

European Madness and Gender in Nineteenth-century British India

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SUMMARY. The aim of this article is to explore whether gender was a linchpin in the construction of Europeans' mental health in nineteenth-century British India. A relational model of gender will be employed which places emphasis on the complementarity of men's and women's mental problems within the socio-economic, political and cultural confines of nineteenth-century colonialism. The postulate of a 'female malady' which has been promulgated in recent accounts of women's mental health will be shown to be inapplicable in the context of the *raj*. Instead a reading of the history of mental health in nineteenth-century British India will be suggested which sees different kinds of 'madness' coexisting alongside each other, merely incorporating assumptions about gender relations rather than exemplifying any one exclusively female construct of 'madness'. The primary sources will be female and male patients' case stories and statistics produced in European lunatic asylums in India and England.

KEYWORDS: Gender, colonialism, mental health, race, social class, empire, military life, lunatic asylums, Victorian Britain, British India.

I

Joanah K. was 24 years old when she embarked on the *Duke of Buccleuch* for India in 1835.¹ She left her native Ireland at a time of economic depression and human distress, when her husband, James K. of County Meath, was enlisted at the recruitment depot in Cork as a gunner in the 3rd Battalion Artillery in the East India Company's service. Service with the Company during the nineteenth century not only provided an outlet for a burgeoning English middle class, but also appealed to otherwise impoverished English, Scottish, Irish and Welsh unskilled and semi-skilled labourers. Although the heyday of 'unbridled corruption and bribery',² when big fortunes could be made in the East, was supposed to be over, the promise of self-improvement and economic well-being lingered on—if only in the alluring tales of the recruitment sergeants at the Company's depots in the British Isles and Continental Europe. In any case, life in the East was expected by many lower-class people to be no worse than the starvation,

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¹ India Office Records, London (hereafter IOR), Records of Pembroke House and Ealing Lunatic Asylum 1818–1892 (hereafter PELA): Medical Certificates 1843, and Registers of Admissions 1870–1888. [Case of Mrs Joanah K.]. All unreferenced quotes refer to these sources.

² P. Spear, *The Nabobs. A Study of the Social Life of the English in Eighteenth and Nineteenth Century India* (London and Dublin, 1980) [1932, 1963], p. 126.

poverty or the various different regimens of poor law 'support' they faced in Britain.

Joanah was one of few women permitted at that period to accompany their husbands to India, as the East India Company did not in general approve of European female presence in a country which was then not considered to be a place for permanent European settlement.³ Whether Joanah considered herself privileged in this regard is not known. She lived in the regimental married quarters in the Presidency of Madras, on the south-eastern coast of the Indian Peninsula, and managed to bring up three children against the odds of insanitary conditions, endemic disease, epidemics, and within a male-dominated military environment seen to be characterized by vice, sin, and the temptations of drink and tobacco. Yet against these odds Joanah's and James' children and Joanah herself survived well enough, Joanah being 'much attached' to her children.

However, when James died in 1841, Joanah, then only 31 years old, knew that she and her two boys and a girl would be deported back to Ireland by the East India Company, to face an uncertain future without any means of support. Of course there existed the option of marrying one of the many men in the regiment who lined up for the rare chance to acquire a former comrade's widow for a wife. However, Joanah was Catholic, perhaps more piously so than those other widows who overcame their religious and other personal scruples for fear of destitution, and gained quite some reputation by marrying man after man in the same regiment whenever death by disease or combat struck their previous partner.⁴ Joanah preferred to remain a widow, though lingering in 'a distressed state of mind'.

Shortly after the children's Christmas festivities that year Joanah broke down. On the first day of the new year, which promised only the family's repatriation to Ireland, she became 'so manifestly insane as to render it unsafe to leave her at large'. She did not improve within the confines of the barracks and, as there existed no special quarters within the regimental hospital where she could have stayed safely, she was referred to the hospital at Madras. The regimental surgeon who saw her would have been more familiar with soldiers'—mostly temporary—mental breakdowns, and was anyway over-burdened by the task of administering to the physical health of men suffering from a range of endemic diseases.

While at Madras hospital Joanah is reported to have at times spoken 'rationally' and to have conducted herself 'quietly'. Yet she was also frequently 'excited, incoherent, and somewhat violent, complaining of imaginery grievances and insults'. It does not require much empathy and imagination to discern that it may have been perfectly rational for Joanah to complain of certain 'grievances': the lack of economic prospects in her native Ireland, the temporary expatriation

³ On reasons for immigration restrictions and related colonial policies during this period see D. Arnold, 'White Colonization and Labour in Nineteenth-Century India', *Journal of Imperial and Commonwealth History*, 11 (1983), 133–58.

⁴ See Evidence of Sir J. Lawrence, in *Royal Commission on the Sanitary State of the Army in India* (London, 1863), p. 199.

to the East, the difficulty in achieving social advancement within the confines of barrack life, and James' early death all spring easily to mind. Joanah will also almost certainly have experienced her fair share of 'insults' in her six years of barrack life, if not before. However, we lack further information as to whether her grievances and the alleged insults related to her real experience of poverty and bereavement or were of an 'imaginary' nature, indicating mental illness. She may simply have been in the process of coming to terms with a tragic life event. Be that as it may, things soon took a turn for the worse when, by the end of January, she was described as becoming 'taciturn and melancholic taking no notice of any questions addressed to her, and manifesting no interest in her children, to whom she previously appeared to be much attached'.

Her condition did not improve, so the hospital doctors decided after little more than three months to transfer Joanah to the lunatic asylum at Madras. This followed the standard procedure in this province in cases when Europeans did not recover from a mental plight within a reasonable period at the general hospital, and when no private boarding arrangements could easily be made with members of Madras' small European civilian and commercial communities. On admission to the asylum Joanah was 'taciturn and dejected' and she continued in that same state, 'generally appearing to understand what is said to her, but never uttering more than a single word in reply'.

Joanah was to stay at the asylum in Madras for one long year, remaining in her withdrawn state of mind yet generally of 'pretty good' bodily health. With the approach of the next hot season, in April 1843, Joanah was embarked on the *Minerva* together with five other, male, asylum inmates.⁵ One of the men, Sergeant Henry B. of the Madras Ordnance Department and formerly of Margate in Kent, did not live to see his native England. (He died on board ship when, according to the surgeon in charge of the six lunatics, 'effusion took place into the cavities of the Head and Chest'.) On arrival at East India Docks, Privates James B. and William W., who had served in the Royal rather than the East India Company's army, were handed to the care of Her Majesty's authorities, while those who had been employed by or linked with the East India Company were taken by an escort 'furnished by the Troops at the Tower' to 'Pembroke House', a private lunatic asylum near the Triangle at Hackney. 'Pembroke House' had been under the patronage of the East India Company since 1818 and specialized in the treatment of returned Europeans from India until 1870, when Joanah and her fellow inmates, were transferred to the newly established 'Royal India Asylum' at Ealing.⁶ Meanwhile Joanah's children had been sent to the Military Orphan Asylum in Madras. By remaining silent and permanently withdrawing into herself, Mrs K. at least ensured that even in a situation as devoid of prospects for herself and her beloved children as the one

⁵ IOR (PELA): Medical Certificates 1843. [Cases of Henry B., James B., William W.].

⁶ For further details of the history of Pembroke House and the Royal India Asylum see W. Ernst and D. Kantowsky, 'The Records of Pembroke House and Ealing Lunatic Asylum, 1818-1892', *Society*, 22 (1985), 31-9, and W. Ernst, *Mad Tales from the Raj. The European Insane in Nineteenth-Century British India* (London and New York, 1991).

in which she found herself in consequence of her husband's death, they would all be cared for somehow. Joannah remained institutionalized until she died of 'dementia' at the age of 78—just after the Christmas festivities, in December 1890.

What does the above story represent? What might it be taken to tell us? Mrs Joannah K.'s tale is based on reports drawn up by male medical professionals, guided and restrained by the standard administrative requirements typical of the time and specific to the colonial context. The account is therefore, of course, not Joannah's but a perspective which not only incorporates a male stance, but is also embedded in contemporary assumptions on mental illness by the medical profession, and subject to colonial administrative requirements. As such Joannah's story does not constitute the 'patient's view' but tells us necessarily more about male, professional, and administrative views of a woman's mental predicament. For the purpose of this article, however, this caveat does not undermine the analysis. We could, after all, assume a Foucauldian perspective, focusing on Joannah's story as evidence of a trinity of discourses of power: reason's subjugation of unreason, and men's domination of women, set within the wider context of the oppression of the colonized by the colonizers. For this venture, a male, medical and colonial-administrative account provides suitable source material.

Being attuned to gendered social relations, the modern reader will not have found it surprising that Joannah appears to be defined through her husband, from their departure from Ireland (when she 'accompanies' him) to her reception into Pembroke House (rather than into a less salubrious County Asylum as would have been the case had she not been affiliated with a former East India Company employee). In fact the whole story appears congruent with stereotypical notions of Victorian women's lives. We may also suspect that Joannah would have been a highly competent, organized and resourceful person. She had coped well with the difficult circumstances of life in barracks, which were so obviously dominated by a military spirit with its stress on male camaraderie, discipline and adventure.⁷ The bonds of family relations, and young children's uninhibited playfulness and laughter had little scope here, in an environment structurally bereft of the support network of extended family or traditional neighbourly links. Yet we do not learn much about Joannah's motherly strength from the medical report, nor of her capable self-sufficiency, nor of her capacity to cope with adverse situations for six long years. Instead it is merely noted that she coped and remained a loving mother while her husband was alive. It is implied that his death meant her breakdown, that she could only function as a mother 'much attached' to her little children while her man was around.

