TRADITIONS

OF

SCIENCE

Cross-cultural Perspectives

Essays in honour of
B.V. Subbarayappa

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Munshiram Manoharlal Publishers Pvt. Ltd.

Sponsored by **Sir John Templeton Foundation, United States of America (USA) with Science and Spirituality Research in India Bangalore (India)**

ISBN 81-215-1177-1
First published 2007

Typeset, printed and published by
Munshiram Manoharlal Publishers Pvt. Ltd.,
Post Box 5715, 54 Rani Jhansi Road, New Delhi 110 055.

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Lost Souls, Troubled Minds: The Medicalization of Madness in Mysore State during the British Raj*

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Introduction

The chapter investigates the bare outlines of shifts in knowledge-systems from traditional modes of perceiving and treating insanity to its modern-day incarnations, particularly following the advent in India of European systems of medicine and care for the mentally ill. In part it is also a story about the fusion of the western scientific model of medicalization and institutionalization (in the form of hospitals) with practices drawn from the extant indigenous medical almanacs, such as Ayurveda, Caraka-Susruta, Muslim Unani, and Yoga-Siddha.

The first part of the chapter discusses how traditional Brahmanical view of madness as well as the influences of animism, faith healing and folk medicine influenced day-to-day practices in the handling of mental afflictions. Other outside influences also, particularly the advent of Islam and more importantly the asylum culture, are also discussed.

The second part of the chapter looks at the genesis of mental health that brings this history of development closer to the colonial and contemporary periods. Mental hospitals were first established in the 1780s in Calcutta and Madras, following which, during the indirect rule of the Princely State by British administrators, the first asylum was established in 1881 in the Mysore province. The Maharaja of Mysore was still a young man then, under tutelage of his British teachers; nevertheless, the State was inclined to heed to the departing British doctors' suggestion that western medicine be the mainstay of treatment as there was simply no other universal system available.

By 1900 Indian doctors had taken over; and by 1922, trained Indian doctors (such as Dr Noronha) had been appointed as superintendents of the mental hospitals. The interlocking responses are examined for their impact (or otherwise) during the transition to Indian Independence, whence Nehru wrote into its secular Constitution an Indian "scientific temper" as the lasting legacy of the old and the new.

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* This chapter is dedicated to the memory of the late Dr Renuka Sharma for her initial inspiration and work on the history of psychiatry in India.

Ancient Indian medicine

Indians are said to have adhered to a system of Brahmanical medicine that found elaborate articulation in hundreds of texts dating back to the first and second centuries. These texts expound the principles of what is traditionally called Ayurveda, most prominent among them being the *Caraka-samhita* and *Susruta-samhita.* These two central Ayurvedic references were likely compiled between the third century BCE and the third century CE, a time when Indian philosophical systems more broadly were being developed. While the Ayurveda (from *ayus* meaning "life") and related texts are primarily concerned with general principles of health and well-being – physical, physiological and spiritual – they also contain excursions into psychological and mental ailments and cures. Mental complaints were situated as much within the spiritual contours of life's many challenges as they were within the strictly psychological and affective. For example, the fourth part of *Yajurveda,* "Butavidya" deals with mental diseases supporting the traditional belief in demonic possession, while Susruta (the legendary compiler of the *sutras* by his name) provides advanced theories on mental disease, linking strong emotions and passions with mental and sometimes physical conditions. Just as it has remained two thousand years later, no conflict between science and theology was perceived by Indians in the days of Susruta and his counterpart Caraka. No separation between the two appeared necessary: "Hindus derived their psychological theories from their theology, or, rather, they conceived their psychology as a philosophy of life."[1] Indeed, sages from the Nyaya-Vaiseshika, Samkhya-Yoga, Jaina and later on Buddhist schools of philosophy emphasized the psychosomatic context in their fledgling concepts of medicine and philosophy.

Ancient Indian medical diagnostics, which prevail to this day in certain folk and traditional medical practices, are based on the theory of *dosas* or "humours," the proper balance of which must be maintained with the five elements *(bhutas).* These elements of the human constitution correspond with the five elements of the natural world, namely water, air, fire, earth, and space or ether. The *dosas* are three in kind: *vata* (wind), *pitta* (bile), and *kapha* (phlegm). It is with the vitiation and aggravation of the *dosas* in the body, and the consequent imbalance, excess, increase or decrease of one or other of the humours that results in affliction, disease and disturbance in the individual's physical and/or mental functions.

The second major concept, which Ayurvedic medicine borrows from Indian philosophy, is that of *tri-guna.* This theory proposes that nature is imbued with three inherent qualities (*gunas*) or propertied dispositions: *sattva* (light, purity, excellence), *rajas* (motion, activity, energy), and *tamas* (inertia, darkness). Each *guna,* alone or in various combinations, refracts differently in its precise constitution, qualitative measure and effective outcome ranging from natural manifestations, biotic entities and consumables to human personalities, and even death and the hereafter. Traditional Indian diagnosis and treatment regimes utilize the *guna* framework while paying attention to the somatic and psychological conditions of the patient and the complementary *bhutas* (as compound ingredients). *Bhutas* comprise a broad range of elements, including cellular, bacterial, plant, skin, blood, fluids, sound, breath, prayer, ritual, movement, ambient space, isolation, which may help to restore the equilibrium of disturbed

dosas. The *Caraka-samhita* treats the *dosas* also under Bhutavidya, which brings a discussion of insanity into its ambit as well. These Brahmanical texts cross the spectrum from the very subtle analysis of the intricate workings of the *dosas* in the state of insanity, to rather crude generalizations. For example Caraka makes this broad observation:

