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**'For Allah created the English mad, the maddest of all
mankind!': The Mental Health of the British in Colonial
India, 1900-1947.**

Michael Young

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for the degree of Doctor of Philosophy

February 2018

Statement of submission

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ABSTRACT

The thesis investigates the theory that there were many physical and social factors inherent in the lives of the British in colonial India in the twentieth century which predisposed some of them to mental illness. It seeks to learn more about those individuals who became mentally distressed during their service to the Raj and the treatment they received.

The study begins with an interrogation of the literature of the history of modern Western psychiatry and its relevance to colonial India between 1900 and 1947. With the use of contemporaneous text books and Indian professional medical journals it explores how psychiatry was implemented in the sub-continent.

These considerations are followed by an exploration of the physical and social determinants of stress in such areas as climate and topography. It identifies the stressors associated with the artificial and archaic society of Britons in India, who are shown to be an ethnic minority determined to preserve their privileged position. The use of the *cultural web*, an investigative tool adapted from the study of organisational change, illustrates how the colonial rulers were incapable of changing their lifestyle as national and international developments began to impact on them as a community.

Evidence is provided showing how the profession of psychiatric nursing was generally ignored by the colonial nursing establishment and often disparaged by doctors. Previously unseen medical case records from the European Mental Hospital at Ranchi in northern India give insight into the practice of psychiatrists and their attitudes to their patients. It identifies the rapidity with which methods of treatment newly developed in Europe were implemented at the hospital.

The thesis concludes that there were many stressful factors in British life in colonial India which could lead to mental illness and identifies several topics suitable for further academic research. It also shows that the European Mental Hospital in India was in the forefront of international psychiatric practice in the 1920s and 1930s.

TABLE OF CONTENTS

Statement of submission.....	i
Acknowledgments	ii
Abstract	iii
Glossary	1
List of abbreviations.....	2
List of boxes	3
List of figures	4
List of tables	5
CHAPTER 1	6
Introduction.....	6
<i>A note on language.....</i>	13
<i>Outline of the thesis.....</i>	15
CHAPTER 2	17
Historians versus Psychiatrists: bitter conflict and much enthusiasm.....	17
<i>Introduction.....</i>	17
<i>The doing of history.....</i>	17
<i>'Great Men,' Whigs and Foucault.....</i>	20
<i>The doing of conflict: the attack on psychiatric legitimacy</i>	25
<i>The profession of psychiatry fights back.....</i>	30
<i>The 'force-field' of conflict</i>	33
Social control and discounted paradigms	35
<i>The dearth of historical research into psychiatric nursing.....</i>	41
<i>Historiography of Imperial health</i>	47
<i>Historiography of Imperial psychiatry.....</i>	52
<i>Conclusion.....</i>	66
CHAPTER 3	67
Western Psychiatry in India, 1900-1947.....	67
<i>Introduction.....</i>	67
<i>The Indian Medical Service (IMS).....</i>	68

<i>An overview of the history of modern psychiatry in India</i>	74
<i>A three stage model of psychiatric development in India, 1900-1947</i>	77
The gradual process of modernity, 1900-1918	78
Innovation and self-confidence, 1918-1939	94
The years of emergency and through to Independence, 1939 to 1947.....	107
<i>The creation of neurasthenia and tropical neurasthenia</i>	110
<i>Colonial migration and mental asylums</i>	124
CHAPTER 4	128
Climate, boredom and isolation: stress factors of daily living for the British in colonial India	128
<i>Introduction</i>	128
<i>A definition of stress</i>	129
<i>The impact of climate on mental stress</i>	131
<i>The impact of boredom on mental stress</i>	143
<i>The impact of isolation on mental stress</i>	150
<i>Finding ways to cope</i>	154
<i>Conclusion</i>	160
CHAPTER 5	162
A culture under stress: cultural pressures facing the British in colonial India	162
<i>Introduction</i>	162
<i>Stress within the socio-cultural context</i>	163
<i>British culture in colonial India</i>	165
<i>Culture and stress of the British in India</i>	173
<i>The cultural web</i>	176
<i>Application of the cultural web in colonial India</i>	179
<i>Conclusion</i>	203
CHAPTER 6	205
A 'hidden dimension': nursing distressed British Imperial Minds in colonial India, 1900 - 1947.	205
<i>Introduction</i>	205
<i>The development of the mental nursing profession</i>	206
<i>Perspectives on general nurses and mental nurses</i>	217
<i>Doctors' views of mental nurses</i>	223

<i>Treatments and the role of the mental nurse</i>	231
<i>Conclusion</i>	235
CHAPTER 7	237
A case study of the European Mental Hospital at Ranchi, 1918 to 1947.	237
<i>Introduction</i>	237
A mental hospital for Europeans in India	238
<i>The archives of the European Mental Hospital</i>	241
<i>The case record forms</i>	243
<i>European Mental Hospital records, 1918-1947</i>	245
<i>Diagnoses of patients</i>	253
<i>Forms of treatment</i>	256
<i>Individuals and their treatments</i>	259
<i>Published papers on treatment of EMH patients</i>	268
<i>The patient's voice or the doctor's bias?</i>	270
<i>The patient journey and the EMH</i>	273
<i>The lack of alternative accommodation</i>	276
<i>Repatriation of patients</i>	278
<i>Permeable walls or an impenetrable prison?</i>	281
<i>The 'So-called European Mental Hospital at Ranchi'</i>	285
<i>Conclusion</i>	286
CHAPTER 8	288
Conclusion	288
BIBLIOGRAPHY AND SOURCES	293
Appendix 1 – Warrant of precedence	329
Appendix 2 – Lunatic Asylum, Calcutta, 1851	330
Appendix 3 – Lunatic Asylum, Calcutta, 1851	331
Appendix 4 – Portrait of Owen Berkeley-Hill (1879-1944)	332
Appendix 5 - The Central Institute of Psychiatry, Ranchi, India, formerly the European Mental Hospital	333
Appendix 6 – Awakening, a poem	334

(Word count excluding Bibliography, Footnotes, Table of Contents etc 85,937)