A cultural association of features of madness and of stereotypical characteristics of femininity would appear to be manifest in Mrs K.'s case. To some extent we could then interpret Joannah's tendency to become 'taciturn', 'melancholic',

⁷ For life in the East India Company's army see D. M. Peers, *Between Mars and Mammon. Colonial Armies and the Garrison State in India, 1819–1835* (London and New York, 1995).

and 'dejected', and 'never uttering more than a single word in reply' as evidence of the type of a—somewhat mature—'crazy Jane', described as incarnating one of the three new female faces of madness developing during the nineteenth century.⁸ According to Showalter 'crazy Jane' was the 'typical inhabitant of nineteenth-century Bedlam, not only the image of madness for women but the model of insanity for men as well'.⁹ Indeed, the account of Joanah's case shares similarities with those of a number of European women admitted to the lunatic asylum in British India. Take Mrs Elizabeth C., the wife of a Quarter-Master Serjeant in a Native Corps in Meerut, Northern India. She, too, was in the prime of life (34 years), when, in 1858, she lost 'all her relatives, including her children, during the mutiny'.¹⁰ Despite some short periods of violent behaviour, she too would be 'very quiet and reserved', and would 'never [speak] unless spoken to'. Like Joanah she would only give very short answers and insist—neatly according with Foucauldian and feminist assumptions about male domination being internalized by women themselves—that her first name was 'Mrs C.', that in fact 'I never had any first name', that 'I have always been Mrs C.', and adding that in Meerut, where her husband and children had been violently wrenched from her, she 'had no name at all'. In this account the Memsahib is reported to define her identity through her husband, so that once he is annihilated even this derived identity vanishes.

Joanah's and Elizabeth's cases would therefore seem to fit in well with received historical and anthropological accounts about 'feminine nature',¹¹ and with received feminist wisdom about women and health promulgated by Chesler, Ehrenreich and English, and Oakley, which suggests that men are seen to have the edge in rationality and self-control, so that the ascribed psychological characteristics of a woman have become synonymous with the image of a mentally unstable if not mentally ill person.¹² In similar vein, Showalter has outlined a historical 'transformation of the face of madness', associated with the spread of Romantic thought, supposed to have been apparent since the 1830s, culminating in a 'feminization of madness' to the extent that 'madness, even when experienced by men, is metaphorically and symbolically represented as feminine: a female malady'.¹³

⁸ E. Showalter, *The Female Malady. Women, Madness, and English Culture, 1830–1980* (New York, 1985).

⁹ Showalter, *The Female Malady*, p. 14.

¹⁰ IOR (PELA): Medical Certificates 1863–1864. [Case of Mrs Elizabeth C.]. For details on the rebellion of 1857 (called 'mutiny' by the British and 'war of independence' by Indian nationalists) see R. C. Majumdar, *The Sepoy Mutiny and the Revolt of 1857* (Calcutta, 1957), F. W. Rawding, *The Rebellion in India, 1857* (Cambridge, 1977), E. Stokes, *The Peasant and the Raj: Studies in Agrarian Society and Peasant Rebellion in Colonial India* (Cambridge, 1978).

¹¹ V. Skultans, *English Madness. Ideas on Insanity 1580–1890* (London, 1979).

¹² P. Chesler, *Women and Madness* (London, 1972), B. Ehrenreich and F. English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (London, 1979), A. Oakley, *Sex, Gender and Society* (London, 1972).

¹³ Showalter, *The Female Malady*, p. 4.

II

Although not all female asylum inmates shared Joana's and Elizabeth's background of bereavement there does appear to have been a tendency in the available reports to focus almost exclusively on female inmates' family circumstances. It seems that a loss in the family could easily be linked up by the male certifying doctors with the onset of madness. Was not a widow, after all, only a woman without her man, an anomalous state which could not but be understood as a factor in mental derangement, especially within a colonial context such as nineteenth-century India where female Europeans had a legitimate identity *only* as wives and daughters and, in exceptional cases, as spinster, teacher, servant, and missionary.

It is one thing to find that mad women in British India were seen in a significant number of cases to have suffered from a, typical female, career-sequence of marriage-husband's death-insanity.¹⁴ Yet it would be quite another thing to postulate this as evidence for the dominance of female images of insanity, and hence for a strong link between women and madness. From the case-reports of female asylum inmates presented so far we can assume only that a number of Mem Sahibs shared similar background histories, characterized by typically female and gendered career-patterns, congruent with wider social stereotypes of women in the nineteenth century. Evidence based on autobiographical and other literary sources also suggests that the image of the grief-stricken widow in the prime of her life, left bereft of male connections and therefore going mad in a supposedly alien, dangerous and hostile, far-away place, emerged as a powerful organizing image of female insanity in the colony.¹⁵

However, this image *dominated* conceptions of madness in British India neither in the first nor in the second half of the nineteenth century. Alongside it we find a variety of maladies, some of which would nowadays be, and presumably were then, interpreted as typically 'male', whilst others could easily be applied to both men and women. Take the case of Private William W. whose derangement of mind was believed—as in the case of many women—to be 'natural'.¹⁶ It was also described as having been 'increased by grief at the loss of near relatives'. Or the circumstances of Private John S. whose affections for a woman had been rebuffed and who is reported to have 'become suddenly Insane from disappointed love'.¹⁷ Though less often reported in men, grief and emotional

¹⁴ The superintendent of the Bhowanipur Lunatic Asylum at Calcutta even pointed out that for women asylum inmates 'grief and hereditary transmission are the only antecedents on record'. IOR: Annual Report of the European Lunatic Asylum, Bhowanipore for the Year 1867. Calcutta, 1867.

¹⁵ See for examples J. Alexander, *Voices and Echoes: Tales from Colonial Women* (London, 1983), P. Barr, *The Mem Sahibs. The Women of Victorian India* (London, 1976), M. MacMillan, *Women of the Raj* (London, 1988), M. L. Pratt, *Imperial Eyes: Travel Writing and Transculturation* (London, 1991), M. Strobel, *European Women and the Second British Empire* (Bloomington, 1991), J. Trollope, *Britannia's Daughters: Women of the British Empire* (London, 1983).

¹⁶ IOR (PELA): Medical Certificates 1843. [Case of Private William W.].

¹⁷ IOR: Letter from Medical Board to Government of Madras, 8.1.1821, 13; Military Letter from Madras, 3.4.1821. [Case of Private John S.].

disappointments were not, it would seem, the sole prerogative of women. Neither were a 'natural' disposition or hereditary factors, or generally quiet and dejected behaviour, interspersed by outbreaks of rage and violence.

It may of course be argued that because of the predominance of male Company employees in India, we are bound to find only a small number of female lunatics, who could nevertheless be seen as exemplifying a trend towards the feminization of madness. However, if it were true that female images of insanity became dominant in the world inhabited by the Victorians, and that madness wore female make-up, we would then, independent of the numbers involved, and as suggested by Showalter in regard to England, expect men's madness to be interpreted as a manifestation of the feminine or at least to be influenced by allegedly female syndromes, if not organized conceptually along the lines of the supposed female maladies. There is, however, no evidence that this was the case.

Although Joana, Elizabeth, William, and John shared the features of grief, depression and occasional violence, and although these features might seemingly fit in with 'female' constructions of madness, the madness of the men was not explained simply as a manifestation of the feminine. The certifying surgeons were required by medical etiquette to comment on the factors which may have brought on a person's deranged state ('exciting' and 'predisposing' causes), and to elaborate on the behaviour and events that were seen as indicators of madness (symptoms). They consequently reported any incidents prior to admission which appeared to make the mad behaviour understandable as a seemingly necessary consequence of certain factors. In the case of women, reference to their family and children was seen to suffice: in Joana's case the death of her husband, in Elizabeth's case the slaughtering of her husband, father and children during the Indian rebellion. In the case of men, too, grief and disappointment would at times be seen to suffice as an explanation for peculiar behaviour, whilst on other occasions they would be referred to in combination with other factors.

In Private William W.'s case the certifying doctor made much of the supposedly 'predisposing cause' of natural derangement which was merely 'increased' by factors such as the 'influence of intoxicating agents' or grief. In the case of Private John S. reference to the rejection of his amorous ambitions alone was seen as sufficient to account for his 'sullen despondency' and aversion to military drill. Being of, at times, suddenly violent disposition he was frequently 'calmed by applying the strait Jacket or shackles'—interventions which did not appear to inhibit his habit of 'singing Amatory songs'. Although one might be inclined to detect a somewhat Gothic and Romantic dimension in the way in which John's case was presented, it would stretch credulity to interpret this as harbouring an exclusively feminine quality.