> When the mind is constantly afflicted by passion, hatred, anger, greed, excitement, fear, attachment, exertion, anxiety and grief and when he (the individual) is subjected to excessive physical assault; in these circumstances, the mind gets seriously affected and awareness is impaired. The *dosas* get vitiated and enter the *hrdya* (heart-region) and obstruct the channels of mind causing insanity . . . insanity is to be known as the agitated or unsettled state of mind, awareness, perception, knowledge, memory, involvement, virtue, behaviour and conduct (*Caraka-samhita-nidanasthana*, 7-4, 5).[2]

Insanity manifests in various ways, and is clustered under two basic symptoms: exogenous and endogenous. Unwholesome climatic conditions and environmental factors that cause stress on the mind – such as toxins and intoxicants and poor choices or deficiencies in diet – distort the individual's intelligence and memory. Insanity can also be the result of an individual's bad deeds in previous lives, or other pre-existing conditions and ailments. What is interesting to note here is that the ancients attribute causes in some instances to non-human agencies as well, such as the malign gaze of the gods, the curse of elders and seers, the apparition of manes (souls of the deceased), the touch of Gandharvas (heavenly minstrels), seizures by invisible objects (*grahas*), such as demons, and possession by animist spirits (*Susruta-samhita-sutrasthana*, I.74).

Two philosophical points stand out: there is no discourse of the mind (*manas*, the mental faculty) as a distinctive and totally separate entity from the body and its functions, such as sensory-perceptions, emotions, digestion, etc. In other words, the possibility of a Cartesian-style dualism remained forever closed to their thinking (except in some discursively functional sense as in the philosophical Nyaya ontology).[3] Secondly, insanity is not looked upon as something sacred or a "blessing" by the gods, as was the case in the Greek tradition. Nevertheless, a great deal of compassion was shown for those afflicted with such a condition. In sum, mental health and its constituent causes were not attributed to a singular causal chain, as it was then perceived in the West: the wrath of God; kisses of the gods and angels; disease of the body; or derangement of the mind. Rather, a complex set of factors and a multivalenced symptomatology was developed which encompassed religion and the spiritual dimensions as integral to an understanding of the human condition. In the positivist post-Darwinian West, this kind of complexity in thinking on madness had been lost and replaced by one-dimensional modalities and cognitive frames, in which the doctrines of Christianity had a significant role to play, as it had indeed in the pre-Darwinian history.[4]

Indeed, the category of "madness" is worth pondering in this translational context. Sanjeev Jain notes that the term *unmaad*, which is to be found in the earliest known texts, while not directly translating as "madness," was used to describe a number of behaviours, stemming from internal and external causes, such as drug use, or the effects of love or religion: "These perceived causes were

thought to influence the symptoms and guide the treatment."[5] Further, as Kenneth Zysk explains, madness could be caused by transgressions against the gods, or through improper conduct (*unmadditam*), or by interference by the demi-gods or demonic forces (*unmattam; bhutonmada*), which could lead to quite a severe form of insanity.[6] In all, the system of *dosa* classification under various subdivisions encompassed the various forms of insanity as experienced by perturbed individuals. While the exact location of the disease was never so clear, the brain was most certainly not thought of as the most likely or favoured site – at least this view is not be found in *Caraka-samhita*.[7] Rather, the traces of the condition seemed diffused across the nerve-centres and blood and humour vessels through which the life-force (*ojas*) and arguably the mind (*manas*) flowed, in consonance with the *dosas*, back and forth to various parts of the body. Any dissonance or disruption within the complex ecology of the fine-tuned life-mind system could result in an altered state of subjective feeling and objective behaviour. Both emotions and passions may abet, or be a by-product of, some heightened or excessive form in the causal *un-mana'adhic-dosa* chain.

Extreme fear, anxiety due to loss, solitary confinement, harassment, a blow to the head, excessive solar exposure, and various such physical and extra-material inflictions could precipitate certain kinds and degrees of insanity, ranging from dysfunctional bodily responses, immoral conduct, vociferousness, hysterical outbursts, or just loss of wit.[8] Curiously, there is a conspicuous absence in the traditional descriptions of the subjective experiences where one presents with the external symptoms of insanity. In other words, the kinds of phenomenological analyses that were being developed in the Indian philosophical and literary systems, of the cognitive and conative states (*jnana*, thinking, remembering, doubting, wondering, feeling, imagining, etc), and the aesthetic and musical sensibilities and emotions (*rasa, bhava, dhvani, svara*), seem not to have been a forté of the Ayurvedic *dosa* pathology.[9] It would take a millennium for this deeper phenomenology of the mind to enter into the Indian medical system. Some will want to argue that perhaps it did: for the reason that the insane were considered to be lower than all caste groups; and physicians were advised not to treat them as they were essentially incurable and thus brought ill-fame to the profession.

As to the prognosis and treatment regime prescribed, it seemed logical that these depended on the exactness of the diagnosis of symptoms proportionate to the intersections of *dosas, bhutas, ojas, manas* (humours, elements, bile, life-force, mind, etc.). The treatment could simply be somatic (body treatments, herbal bath), or physiological (internal organ medication), or it could extend to psychotherapeutic (hypnotic meditation, yoga, *guru-chela* analysis) or indeed ritual-spiritual (prayer, sacrifice, surgical exorcism).

The Islamic interlude

Islamic medicine arrived in India with the advent of the Muslims who began their approach into India from Sind in the eighth century. They brought with them a unique amalgamation of medical traditions that the Arabs had developed from the Greek and Latin systems of Hippocrates and Galen, together with Arabic medical techniques, such as those developed by Ibn Sina (Avicenna, 980-1037 CE) who, in turn, deeply influenced European medicinal traditions. Once in India, Muslim scholars incorporated certain traditional Brahmanical medicinal

theories into their own systems. Some Indian philosophical works along with medical treatises were translated from Sanskrit into Persian. At least, to this extent, the systems of Caraka, Susruta, and Vagabhata were preserved. One spectacular innovation that the Muslims introduced was the system of hospitals, modelled, most likely, on the earlier Egyptian hospital known as *bimaristans* (the "house of ill health") which provided asylum-like shelter and care for the mentally ill.[10] As Jain notes:

> From the very beginning of the Muslim influence in India, hospitals became an important part of the state. Firoz Tughlak, one of the early rulers, took a keen interest in medicine. . . . During his period, there were already 70 public hospitals in Delhi.[11]

Muslim scholars questioned the prevalent Hindu beliefs of demonic possession as such superstitions presented difficulties in treating patients themselves possessed by such beliefs. The Muslim elite had its own system of medicine known as Unani and within its contours there was a more rational approach to mental ill-health influenced by Galen. But folk Muslims held their own superstitious beliefs in possession by *jinns* (spirits, ghosts) and similar disturbances that affected a person physically as well as mentally. And they took recourse to *hakims* (charm-priests) and herbalists for remedial relief from such ill-understood ailments.