GLOSSARY

Ayurvedi	Traditional Hindu form of healing
Burra	A senior sahib, an important European.
Chi chi	An offensive racial term used by Europeans about Anglo-Indians
Chota	Small
Dargah	Religious shrine associated with healing
Doolally tap	Mentally deranged behaviour
Domiciled Europeans	People of European origin with no Indian blood connections and settled permanently in India
Independence	For India and Pakistan 15 th August 1947. For Burma 4 th January 1948
Loafer	A white vagrant or beggar, a white scrounger
Ma Bap	The Raj as mother and father of Indians
Memsahib	A respectful term for a married European lady.
Moffusil	Up-country, as opposed to urban
Nabob	Wealthy British merchant in India in 18 th century
Punkah	A manually operated fan
Raj	Rule; British sovereignty in India
Sahib	A respectful term for a European man in India.
Sepoy	An Indian soldier of low rank
Shikar	Hunting and shooting of wild animals
Sola topi	A pith helmet
Station	The, usually, self contained British settlement on the edge of an Indian town
Subadar	An Indian soldier in the Indian Army, roughly equivalent to a captain
Unani	Traditional Islamic form of healing
Wallah	Person with a particular occupation

LIST OF ABBREVIATIONS

BMJ	British Medical Journal
CIP	Central Institute of Psychiatry, Ranchi, India
EMH	European Mental Hospital
ICS	Indian Civil Service
IMG	Indian Medical Gazette
IMS	Indian Medical Service
INS	Indian Nursing Service
JMS	Journal of Mental Science
MPA	Medico-Psychological Association
NJI	Nursing Journal of India
QAIMNS	Queen Alexandra's Imperial Military Nursing Service
TNAI	Trained Nurses Association of India

LIST OF BOXES

Box 3.1	Mills’s overview of Western psychiatry in India.....	74
Box 3.2	Three stages of psychiatric development in India, 1900-1947.....	78
Box 3.3	Ewens’s Classification of Mental Diseases.....	81
Box 3.4	Bruce’s Classification of Insanity.....	87
Box 3.5	Army Council Nomenclature of Mental Diseases, 1917/18.....	91
Box 3.6	Jagoe Shaw’s classification.....	97
Box 5.1	Elements of the Cultural Web defined.....	178
Box 7.1	Demographics at the EMH – summary of key findings.....	248

LIST OF FIGURES

Figure 2.1	A force field analysis of conflict between radicals and psychiatrists...35
Figure 5.1	The Cultural Web.....177
Figure 5.2	A cultural web for British culture in India.....182
Figure 7.1	The Patient Journey into, through and out of the European Mental Hospital.....275

LIST OF TABLES

Table 3.1	Officer strength of the IMS (Permanent).....	69
Table 3.2	Officer strength of the IMS (Temporary).....	629
Table 7.1	Number of admissions to the EMH per patient.....	24637
Table 7.2	Occupations of male patients at the EMH.....	2494
Table 7.3	Occupation of female patients at the EMH.....	250
Table 7.4	Ethnic origin of patients at the EMH.....	25143
Table 7.5	Diagnoses recorded on patients' case notes.....	25445
Table 7.6	Cost of repatriation of Mrs E S to the UK in 1948.....	2871

CHAPTER 1

Introduction

For Allah created the English mad – the maddest of all mankind!

Rudyard Kipling, (1898)¹

The purpose of this thesis is to argue that there were many factors inherent in the lives of the British in colonial India which predisposed them to mental illness. It will be shown that issues such as the climate, boredom, geographical and social isolation, and the culture which the British created for themselves in India were major sources of potential mental distress. The thesis contends that, as a heavily outnumbered ethnic minority and the ruling race, the British endured a permanent source of anxiety leaving many sometimes unable to cope with the stresses and challenges inherent in imperial life.

The above epigraph and title of this thesis came from a poem by Kipling entitled *Kitchener's School* written in the aftermath of the latter's victory at Omdurman in the Sudan in 1898. The words were adapted by Kipling from a popular Bengali song which expressed disbelief that Kitchener, the British General, could defeat an enemy in battle and then fundraise in England to build them a secondary school in Khartoum, where pupils might acquire sufficient knowledge to be able to fight their colonial rulers more successfully in the future. As Kipling's latest biographer pointed out, the composer believed the English were mad victors for treating their foes with such respect (and teaching them the mysterious game of cricket!).² Kitchener's machinations may have been part of a calculated political strategy rather than an act of madness but, as will be shown, the interpretation of madness through the decades has been consistently subjective.

Elizabeth Collingham has written of how the British experience of India was essentially physical.³ She described how the individual Briton embodied the physical

¹ Kipling, Rudyard (1960) 'Kitchener's School,' *The Definitive Edition of Rudyard Kipling's Verse*, Hodder and Stoughton, London, p, 202.

² Lycett, Andrew (2015) *Rudyard Kipling*, Weidenfeld and Nicolson, London, pp 415-416.

³ Collingham, Elizabeth M. (2001) *Imperial Bodies: The Physical Experience of the Raj*, Polity Press, Cambridge.

appearance of the *Raj*, a metonym for British rule in India. Their clothes proclaimed the bodily presence of a superior civilisation and race. As the nineteenth century progressed the stereotypical Briton in India changed from the *nabob*, the merchant gradually and purposefully acquiring personal wealth, who was often friendly with Indians, sometimes marrying them, and imitating their dress and customs, to the *sahib*, the sober, bureaucratic representative of empire who retained a superiority and aloofness from Indians. Collingham's work described how the *sahib*, and his dependents as members of the elite, developed the persona of *Imperial Bodies* justified by concepts of racial and civilisational superiority. It is the contention of this thesis that the British experience of India was also a mental one and sometimes distressed *Imperial Minds*, those individuals who were unable to cope with the mental stresses inherent in maintaining the *Raj*, were clearly unsuited for their role within it.

The aim of the research was to gain greater understanding of distressed British *Imperial Minds* in colonial India. It considered and analysed the methods designed and implemented by Western psychiatrists practising in India to treat them. It will show that Western psychiatry was innovative in its treatment of European patients with the adoption of new methods of treatment soon after their invention in Europe. The work will concentrate on the period between 1900 and Indian Independence in 1947 with special reference to the European Mental Hospital (EMH) at Ranchi in northern India in present day Jharkhand state.

This thesis is original in its exploration, within the context of the development of a Western model of psychiatry in India, of the mental stresses experienced by Britons who were the visible representatives of the *Raj* to Indians. It uses primary sources combining contemporary medical case notes on individual patients, previously unseen by researchers, with the writings of psychiatrists who treated them. It also incorporates interpretations by academics from different disciplines together with those of journalists, diarists and recognised literary figures from the period. Their findings are used in the research to provide the foundation for the theory that there were distressed *Imperial Minds*, British people unable mentally to fulfil the roles expected of them in colonial India.

