O'Shaughnessy, 'On the Preparations of Indian Hemp or "*Gunjah*"' (Calcutta, 1839).

role in causing madness.[85] The final report of the Indian Hemp commission, after interviewing a number of Indian and European experts, stated that there was insufficient reason to identify ganja as a cause of psychosis. By 1900, this opinion was widely shared, thus accounting for the rapid decline in rates of diagnosis.

Case notes from the 1930s included detailed psychopathological observations, family history, social functioning and a thorough medical review. Patients were seen everyday for the first few days after admission, and less frequently later. Laboratory tests such as the Wasserman reaction, blood counts and x-ray were available. Drugs in use included opium, chloral, paraldehyde, bromides, antipyrin and Jamaican dogwood. The residency surgeon, from the British Army, justified the expense in a letter to Dr Govindswamy, stating that 'a large number of cases are due to organic causes . . . the more patients are cured, the less will be the recurring expenses. In other words, it is better to spend money on drugs that cure, rather than on maintenance, that does not'.[86]

The development of the asylum in Bangalore encapsulates the various trends in institutional care in India. It started as a ward in a general hospital for civilians, as part of the services by the British Army in the first half of the nineteenth century. It became an institution, acquired a building, full-time staff and, after 1881, was administered by an Indian kingdom. Western medicine by now had gained social and intellectual acceptance, and Indian doctors managed the asylum well. Advances in medicine were incorporated quickly, and there was only minor evidence of any deliberate attempt to maintain social distinctions. Other asylums were not so fortunate.

The Royal Indian Medical Psychological Association

India by this time was well on its way to independence, and the Second World War was looming. A growing number of specialists in psychiatry were now practising in the hospitals and asylums. In 1936, a move to establish an Indian division of the Royal Medical Psychological Association (RMPA)[87] had been initiated, allegedly the first in the Empire, outside the UK. Dr Banarsi Das, superintendent of the Agra Mental Hospital, wrote to Dr R. Worth, the president of the RMPA, with a plan for the association and an estimate of the costs involved. It was also suggested that all those who had worked in asylums for a

[85] J. H. Tull-Walsh, 'On Insanity Produced by the Abuse of Ganja and other Products of Indian Hemp', *Indian Medical Gazette* 29 (1894), 333–7, 369–73.

[86] Mysore Residency Files 621/1, 1937, correspondence regarding a grant to the Mental Hospital, Bangalore for purchase of European medicines for the treatment of the mentally ill patients of the Civil and Military station, Bangalore. Karnataka State Archives, Bangalore.

[87] Records of the Indian Division of the Royal College, Royal College of Psychiatry, London.

long time but had not acquired specialist degrees (at that time, this was possible only from the UK) be allowed to become members. This was not permitted by the RMPA. Eventually, the Indian division came into existence and held two meetings in Agra (1938) and Lahore (1941). At the first meeting, Dr Thomas, the superintendent of the Hants County Mental Hospital in England, represented the RMPA, thus signifying some degree of co-operation between the psychiatric professions in the two countries.

The issues discussed were overcrowding of the hospitals, training of hospital attendants, improved undergraduate education and opportunities for postgraduate study, and the design of single cells best suited for use in India. The need for reform and expansion was thus acutely felt, both by the practitioners in India and visitors from abroad. The members of this association were the superintendents (by now largely, but not exclusively, Indian) and the growing number of psychiatrists in general hospitals and medical colleges.

After the death of Dr Banarsi Das in 1943, Lt. Col. Moore Taylor, superintendent of the European Mental Hospital at Ranchi, took over as president. By this time the war and the Indian political unrest was well on its way. In 1946, moves had been made to establish a separate Indian society. In April 1947, Taylor resigned as he felt that the Indian division was being allowed to die. The Indian Psychiatric Society with Col. Davis as its secretary had already been established, and the Indian division of the RMPA had 'ceased to function as such', as Dr Davis told the RMPA during a visit.[88] By November 1947, a few months after Independence, the Indian division was dissolved. Despite its short life, this association affirmed the close links between the Indian and the British medical professions, and their similar preoccupations.