Asylums and incarceration

The first recorded institution for the mentally afflicted in human history was the *morotrophium* or house for lunatics in Byzantine in the fourth century CE. A similar institution, where ailing patients were cared for by monks, was in existence in Jerusalem in 491 CE. The Arab world is also said to have had asylums in the seventh century as noted earlier, and it is believed there were places of refuge for the mentally ill in England before 700 CE.[12] Britain and Europe were slower to evolve in their methods of care for the mentally ill. The Hospital of St. Mary of Bethlehem in London, the oldest hospital in Europe dating back to 1247, started taking mentally afflicted patients in 1377 and became a lunatic asylum in 1547. The hospital became known as Bedlam and "treatment" revolved entirely around restraint by manacle, iron chains and stocks. The least harmful lunatics were allowed to wander free to beg for alms wearing a badge and a tin plate on their left arm; however, permission to beg was sometimes exploited by the sane. Patients at Bedlam were put on display for public amusement and a viewing area was even developed for fee-paying voyeurs.[13] Stories of the insane being left naked and locked in cells more akin to imprisonment than hospitalization, with only straw matting soaked in their own excreta, abound.

The situation was turned around in England by the efforts of a wealthy Quaker, William Tuke, who was horrified when discovering the appalling conditions in an asylum in York where thirteen naked women were discovered to be confined within a cell measuring eight feet on each side.[14] He canvassed the authorities until something was done to alleviate the patients' misery. Tuke proposed an alternative in 1792 to the Society of Friends, an institution for the insane where "a milder and more appropriate system of treatment than that usually practised might be adopted."[15] This led to the opening of the York Retreat in 1792 by

Tuke, where patients were allowed to work and exercise in the garden. In 1813 a paper, "A Description of the Retreat," was published to inform the public of the benefits of Tuke's improved care of the insane. The York asylum was defensive of the implied criticism which subsequently prompted an investigation. Before this could take place, however, the most controversial part of the asylum was curiously destroyed by fire. As a consequence, the House of Commons established an inquiry into madhouses in 1814 and its report the following year was damning. Reform was slow and a "Commissioners of Lunacy of England" report in 1848 still found that medieval-style horrors were taking place in English asylums.

Meanwhile, even going back couple of centuries, there were "madhouses" aplenty across Europe, but Europeans took longer to establish hospitals for the mentally ill. Although reforms of the Parisian madhouses Bicétre and Salpétriére occurred under Philippe Pinel around 1790s – coinciding with Tuke's reforms – continental Europe was a little slower. A certain Enlightenment teleology undergirded these reforms. Although Foucault, writing in *Madness and Civilization,* exaggerates when he argues that Pinel's work at Bicétre and the Tuke retreat at York, rather than liberating the insane, subjected them to further incarceration under the yoke of Reason (against the Unreason of the Dark Ages and of the Renaissance). In other words, the reforms were simply an extended form of societal control characteristic of the modern world. At least in Germany, the reforms had certain humane and humanizing trajectories.[17]

The first reformed hospices in Germany date from around 1802, such as the Eberbach asylum, founded in 1815 following the "moral turn" in psychiatric care that swept across Europe and North America.[18] Hence, "the sixteenth and seventeenth centuries saw large-scale institutionalization of those considered lunatic along with rogues, vagabonds and disorderly persons."[19] It was not until the nineteenth century that compassion and moral concern entered the care of the mentally ill, corresponding with the nascent science of psychiatry.

British medical interventions in Mysore State

In the eighteenth century Bangalore had formed part of the Princely State of Mysore. Under the rule of the tenacious Haidar Ali and later his avidly anti-Anglo-Saxon son, Tipu Sultan, Mysore repelled the British invaders with a determined resistance.[20] After their fourth battle with the British, however, Tipu finally succumbed in 1799. He was killed and, to Britain's relief, removed as an obstacle to their designs on the southern peninsula. The British negotiated the ascendance to rule of an earlier, and more pliable, head of state from the Wodeyar dynasty. Bangalore's comparatively clement weather was particularly attractive to the Northern Hemisphere constitution and the British established a cantonment there, which included elaborate hospitals for the care of both European cavalry and infantry, and Indian soldiers and civilians.[21]

From 1831 to 1881 the city of Bangalore came under the administration of British Commissioner, Sir Mark Cubbon. Unlike other parts of British-occupied India, however, Mysore enjoyed a more egalitarian relationship with the coloniers and Britain's administration ended in 1881. Bangalore then reverted to the administrative rule of the Maharajah and came under the jurisdiction of the Kingdom of Mysore.

The Bangalore Lunatic Asylum[22] was founded in 1847 during Commissioner

Cubbon's period of administration, some ten years prior to the War of Independence (or Indian Mutiny) of 1857 which precipitated the East India Company's cession to the direct governance of the British Crown. The battle of 1857 irrevocably altered the British-Indian relationship, with Britain resolving to subdue the "natives" and reinforce its sovereignty. Its control over the Kingdom of Mysore, however, remained ambiguous.