This is not to say that the criteria for these individuals' admissions were not gendered. The spaces which women and men occupied outside the asylum, and the different duties and roles corresponding with these were of course highly gender-specific. Given the typical and stereotypical field of action of women,

indicators of mental problems were necessarily seen in such things as a Mem-sahib's failure to fulfil her role as a good daughter, wife, or mother. In the case of men, relevant factors were related to those areas of life which were typically and stereotypically taken up by them: failure to submit to the behavioural codes and duties expected of soldiers, sailors, or civilian administrators. In particular failure in the performance of military drill or submission to or enforcement of discipline were crucial factors. Each patient had thus failed to pursue their expected—gender-specific—role: Joanah K. had stopped fulfilling her duty as a good mother; Mrs C. had lost her identity as daughter, wife, or mother; whilst Private William W. and Private John S. failed to act as obedient disciplined soldiers when the former 'attempted to strike a Sergeant with a steel fork' and the latter preferred the composing of love songs to the performance of military drill.

In regard to many other cases where loss, grief, and disappointments were presented as having played a crucial role, a gendered division emerges again in regard to the men's and women's personal histories prior to psychiatric treatment: women tended to grieve the loss of relatives whilst men, especially those belonging to or aspiring to belong to the middle class, were more likely to bemoan some loss of fortune, or career problems. The mental derangement of a gentleman by the name of Mr W. P., for example, was presented as having been 'induced by disappointments followed by habits of intemperance'.¹⁸ Private John M.'s madness was seen to have been due to 'losses he sustained whilst acting as a Butcher in his regiment'.¹⁹ Alexander W., acting as manager of a coal company at Ranigunj, had been 'much troubled with his business' and consequently took to 'drinking a bottle of Brandy every day',²⁰ whilst Sub-Conductor Robert W., who was 'always considered temperate' and who for twelve years 'bore a very high character in his Regiment', was presented as having gone mad on 'account of his promotion to Warrant Officer, in addition to 'domestic affairs'.²¹

Career and work-related pressures played a major role in men's life, so that—in contrast to women's stories and not altogether unexpectedly—mental derangement tended to be seen in relation to these. Although at times domestic affairs or rejected love were considered as sufficient causes to rob a man of his sanity (as was the case for Private William W. and Private John S.), it was also not uncommon for these factors to be mentioned only in combination with others, or even for difficult domestic circumstances to be ignored altogether. Private Thomas C., for example, was described by his doctor as being 'affected with depression without sufficient external cause'—despite the fact that he had

¹⁸ IOR: Letter from Medical Board to Government of Madras, 8.1.1821, 1; Military Letter from Madras, 3.4.1821. [Case of Mr W. P.]

¹⁹ IOR: Letter from Medical Board to Government of Madras, 8.1.1821, 10; Military Letter from Madras, 3.4.1821. [Case of Private John M.]

²⁰ IOR (PELA): Medical Certificates 1867–1870. [Case of Alexander W.]

²¹ IOR (PELA): Medical Certificates 1876–1878. [Case of Sub-Conductor Robert W.]

experienced a family break-up when his wife went back to England shortly after their arrival in India, leaving Private C. at the regimental camp near Tiruchchirappalli, South India, with their four year old daughter.²²

Whilst the circumstances and factors seen to explain a person's mental illness predictably appear to have been gendered, the maladies suffered were not necessarily represented as, in essence, gender-specific. Even alcoholism, the scourge of the army and navy, implicated in the majority of cases of mental breakdown in men, was not necessarily unknown amongst women. Those who were afflicted by it, were hardly 'masculinized' for it. Mrs E. M. S., pensioner on Lord Clive's and Military Fund (deriving the handsome sum of between £400 and 500 per annum from it), became insane 'soon after the death of Her Husband', a Colonel in the Madras army.²³ The loss of her man was followed by 'solitude and aversion to society', and, as reported by the surgeon of the station, she 'indulged to excess in spirituous Liquors'. On admission to the lunatic asylum the lady was seen to suffer from insanity of 'a very outrageous nature', and her language was described as 'always violent and abusive, and sometimes horribly indelicate'. Nevertheless Mrs S. was still considered a 'lady', and there was no suggestion that she may have suffered from any 'male' or 'female' malady.

Similarly, Mrs Catherine D. who, like the above lady, indulged in intemperate habits, still remained what she had been before the onset of her mental malady: an Irish private's wife.²⁴ Her derangement was supposed to have been 'produced by intoxication and other Vices incidental to a Barrack'. Her behaviour in the asylum, too, was 'uniformly Violent and Mischievous'. Unlike Mrs S., she was no 'lady', being described as 'uneducated and disposed to be uncleanly in her person and vulgar in her Manners'. Far from incorporating exclusively masculine or feminine images, these descriptions may fit in more readily with the stereotypical *English* representation of a nineteenth-century Irish soldier's wife, and would as such be shot-through with assumptions of social class and ethnic prejudice rather than gender alone.

Of course, both Mrs S. and Mrs D. failed in the pursuit of the idealized Victorian images of middle-class femininity. Yet, those men who drank themselves crazy—for whatever reason—were not considered paragons of Victorian masculine virtue either. Nor was there any trace of the self-control or of the 'reason, discourse, culture, and mind' conjured up by feminist theorists as having typically been reserved for men. Although intemperance was tolerated to a large extent in both Sahib and Memsahib, once a person no longer performed according to the expected norms of role-appropriate behaviour, suffered from physical and psychological symptoms, and was unamenable to reason, the

²² IOR (PELA): Medical Certificates 1846. [Case of Private Thomas C.].

²³ IOR: Letter from Medical Board to Government of Madras, 8.1.1821, 6; Military Letter from Madras, 3.4.1821. [Case of Mrs E. M. S.].

²⁴ IOR: Letter from Medical Board to Government of Madras, 8.1.1821, 7; Military Letter from Madras, 3.4.1821. [Case of Mrs Catherine D.].

suspicion of intemperance rather than that of 'gender-ance' arose.²⁵ A drunk, delirious woman was no more able to live up (or down) to the behaviour expected of a lady (or of a common man's wife or daughter) than a man with the jitters of *Delirium Tremens* would find himself in a position to fulfil his gentlemanly duty of maintaining control of his regiment or crew (or of parading in full kit for military drill without attracting adverse comment). Different norms of behaviour were expected of women and men, soldiers and officers, Irish people and English men and women. A combination of these norms—translated into stereotypical behavioural assumptions—fed into the criteria by which a person was seen to suffer from a mental malady.

Similarly, treatment of male and female asylum patients was also gendered, as women were permitted to occupy themselves with what could be seen as 'female' activities (such as sewing) while men were allowed to engage in 'male' pursuits (such as playing at cards). On the other hand, literate representatives of both genders were encouraged to read.²⁶ Patients' gender as well as their educational and social background played a role in regard to the recreational pursuits offered. However, the treatment and activities chosen did not generally discriminate between men and women in a way which might have implied that men's and women's madnesses were seen to be of a different quality, requiring gender-specific therapies. From a present-day perspective this tendency towards gender-blindness in psychiatric therapy could well attract criticism by feminist health professionals for neglect of women's special medical requirements.²⁷

More to the fore in the colonial context in India though, was the factor of 'race' and the insistence on racially appropriate treatment—even to the extent that some considerable modification was effected in the otherwise closely followed English and Scottish blue-prints of asylum management. For example, both European men and women, even when they belonged to the lower classes, were exempted from engaging in work, although industriousness in the asylum was regarded by many Victorian asylum reformers not only as an important means of moral uplift but also as an indicator of social virtue, psychological well-being and personal integrity. The ideal asylum in England and Scotland was one where 'all are anxious to be engaged, toil incessantly, and in general without any other recompense than being kept from disagreeable thoughts and

²⁵ Intemperance, insanity and crime were also seen to be linked. It was unacceptable that a person should 'be exempted from Criminal responsibility by reason of any temporary incapacity, which he shall have wilfully incurred by intoxication or other means'. IOR: Minute by I. D. Bethune, 30 June 1848; Minutes of the Rev Jud Leg Committee, 1851, No. 30.

²⁶ For medical and other treatment within European asylums in British India, see Ernst, *Mad Tales from the Raj*, pp. 143–60.

²⁷ In fact, feminist doctors (such as the cardiologist M. J. Legato) have recently come to demand that men and women ought to undergo medical treatment which is gender-specific, as women's bodies are identified as working differently from men's. See for examples E. Eitorre and E. Riska, *Gendered Moods. Psychotropics and Society* (London and New York, 1995), *NIH Guidelines on the Inclusion of Women and Minorities as Subjects of Clinical Research, Federal Register*, Part VIII (Washington, 1994), and *The Commonwealth Fund's Survey of Women's Health* (New York, 1993).

the pains of illness'.²⁸ Whilst lunatics in some of Britain's model institutions therefore were in principle supposed to 'work in order to please themselves',²⁹ such a disposition was considered unsuitable for European asylum inmates of all social classes and both genders in British India. Within the colonial context it was the 'natives' who were supposed to perform menial tasks. Indians were expected to engage in work such as rope-making, coffee cultivation, and cleaning cells,³⁰ although 'prejudices of Cast' [sic] were in some cases blamed for patients' idleness.³¹ Indian lunatics were reported to delight in recreational pursuits such as 'ball, shooting with the Bow, Parhus' and keeping pets like dogs, cats, goats, fowls, pigeons, deer and monkeys,³² although emphasis later in the nineteenth century shifted to commercially marketable production of agricultural goods and materials.³³ In contrast, the library, centre-piece of the European asylums in Calcutta and Bombay, was accessible to both European ladies and gentlemen³⁴—though not to illiterate European soldiers, sailors and lower-class women.