Bhore Committee and the Moore Taylor Report

The Health Survey and Development Committee 1946 (Sir Joseph Bhore Committee) included reform of psychiatric services in its ambit and Colonel Taylor was asked to survey the mental hospitals. His report was based on his observations of nineteen mental hospitals with 10,181 beds. His findings were quite similar to those of Mapother a decade earlier. Asylums were designed for custodial care and not for cure. 'The worst of them were the Punjab Mental Hospital, the Thana Mental Hospital, the Agra Mental Hospital and the Nagpur Mental hospital ... conditions of many hospitals in India today are disgraceful and have the makings of a major public scandal.' Increasing bed capacity, without concomitant increase in personnel, lack of attention to training and education at all levels, inadequate provision for rehabilitation, and poor liaison with medical services were pressing problems, and it was time he felt 'for Government to

[88] *Ibid*., undated note.

take account of stock, overhaul resources, and rechart the course for the next 30 years'.[89]

The Bhore Committee chronicled the dismal state of health services in India.[90] There were only 73,000 medical beds in the whole of British India (0.24/1,000), the doctor – population ratio 1/6,000, and the nurse – population ratio 1/43,000. Life expectancy was only twenty-six years, compared to above sixty years in other parts of the empire, like Australia and New Zealand; and infant mortality rates were five times higher. However, the committee made sweeping suggestions for the development 'in forty years', of 'an integrated, preventive and curative National Health Service embracing within its scope institutional and domiciliary provision for health protection of a reasonably high order'. Loosely planned on similar reform in the UK, these suggestions had been hinted at by Dr Dalrymple-Champneys[91] (an adviser to the Bhore Committee) and Professor A. V. Hill[92] in the early 1940s. The Committee envisaged the setting up of a health administrative unit for every three million population, with primary health centres for every 20,000 and a specialist general hospital with 2,500 beds that would include care of the psychiatrically ill. The estimated cost would be Rs 2 per annum. However, as a unit, the costs were several times lower than those budgeted for similar services in England, prompting some to question the feasibility of it all.[93]

Suggestions for increasing the number of asylums, and beds for psychiatric services were made. However, progress was slow. By 1980, the number of mental hospitals had been increased to thirty-seven, but there were only 18,918 beds. The post-Independence expansion of services in India coincided with the introduction of pharmacological treatments. These became available widely in India very quickly, and were the mainstay of treatment by the end of the 1950s. Indeed, the first workshop of medical superintendents on improving mental hospitals called for a restraint in the use of tranquilizers! The growing awareness of the drawbacks of aslylum-based long-term care was also evident. As a result of all these diverse influences, between 1951 and 1961, only five more asylums were added, with approximately 2,500 beds.[94] However, the number of admissions increased several fold, as did the number of discharges.

[89] As quoted in 'Quality Assurance in Mental Health: National Human Rights Commission' (New Delhi, 1999).

[90] Lt. Gen. Sir Bennett Hancie, 'The Development and Goal of Western Medicine in the Indian Sub-Continent (Sir George Birdwood Memorial Lecture)', *Journal of the Royal Society of Arts* 25 (1949).

[91] Sir Weldon Dalrymple-Champneys, Health Review of India, GC 139/H2, Wellcome Library, London.

[92] A. V. Hill, 'Health, Food and Population in India,' *International Review* 21 (1945), 40–50.

[93] *Ibid*.

[94] S. Sharma and R. K. Chadda, *Mental Hospitals in India: Current Status and Role in Mental Health Care* (Delhi, 1996).

In the first two decades after Independence, the emphasis on asylum-based care for the mentally ill continued. Hospitals were added in Amritsar, Hyderabad, Srinagar, Jamnagar and one of the last in Delhi in 1966. Surprisingly, the one in Delhi was finally built at a site identified almost a century earlier to replace the asylum destroyed during the Indian Mutiny. Institutional care in India now consists of these forty-odd hospitals, with a total of 20,000 beds. Dr Vidyasagar in the Amritsar Mental Hospital introduced one of the most remarkable innovations in mental hospital care in the early 1950s.[95] He erected tents in the grounds, and encouraged families to live with the patients, until they recovered. He shared almost all his working hours with the patients and their families. Principles of mental health, derived from religious and medical sources, were shared. This significantly reduced the stigma of mental illness, and demonstrated the feasibility of community care.

The rapid availability of pharmacological treatments for psychiatric disorders allowed the government to envisage that care for mental disorders could be successfully amalgamated into the general health services, as perhaps suggested by the Bhore Committee.