The Government Mental Hospital (*née* Bangalore Lunatic Asylum), which predated this shift and the more insistent assertion of the British Raj elsewhere, makes it somewhat distinct from similar institutions which were established post-1858. The asylum evolved from the work of Dr Charles Irving Smith, a British medical practitioner whose clinical practice in Bangalore commenced in 1833 at the Hospital for Soldiers, Peons and Paupers.[23] Smith also attended to Commissioner Cubbon and patients in the surrounding district. He wrote in his diary: "In 1838 with the sanction of the Commissioner I opened a ward for insane native patients (male) and the following year another for females;"[24] and it was out of this segregation of the mentally ill that an independent facility was established for them in Bangalore.

James Mills identifies four main periods in the development of psychiatry in India, namely: 1795 to 1857, 1858 to 1914, 1914 to 1947 and 1947 to the present. The Bangalore Lunatic Asylum (Government Mental Hospital after 1924) falls into the first phase; however, it is not until the second phase that he considers that "the foundations of modern psychiatry were laid in India."[25] It can, therefore, be reasonably presupposed that the work of Smith – and Cubbon's consequent approval to establish an asylum – was quite progressive.

While modern psychiatry in the period 1795 to 1857 was very much in its infancy in India, as elsewhere, Smith's work in Bangalore reflected more than an exercise in punitive or social isolation of the mentally ill. His cerebral autopsies and clinical findings suggest a rigorous scientific and pathological approach to mental disease.[26] The Bangalore Lunatic Asylum in the Kingdom of Mysore was, from its inception, at the forefront of the medicalization and institutionalization of the mentally ill in India, but in so doing it recreated a *vraisemblant* or simulacrum of similar de-mystification with concurrent biologization of madness in medieval Europe as it came under the sharp gaze of the Enlightenment and the machinations of modernity.

Asylum culture in India

While the advent of the British administrative and institutional systems had a considerable role to play in further developing treatment of the mentally ill, it is a general fact that "the growth of asylums in India from 1793 to 1900 could be viewed simply as a diffusion of ideas from one culture to the other."[27] European doctors had often been in close proximity to, and even worked in partnership with, Indian practitioners of Ayurveda and indigenous or folk medicinal dispensers (*vaidyas, munis, hakims*). Garcia de Orta (1502-68), a Portuguese Jewish physician, naturalist and pioneer of tropical medicine, sailed for India in 1534. In 1538, he settled in Goa, where he was physician to Burhan Shah I of the Nizam Shahi dynasty of Ahmadnagar, and concurrently to several successive Portuguese Viceroys and governors of Goa. In the same vein, Portuguese physicians and naturalists contributed services to the mentally ill in asylums

established during the reign of Alauddin Khilji in the sixteenth century. That kind of exchange provided a significant foreground for India's receptivity to Enlightenment ideas and Europe's own evolving medical knowledge-systems. However, the complete "westernization" of the Indian medical system did not register until the middle of the nineteenth century. Indeed, the degree of European medical influence in India proceeded piecemeal and intermittently, and it paralleled the trajectory of European determination to colonize not just the land, but the mind too.

The first "lunatic asylum" was opened in Calcutta in 1787-88. A succinct account of this era and the circumstances surrounding the establishment of the asylum and similar institutions is given by S.D. Sharma:

> After Lord Clive, it was during 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. It was during his rule that reference to the first mental 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 remnants of this building are still to be found at Shyamal Das Chakravarty Road and is known as the "Paghla Ghar building" (house of lunatics).[28]

While the East India Company banned these asylums from its territories, nevertheless it encouraged newer services. Hence, similar privately serviced hospitals followed in Bombay and Madras. The asylum in Madras was ordered to be built in 1793 on fee-free land leased from the Company as long as it remained for public use. Valentine Conolly took charge of this asylum, but then "privatized" it and began to pay rent.[29] This was sold some years later to become Daltons Madhouse, a memorial to which stands to this day.[30] Again in Calcutta, separate facilities for those the British considered insane had been created since 1795 when the Commander in Chief of the Bengal Army requested, and was granted, a house for "mad sepoys."[31]

Then in 1802 the East India Company decreed to establish asylums for criminals and insane Indians.[32] This continued into the 1820s, and separate services for the English were also established. The local governing directorates of the Company secured similar institutions in the districts of the Madras Presidency and also a small one in Colaba, Bombay. But the conditions in these asylums were not the most optimal. Despite the care and kindness of the best among the staff, some patients would refuse to accept food from the hands of Europeans, consideraing them to be "untouchables" (*mleccha*).[33] As described, Commissioner Cubbon had instigated separate wards for patients diagnosed with mania in the burgeoning hospitals in Mysore State in 1838-39. By 1848, the

wards were transformed into asylums where resident doctors continued to investigate brain debility as the major cause of mental illness, pre-empting the rise of Cartesian organic psychiatry. Twenty-nine "lunatic" asylums were established in nineteenth-century India,[34] sixteen of which mushroomed in the 1860s and 1870s[35] as Britain sought to administratively and institutionally secure the jewel in the Victorian crown after 1857.