Even in regard to the practice of mechanical restraint (then strongly criticised in Britain, where 'kindness, gentleness and watchfulness' were seen as preferable, with physical restraint ideally, though not often in practice, reserved for exceptional circumstances), doctors in India felt that 'a peculiar condition well deserving of notice' had to be considered, namely 'the sense of humiliation or degradation which certain classes, Soldiers and Sailors in particular, are in the habit of attaching to coercion by the hands of native Attendants'.³⁵ It was even claimed that 'convalescents who distinctly remembered the paroxysm, have expressed gratification at having escaped the "shame of being laid hands upon by natives"'.³⁶ This was as true for European men as women, particularly during the decades following the Indian rebellion of 1857. Within the colonial context of the *raj* gender differences were at times subordinated to those between the ruling group and its vassals—even within the lunatic asylum.

²⁸ W. A. F. Browne, 'What Asylums were, are, and ought to be' [1837], in A. Scull (ed.) *The Asylum as Utopia. W. A. F. Browne and the Mid-Nineteenth Century Consolidation of Psychiatry* (London and New York, 1991), pp. 229–30.

²⁹ Browne, 'What Asylums were, are, and ought to be', p. 230.

³⁰ IOR: Rules for the future management and control of the Insane Hospitals; Bg Jud Proc, 28 Aug. 1818, 55. Assistant Surgeon F. P. Strong, Rasapagla Asylum (India) mentioned spinning, weaving, cleaning, gardening, cultivation. The asylum inmates were said to have raised 'coffee, cotton, sugar-cane, anuath, mulberry, casaiva, tapioca, sapan-wood, alva plant'. Apparently 'their coffee in 1832 was highly approved by the London brokers'. IOR: Summary of Correspondence relating to the Calcutta Asylum for Insane Patients, 30 Oct. 1847; B. Coll., 1852, 2494, 141.296, 52.

³¹ IOR: Medical Board to Govt., 6 June 1821; Bg Jud Proc, 21 Aug. 1821, 4, no para.

³² IOR: Asylum Report, 31 March 1852, in Med B to Govt, 24 May 1853; Bm Pub Proc, 9 July 1853, 4537, 76.

³³ W. Ernst, 'The Establishment of "Native Lunatic Asylums" in Early Nineteenth-Century British India', in G. J. Meulenbeld and D. Wujastyk (ed.) *Studies on Indian Medical History* (Groningen, 1987), pp. 196, 200.

³⁴ IOR: Medical Board to Govt., 6 June 1821; Bg Jud Proc, 21 Aug. 1821, 4, no para. Asylum Report, 31 March 1852, in Med B to Govt, 24 May 1853; Bm Pub Proc, 9 July 1853, 4537, 76.

³⁵ IOR: Asylum Report, 14 June 1856, Bg Pub Proc, 24 June 1856, 52, n. para. For a discussion of mechanical restraint in British India, see Ernst, *Mad Tales from the Raj*, pp. 152–5.

³⁶ *Ibid.*

It may well be argued that the pressure to comply with gender-role appropriate behaviour was particularly acute within the colonial context. After all, the pre-occupation of the British community in India with Rules of Precedence and British women's involvement in 'keeping up standards', and the social pecking order, have become legendary. It has been concluded that any knowledge produced and applied within a colonial context would be 'profoundly gendered'.³⁷ It is also true that the preservation of British rule was seen to depend not only on military power but also on the preservation of the image of the British rulers as civilized, controlled, disciplined, rational and well-meaning people—superior to the allegedly uncivilized, uncontrolled, undisciplined, irrational, and deceitful 'natives'.³⁸ The stereotypical image of British colonial rule as 'gentlemanly' power does of course lend itself also to being juxtaposed with Chesler's and Showalter's analysis of the stereotypical characteristics attributed to woman (unreason, emotion, nature, body). However, the pressure to live up to the colonial role would have applied to both European men and women, albeit not in the same way.

According to O'Hanlon's critical analysis of 'cultures of rule' and 'communities of resistance' in South Asian historiographies, gender played a vital role in the way in which the 'Orient' itself was represented by 'the persistent reference to the effeminate sensuality of Asiatic Subjects, their inertia, their irrationality, their submissiveness to despotic authority, the hidden wiles and petty cunning of their political projects'.³⁹ If we consider the dominant discourse in the *raj* to have been that of a colonial power which represented itself as 'gentlemanly' and its 'Oriental Other' as 'effeminate', it could well be argued that Memsahibs may even have gained to some extent from the 'feminization of the Orient', as the characteristics of the subservient and subdued group were allocated to Britain's colonial subjects, whilst European women were elevated to and could share in the stereotype, essentially male, characteristics attributed to the representatives of colonial power. Even in times of madness, a feminization of Europeans' maladies might have been too close to what was regarded as 'native people's prerogative, and therefore would have been politically and socially unacceptable within the wider context of a Western ruling group which preferred to construct itself as imparting reason, discipline, and civilization on its colonial subjects.

Further, the stereotypes of gentlemanly colonial power in contrast to the 'feminine Orient' could be seen also as indicative of a tendency towards conceptual homogenization and the creation of 'imagined communities'⁴⁰ as part of an implicit imperialist strategy, rather than as an adequate representation

³⁷ See for example S. Mills, 'Knowledge, Gender, and Empire', in A. Blunt and G. Rose (eds.) *Writing Women and Space: Colonial and Postcolonial Geographies* (New York, 1994), p. 34.

³⁸ K. Ballhatchet, *Race, Sex and Class under the Raj. Imperial Attitudes and Policies and their Critics, 1793–1905* (London, 1980).

³⁹ R. O'Hanlon, 'Cultures of Rule, Communities of Resistance: Gender, Discourse and Tradition in Recent South Asian Historiographies', *Social Analysis*, 23 (1989), 94–114, p. 106.

⁴⁰ B. Anderson, *Imagined Communities: Reflections on the Origins and Spread of Nationalism* (London, 1983).

of the existing heterogeneity amongst both the Indian and British colonial communities.⁴¹ In a similar vein the (homogenizing) characteristics ascribed to women by Showalter, for example, could be seen to obscure other factors which cut across and modified them: women's social class background, ethnicity (English, Scottish, Irish, Welsh), and—last but not least within a colonial context—'race' (European, Eurasian, Indian). Showalter's sweeping postulation of an allegedly universal 'female malady' emanating during the Victorian era needs to be challenged. A perspective which aims at criticizing gender stereotyping and its severe social consequences ought to take cognizance of the elusive factors involved in the process of homogenizing and stereotyping, question rather than collude in its representations and normative prescriptions, and try to refute analyses which are restricted to and confined by a stereotypical gender dichotomy.

III

In regard to nineteenth-century asylum statistics from British India the restricted value of mono-dimensional interpretations becomes particularly apparent. For example, the average number of men admitted per year to the European Lunatic Asylum at Calcutta amounted during the 1830s to fourteen, and during the 1820s and 1840s to eighteen, whilst the average number of women remained at three.⁴² Similarly, the number of women transferred from British India to the East India Company's asylum in England (first Pembroke House, and later the Royal India Asylum at Ealing) constituted but a fraction of the number of men,⁴³ and the proportion of men to women confined at the East India Company's asylum in England was also highly skewed to the former.⁴⁴ Even in the second half of the nineteenth century the number of European female asylum inmates in India was still very small, namely only eight women in contrast to 154 men.⁴⁵ These numbers, of course, reflect the fact that the bulk

⁴¹ D. Arnold, 'European Orphans and Vagrants in India in the Nineteenth Century', *Journal of Imperial and Commonwealth History*, 7 (1979), 106–14. A. L. Stoler, 'Rethinking Colonial Categories: European Communities and the Boundaries of Rule', *Comparative Studies in Society and History*, 31 (1989), 134–60.

⁴² IOR: *Table shewing the number of public patients treated in the Lunatic Asylum at Bhowanipore, and the results from 1 January 1824 to 30 December 1850*, 10 March 1951; Bg Pub Proc, 24 June 1852, 7. It should be stressed that the admission rate does not reflect an 'incidence rate' of lunacy in British India.

⁴³ For example 12 men, no women in 1839; 8 men, 1 woman in 1840; 15 men, 3 women in 1841; 5 men, no women in 1842; 20 men, 2 women in 1843; 15 men, 1 woman in 1859; 27 men, no women in 1860; 17 men, 1 woman in 1861; 9 men, 2 women in 1862; 8 men, 4 women in 1863; 10 men, 7 women in 1864. IOR (PELA): compiled from Medical Certificates, 1830–1889, Registers of Admissions 1845–1892, and Miscellaneous Correspondence and Numerical Returns of Patients, 1857–1865.

⁴⁴ 75 men, 5 women in 1838; 112 men, 10 women in 1859; 122 men, 15 women in 1865; 122 men, 10 women in 1882; 63 men, 13 women in 1892. *Ibid.*

⁴⁵ European asylum patients in Bengal: 82 men, 3 women; in Madras: 40 men, 1 woman; in Bombay: 32 men, 4 women. IOR: *Annual Administration and Progress Report on the Insane Asylum in the Bombay Presidency* (Bombay, 1875), para. 39.

of Europeans in India were soldiers. Although the number varied,⁴⁶ and despite the fact that more single women were permitted to proceed to the East towards the latter part of the century, men still by far outnumbered women. This demographic situation is very different from the one on which Showalter's statistical reflections in regard to Victorian England are based.