A series of public interest litigations in the 1980s has led to sporadic attempts at reform. A review by the National Human Rights Commission[96] in 1999 pointed out the deficiencies in the system. This report again highlighted the exceedingly disparate standards of care, commented upon a century-and-a-half earlier.[97] The cost of maintaining a patient varied from Rs 19 ($ 0.3) to Rs 275 ($ 7) per day, an average of Rs 106 ($ 2.5). More than a third were still housed in converted gaols, with all the custodial trappings of a century ago. Twenty per cent lacked any investigation facilities at all, and the wide range of services for psychosocial intervention and rehabilitation were woefully inadequate. 'Despite the increase in budget . . . utilization is so variable . . . no appreciable improvement in many hospitals' observed the review.

Conclusions

Although hospitals are an 'article of faith' by several historians, there is little to suggest that they were widely available before the advent of European, and specifically, British influences.[98] Medical care was provided by trained doctors at patients' homes, and social divisions perhaps precluded any creation of a common public space for care. However, the choice of physician was often

95 M. K. Isaac, 'Trends in the Development of Psychiatric Services in India', *Psychiatric Bulletin* 10 (1995), 1–3.

96 'Quality Assurance in Mental Health: National Human Rights Commission' (New Delhi, 1999).

97 Ernst, *Native Asylums in Colonial India*.

98 A. L. Basham, 'The Practice of Medicine in Ancient and Medieval India', in C. Leslie (ed.) *Asian Medical Systems* (Berkeley, 1976).

very eclectic – and Ayurvedic, Unani and European doctors would be consulted with equal felicity. Traditional medicine also suffered from a lack of acceptance of insanity. It has been suggested that the insane lost all caste distinctions, and were considered defiling, and pious householders and Brahmins were advised not to look at insane persons.[99] Islamic societies (and medieval India was administratively an Islamic society) did not make a specific provision for public institutions and services for the poor. Although the notion of charity allowed the setting up of poorhouses, these were often run on private donations and not systematically supported.[100] Troublesome lunatics were often locked into gaol, while harmless ones wandered the streets and joined the poor and vagabonds near the mosques and temples.[101]

Medicine was often outside the traditional social systems, as doctors, by the nature of their profession, had to handle unclean substances. The practice of medicine – both by the professions and the people – did not conform to the rigid demands of religious dogmas. The origins of European medicine, and its use by a wide section of the population in India, were thus no surprise. In essence, in public approaches to illness, whatever was empirically effective, was used. Charles Smith, at the Hospital for Peons, Paupers and Soldiers referred to earlier, was able to document 23,406 consultations between 1836 and 1849, and in 1849 alone had 4,336 admissions through the year, from a population of only 100,000 in Bangalore. And this despite the fact that rich Indians and Brahmins seldom used the hospital. Despite other allegations of colonial imposition, hospitals and asylums thus proved quite popular and acceptable to the population of India.

Medical colleges were established in 1835 in India, and created a large body of Indian professionals trained in western medicine. Leaving service conditions and administrative rules aside, this implied that western notions of hospital care became a part of social and intellectual life. Rich businessmen offered to fund special facilities, such as the special wards for Parsees in the Pune Asylum which was a 'charming villa for 40 patients',[102] or donations to the asylums. Medicine was seldom seen as a tool of Empire, unlike the railways.[103] There have been suggestions to the contrary, but there is little evidence that colonizing the mind was as useful (or successful) an enterprise as colonizing the body.[104] The growing Indian medical elite identified themselves closely with the Raj, as

[99] M. Weiss, 'History of Psychiatry in India: Towards a Culturally and Historiographically Informed Study of Indigenous Traditions' *Samiksa* 40 (1986).

[100] M. W. Dols, *Majnun: The Madman in Medieval Islamic Society* (Oxford, 1992).

[101] B. Pffeiderer, 'Mira Datar Dargah: the Psychiatry of a Muslim shrine', in Imtiaz Ahmed (ed.), *Ritual and Religion among Muslims of the Sub-Continent* (Lahore, 1995).

[102] Report of Mapother to Migaw.

[103] D. R. Headrick, *The Tools of Empire* (New York, 1981).

[104] D. Arnold, *Colonising the Body: State Medicine and Epidemic Disease in 19th-Century India* (Delhi, 1993).

seen in the attempts to create an Indian association aligned to the Royal Society, just years before Independence.