Although the East India Company's administration was replaced by direct sovereign rule under the British Crown in 1857, the situation did not change considerably but for a sizeable increase in the number of hospitals established. The 1871 Census listed 2,980 persons as "insane" in Mysore State alone, across the social spectrum.[36] The Indian Lunacy Act of 1912 required specialist doctors trained in psychiatry to be posted in the hospitals, and the hospitals came under the charge of civil surgeons rather than police superintendent. This brought about some change in the attitude within the institutions, spearheaded particularly in the Central European Hospital in Ranchi. In 1920 the government recommended a change in the name from lunatic asylums to hospitals. Gradually, Indian doctors and custodial carers were trained to operate the asylums. By the 1920s also, local doctors underwent training in England, in the renowned institutions of Bethlehem and the Maudsley. While Maudsley's own influence extended to Australia, his impact in India was far greater, leading to the founding of the All India Institute of Mental Health in Mysore State in the mid-1950s. The Institute, modelled on the Maudsley, was attached to the Bangalore Mental Hospital and was the precursor to the National Institute of Mental Health and Neurosciences (NIMHANS). This came about after Prof Dr Edward Mapother, a visiting psychiatrist from the Institute of Psychiatry and Superintendent of the Maudsley Hospital in the U.K., made a damning comparison between psychiatric services in London and India in his report dated 1938. The demand for beds for the psychiatrically challenged exceeded those provided. Despite the provision of buildings for the hospital, beds were not provided until the 1960s and services remained sporadic and rather paltry by British and European standards. The situation was not any better at the parallel mental hospital in Madras, where the questionable methods mentioned earlier continued. Mapother's recommendations, based on a comparative scale of "badness" *inter-alia* of the services provided, were geared toward a more professional and medically-informed reorganiation of services. Another such set of extensive recommendations, which reinforced Mapother's recommendations, was issued by Col. M. Taylor in 1946, one year before India's independence from British rule, and which served as the framework for the suggestions for reforms in health services as outline by the Bhore Committee, which was to be implemented post-Independence.[37]

It should be noted, however, that the British authorities also imposed an overly legalistic framework on the diagnosed condition. The 1858 Indian Lunacy Asylum Act paved the way for this approach, and the 1906 and 1912 Indian Lunacy Acts reinforced the criminality of the mentally ill as decreed in the Penal Code adopted in the previous century. The practice echoed British Common Law and early nineteenth century categories and nosology of mental illness.

Native and European forms of Insanity

Initially, the resident British authorities did not distinguish between the

nosologies of the native and those of the expatriate, although diagnoses used varied across both the groups for example, they introduced categories of moral insanity, female alcoholism, hysteria, and delirium ("tropo"), for expatriates, most of whom were subsequently repatriated to their home country. It baffled the authorities that the native patient diagnosed with mania or other mental disorders appeared to respond remarkably well to the prognostic treatment, and that the ambient support from the extended community and local healers complemented rather than interfered with the treatment. A study of the tension between the two classes of diagnosis will significantly enhance our understanding of how culture-bound the colonial conception of mental illness proved to be. The socio-demographic patterns of the patients, taking into account variables of class, caste, region, linguistic and gender differences, can be discerned from case notes and hospital records from the earliest period of British intervention in this area of health control, as well as from private diary entries of doctors, specialist or community-based private hospital records, and recorded oral narratives. This history will need to be read against the grain or overt textuality of the official records.

Why were *anmanaa*, mania, rabidity and hysteria (*unmaada*) singled out as the pervasive maladies, especially, among natives in colonial India? One could argue that a particular construction of the mental state of the "other" was a necessary ruse in the colonial subjugation of the native.[38] Although this contention is debated, the cross-cultural work of A. Kleinman *et al.* on cultural variations of affective disorders based on the Malaysian experience of "amok," and Japanese notions of *amae*, strongly underscore the cultural context of psychiatric diagnosis. Recent debates in psychiatry and cultural anthropology have influenced re-designation of culture-bound syndromes, notably in DSM-IV, inclusive of a handful of South Asian categories.[39]

The role of colonialism

A question related to an issue raised in the earlier section is: how has the European model of mental health and the legacy of colonial practices in the subcontinent impacted on, continued to influence, or alternatively constrain, local Indian responses to mental illness?[40] We shall continue with this part of the story.

One school of (sceptical) thought has it that, first, the treatment of the mentally ill moved towards becoming an instrument of the British Government's medical administration and hence the segregation of the mentally diseased gradually found the ideal habitat within modernity's favourite structure – the *institution.* Second, the patronage of the institution(s) gradually moved under the generous and able hands of local Indian Dewans and doctors. We revisit the founding of the Bangalore Asylum with these questions in mind to demonstrate that the motivations and intentions of British intervention, at least in the context of the Maharaja of Mysore's fiefdom, was somewhat to the contrary.

The Mysore syndrome

As noted earlier, it was in 1847-48, when the East India Company was still Britain's operative force in India, that The Bangalore Lunatic Asylum[41] was founded in Mysore.[42] In 1850, a jail was added to the asylum, and subsequently a new building was constructed on an elevation near a large lake, the Dharmambudi Tanki

(which today houses the headquarters of the Mysore Bank). The site was chosen in accordance with ideas at that time which found most public facilities (poor-houses, asylums, etc.) situated on elevations so that drains could be cut, and a supply of fresh water could be maintained. Although the bacterial origins of disease had not been established, the link between sewage and health was suspected. The banks of the Dharmambudi Tank thus boasted a jail, an asylum, a tuberculosis sanatorium, and on the other side, the lepers' home. Of this, only the TB dispensary remained (which too was demolished in 2005 to make space for a shopping mall), while the asylum building was sold to the State of Mysore and the lands auctioned in the 1930s. The property is very fondly described in personal reminiscences as an orchard full of trees stretching almost all the way to the lake.

The asylum offered accommodation for 260 patients, at 50 superficial feet per person. The buildings were described as simple but airy. The annual reports repeatedly emphasized the importance of moral influence. The dreary misery was enlivened by amusements suited to the patients' condition and capacity. Work was emphasized, and a number of opportunities like gardening, rope weaving and domestic work were offered.

Food was carefully cooked and sufficiently varied. Expenses for Natives and Eurasians were separately calculated. Popular or "bazaar medicines" were used, which indicates that European doctors of the day were not averse to using folk and native medicines. The asylum was managed by doctors from the Indian Medical Service with a number of Indian assistants. After the transfer of power to the Kingdom of Mysore, it became the only asylum that was supported by a "native" kingdom.

Overcrowding became evident very soon after the asylum's establishment and staff shortages were always a problem. Dr. Oswald, one of the doctors of the asylum 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 only two temporary peons for 100 patients.[43] The seriousness with which this complaint was viewed is reflected in the fact that the Viceroy sanctioned the said posts as early as June 1868.