Some Britons clearly relished the lifestyle presented to them in India which was not available at home.⁴ The privileges associated with membership of the ruling class, the quality of life which came with an ample supply of servants, and the chance to indulge in sports and *shikar*⁵, are a few examples of what awaited the white middle class *sahibs* and *memsahibs*.⁶ The majority of whites in India however were, being mainly soldiers and their dependents, relatively poor⁷ but enjoyed privilege because of their whiteness. Irrespective of their background many whites experienced great difficulties managing the extremes of climate, the absence of European company in remote areas and the consequent loneliness through their self-imposed barrier to relationships with other races. There was also the widespread fear amongst the British of a recurrence of the unexpected and violent rebellion of 1857-58 and, for some, the dislike and open contempt for Indian religions and culture and even for Indians themselves. The research carried out will show that some Britons suffered from mental distress in India and, although its occurrence was occasionally acknowledged in print outside of medical publications, its description was often disguised by euphemism.

To explain the research findings it has been essential to acquire an understanding of how the social, cultural and political life of Britons in India had developed and how these aspects operated between the two world wars, together with a study of its interpretation by scholars. It has also been necessary to appreciate how individuals survived in an alien environment and to recognise that some were less able than others to cope mentally with the challenges it presented to them.

In a recent collection of articles edited by Angela McCarthy and Catherine Colborne concerned mainly with European and Asian emigration to Australia, New Zealand and Fiji, the various contributors analysed medical case notes from the nineteenth and twentieth centuries in the asylums set up in those countries by the

⁴ See, for example, Noble, Fraser (1997) *Something in India*, Pentland Press, Bishop Auckland. Co. Durham, and Cartwright, Jill (1998) *The Garlands of Ranpur*, Pentland Press, Bishop Auckland, Co. Durham.

⁵ *Shikar* was the hunting and shooting of wild animals.

⁶ 'A respectful term for a married European lady,' as defined in Yule, Henry and Burnell, A. C., (1886) *The Concise Hobson-Jobson: An Anglo-Indian Dictionary*, Wordsworth, Ware, Hertfordshire, Concise Edition, 2008 (facsimile of 1886 edition) p. 274.

⁷ Arnold, David (Jan 1979) 'European Orphans and Vagrants in India in the Nineteenth Century,' *Journal of Imperial and Commonwealth History*, vol. vii, no. 2.

colonial authorities.⁸ McCarthy and Coleborne considered the overall situation of migrants travelling from Britain and proposed that white settlers could be regarded as an *at risk* category both because of their weakened family links or because of their frequent poverty.⁹ The thesis will build on their research in the Indian colonial context.

The low numbers of the British in India was evident from census figures. Thus the Census of India returns for 1921 indicated that there were 124,991 males and 50,746 women of 'European and Allied Races' living in India in 1921, a ratio of European males to European females of 2.5 to 1.¹⁰ These figures were considered to have been inflated by some Anglo-Indians claiming to be 'fully' European. Many Britons believed that, as a tiny minority in India, never more than 0.05% of the total population,¹¹ their rule was dependent on maintaining their prestige amongst Indians. They sought to preserve the Raj by presenting a view, and ideally a united one, that they were the official representatives of a superior race, culture and level of civilisation. For British leaders in India the imperial project meant the civilised path to social progress and the whole of the British community, rich and poor, were to be part of it. The pressures and anxieties associated with these principles proved stressful for many in this imperial diaspora. Modern research studies have shown that ethnic minorities and migrants are regarded as vulnerable groups when predisposition to mental illness was being considered.¹² Evidence has shown that ethnic minorities who have moved to live or work in a foreign country suffered disproportionately from mental illness when compared to the majority indigenous community.¹³ The British in colonial India were such a minority, albeit a privileged

⁸ McCarthy, Angela and Coleborne, Catharine (Eds) (2012) *Migration, Ethnicity and Mental Health: International Perspectives, 1840-2010*, Taylor and Francis, Abingdon, Oxfordshire.

⁹ McCarthy and Coleborne, *Migration*, p. 2.

¹⁰ See the Census of India 1921 at <https://ia800205.us.archive.org/18/items/cu31924014522746/cu31924014522746.pdf> (Accessed 6th June 2017).

¹¹ Maddison, Angus (1971) *Class Structure and Economic Growth: India and Pakistan since the Moghuls*, George Allen and Unwin, London, p. 44.

¹² See, for example, World Health Organization (2014) <http://www.who.int/mediacentre/factsheets/fs396/en/> (Accessed 9th May 2016); and Fernando, Suman *Mental Health Worldwide: Culture, Globalization and Development*, Palgrave Macmillan, Basingstoke, Hampshire.

¹³ See for example McKenzie, Kwame *Improving mental healthcare for ethnic minorities* (2008) at <http://apt.rcpsych.org/content/14/4/285> Royal College of Psychiatrists, Published 30 June 2008 (Accessed 3rd March 2015) and World Health Organisation, *Mental Health Action Plan 2013-2020* at http://www.who.int/mental_health/action_plan_2013/bw_version.pdf (Accessed 3rd March 2015)

one. They were faced with the stresses from loneliness and isolation, from the misunderstanding and sometimes dislike or even abhorrence of different cultures, races or religions, from a climate which could be both alien and debilitating, and from an underlying fear that the unexpected and bloody *Great Rebellion* or *Mutiny* of 1857-8 might happen again.¹⁴

As is the nature of mental disorder some Europeans were more affected than others by these stresses of rule in India while some of these *Imperial Minds* were better able to cope with them than others. Many Britons in India enjoyed the challenges of imperialist conquest and administration and responded proudly and devotedly to the inherent responsibilities of duty and colonial service.¹⁵ Others however succumbed to mental illness as a reaction to what Mrinalini Sinha has termed the 'trauma' of imperialism,¹⁶ which might arise from the response to the factors inherent in the exploitation of subject peoples.

The British in India developed a culture of their own which gradually diverged from that in Britain, especially after 1914 when many of the connections with home were severed for four years by war. A consequence of this was an increasing feeling of isolation and neglect as the British government at home promoted Indianisation as the official route to Independence whilst many Britons in India believed fundamentally that Indians would be incapable of managing their own affairs for many decades to come.

The extent to which mental ill health in a society can be quantified must always result in varying estimates because of the subjective nature of diagnosis itself. Some who were diagnosed may dispute that they were ill at all.¹⁷ When, how or if eccentricity or genius becomes mental illness is the subject of permanent debate. Modern research suggests that one in four adults in Britain will experience a mental illness in their

¹⁴ See for example, James, Lawrence (1997) *Raj: The Making and Unmaking of British India*, The Softback Preview, London, *passim* and Washbrook, David 'The Indian Economy and the British Empire, in Peers, Douglas M and Gooptu, Nandini (2016) *India and the British Empire*, Oxford University Press, Oxford, especially pp. 44-74.