However, the statistical preponderance of male asylum patients does not necessarily impede a gender-focused argumentation, especially as Showalter's conceptualization of the 'female malady' does not rest on statistics alone, and even suggests that men's insanity became constructed in feminized terms. What is more, some of the statistics from asylums for Europeans in India do indeed seem to reveal gender-specific tendencies. For example, only 7 per cent of the women admitted to the Lunatic Asylum at Calcutta were sent back to Europe for further treatment—in stark contrast to 51 per cent of the male patients.⁴⁷ Further, whilst classification of patients into first and second class does not seem to have impacted on the overall number of cured discharges from the Calcutta asylum (which remained at 36 per cent or 37 per cent), the gender of the patients does appear to have had an impact: female patients were less often discharged as 'cured' than men and much less so if the women happened to be in the first-class category.⁴⁸ Such data could easily be interpreted in terms of prevailing gender discrimination. For example it could be argued that men received more favourable treatment at Calcutta than women, because they were much more likely to be repatriated for further treatment, and even if they were not sent back, they were more likely to be discharged as cured. This would be indicative of society's bias against women in general and gentlewomen in particular, with male diagnosticians being less likely to accept a woman's deviancy from the desired social behavioural norm, with higher-class women enjoying a particularly narrow range of permissible self-expression.

However, it could be equally plausibly speculated that these statistical trends reflect other factors, such as changing admission policies, demographic changes, prejudices of 'race' and social class, as well as financial considerations and demographic peculiarities. For example, the willingness of European middle-class

⁴⁶ For example, the combined military strength of the Company and Crown are given as 45,000 Europeans before the rebellion of 1857 (Smith, p. 679, Spear, p. 278); 38,000 Europeans in 1857 (Smith, p. 666); 13,000 European Army in 1858 (Spear, p. 278); 76,000 British Army in 1861 (Roberts, p. 391); 65,000 Europeans in 1863 (Spear, p. 278, Smith, p. 679). Interpretation of these numbers, too, is problematic because: the army in India consisted largely of infantry and cavalry (its size could therefore fluctuate rapidly as its budget was increased or decreased); restructuring of the army (for example in 1859); deficit in soldiers during times of temporary deployment of troops to other countries (for example America); high death and casualty rates, especially during times of war (for example annexation of Sind, Burma): P. E. Roberts, *History of British India under the Company and the Crown* (London, 1953 [comp. by T. G. P. Spear]), V. A. Smith, *The Oxford History of India* (Oxford, 1956), P. Spear, *India: A Modern History* (Ann Arbor, 1972).

Shortly after the Indian revolt, in 1861, the English population in India was 125,945. Of these only about 41,862 were civilians as compared with about 84,083 military servants. Of the 41,862, 22,556 were male and 19,306 were female. Of the women 8,356 were 'wives', 1,146 were 'widows', and 1,001 were unmarried. *Royal Commission on the Sanitary State . . .*, Vol. 1, p. xxiv.

⁴⁷ IOR: *Table shewing number*, p. 7.

⁴⁸ *Ibid.*

families to have a relative admitted to the Calcutta asylum decreased once the East India Company agreed with the asylum's owner, Mr. Beardsmore, to send its military and naval lunatics (the majority of which were necessarily lower-class soldiers and sailors) to the asylum.⁴⁹ The Calcutta asylum was perceived to have changed from an exclusive private to a public institution, and what is more, the number of Eurasian patients (usually the lower-class offspring of, at times forced, liaisons between European men and Indian women) increased during the same period. The fact that fewer women than men were repatriated can be accounted for by the rules governing eligibility for transfer. Eurasian women and those women born of European parents in India together made up the majority of the female asylum population, and whilst the former would but rarely be sent to England on account of their lack of family and parochial support network outside of India, the fate of the latter depended very much on their individual family and financial circumstances. Men, in contrast, were usually automatically eligible for repatriation as they would in the majority of cases have been affiliated with the East India Company. What is more, the maintenance rates for inmates in asylums in India were much higher than in England, so that some considerable savings could be made by repatriating Company servants as soon as possible.

Why then were women less likely to be discharged from the Calcutta asylum than their male counterparts? Early discharge would, after all, have been no less cost-saving than repatriation. It could, of course, be said that women might have been seen to possess a peculiar tendency towards chronic insanity, or that men, due to their former experience of and greater familiarity with (military or civil public) institutions than the allegedly home-and-hearth bound women were more uniformly socialized into showing behaviour properly adapted to the norms prevailing in a lunatic establishment, and thus being more likely to appear well-adapted, they would subsequently get discharged. However, there may also have been other, socio-structural, factors at work. Whilst men could be sent back on duty after cure, it is less clear what would happen to cured women if they were not cared for by a husband, a father, or some other relative. A single or widowed woman without family connections is 'out of place' in a militarized colonial society. She is at least 'in a place' when she is confined inside an institution. Further, members of the Eurasian community were seen to have lived 'on the margins' of colonial society anyway,⁵⁰ so that mad, and usually poor, Eurasian women who constituted the majority of female asylum patients, would have found it difficult to find willing support networks following discharge from the asylum, even when apparently 'cured'.

The numbers for patients 'consigned uncured to the care of relatives and friends'⁵¹ make it clear that factors of gender, social class, race as well as the militaristic nature of colonial society overlapped in a complex way. Whilst only

⁴⁹ See W. Ernst, 'Psychiatry and Colonialism: The Treatment of European Lunatics in British India, 1800–1858' (unpublished Ph.D. thesis, University of London, 1986), especially pp. 71–142.

⁵⁰ Ballhatchet, *Race, Sex, and Class under the Raj*, pp. 96–122.

⁵¹ IOR: *Table shewing number*, p. 7.

11 per cent of second-class men and 17 per cent of first-class men were made over to the care of others, five out of fourteen, or 36 per cent of gentlewomen were discharged uncured.⁵² It is likely that these women were discharged at the request of their relatives, who would have been scarcer in the case of 'common women' (and men), and in particular in regard to common Eurasian women (and men), who may not have had any relations at all in India, and even if they had, it is doubtful whether they would or could afford to provide for an unproductive family member.⁵³

As indicated by the above statistics, there is reason to assume that gender-specific factors were at work, as in the case of mixed-race female patients. However, other factors, too, such as patients' social class, their 'race', their affiliation with the Company's service, financial factors, and demographic peculiarities cut across the dimension of gender.⁵⁴ Yet another complication is that asylum statistics which span several decades necessarily emerge within very different social, cultural and economic circumstances, all of which would need to be taken into account, if any sensible analytical statements were intended. What is more, asylum superintendents' diagnostic and therapeutic frames of reference, not to speak of their skill at the compilation of statistics, varied considerably, not only between the first and second half of the nineteenth century, but over the whole of a period when a multitude of medical paradigms existed alongside each other, and when the standard of professional training among medicos in the East varied considerably. It is not at all uncommon for those in charge of European lunatics to refer to very different, and at times contradictory, frames of reference, as is illustrated by the statement in a report of 1874 that 'Women do not die and do not recover as we do, hence they accumulate', which can be contrasted with the claim of 1880 that 'The female structure, as most of us know, predisposes to what may be termed transient aberration'.⁵⁵

The few selected statistical data presented above do admittedly raise more questions than they are designed to answer within the confines of this paper. However, it is to be wondered whether a construct such as the 'female malady', which has been partly based on similarly complex statistics from Victorian England, could possibly greatly enhance our understanding of the complexity of the situation to which such statistics refer. Concepts such as 'gender' can never

⁵² Ibid.

⁵³ Similar considerations were at play in regard to the Irish situation where asylums constituted a means of relief for hard-pressed families during times of famine and economic hardship. See M. Finnane, *Insanity and the Insane in Post-Famine Ireland* (London, 1981) and M. Finnane, 'Asylums, Families and the State', *History Workshop*, 20 (1985), 134–8.

⁵⁴ Proof of statistical significance is problematic in regard to some of the above figures anyway because of the low number of women involved. For example, the total number of female first-class patients was merely 14, and the number of cases cured too low ($N=2$) to allow testing for statistical significance. Of course, statistical significance does not necessarily map directly on to actual or material prominence.

⁵⁵ IOR: Report Surg Gen to Govt, 4 Sept. 1874, in *Annual Administration and Progress Report of the Insane Asylums in the Bombay Presidency*, 1874, p. 3; and 4th Annual Report on the Lunatic Asylum, Amraoti, 1880.

be universally valid, but need to be looked at in relation to the particular circumstances of their enunciation.