The East India Company passed laws regarding the detention of the insane in its territories several years before similar Poor House Acts were enforced in England. The nineteenth century was marked by a frenzy of asylum building. Although it has been suggested that these were symbols of imperial domination, their actual utilization by the Indian people was quick. The prevailing ideas about the causes of insanity were extrapolated to the region. Though racial issues were recognized, it was equally evident that a considerable degree of effort to understand and improve the services was made. There is little evidence that a systematic denial of the psychological space of 'natives' was attempted. This was a reflection of the trends in psychiatric care in the UK in the nineteenth century.

Other issues in medical science and technology are also important. Until the early part of the nineteenth century, there was a significant give and take between the healing traditions of India and the British. However, scientific advances increased the distance between the two approaches. Unlike Canada and Australia, a comprehensive techno-scientific education was not provided, but one more akin to achieving technical skills and a 'PWD type' of education.[105] In the absence of this broad scientific background, progress in medicine was slow. The lack of adequate sharing of scientific knowledge was to prompt a severe rebuke by A. V. Hill.[106] This was quite apparent in medical services, and perhaps equally true of psychiatric care.

By the early twentieth century, there was an increasing dependence on Indian professionals, and provincial governments in any case were responsible for health care. This perhaps prevented the kind of formal analysis of the issue of race as a factor in mental illness that was to bedevil African psychiatry. The first asylums in Africa were established only towards the end of the nineteenth century and the early years of the twentieth, and social contacts between the two cultures were not as complex as had been established in the Indian subcontinent over the past 300 years. There is seldom any use of metaphors of race in describing the Indian insane, nor is there a difference in their symptoms. The sameness is repeatedly emphasized, although differences on account of geography, climate and organic disease are often suggested.

In the nineteenth century, moral treatment was sought to be extended to all the citizens of British India. Although initiated as an exercise to reduce public nuisance, it was soon regarded as a 'noble work'. However, by the end of the nineteenth century, increasing reparations to the UK, and the costs involved,

[105] D. Kumar, *Science and the Raj* (Delhi, 1997).

[106] A. V. Hill, 'India-Scientific Development or Disaster', in *The Ethical Dilemma of Science and other Writings* (New York, 1960).

proved prohibitive. Endless debates about separate asylums for Europeans culminated in two buildings: one in Berhampore (which was quickly discarded as it turned out to be too much like a gaol), and at Ranchi.

For most of this period, asylum populations remained almost static at below 15,000 beds for a population of several hundred million. Financial and administrative lacunae (parsimony and neglect) were blamed for this appalling state. But the great incarceration simply never happened.

This was to have several consequences for services in India. Unlike the West, where social psychiatry and community care evolved as extensions of the asylum, there were no comparable services. The ancillary professional staff – psychologists, psychiatric social workers, mental-health nursing, etc., were woefully inadequate. Prompted by developments in pharmacology and innovations in community care, asylums began playing a diminishing role in the provision of care, reserved only for the destitute and abandoned. General hospital psychiatry units, established in only half of the medical colleges, attended to acute cases, and chronic cases fell into the background. Sporadic attempts at reform have been partially successful, and a few of the asylums have been made autonomous, and provided increased funds to improve the quality of care. It is quite likely that no new facilities will be established, though the need for long-term care is quickly being filled up by private asylums and halfway homes that were permitted under the revised Indian Mental Health Act of 1987. Whether these will go the way of the private madhouses of the eighteenth and nineteenth centuries remains to be seen. Economic reforms have increased the role of the private sector in health provision, and have been accompanied by reduced funding for public health. This raises questions about the retreat of the state from the responsibility of care for the chronically ill, and these are likely to intensify in the future as families become smaller, society more 'industrial' and the demands for care more complex.

Colonial institutions in India include the railways and the parliament, as well as the asylums. Though setting up of each of these was prompted by the needs of the colonial administration, they have been incorporated into all aspects of contemporary Indian life. There is constant debate about the relevant adaptations of each of these to the needs of the Indian society. As perceptions about the nature of psychiatric disease and care changed over the past two centuries, so did attitudes towards institutional care. The sheer paucity has sometimes been viewed as an advantage, as the ills of 'chronic institutionalization' were avoided. The needs of the chronic mentally ill are still woefully neglected, and a more responsive institutional care service will perhaps be necessary. Asylums in India will necessarily have to reinvent themselves to continue to be relevant.