¹⁵ See for example the memoirs of Yeats-Brown, F. (1930) *Bengal Lancer*, Victor Gollancz, London; Wakefield, Sir Edward (1966) *My Life in India, 1927-1947*, Chatto and Windus, London; and Trevelyan, Humphrey (1972) *The India We Left*, Macmillan. London.

¹⁶ Sinha, Mrinalini 'Foreword,' in Burton, Antoinette (2011) *Empire in Question*, Duke University Press, Durham, North Carolina, USA, p. xv.

¹⁷ Burns, Thomas (2013) *Our Necessary Shadow: The Nature and Meaning of Psychiatry*, Allen Lane, London, pp. 203-4.

lifetimes¹⁸ and that for ethnic minorities in a foreign country, of which the British in India were one, the rate is higher than for the indigenous population.¹⁹ Attempting to gauge precisely the incidence of mental illness amongst the British in colonial India would be an impossible, unwise and futile exercise as it would become mired in the prejudices and fashions of then and now.²⁰ However what the research did show was that many Britons suffered mental distress in forms recognisable today and that British society in India responded at an individual level with a mixture of sympathy, embarrassment, shame and fear. At an organisational level they reacted with an efficient bureaucracy driven by officials who sought to protect their mentally ill from the eyes of their colonial subjects and by psychiatrists who were keen to extend the knowledge in their profession whilst being committed to consolidating their role in the colonial state.

Methodology

The methodology used to complete this thesis was underpinned by professional experience gained through a lifetime's career as a social worker and a senior manager in statutory mental health services. This was based in a variety of settings including long stay hospitals, the former *lunatic asylums*. I have seen the grief caused to individuals and those close to them by mental distress and suicide and how, sometimes, it could be relieved by combinations of medical, social work and nursing skills with the support of the persons' friends, families and others. I have adapted some of the management tools I acquired during my career to assist with the explanations used in the thesis.

As the author of this thesis I am guilty but not ashamed of my 'knowledge by acquaintance' of mental ill health. The phrase was first used in 1994 by German Berrios, at the height of the conflict between historians of psychiatry and psychiatrists who studied the history of their own discipline. One of the latter, Berrios,

¹⁸ Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. (2001) *Psychiatric Morbidity Among Adults Living In Private Households 2000*, The Stationery Office, London, p.32.

¹⁹ Fernando, Suman (2014) *Mental Health Worldwide: Culture, Globalization and Development*, Palgrave Macmillan, Basingstoke, *passim*.

²⁰ Andrews, Jonathan (1998) 'Case Notes, Case Histories and the Patient's Experience of Insanity at Gartnavel Royal Asylum, Glasgow in the Nineteenth Century,' in *Social History of Medicine*, vol. 11, no. 2, p. 265.

coined the term 'knowledge by acquaintance' when relating how clinicians used their professional language of description and observation of behavioural changes.²¹

I enhanced my 'knowledge by acquaintance' with visits to Pakistan and India to learn more of the culture of the extended families with whose members I had worked in West Yorkshire. My time on the sub-continent fuelled my interest in the Britons who had represented the Raj in a sometimes hostile environment and in the implications of being a heavily outnumbered ethnic minority.

When my formal research began I studied academic works on the history of Western psychiatry and found that there were relatively few studies of its implementation in colonial India. Textbooks on psychiatry produced especially for use in India gave insight into the views and knowledge of psychiatrists and of the latter's patients, and how these changed in the last fifty years of British rule.

I read numerous diaries and memoirs of Britons who had lived in colonial India. The information acquired from them elicited valuable insights into the everyday activities and challenges faced by soldiers, civil servants, telegraph workers, forestry officials and others. In addition I read numerous contemporaneous novels written by Britons in India which had run into many editions. Whilst of course these contained fictional accounts of events they identified issues which were important to the British community. The novels had recurrent themes of their heroism, their moral superiority and their self-sacrifice in duty in adversity. In my view this interdisciplinary approach has added to my understanding of the lives and culture of the British in colonial India.

Knowledge was acquired through personal research at the National Archives of India in New Delhi and by visiting and studying at several psychiatric hospitals in the country including the Central Institute of Psychiatry for India (CIP), formerly the EMH. I visited the CIP between 26th November and December 3rd 2013 and again between 26th March and 6th April 2016. Permission was given to me by the Director to stay at the hospital Guest House, to meet and talk with doctors and other staff and to study the original medical case notes which had been recorded onto DVDs around 2008. The perusal of these archives at the EMH proved problematic as many original files had not survived and some were incomplete. Some had been damaged by termites whose work could still be seen in extant records. The limited number of files

²¹ Berrios, G. E. (1994) 'Historiography of mental systems and disease,' *History of Psychiatry*, vol. 5, p. 176.

left gaps and required caution in their interpretation. Whilst reading the records I was always conscious that, apart from occasional and anonymous notes by mental nurses, the entries had all been written by male doctors and contained extremely rare appearances of the female voice.

This study of novels and life-writing authored by Britons who had lived in India helped me to develop my arguments that the community faced challenges from their environment and from the unremitting unease about the possibility of another rebellion against their authority. Using an interdisciplinary approach throughout the thesis ensured a wider and deeper understanding of the topic. Thus, in the same way that Mark Jackson in his work on stress²² combined research in history with various branches of science and sociology my thesis linked history with psychiatry, literature, geography and management studies.

A note on language

In any study of the British in India there are two recurring terms which can cause confusion because of their different meanings when used in different contexts and so need a more precise definition: *Anglo-Indian* and *European*.

Britons with strong family links with the UK usually called themselves Anglo-Indians until the end of the Raj and this was how they were generally referred to in newspapers and novels. In the eighteenth century *Anglo-Indian* had applied to both the British in India and their Indian-born children. The term was often interchangeable with *white*, *European* or simply *British*. As the nineteenth century progressed people of mixed British and Indian heritage began to refer to themselves as Anglo-Indian emphasising their Britishness over their Indianness. Their entries as *British* in the census of India caused problems for the collectors of statistics as the latter preferred to categorise them as *Eurasians*.²³ From 1911 the term *Anglo-Indian* was officially defined as

a person whose father or any of whose other male progenitors in the male line is or was of European descent but who is domiciled within the territory

²² Jackson, Mark (2013) *The Age of Stress: Science and the Search for Stability*, Oxford University Press, Oxford.

²³ Buettner, Elizabeth *Empire Families: Britons and Late Imperial India*, Oxford University Press, Oxford, 2004, p. 8.

*of India and is or was born within such territory of parents habitually resident therein and not established there for temporary purposes only.*²⁴

This definition became incorporated in the Government of India Act in 1935 and later in the Constitution of India produced after Independence. In this thesis *Anglo-Indian* will refer to people of mixed British male and Indian heritage unless stated otherwise. By definition Anglo-Indian status could not legally be conferred on women of mixed heritage lacking white male ancestry. Those with mixed parentage became known as half-caste during the nineteenth century or as, Eurasian, Indo-Briton, Asiatick or East Indian.