IV

If, despite these considerations, we still believed (for descriptive rather than conceptual purposes) in the usefulness of putting any 'typical' face on European madness during the *raj*, it would need to be the physiognomy of a stereotypically male mad-person. Even once European women were allowed to proceed to India in larger numbers, mad men would outnumber their female counterparts. In the majority of cases it was men's failure to submit to or to enforce military or naval discipline, or to carry out civilian work duties which was taken as an indication of madness. Take the example of Midshipman Edward Z. of the Indian Navy who was ordered to assume temporary charge of the Company's steam vessel *Atalanta* moored in Bombay Harbour in 1840, yet failed to keep control of the situation when the ship caught fire.⁵⁶ When other superior officers rushed to the burning vessel, taking over command from him, an argument ensued during which Edward Z. was accused of being too drunk to perform his duty. Although he was eventually not found guilty of drunkenness by a court martial, his superiors' had no doubt that his excited behaviour was attributable to intoxication. In consequence Midshipman Z. was censured for 'highly irregular conduct' and 'neglect of duty'. The commander of the local forces and government even went as far as strongly disapproving of the outcome of the court martial, maintaining that it was important to 'counteract as far as possible, the serious evil that must result to the respectability, general efficiency, and well-being of the Indian Navy, were such an aggravated breach of duty . . . permitted to pass by unnoticed'.⁵⁷

However, Edward Z. got off lightly, and five years later, having advanced to the rank of Lieutenant, he even tried to obtain a long awaited furlough in England. The Company authorities were however anxious to relieve the navy's then pressing manpower needs by keeping its men in service as long as possible. Being frustrated in his wish to go back to England, Lieutenant Z. developed symptoms of 'mania'. These did not fit in well with the demands of naval order and discipline, as Lieutenant Z. was reported to have 'imagined himself transformed into a vegetable, an artichoke, and was in the habit of taking advantage of every shower, that fell in order that he might be properly watered'.⁵⁸ Edward's admission to the lunatic asylum and, subsequently, his transfer back to England was recommended.

Undisciplined behaviour and neglect of duty could never be taken lightly

⁵⁶ IOR: Charge of E.C. Z. by Sup Indian Navy, Bombay, 9 Nov. 1839; Bm Castle Marine Proc, 1840, 6.

⁵⁷ IOR: Sec to Govt, Bombay, 1 Jan. 1840; *ibid*.

⁵⁸ IOR (PELA): Medical Certificates 1845. [Case of E.C. Z.], 13 Dec. 1844. See also Ernst, *Mad Tales from the Raj*, pp. 113–17; Ernst and Kantowsky, 'The Records of Pembroke House and Ealing Lunatic Asylum'.

within the navy and the military. Edward Z. suffered considerable social embarrassment in consequence of the *Atalanta* affair, although he was spared the even more humiliating experience of incarceration, flogging or prolonged suspension from duty. In many other cases, in particular when the 'other ranks' were implicated, any deviancy from the norm of expected behaviour was seen as inexcusable, deliberate and wilful disobedience and recalcitrance which was accordingly countered by severe disciplinary punishment. Richard Riley Atkins, for example, was charged with 'the crime of striking the Surgeon belonging to, or doing duty with, the Hon. Company's Artillery, with his shut fist', and was 'after what was called a due deliberation, sentenced . . . to be shot'.⁵⁹ The fellow soldier who recorded this event, remarked in his diary that 'the awful Drama was not to finish here, the Rulers of the Army were not satiated, they still craved for the blood of more victims; for during the remaining 11 days of this month we witnessed two more Military Murders. One of the Lancers, and one of the 23rd, the latter for striking a Sergeant', concluding that 'Such scenes . . . only tend to make the soldier loathe instead of honouring his profession'.⁶⁰ And many 'other ranks' did exactly that, witness the gunner who, signing his first letter with the words 'i remane yours your unforchenate son J Luck & if for ever o adue my time is expird sell not my ole close', later on expressing his doubt to meet his mother 'agane this side the grave', mentioning his continued 'despair' about life in the army in India, and finally thanking his mother for buying him out as he was 'so anxious to se my dear native home agane'.⁶¹ Only when the usual range of disciplinary actions failed to have any desirable effect, or when measures such as solitary confinement occasioned the breakdown of prisoners' state of mental health, would punishment be substituted by treatment in the lunatic asylum.

Although it might be plausible to claim that the 'artichoke'-syndrome could be seen as one manifestation of a 'colonial male malady' (which was in the case of lower-class soldiers and sailors more likely to be designated as malingering, wilful neglect of duty or insubordination), it is questionable to what extent such a postulate would aid our analysis to any great extent. Any concept of a 'male malady' and of the 'masculinization' of madness within a colonial context would be problematic—for the same reasons for which a 'female malady' for Victorian Britain, arrived at on the basis of seemingly numerical preponderance and occasional public representation, needs to be looked at with much caution.⁶²

⁵⁹ IOR: Ms. Photo.Eur.97, [A soldier's diary, 26 July 1847].

⁶⁰ *Ibid.*

⁶¹ IOR: Ms. Eur.E.339. 'My Dear Mother . . . if for ever o a due, sell not my ole close'. Gunner John Luck's Letters from India, 1839–1844.

⁶² J. Busfield, 'Mental Illness as Social Product or Social Construct: A Contradiction in Feminists' Arguments?', *Sociology of Health and Illness*, 10 (1988), 521–42, J. Busfield, 'The Female Malady? Men, Women and Madness in Nineteenth-Century Britain', *Sociology*, 28 (1994), 259–77, N. Tomes, 'Feminist Histories of Psychiatry', in M. Micale and R. Porter (eds.) *Discovering the History of Psychiatry* (New York and Oxford, 1994), N. Tomes, 'Historical Perspectives on Women and Mental Illness', in R. Apple (ed.) *Women, Health, and Medicine in America: A Historical Handbook* (New York, 1990), pp. 157–66.

To begin with, we lack evidence of female patients being diagnosed mad for failing to meet the requirements of the stereotypical colonial male. Unless we wish to restrict ourselves to equating psychiatric classification with symptomatology, we are faced with a plethora of background histories (aetiologies, in medical terms) prior to the reported onset of madness, which make any generalizations about types of madness difficult. In the overwhelming majority of cases we are told of the existence of a combination of factors, most prominent of which are acute or chronic physical illness (malaria, liver disease, various stages of syphilis and other sexually transmitted diseases, scurvy, typhoid, 'enteric' and 'zymotic' diseases), injuries (blows on the head), and alcoholism.⁶³ Disappointments, nostalgia, boredom, anxiety, trauma, aversion to and the stress of heat and dust, quarrels and incompatibility with comrades (on account of different class, educational, religious and ethnic backgrounds) could be read between the lines of the case reports, and were frequently part and parcel of representations of the legendary 'mad-dogs and Englishmen'.

The case of Able Seaman Charles C., who was admitted to the Bhowanipur Lunatic Asylum in Bengal in 1860, is a good illustration of the combination of psychological, organic and social factors which were seen to be implicated in many cases of insanity.⁶⁴ Charles C., of Wickham in Essex and son of Samuel C. (who worked at a water mill in Essex) had, soon after his arrival in India, served for twelve months in the Naval Brigade at Buxar during the aftermath of the Indian rebellion of 1857. He had then just turned twenty. It was reported that he 'did his duty very well when in the Naval Brigade'. Yet his principal delusion while in the asylum was that 'he is going to be killed'. He was despondent about hearing 'at all times the voices of his murderers', and made 'repeated attempts at escaping from the Asylum' as well as talking of 'committing suicide'. The stress of active duty during an uprising soon after arrival in a foreign country may well be taken as a factor in this young man's mental breakdown (in today's terms an indication of possible post-traumatic stress disorder). However, prior to his admission straight from the hospital at Buxar, Charles had also suffered from 'intermitting fever', and from an ulcer on the penis. His comrades 'attributed his depression to the fact of his having syphilis'. Further, although asylum superintendent T. Cantor could not find out whether Charles 'ever was a hard drinker', he held that his 'derangement much resembles the melancholia that follows delirium tremens'. And last but not least, Charles showed signs of malnutrition, being of 'anemic' appearance, 'emaciated and debilitated'.

Charles C.'s case thus reveals traces of possible post-traumatic stress disorder, nostalgia, malaria, syphilis, alcoholism, and malnutrition—not to mention any possible endogenous factors. For Charles' comrades his madness bore the face of

⁶³ For example, in regard to patients admitted to Pembroke House, and the Royal India Asylum at Ealing, a variety of physical conditions was mentioned, such as Delirium Tremens (16 per cent), sunstroke (15.3 per cent), general or partial paralysis (12.3 per cent), fever (9.8 per cent), stomach and intestinal troubles (9.2 per cent), fall, shot or blow to the head (8.6 per cent), epilepsy (8 per cent). (Data compiled from IOR (PELA): Medical Certificates and Medical Case Books.)

⁶⁴ IOR (PELA): Medical Certificates 1860. [Case of Seaman Charles C.]

syphilis; for the certifying doctor that of alcoholism. The variety of factors could lend support to a similar variety of speculations about the presumed face of Charles' madness. To those inclined to look for mono-causal or mono-dimensional explanations, cases like that of Charles—which were legion—therefore did, and still do, offer a mine of pick-and-choose opportunities for analysis and speculation about the nature of the face of madness. However, what faces us is far from conclusive: we look at a multitude and variety of factors, each one of which can by itself be implicated in mental problems.⁶⁵ The predominance of physical, neurological, nutritional, drug-induced and traumatic factors in nineteenth-century representations of mentally ill men in India makes an *exclusive* emphasis on Romantic images of madness and genderization appear somewhat tangential if not misguided. As the Royal Commission on the Sanitary State of the Army in India emphasized in 1863, when summing up statistics on the shockingly bad state of health of soldiers in particular,⁶⁶ that 'it is necessary to bear in mind that the soldier's health in India, as elsewhere, is the product of all the conditions to which he is exposed. It is not solely the result of climate, nor of locality and dwelling place, nor of diet, habits, nor duties; it is the product of all of these'.⁶⁷

At best we might be able to trace the emergence of organizing images of madness isomorphic to stereotype images of maleness and femaleness. In regard to nineteenth-century Britain, Busfield mentions the 'mad genius', the 'criminal lunatic' and 'masturbatory insanity', suggesting that these arguably male representations of madness were also gendered, albeit only as part of a 'highly differentiated landscape in which madness did not exclusively take on the cloak of one gender or the other, but took many forms'.⁶⁸ The 'mad genius' is for some reason but rarely found on the plains and hills of British India—which may or may not be taken to disadvantageously reflect on the *raj's* profile of military and naval recruits. The 'criminal lunatic' on the other hand certainly was a more ubiquitous type who—within the confines of empire—frequently tended to lash out at 'natives'.⁶⁹ The representation of the 'Exposed-Young-Lad-In-The-East'—suffering from an alleged 'exposure' to a combination of

⁶⁵ For the connection between various physical diseases and mental illness see M. Weiss, 'The Interrelationship of Tropical Disease and Mental Disorder: Conceptual Framework and Literature Review', *Culture, Medicine and Psychiatry*, 9 (1985), pp. 121–200.