It was observed in 1872 that a large number of paupers were being admitted for humane reasons. Patients' 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. Diagnoses and methods of care were consistent with those in use in asylums in England at the time, as revealed in the NIMHANS medical records, where a close congruence to classification used in England are found. In the early part of the nineteenth century, infections, intoxicants and injury were considered important causes of insanity. Although the bulk of the patients were classified as suffering from one form of mania or another, there were a few (mainly Europeans) diagnosed with "moral insanity." By the end of the century, it was specifically recommended that future medical care follow western models in the Kingdom of Mysore.

In Mysore State's 1871 census, 2,980 people (0.058 per cent of the population) were listed as insane. A decade later, in 1881, this had fallen dramatically – by 70 per cent – to 0.018 per cent due to the great famine of 1876-78 which killed 20 per cent of the population. At the time of rendition in 1881, an elaborate status

paper on the condition and future of health services was prepared. This included suggestions for a larger mental hospital, as the population was expected to increase from one lakh to considerably more. The western medical system was to be followed, as there was no other system to replace it, though the lack of trained personnel to manage the hospitals was keenly felt.

Analysis of hospital records from the first half of the twentieth century, indicate steady changes in the description of psychopathology, methods of diagnosis, and treatment practice. These were indicative of the rapid spread of ideas and technologies in psychiatry. The need for reforms, improvements in professional standards and for specialists was recognized, and so doctors were sent to the United Kingdom for training. However, at the same time, concerns were voiced about the need to develop more locally relevant models. Given the caste rigidities in Indian society, it was felt that it might soon be necessary to provide additional accommodation based on caste, but it was also felt that this should be done without prejudicing the interests of those Indians who were of European temperament, including Eurasians. These changes were slow to execute but by 1913, European wards (for women only), as well as wards for Brahmin women, were established at the asylum. Separate cooks were also provided for Brahmin, Lingayat (another caste group) and the others.

While a gradual increase in the number of patients led to additional wards being constructed, by 1914 no further expansion was possible. The asylum now accommodated 200 patients, including 27 Europeans and Eurasians, and the number of admissions continued to increase every year so that by the second decade of the twentieth century there more than 100 admissions every year. By 1920, the asylum was run exclusively by Indians to whom it was evident that "a new building for the Lunatic Asylum is absolutely necessary . . . there will have to be specialists in nervous diseases."[44] In February 1920, the Maharaja approved the decision to construct a new asylum. Two locations – Basavanagudi in Bangalore and Huikal in Mysore – were suggested, however, all action was deferred until the designs were ready and sufficient funds were available. Finally a hillock south of Lal Bagh was chosen as the site for the new, sprawling asylum, which would house 400 to 500 patients, serving the needs of the entire Mysore Kingdom. Around this time, many doctors from the Indian Medical Service were sent to Britain to train in the newly formed Department of Psychiatry at Maudsley. In 1921, Dr Frank Noronha was deputed by the State Government to London for higher studies in mental disease. On completion of his postgraduate Diploma in Psychological Medicine (DPM) he returned to Bangalore and in June 1922 was appointed Superintendent of the new Mental Hospital, a term that in 1924 replaced the rather insensitive and outmoded "Lunatic Asylum." Dr Noronha was joined a few years later by Dr M.V. Govindaswamy, who had also studied at Maudsley and at John Hopkins University in the USA. Govindaswamy became the superintendent after Dr Noronha's retirement in 1935 and remained in this position until 1959.

Upon his return to India, Dr Govindaswamy became actively involved in research. He began using cardiazol-induced convulsions, insulin coma, and later, psychosurgery, almost as soon as these were available in Europe. 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. In 1936, the erection of a new Mental Hospital was sanctioned by the Dewan of Mysore, Sir Mirza M. Ismail K. C.I.E., O.B.E. (generously endowed with the titular ornaments of Empire) who, like many of his similarly decorated counterparts, was keen to see India merge with modernity. But it was under Dr Govindaswamy's leadership that the Bangalore Mental Hospital became what Dr Mapother, a pioneer in British Psychiatry (we mentioned earlier) would describe as "a monument to the vision and wisdom of all those responsible for the mental defectives in the East."[45]

The new hospital was designed to accommodate 300 patients – 200 men and 100 women – and included cottages for "well to do patients." Both Indian and European styles of bathrooms were fitted to suit all patients. The booklet outlining the project in 1938 stated that: "The aim of the Mental Hospital must be, not merely the protection of Society, but also the protection of the patient."[46] By the late 1930s, under Superintendent M.V. Govindaswamy, modern treatments had been adopted at the Bangalore Mental Hospital within the contemporary medical structure. Perfectly innocuous measures such as occupational therapy were implemented, through to rather more risky procedures such as pre-frontal leucotomy and still scientifically evolving remedies such as cardiazol and insulin shock treatment. Govindaswamy acknowledged that the nutritional anaemia and vitamin deficiency often leading to the mental ailment in indigenous patients rendered them too weak for shock treatments, which could be fatal.[47] This suggests yet another area in which indigenous Indians were possibly unsuited at that time to full exposure to, and integration within, medical scientific technology and a modern institutional structure, particularly at a time of acute physical, mental and emotional vulnerability.

Dr William (Willi) Mayer-Gross, who strongly influenced the intellectual growth of psychiatry in the last half century, was invited to India to advise on mental health reform in 1951-52, and then again in 1956-57. He spent these years at Bangalore Hospital, and while there, planned the course material for the training of psychiatrists. He confessed that many of his notions of psychiatry had been dramatically altered by his experience in India. His work at Bangalore was described as fitting recognition of his attempt to forge a synthesis between the German school and British empiricism. This unique lead in pioneering mental healthcare resulted in the establishment of the All India Institute of Mental Health in 1954, renamed NIMHANS in 1974. This subsequently became the first post-graduate training facility in independent India, and continues to play an important role in the development of psychiatry in the country.