When Westerners began to travel to and trade with India and to live there *European* was their preferred description. It was also used to include other nationalities such as French or Greek. It was a definition based on race and implied a strong connection with European countries and the expectation that those so termed would retire there after their work in India was completed. *European* became interchangeable with *British* or *white* and was used generally by British and Indians to describe someone of white racial appearance and it will be used in this context throughout this thesis. The word *English* almost became synonymous with *British* and included Scots, Welsh and Irish colonists.

The term *Domiciled European* was used to describe poor whites who no longer had a family connection with Britain and could not afford to return there. It became a term of abuse from those who regarded themselves as superior because of their continued links with the motherland.²⁵

Until the late 1930s British doctors of the mentally ill in India called themselves *alienists* before adopting the name *psychiatrist* which had become commonly used in the German-speaking world from the late nineteenth century. The two terms will both be used in this thesis.

²⁴ See James, Sheila Pais (2010) 'The Origins of the Anglo-Indians' in *International Journal of Anglo-Indian Studies*, vol. 10, no. 2, <http://home.alphalink.com.au/~agilbert/covij18.html> Accessed 6th March 2015. There was no pagination.

²⁵ Buettner, Elizabeth (2000) 'Problematic spaces, problematic races: defining 'Europeans' in late colonial India,' *Women's History Review*, vol. 9, no. 2, pp. 278-80.

Outline of the thesis

The thesis takes the form of a series of layers beginning with an academic historiographical approach to the subject from both international and colonial perspectives. It will then move from the history of Western psychiatry and its implementation and development in India to that of the professions delivering it. It will then consider the contribution to psychiatry of individual doctors and nurses. Finally it will consider the journey of individual patients, those distressed *Imperial Minds* at the end of the psychiatric process.

Chapter 2 will analyse existing academic studies related to the mental health of the British in colonial India and how this was influenced by Western psychiatry. This historiography considers research from both Western and Indian scholars and the different interpretations of what constituted mental ill health in the context of race and gender. It will review the literature which has been produced and identify the gaps which need to be addressed in this thesis for further research into the practice of psychiatry amongst the British in colonial India.

How the model of Western psychiatry was implemented in India between 1900 and 1947 will form the basis of Chapter 3. It will look at the growth of psychiatric text books designed specifically for European practitioners in India, articles they wrote in medical journals and some of the attitudes which accompanied these writings. The chapter will assess the influence of research and practice in the German-speaking world on British psychiatrists including those who practised in the colonies. It will also address how tropical neurasthenia, as a mental condition, was debated amongst doctors in India and in other colonial countries.

Chapters 4 and 5 will address the issues associated with stress and how these impacted on colonialists. The Indian climate, boredom and geographical and physical isolation experienced by some of the British in India were factors leading to stress and the possibility of mental illness and will be addressed in Chapter 4. It will be proposed in Chapter 5 that Europeans in India were part of a culture under stress. The potential stress factors will be analysed adapting a tool known as the *cultural web* derived from organisational management studies.

Whilst much of the thesis concerns knowledge acquired from the publications or medical case notes of psychiatrists it should not be forgotten that other professionals such as nurses played an important role in treating and caring for the

mentally unwell. Despite the paucity of primary resources Chapter 6 aims to determine the contribution of mental nurses who cared for distressed *Imperial Minds* in colonial India. It will show how their role was stressful and shared the isolation and climatic extremes of their fellow Europeans and how their weakness within the nursing profession was compounded by their gender and domination by male psychiatrists.

Chapter 7 contains a detailed analysis of original individual medical case records researched at the former European Mental Hospital (EMH) at Ranchi in northern India. It will attempt to define the attitudes of psychiatrists and, with caution, to relay the voice of some of those patients for whom records have survived.

Whether the English were 'the maddest of all mankind' can never realistically be determined objectively but the statement provides an intriguing proposition which will be referred to throughout this thesis. The next chapter will consider the historiography of the development of psychiatry and its relevance to India in the first half of the twentieth century.

CHAPTER 2

Historians versus Psychiatrists: bitter conflict and much enthusiasm

In the end, the history of psychiatry is a history of therapeutic enthusiasm, with all of the triumph and tragedy, hubris and humility such enthusiasm brings.

Brendan Kelly (2016)²⁶

Having a history confirms the legitimacy of the service one provides; mere inclusion in the history of another group implies mere subordination.

Peter Nolan (1993)²⁷

Introduction

This chapter will explore the scholarly narrative of the study of psychiatry in Western Europe and how it has been adapted to an understanding of the mental health of the British in colonial India, particularly in the period between 1900 and 1947. As the model of psychiatry which the British brought to India was deeply rooted in developments in nineteenth century asylum science in Britain attention will be given to its historiography in that location. Particular attention will be given to the works of Michel Foucault and the insight which he brought to the topic. In addition, the contributions to the historiography by both academic historians and those enthusiastic psychiatrists who were concerned with the history of their own profession will be considered, as will the polemical debate which ensued. The understanding of the historiography, including that of psychiatric nursing, will be assisted by comparative findings from historians of imperial psychiatry in other colonies. The interpretations of Indian scholars, often different to those of their Western counterparts and sometimes overlooked, will be given close attention.

The doing of history

Historiography has been defined by Ludmilla Jordonova as ‘the writing of history and the study of historical writings...an awareness of doing history.’²⁸ In her study of this

²⁶ Kelly, Brendan letter in *The Guardian*, Review section, 19th November 2016, p.2. Kelly is a professor of psychiatry at Trinity College, Dublin.

²⁷ Nolan, Peter (1993) *A History of Mental Health Nursing*, Stanley Thornes, Cheltenham, p. 1.

doing of history she warned that it was crucial to recognise the interests, prejudices, working assumptions etc. of the historian presenting his or her arguments. She stressed that to use the term *biased* would be wrong as it would imply that *unbiased* judgements could also exist. These exhortations are particularly apt for anyone compiling a historical study of psychiatry. Thus for example the medical case notes analysed in Chapter 7 were written by practising psychiatrists and limited information was found concerning patients themselves or their carers. An awareness will be demonstrated throughout the thesis of the risks, conscious or not, associated with working within a Eurocentric model of the history of psychiatry.