⁶⁶ Cholera, for example accounted between 1830 and 1846 for about 10 per cent of deaths among the British in Bombay, and between 1818 and 1854 killed more than 8,500 British soldiers. See *Royal Commission on the Sanitary State of the Army in India* (London, 1863), p. xv, and D. Arnold, 'Cholera and Colonialism in British India', *Past and Present*, 113 (1986), p. 127. During the early part of the nineteenth century the mortality rate for the rank and file was 82 per cent higher than that for officers. The hazards of 'fevers' and 'dysentery and diarrhoea' killed on average about one-quarter and one-third of the sick, respectively. During the early decades of the nineteenth century the mortality rate from disease was seven times higher than that from wartime casualties, and even by the middle of the century army personnel in India would have to suffer mortality rates double those for the military in Britain.

⁶⁷ *Royal Commission on the Sanitary State of the Army in India* (London, 1863), p. xv.

⁶⁸ Busfield, 'The Female Malady?', p. 271.

⁶⁹ See for an example the case of Captain B. in Ernst and Kantowsky, 'The Records of Pembroke House and Ealing Lunatic Asylum'.

factors such as heat, boredom, military hierarchy, superiors' and comrades' cruelty and vindictiveness, 'vice', homesickness and, frequently, alcoholism, bad nutrition, some sexually transmitted disease and a variety of physical illnesses—would be another, typically colonial, male representation of madness squarely located within the discourses of psychiatry, gender, and empire. This representation was caricatured in the twentieth century by Kipling in his *Toolungala Stockyard Chorus*:

Thrown away

And some are sulky, while some will plunge.

[*So ho! Steady! Stand still, you!*]

Some you must gentle, and some you must lunge.

[*There! There! Who wants to kill you?*]

Some—there are losses in every trade—

Will break their hearts ere bitted and made,

Will fight like fiends as the rope cuts hard,

And die dumb-mad in the breaking-yard.

V

Further questions arise in regard to gender and madness during the nineteenth century. For example, if we believe in the prevalence of a strong correlation between women and madness in post-Second World War Western Europe and North America, how could we explain the lack of evidence for it in the preceding century?⁷⁰ One explanation (advanced, for example, by Stearns) could of course be that the incidence of mental illness, and in particular of neurotic complaints which are nowadays more frequently ascribed to women, increased; in other words, that we, and in particular women, simply have become more neurotic during the course of the twentieth century as the pressures of life increase.⁷¹ This argument is very much in the tradition of ideas which link civilization and madness, and date at least back to Cheney and his *English Malady*.⁷² Cheney's 'English malady' represents yet another construct developed not only as a catch-all for a number of nervous and physical ailments, but also as an expression of the general state of unease felt at societal, political and economic developments during the eighteenth century. And, significantly, the

⁷⁰ The existence of a female malady in the nineteenth century has been substantiated neither by Brookes for New Zealand, Busfield for England, Ernst for British India, Finnane for Ireland, Fox for California, Garton for New South Wales, nor by Tomes for North America. See B. Brookes, 'Women and Madness: A Case Study of the Seacliff Asylum, 1890–1920', in B. Brookes, C. Macdonald and M. Tennant (eds.) *Women in History*, vol. 2 (Wellington, 1992), 129–47; Busfield, 'The Female Malady?'; Finnane, *Insanity and the Insane in Post-Famine Ireland*, London, 1981; Finnane, 'Asylums, Families and the State', 134–8, R. W. Fox, *So Far Disordered in Mind: Insanity in California, 1870–1930* (Berkeley, 1978), S. Garton, *Medicine and Madness. A Social History of Insanity in New South Wales, 1880–1940* (Sydney, 1988), Tomes, 'Historical Perspectives on Women and Mental Illness', 154–8.

⁷¹ P. N. Stearns, 'Working-Class Women in Britain, 1890–1914', in M. Vicinus (ed.) *Suffer and Be Still. Women in the Victorian Age* (Bloomington, 1972), 100–21.

⁷² G. Cheney, *The English Malady or a Treatise on Nervous Diseases of all Kinds* (London, [1733]), ed. Roy Porter (London, 1990).

'English malady', not unlike Showalter's 'female malady', was seen to be restricted to particular groups in society—to literate, if not literary circles'.⁷³ It therefore needs to be asked whether Cheney's attempt at linking civilization and madness (echoed by Foucault and, to a certain extent, by Elias), could be seen to constitute a more accurate representation of those authors' dissatisfaction with the body politic of their day or of what Freud described as *Unbehagen an der Kultur*, than representing a valid organizing image for their mentally ill contemporaries' afflictions. Just as historians of thought may be careful not to take Cheney's construct too literally as a solely psychiatric category, neglecting its literary role in social and political criticism, so social historians of medicine may find it more appropriate to take the 'female malady' as a challenging device for highlighting the social malaise and oppression of women during the late twentieth century.

An alternative explanation for the increasing prominence of women in twentieth-century mental health statistics and representations could be, as pointed out, for example, by Zola, that 'by "medicalizing" much of daily living' an ever-increasing part of human life has become subject to a medical and psychiatric gaze.⁷⁴ In the wake of this growth of medical influence, the impact on women's lives during the second half of this century has been, as suggested by Miles, disproportionate in comparison to men, so that by 1973 Gove and Tudor could proclaim that 'all the data on mental illness indicate that more women than men are mentally ill'.⁷⁵ Prior, too, assumes that gender-specificity might have emerged 'only after the inclusion of the "neuroses" as identifiable forms of mental illness' in the post-1945 era.⁷⁶ Busfield, in her criticism of Showalter's thesis (which is based on both asylum statistics and representational evidence), makes the additional relevant point that in regard to nineteenth-century Britain 'the difference in the gender balance of the [asylum] inmate population was not large, even in absolute terms', and that gender differences in mortality played a key part in producing what small female excess of asylum residents there was.⁷⁷

It could be argued that the medicalization of evermore areas of social life (the community, family, marriage, child-care) and the emphasis on prevention and healthy life style which has become more pronounced since the Second World War, are bound to impact on women in a particularly strong way, as it is wives and mothers who are in the main held responsible for the good management of their families in the private sphere. Armstrong has, in Foucauldian vein, even identified a new kind of medicine that evolved in the late twentieth century, based, according to him, on the 'surveillance of normal populations', and having become increasingly manifest in the 'shift in the psychiatric/medical

⁷³ Skultans, *English Madness*, p. 26.

⁷⁴ I. K. Zola, 'Medicine as an Institution of Social Control', in C. Cox and A. Mead (eds.) *A Sociology of Medical Practice* (London, 1975), p. 170.

⁷⁵ A. Miles, *Women, Health and Medicine* (Milton Keynes, 1991), p. 182, W. R. Gove and F. Tudor, 'Adult Sex Roles and Mental Illness', *American Journal of Sociology*, 78 (1973), 812–35.

⁷⁶ L. Prior, *The Social Organization of Mental Illness* (London, 1993), p. 141.

⁷⁷ Busfield, 'The Female Malady?', p. 270.

gaze from the binary problem of insanity/sanity to the generalized population problems of the neuroses'.⁷⁸ These, according to Armstrong, 'affect everyone', but might, we may surmise, affect women more, as community and lifestyle become the focus for preventive medical intervention.⁷⁹

A further question is whether the difficulty of authors other than Showalter in tracing the female malady in nineteenth-century statistics and case histories may be partly due to the fact that we may need to be more alert as to what 'representations' are supposed to be representative of. It is fine to analyse mental illness in terms of the framework of public and collective categories through which individual women's madresses are organized. It is however equally important to point out that such collective frameworks, nurtured within the Durkheim tradition, do not necessarily rest on a consensual social basis. This point is taken up not least by feminist writing on gender and empire which is guided by a thinking of 'gender differences as both structuring and structured by a wide set of social relations',⁸⁰ and prefers a reading of gender in which women have not been 'merely passive victims of patriarchy' but have also 'colluded in, undermined and survived' it.⁸¹ Recent work on empire after Said's 'Orientalism'⁸² has come to criticize exotic representations and the hegemonic tendencies inherent in Western discourse of 'other' people. Colonial discourse is being scrutinized not only for representations of domination, hegemony and subordination but also for evidence of complicity and resistance.⁸³ The heterogeneity—rather than the uniformity—of colonial discourse and of colonial relationships has moved centre stage,⁸⁴ and so has, slowly, the social heterogeneity of mental maladies and of women's and men's versions of them.⁸⁵ As

⁷⁸ D. Armstrong, 'The Rise of Surveillance Medicine', *Sociology of Health and Illness*, 17 (1995), pp. 393, 401.