Hybridity, science and legal reform

On a visit to Bangalore in 1927 when he expressed concerns for villagers exposed to modern scientific practices, Gandhi asked the Indian Institute of Science:

> How will you infect the people of the villages with your scientific knowledge? Are you then learning science in terms of the villages and will you be so handy and so practical that the knowledge that you derive in a college so magnificently put and I believe so magnificently equipped – you will be able to benefit the villagers?[48]

Gandhi's views on science might have seemed frustratingly conservative in the 1920s and 1930s, a time of simmering preoccupation with ending British rule. Amid the rush for independence caution to ensure rational and sympathetic integration of modernity and tradition appeared to simply entail a deceleration of the coveted outcome. While science was undoubtedly a powerful instrument of Empire, which Gyan Prakash explores in *Another Reason: Science and the Imagination of Modern India,* as a hybrid form intertwined with indigenous forms of knowledge, it did not serve well as an instrument of independence. The enthusiastic uptake of modern medical practice continued to be stymied after independence by a lack of resources and expertise to implement its full application.

As the humane treatment of the insane became institutionalized and influenced by technology at the end of the nineteenth century, modern training schools began to appear in England. In 1882 training was organized at the McLean Hospital and a certificate "for proficiency in nursing" was awarded by the Medico-Psychological Association in 1897.[49] Yet half a century later in the 1950s, Govindaswamy was lamenting the fact that "systematic clinical and theoretical training is nowhere given" in India due to a lack of well-qualified mental specialists and that "examination to the standard of DPM or MD is out of the question."[50] Despite the structural façade of modernity and the establishment of organizations such as Girindrasekhar Bose's Indian Psychoanalytic Society in 1921,[51] no institute of applied psychology existed which included training in aspects of psychiatry. The immediate institution of such a training institution in India had been recommended to the Central Government by the Indian Science Congress, which concluded its sessions in Bangalore in 1946, but little progress had been made by the following decade.

Traditionally, science as it is perceived in the West and East reflects two, apparently irreconcilable, philosophical natures. Within Western Christian thinking, science is dualistic (*dvaita*) – modernired, institutionalized, empirical, detached, synthetic, compartmentalized and incompatible with divinity. Hindu non-dualism (*advaita*) philosophy, on the other hand, is ancient, intuitive, ritualistic, organic, holistic and spiritually integrated. Although Bose was at the forefront of Freudian psychoanalysis in 1920s and 1930s India, he was not a pure empiricist. As a young general practitioner he was influenced by an early fascination with yoga, hypnosis and magic rather than a purely Western medical inclination. Ashis Nandy suggests Bose's move towards psychoanalysis reflected an Indian fascination with omniscience,[52] rather unlike Freud whose early years as a neurologist set him firmly within empirical scientific parameters. Freud was a neurologist, and his theory takes a *mechanistic* form such as one might expect from a neurologist of the nineteenth century; and it was based on the *dualistic* approach to body and mind which was universal in Continental psychiatry at the time. This unresolved dualism is, even now, the greatest source of weakness in Freudian theory.[53] In any case, Govindaswamy, trained as he was in both the Hindu scriptures and modern biology, found the whole edifice of analysis, a "strain on one's credulity;" an opinion perhaps shared by several of the contemporary practitioners and teachers in mid-twentieth century India (including, one might add, the Heidelberg School of Jaspers and Mayer-Gross).

Europe's towering surety of its own dominion over rationality saw Indians dismissed as unsuited to anything but applied science, or at worst, found ways to diminish their efforts as novelty. Should indigenous scientists in pre-independence India wish to be embraced by their international colleagues, engagement on strictly Western terms was mandatory. The three decades leading up to independence in 1947 were marked by a fixation with ending British rule which, over just two centuries, superimposed what epitomized the modern, culturally dysfunctional colony, over an ancient, yet well-preserved, civilization. The fixation included a desire, and a belief in its ability, to become a fully functional modern nation-state, embracing all the technological trappings of the West.

India is still beleaguered by eighteenth and nineteenth century colonial attitudes to mental illness/disability and cultural "deviancy" judged from within the parameters of British-European patterns of acceptable social behaviour. In particular, the social upheaval during the partition of India into two major nations witnessed a substantial increase in mental illness out of sheer dislocation, dispossession, and dishonour. Added to this was the psychologically debilitating prospect of long-term unemployment, particularly among those on the move. Records of the extent of suffering under these circumstances only remain in oral history of women survivors on all three sides of the partitions, which present-day feminist activists in India, Pakistan and Bangladesh have begun to systematically document.

The National Mental Health Policy of 1986 and the ensuing Mental Health Act of 1987, which supposedly brings up-to-date the 1912 Lunacy Act in line with contemporary psychiatry, still fail to make clear distinctions between madness, insanity and criminality, and mental retardation. Thus the West Bengal High Court in 1992 identified 1,250 mentally ill patients confined under lunacy ordinances alongside criminal offenders. The Bench emphasized the fundamental rights of every citizen to physical and mental health, and ordered the state to upgrade psychiatric services and integrate mental health with primary healthcare provisions.[54] Elsewhere, ethical concerns about malpractice in psychiatric institutions are reported by women's group, NGOs and investigative journalists.