Any writing of history is subject to Jordonova's warnings about bias. This is especially so in studies of the history of psychiatry, a discipline whose development has been the subject of heated political, scientific and philosophical argument. There is no consensus amongst academics on what constitutes madness or mental illness. Discourses involved in understanding the history of modern psychiatry cover a range of studies from those who accepted that psychiatry has developed into a branch of the medical profession which can alleviate the suffering of the mentally ill²⁹ to those who flatly rejected the very existence of mental illness at all.³⁰ It covers the writings of those committed to the Hippocratic Oath and the term often associated with it "First Do No Harm,"³¹ and those, sometimes the same people, who are seen as agents of imperial control. The content of these often contradictory arguments were characterised by the enthusiasm identified in Kelly's epigraph.

In the search for historical honesty Jordonova advocated a healthy scepticism calling on historians to be as transparent as possible in explaining how opinions declared in writing have been obtained.³² In an extension of this point J G A Pocock pointed out that the presentation of historiography was necessarily selective and might even consist of narratives whose interpretations were deliberately not made to

²⁸ Jordonova, Ludmilla (2000) *History in Practice*, Arnold, London, p. 213.

²⁹ See Bhugra, Dinesh, Ventriglio, Antonio and Bhui, K.S.(December 2016) 'What's in a name? Reclaiming mental illness, *The Lancet Psychiatry*, vol. 3, pp. 1100-1101. Bhugra is a consultant psychiatrist and a former President of the Royal College of Psychiatrists.

³⁰ Disbelief is well represented in the works of Thomas S. Szasz such as (1974) *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, Perennial Library – Harper Row, New York, and (1973) *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement*, Paladin, St Albans.

³¹ See Sokol, Daniel K (25th October 2013) "First Do No Harm," Revisited,' *British Medical Journal (Clinical research edition.)* vol. 347, p. 6426. This phrase does not actually appear in the Oath itself.

³² Jordonova, *History*, p xvi

be truthful. He asserted that historiography was fundamentally political and to claim otherwise would be a political statement in itself. Important sources of material for the historian are archives which literate societies have chosen to compile. In this manner, said Pocock, societies have kept a narrative presentation of their histories from which, of course, other 'unwanted' material could have been excluded. There will be material in archives which was circumstantial and was subject to different interpretations by different researchers.³³ The presence of colonialism in this research study has added another dimension of complexity for consideration.

Pocock's work on historiography can be adapted to the study of psychiatric hospitals or lunatic asylums which played a dominant role in the history of mental illness in the nineteenth and twentieth centuries. He stated that:

*[I]nstitutions are structures of regulated actions in which agents are directed to act in certain ways when they find themselves, or can claim to be, in certain circumstances.*³⁴

Such institutions, he maintained, developed a memory whose medical records and other documentation are recorded according to the agencies' rules and regulations. This point was illustrated in research undertaken by the historian Jonathan Andrews who found that:

*the foremost difficulty in using case notes and questionnaires is that they often convey more about the preoccupations of the Asylum's medical regime than about patients and their histories. Far from representing patients' impressions case notes pre-eminently constitute the impressions of the medical officers who wrote them.*³⁵

Andrews believed that doctors, Pocock's 'agents' in this instance, wished to portray a favourable impression of their own practice. The compiler would know that his

³³ Pocock, J.G.A. (2005) 'The politics of historiography,' *Historical Research*, vol.78, no. 199, pp. 2-3-

³⁴ Pocock, 'The politics,' p. 5.

³⁵ Andrews, Jonathan (1998) "Case Notes, Case Histories, and the Patients' Experience of Insanity at Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century," *Social History of Medicine*, vol. 11, no. 2, p. 265.

patients' records could be consulted in future years by practitioners responsible for treating long stay residents. These warnings by Pocock and Andrews will be heeded throughout the thesis particularly in the examination of the medical case records at the former European Mental Hospital in Ranchi.

'Great Men,' Whigs and Foucault

There is perhaps no other branch of medicine than psychiatry which has been subject to such consistent and aggressive challenge whilst generating so much controversial political debate. One recent study of prominent historians of psychiatry questioned whether *madness* was a medical disease, a problem with everyday living or a labelling of social deviance.³⁶ It concluded that the answer was dependent on such factors as the historian's personal viewpoint and agenda and his or her use of language. It seems inevitable that any new academic contribution to the history of psychiatry, including this one, will be scrutinised immediately for evidence of the author's prejudices. Reference to psychiatry as a genuine medical discipline is also, of course, a statement of bias.

Until the mid twentieth century the history of psychiatry had been mostly the province of the clinicians themselves. Their narratives were generally self-congratulatory, spoke of benign progress and sought to legitimise their authors' profession. Their stories were those referred to by Charles R. King as the *Great Men* of medicine, never women, who recorded great deeds in the service of humanity.³⁷ The Tukes, James Crichton-Browne, Henry Maudsley and Charles Mercier³⁸ in Britain, Emile Kraepelin in Germany, Adolf Meyer in Switzerland and the USA and others, were revered as heroic figures who had pushed back the boundaries of psychiatric knowledge with their pioneering practice, dedication and discoveries of the workings of the human mind.

³⁶ Gomory, Tomi, Cohen, David and Kirk, Stuart A. (2013) 'Madness or Mental Illness? Revisiting Historians of Psychiatry,' *Current Psychology*, vol. 32, 1968. DOI: 10.1007/S12144-013-9168-3.

³⁷ King, Charles R. (September-October 1991) 'The historiography of medical men: from great men to archaeology,' *Bulletin of the New York Academy of Science*, vol. 67, no. 5, p.408-410. King was a physician who wrote of a past tendency of doctors, without any pretence of objectivity, to glorify the deeds and times of some medical doctors as great men who had selflessly promoted their own profession for the benefit of all.

³⁸ See 'Obituary – Charles Mercier' *BMJ*, (September 13th 1919), pp. 363-365. Available at <http://dx.doi.org.libaccess.hud.ac.uk/10.1136/bmj.2.3063.363-d> Accessed 18th September 2016.

Career historians of the time had often hosted a common perspective, the one described by Herbert Butterfield in 1931 as the Whig interpretation of history.³⁹ Butterfield wrote that Whig narratives related their belief in the inevitable and inexorable progress in Western society. Their histories were often coloured by an enthusiasm for the liberal tradition of the present⁴⁰ but were tempted to forget the sufferings of the past.⁴¹ From the 1950s historians began to research in great detail the archives of British and other asylums and to identify evidence of an improvement in the lives and treatments of their residents. One such academic was Kathleen Jones who held an optimistic view about the role of central planning and supervision by the state.⁴² For Jones asylums were a reflection of a new humanitarianism promoting the state's recognition of its responsibility for the mentally ill.⁴³ She believed that the existence of social control, so loudly criticised by anti-psychiatrists,⁴⁴ as will be seen later in the chapter, was better explained by the two great social movements of the nineteenth century: Benthamism and Evangelicism.⁴⁵ Jones argued that there was a 'thread of progress' in the unremitting improvement of care for the mentally disabled and that the Mental Health Act 1959 would be instrumental in continuing the assault on the stigma of mental illness.⁴⁶

The gentle, conservative approach of Whig historians was shaken by the work of Michel Foucault, a French philosopher and political radical with wide ranging academic interests and little faith in authority. His writings on psychiatry have remained immensely influential amongst academics in many disciplines beyond history. Foucault criticised the way in which asylums enabled alienists to acquire power and dominate totally the lives of their patients by such methods as taking control of their diagnoses. Thus, for example, alienists were able to claim hysteria

³⁹ Butterfield, Herbert (1951) *The Whig Interpretation of History*, G. Bell, London. The original was published in 1931.