⁷⁹ Miles, *Women, Health and Medicine*, pp. 183–206.

⁸⁰ K. Sangari and S. Vaid (eds.), *Recasting Women: Essays in Colonial History* (Delhi, 1989 and New Brunswick, 1990), p. 3.

⁸¹ Judith Bennet, quoted in N. Chaudhuri and M. Strobel (eds) *Western Women and Imperialism: Complicity and Resistance* (Bloomington, 1992), p. 4.

⁸² E. Said, *Orientalism* (New York, 1978).

⁸³ F. Barker, P. Hulme, and M. Iversen (eds) *Colonial Discourse/Postcolonial Theory* (Manchester, 1994), A. Brah, 'Time, Place, and Others: Discourses of Race, Nation, and Ethnicity. Review Essay', *Sociology*, 28 (1994), 805–13, J. Fabian, *Time and the Work of Anthropology. Critical Essays 1971–91* (Chur, 1991); R. Guha (ed.) *Subaltern Studies*, vol. VI (Delhi, 1989), R. Kabbani, *Europe's Myths of Orient: Devise and Rule* (London, 1986), R. O'Hanlon, 'Recovering the Subject: "Subaltern Studies" and Histories of Resistance in Colonial South Asia', *Modern Asian Studies*, 22 (1988), 189–224, R. O'Hanlon and D. Washbrook, 'After Orientalism: Culture, Criticism, and Politics in the Third World', *Comparative Studies in Society and History*, 34 (1992), 141–67; G. Prakash, 'Writing Post-Orientalist Histories of the Third World: Perspectives from Indian Historiography', *Comparative Studies in Society and History*, 32 (1990), 383–408; R. J. C. Young, *Colonial Desire. Hybridity in Theory, Culture and Race* (London and New York, 1995).

⁸⁴ Anderson, *Imagined Communities*, Fabian, *The Time and the Work of Anthropology*, E. Hobsbawm and T. Ranger (eds.), *The Invention of Tradition* (Cambridge, 1983), N. Thomas, *Colonialism Culture. Anthropology, Travel and Government* (Cambridge, 1994), Stoler, 'Rethinking Colonial Categories'.

⁸⁵ See for example J. Oppenheimer, 'Shattered Nerves'. *Doctors, Patients, and Depression in Victorian England* (New York, 1991); M. Micale, 'Hysteria Male/Hysteria Female. Reflections on Comparative Gender Construction in Nineteenth-Century France and Britain', in M. Benjamin (ed.) *Science and Sensibility: Gender and Scientific Enquiry, 1780–1945* (Cambridge, 1991), 200–39.

O'Hanlon pointed out, 'the attempt to reintroduce homogeneity and consensus within a redrawn idea of an essential collectivity, has arisen in the feminist debate', and First World feminists have rightly been invited to 're-examine their own sometimes totalitarian conception of "woman" as a homogenous category'.⁸⁶ Porter's point that Showalter wrote for 'all those concerned with what psychiatry has done to women, and what a new psychiatry could do for them'⁸⁷ is politically important. However, as discussed by Porter and Micale in their introduction to *Discovering the History of Psychiatry*, 'scholars have told us a great many tales about the past, in the present, for present purposes', what remains to be hoped for now is that future histories of psychiatry will 'be more self-aware'.⁸⁸

It may well have been the case that at one representational level the 'female malady' appeared to have been ubiquitous in nineteenth-century Britain and British India just as autobiographical accounts, visual art and literature teem with Romantic heat-and-dust representations of the exotic *raj*.⁸⁹ The dust gathered on historical records may be less fascinating than that evoked in Victorian travellers' accounts, but it is important to resist the temptation to get carried away with Romantic and exotic representations—appealing though they may have been to some social strata among 'the Victorians' as much as to the narrative-loving historical nomads of post-modernism.

The 'female malady' is certainly a historical construction which is highly relevant to women living in an age where they are in some countries on average about twice as likely as men to be diagnosed as depressed, anxious or neurotic. It also certainly captures the imagination more than the dry bones of analyses of institutional statistics, government proceedings, and medical reports. One important question, however, arising from the postulate of a nineteenth-century female malady is how we can challenge a hitherto male-dominated history without re-writing history in terms of the political requirements of the present, yet still managing to engage with and make history relevant to people who live in that present.

VI

Images of 'doolally-tap' expatriates and of 'mad-dogs and Englishmen' have become part and parcel of the folklore about life East of Suez. Along with these goes the image of European women—delicate, frail *English* roses in particular,—being subject to frequent nervous breakdowns and emotional over-reaction when faced with the strains of life in an alien tropical land. Yet, these images

⁸⁶ O'Hanlon, 'Recovering the Subject', p. 212.

⁸⁷ Roy Porter, quoted on back-cover of Showalter's book.

⁸⁸ R. Porter and M. S. Micale (eds.) 'Introduction: Reflections on Psychiatry and Its Histories', in Micale and Porter, *Discovering the History of Psychiatry*, p. 26. Porter and Micale's statement refers to the quote at the beginning of their chapter: 'History is a tale told about the past in the present for present purposes' (P. Ricoeur, *The Narrative Function*, 1979).

⁸⁹ See for bibliographic references the many examples cited in Kabbani, *Europe's Myths of Orient*, S. Suleri, *The Rhetoric of English India* (Chicago, 1992), Young, *Colonial Desire*.

which partly owe their—long-enduring—existence to the influences of the Romantic and Orientalist traditions, are, just as much as Romanticism and Orientalism, representative of but one strand of thought. It is therefore not surprising that medical reports and institutional statistics do not always necessarily substantiate these common representations—although some medical practitioners may have been tainted more than others by a Romantic strain in their conceptualization of patients' cases. Showalter's account of madness as a typically *female* malady may well have encapsulated an intriguing point in regard to one particular, not necessarily predominant, strain of public representations and gender stereotypes. Still, the general validity of her description for the purposes of conceptual analysis needs to be challenged as thoroughly as the implied assumption that Romanticism was the main driving force behind nineteenth-century psychiatric thinking in Britain and the *raj*.

There is evidence that women sometimes shared men's maladies, and sometimes suffered from different afflictions from the men in the colony. Either way we are able to trace organizing images of madness which appear to fit in with stereotypical images of femaleness and maleness. However, when we open up our perspective by contextualizing women's and men's maladies and relating them to other factors, such as social class, ethnicity and assumptions of colonial prestige and racial superiority, the face of madness becomes distinctly blurred to the extent that it is difficult to make out its gender. No single 'female malady', nor 'madness' alone and by itself, strode in British India's plains and hills. Rather, men's and women's mental illnesses presented themselves in varied ways, cut down by premature death on account of ubiquitous disease; restrained by military procedures; exacerbated by the ambition to maintain the prestige and rational ambience of the ruling class; complicated by an ethnic perspective which appeared to over-emphasize Englishness, yet was in practice challenged by a strong Scottish presence within government and the medical profession;⁹⁰ and, last but not least, further complicated once we venture to assess how racial assumptions impacted on the definitions of Europeans' and Indians' mental problems.

The focus of 'his' or 'her' malady is too narrow, and needs to be located within a wider perspective, which allows us to look at 'their' stories as set within a racialized, politicized, culturally modified, economically determined and therefore class-specific, *and*, last but not least gendered context. We would need to acknowledge that far from dealing with *one* type of 'madness', with *the* construct of 'femininity', or with *one homogenous* colonial setting, we ought to look at several different ones.⁹¹ Just as the sort of empire common soldiers and

⁹⁰ For the workings of metropolitan colonialism, see M. Hechter, *Internal Colonialism. The Celtic Fringe in British National Development* (London, 1975), and T. Nairn, *The Break-Up of Britain* (London, 1981).

⁹¹ Busfield suggests an 'increasing diversification of medical categories of madness in which assumptions of gender are embedded'. See Busfield, 'The Female Malady?', p. 276. Micale points at national differences in the way in which gender and psychiatry were constructed. See Micale, 'Hysteria Male/Hysteria Female'. The course of conceptually and empirically grounded localized theories and historically specific accounts is also taken by people working on racialisation, nationalism,

their wives lived in was different from that inhabited by officers and their spouses or from that created by civilians of different social standing and ethnic background, so would the men's and women's mad worlds be a diverse universe rather than one ruled only by gender. While it is important always to incorporate a gender perspective into accounts of socially constructed phenomena such as health and illness, we may lose sight of the complexity of reality by over-focusing on one factor. As Tomes put it 'feminist historians have to appreciate that medical theories about all sorts of diseases, including those that afflict women, circulated in an intellectual economy that did not have as its *only* purpose the definition and control of women'.⁹² We may run a danger of substituting a restricted and restrictive discourse of male power with a myopic discourse of femininity which neglects other, equally important, factors which impacted on the lives of mad men and women in diverse settings.

and cultural studies and anthropology. See for examples J. Solomos and L. Back, 'Conceptualising Racisms: Social Theory, Politics and Research', *Sociology*, 28 (1994), 143–61, Thomas, *Colonialism's Culture*; Fabian, *Time and the Work of Anthropology*, Brah, 'Time, Place, and Others'.

⁹² Tomes, 'Feminist Histories of Psychiatry', footnote 97.