As Ratnaboli Ray points out in his shocking discussion paper on the current state of "care" for the mentally ill in West Bengal,[55] patients are literally left to languish in appalling conditions. Visiting facilities for family and friends, for example, are not provided, with nil visiting hours, visiting rooms or access towards by concerned relatives. Visitors must talk to their loved ones through bars, again reinforcing the association of mental disease with criminality. Harking back to the dark days exposed by Tuke in eighteenth-century Britain, no rehabilitation facilities are offered to patients and no privacy is extended to those interred, except when they are placed in an isolation cell. The state, Ray observes, continues its withdrawal from the social sector and it is left to civil society to step in and take up the cause for basic human rights as enshrined in the UN Declaration, to which India is a signatory. While the civil lobby to overhaul the national policy on "lunacy" is strong in India, neither its Supreme Court nor Parliament has yet moved to strike down the Lunacy Act in its basic presupposition and purview as mentioned earlier. There are also a number of NGOs and voluntary groups

comprising psychiatrists, psychologists and nurses, attempting to set up alternative hospices and psychiatric care centres so that those individuals with symptoms of mental illness, or the onset of advanced infirmity, can be saved from confinement in rundown asylums, or worse, in prisons.

A substantial amount of work in both conceptual and policy management areas, with a keen interest in the ethical issues arising from either the neglect altogether of mental illness (or its classification under other reductive social categories, despite DSM-III) or the over diagnosis of symptoms (as well as over-prescription of drugs and the therapy-syndrome) remains to be done in India. Of course, the lingering burden of colonial perceptions of Indian society and the psychological constitution of its people – or its "Indianness" as coined by Berkeley-Hill and Daly – the traditionally inscribed approaches to healthcare languish. Ayurveda, Unani, Siddhic, shamanic, homoeopathic, herbal, tantra, yoga and such practices, alongside the codes of ethics set out in the ancient *Caraka-samhita* texts are, by and large, overlooked in preference for modernity as the medical "holy grail." Pockets of India's medical profession have sought to embrace Ayurveda practice, as Bangalore Mental Hospital's Govindaswamy himself advocated in the 1950s. He believed that the glory of Ayurveda lay in the fact that it was the first medical system to emphasize the psychosomatic aspects of medicine, as similarly recognized by Hippocrates. Govindaswamy was keen to see psychological medicine pioneered by India, through "a coherent system of interpretive psychiatry" which would "throw light on the psychological problems peculiar to India."[56] However, at the same time, Govindaswamy warned against a simplistic return to the practice of Avurveda as a prescriptive medium; rather he advocated a return to the First Principles based on Indian philosophy to define psychopathology and to learn more effectively from that basis.

Discussions between the Indian Medical Council and government health authorities are now evaluating the extent to which Ayurveda should be taught in medical colleges and the degree of Accreditation that should be applied to Ayurvedic training alongside all the requisite funding, rebates and powers in parity with those available to the allopathic guilds. The one danger of this trajectory is that it leads to the creation of a cheapened, multi-tiered system of care with a substantive lack of transparency, as the two systems are based on quite different premises.

Conclusion

Bangalore in the eighteenth century was part of the princely state of Mysore. Under the rule of Haidar Ali and later his son, Tipu Sultan, Mysore repelled the British invaders.[57] After 1799, he was killed. The British negotiated the new head of state from the Wodeyar dynasty. Bangalore was particularly attractive to the constitution and the British established a cantonment there, which included elaborate hospitals for the care of both European cavalry and infantry, and Indian soldiers and civilians.[58] The Bangalore Lunatic Asylum was founded in 1847 during Commissioner Mark Cubbon's period of administration, some ten years after the Indian Mutiny of 1857. Separate facilities for those considered insane had been created since 1795 when the Commander-in-Chief of the Bengal Army requested, and was granted, a house for "mad sepoys." Twenty-nine "lunatic" asylums were subsequently established in nineteenth-century India, sixteen of

which emerged in the 1860-70s as Britain sought to secure the jewel in Queen Victoria's crown. While modern psychiatry in the period 1795 to 1857 was very much in its infancy in India, as elsewhere, British intervention in Bangalore reflected more than an exercise in punitive or social isolation of the mentally ill. The Bangalore Lunatic Asylum was at the forefront of the medicalisation and institutionalisation of the mentally ill in India, but it also recreated a simulacrum of similar de-mystification with biologisation of madness in medieval Europe as it came under the sharp gaze of the Enlightenment and the advent of modernity.

Through the eighteenth and nineteenth centuries, science's preoccupation with classification evolved into an intricate fusion of medicalisation and institutionalisation, or simply science and state as "hand-in-glove," which struggled to similarly fuse "East-West" notions of utility and ethics, empiricism and intuition, modernity and tradition. Indigenous practices drawing on Ayurveda, Caraka-Susruta, Unani, Yoga-Siddha, Jaina non-injury and Buddhist *karuna* (compassion/empathy) responses might now be re-considered, not only for their contemporary and future efficacy, but examined for their impact (or otherwise) during the transition to independence and why these customary practices were allowed to recede from the public health domain. While the line of demarcation and the blending of contemporary thinking with traditional mores and practices remain blurred, it is observed at the same time as the phenomenon of 'mental illness' becomes increasingly medicalised, "mental well-being" continues to draw significantly from the past and from other divergent resources.

More broadly in the ethical domain, as India's medical predicament deepens, falling further into the moral abyss created by the east-west economic divide, a sense of urgency prevails in defining an indigenous psychiatric and biomedical discourse. This imperative we have highlighted in case studies elsewhere specifically in relation to madness, its alienation, individuation, criminalization, incarceration, desocialisation in British India and in the ex-colonial contexts. The issues raised speak unequivocally of India's medical despair, a system displaced by the dominance of science and techno-culture spawned by colonialism and the façade of modernity, which has left in its wake a wrecked public health system. This is an insufferable state of affairs.

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7. Jain (op. cit.)mentions one *Bhela-samhita* text that postulates the *manas* as located in the head, and insanity is caused by alternations in the *buddhi* and *citta* (intellect and conscious processes).
8. See references in Jain pp. 5, 7. (Note them all from his Further Recommended References at end.)
9. Jain (in ibid.) cites Jadunath Sinha on this lacuna. See also infra, n. 32.
10. Jain, op. cit., p. 7, *bimari* literally means "illness;" though the word *aspatal*, from the English "hospital" has replaced the Urdu/Arabic word for such places of care and treatment.
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