⁴⁰ Butterfield, *The Whig*, p. 96.

⁴¹ Butterfield, *The Whig*, p. 89.

⁴² See, for example, Jones, Kathleen (1972) *A History of the Mental Health Services*, Routledge and Kegan Paul, London.

⁴³ Bartlett, Peter and Wright, David (1999) (Eds) *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000*, Athlone Press, London, p. 2.

⁴⁴ For a brief history of the anti-psychiatry movement see Lieberman, Jeffrey A. (2015) *Shrinks: The Untold Story of Psychiatry*, Weidenfeld and Nicolson, London, pp 109-121.

⁴⁵ Jones p. 21.

⁴⁶ Jones, *A History*, p. 3.

and hypochondriasis as mental illnesses⁴⁷ and develop an expertise in their treatment to the exclusion of doctors in other branches of the medical profession.

Foucault wrote extensively and influentially on power relationships and their impact on societies over the last few centuries. Positioned on the libertarian left of the political spectrum he criticised academic Marxism for its failure to deal with groups on the margins of society such as the mentally ill, criminals, the physically disabled and those who were, like himself, homosexual. He argued, in contradiction to the standard Marxist view of the time, that the circumstances of such individuals, who were classified and considered as social deviants by those in power, were not wholly determined by their economic position. Foucault developed a concept of the particular discourse associated with specific agencies of dominance such as government, prison or lunatic asylum, and which were used by those institutions to maintain their dominance.⁴⁸

In Western Europe 'madness' was a condition, argued Foucault in 1961, created by those in power to prevent humans confronting their personal distress and looking at their individual mental framework in any great depth.⁴⁹ Instead the powerful chose to project their personal fears of mental disturbance onto those they termed social misfits such as the mentally ill. Foucault stressed that the latter lived out the chaos that those in power deliberately refused to confront in themselves.⁵⁰ Tracing the history of madness, or *unreason* as he called it, from the Middle Ages to the late nineteenth century he showed how the relative tolerance of the harmless mad was gradually translated into a repressive attitude towards those who became regarded as deviant and, therefore, a threat to society. He declared that there had been a *Great Confinement* across Europe typified in the late seventeenth century in Paris where beggars, vagrants, petty offenders and the mad were imprisoned by the state.⁵¹ This incarceration was a major event in history, he maintained, as it defined the moment

⁴⁷ Foucault, Michel (2001 edition) *Madness and Civilization*, Routledge Classics, Abingdon, Oxfordshire. Foucault died in 1985.

⁴⁸ See Marwick Arthur (1990) *The Nature of History*, MacMillan, Basingstoke, p. 111.

⁴⁹ Foucault, *Madness*, p. 149.

⁵⁰ Foucault, *Madness*, p. viii.

⁵¹ Foucault, *Madness*, p. 37.

*As part of the when madness was perceived as the social horizon of poverty, of incapacity for work, of mobility to integrate with the group, the moment when madness began to rank among the problems of the city.*⁵²

He argued that the now imprisoned madmen and madwomen were reduced to being regarded as animals and, as such, in the eighteenth century, had to be treated with 'discipline and brutalizing.'⁵³

The exclusion of the mad from society was a moral condemnation of their very existence by those in authority, argued Foucault. He wrote that the mad had made a radical, though possibly unconscious, choice not to conform to society's expectations. They came to be regarded as being dominated by their passions, a domination that led them to a delirium in which they mistook the unreal for the real.⁵⁴ Foucault believed that this passion was viewed as a weakness by those in power and so the mad were excluded from society as unreasonable: they were moral offenders and should be made to feel guilt at their condition. This created an ambience which made them feel guilty for their madness and the problems it caused to themselves and others.

As the number of studies of individual asylums using contemporaneous records were produced, their evidence consistently discounted his *Great Confinement* theory. This concept has now been dismissed by historians as inaccurate or vastly overstated, at least outside of the city of Paris in one period of history.⁵⁵ Further research into the history of psychiatry in Britain⁵⁶ and in its empire⁵⁷ including India⁵⁸ ended any lingering support for this theory. Foucault had been censured by Arthur Marwick for not only having 'sought refuge in imaginative leaps

⁵² Foucault, *Madness*, p. 59.

⁵³ Foucault, *Madness*, p. 70, emphasis in the original.

⁵⁴ Gutting, Gary (2005) Foucault: *A Very Short Introduction*, Oxford University Press, Oxford, p. 73. For further commentary see Gutting's Chapter 7 in this book, entitled 'Madness,' pp. 68-78.

⁵⁵ See, for example, Scull, Andrew (2015) *Madness in Civilization*, Thames and Hudson, London, p. 127. Whilst Scull expressed criticism of Foucault in this book it is no coincidence that the work has a similar title to the latter's *Madness and Civilization*.

⁵⁶ See, for example Porter, Roy (2004) *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics*, Tempus, Stroud, Gloucestershire, p. 19.

⁵⁷ See, for example Vaughan, Megan "Introduction," in Vaughan, Megan and Malone, Sloane (2007) (Eds) *Psychiatry and Empire*, Palgrave Macmillan, Basingstoke, p. 2.

⁵⁸ See for example Ernst *Mad Tales*.

of greater and greater incredibility, rather than in any coherent theory'⁵⁹ but also avoiding detailed discussion of events giving little sense of the evidence on which he had based his conclusions.⁶⁰ In other words Marwick was stating that this was definitely not how *to do* history. Nevertheless Foucault's legacy has inspired many scholars to study the lives of powerless and inarticulate groups in Western and other societies. In the case of the mentally ill he encouraged criticism of the psychiatric profession which he said had sought to control them as part of their promotion of the best interests of its own medical discipline.⁶¹

The link between the madman, who was possessed of unreason, and the man of reason who was officially considered sane, was fear.⁶² Foucault was particularly critical of asylums where, in effect, fear was used by the authorities to punish the madness of the inmates. He cited as examples of this the way in which *moral management or moral treatment*⁶³ was used as a treatment tool in the late eighteenth and early nineteenth centuries by the Tukes at The Retreat in York and by Philippe Pinel in the Salpêtrière and Bicêtre in Paris. Their philosophy of moral management, which had replaced physical restraint with a mental one, said Foucault, required the madman to feel morally responsible for his or her actions. The asylum no longer punished the individual for their 'guilty' state of mind but instead organised that guilt so that he or she became aware of their own madness and was then encouraged to take a personal road on the return to reason.⁶⁴

Foucault dismissed moral treatment as a 'gigantic moral imprisonment,' which was used to control without resorting to violence those who otherwise might have been uncontrollable.⁶⁵ The regime at the Retreat attempted to control their minds through a rigid adherence to work. The patient thus became immersed in "a universe of judgement"⁶⁶ an existence in which they were effectively being infantilised. Their world of *unreason* was not recognised and they had to conform to the rules of the

⁵⁹ Marwick, *The Nature* p. 145,

⁶⁰ Marwick *The Nature*, p. 197.

⁶¹ Scull, Andrew (2006) *The Insanity of Place/The Place of Insanity*, Routledge, Oxford, passim.

⁶² Foucault, *Madness*, p. 232.

⁶³ Attempting a definition of these terms is a lexicographical nightmare. The words have generated deep political passion but can be understood initially as implying a mental rather than a non-physical restraint. Wider definitions would be related to their authors' political views.

⁶⁴ Foucault, *Madness*, p. 235.

⁶⁵ Foucault, *Madness*, pp. 237-238.

⁶⁶ Foucault, *Madness*, p. 237.

establishment and cope internally with the moral disapproval of those in authority around them. The use of moral treatment as a form of social etiquette at the EMH will be considered in a later chapter as will Foucault's influence on the interpretation of colonial psychiatry.

The doing of conflict: the attack on psychiatric legitimacy

The writings of Foucault inspired a general anti-psychiatry movement in the 1960s and 1970s. This radical campaigning group considered institutionalised psychiatry to be harmful and questioned the very existence of mental illness itself.⁶⁷ Anti-psychiatrists challenged established professional views, maintaining, for example, that schizophrenia was caused by schizophrenogenic⁶⁸ parents who dominated their children and required them to conform socially or, if they did not, force them to face biological treatment.⁶⁹

Whilst one British psychiatrist linked to the movement, R. D. Laing, accepted that mental illness did exist an American psychiatrist, Thomas Szasz, did not. Szasz regarded mental distress as a problem caused by everyday living and he portrayed psychiatry as a pseudo-science akin to mediaeval alchemy, which sought to legitimise its judgemental actions in medical or biological terms.⁷⁰ Szasz had condemned the use of the *metaphor* of mental illness⁷¹ which in his view gave a false legitimacy to compulsory psychiatry and as there was 'no medical, moral or legal justification for involuntary psychiatric interventions' he regarded the latter as a crime against humanity.⁷² Szasz's obituarist Anthony Stadlen, a British psychotherapist, wrote that he was regarded by some as the leading moral philosopher of psychiatry and psychotherapy in the twentieth and twenty first centuries, but by others as 'a dangerous and seductive influence, advocating neglect of some of society's most helpless members.'⁷³ Like some radical approaches to

⁶⁷ The current author remembers the influence of the movement on his professional social work training in the 1970s and 1980s.

⁶⁸ Defined as 'A now discredited concept that cold hostile parenting can cause schizophrenia' by Burns, Tom (2013) *Our Necessary Shadow: The Nature and Meaning of Psychiatry*, Allen Lane Penguin, London, p. 303. Burns is a psychiatrist.

⁶⁹ Laing, R. D. (1977) *The Divided Self: An Existential Study in Sanity and Madness*, Penguin, Harmondsworth, Middlesex, p. 190.

⁷⁰ Szasz, *The Myth* p. 1.

⁷¹ Szasz, *The Myth*, p. 267.

⁷² Szasz, *The Myth*, p. 268.

⁷³ Stadlen, Anthony (5th October 2012) 'Obituaries – Thomas Szasz.' *The Guardian*, p. 42.

social policy it seemed to me as a practising social worker that anti-psychiatry offered a simplistic approach, and therefore a potentially inappropriate one, to the complex problem of mental ill health. However it was welcomed at the time by many non-professionals unable to comprehend the nature of mental illness and grateful for an, apparently, authoritative explanation. Laing had personal problems of his own but deserved credit for the role he played in changing the way in which the mentally ill were viewed by society and how they were treated,⁷⁴

Another key figure in the study of the historiography of psychiatry was Andrew Scull, an American-based, British born sociologist, who has published numerous books and articles since the 1970s. He has intentionally used the word *madness* in his academic work. Whereas he admitted that it was a provocative and pejorative term disliked by psychiatrists because of its implied stigma, it is one embraced by sufferers or survivors of the mental health system like a badge of honour.⁷⁵ He praised Foucault for his 'intellectual daring'⁷⁶ and for playing a major role in 'rescuing madness from the clutches of drearily dull administrative historians and/or psychiatrists,'⁷⁷ a thinly veiled mockery of the holders of Whiggish viewpoints.

The writings of Scull were characterised by anger at the injustice done to the mentally ill. He began his 1993 book with an epigraph quoting Lord Shaftesbury in 1851 '[Madness] constitutes a right, as it were, to treat people as vermin.'⁷⁸ He named a chapter in one of his books 'Museums for the Collection of Insanity,'⁷⁹ referring to institutions which he said served to provide 'a thin veneer of legitimation for the custodial warehousing of these, the most difficult and problematic elements of the disreputable poor.'⁸⁰ He famously described asylums as 'museums of

⁷⁴ Laing, Adrian (1997) *R. D. Laing: A Life*, Sutton Publishing, Stroud, Gloucestershire. This biography was compiled by his son is honest about his father's own health problems and his professional successes and failures.

⁷⁵ Thus, for example, there was a Mad Pride Festival of creative arts as part of the Hull UK City of Culture 2017 events.

⁷⁶ Scull, *The Insanity of Place/The Place of Insanity*, p. 30.

⁷⁷ Scull, *The Insanity of Place/The Place of Insanity*, p. 30.

⁷⁸ Scull, Andrew (1993) *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900*, Yale University Press, New Haven, USA, p. xv. The 7th Earl of Shaftesbury was a campaigner for improved lunacy laws for over fifty years and chaired the Commission for Lunacy in England from 1845 to 1885.

⁷⁹ Scull, *The Most Solitary*, Chapter 6, pp 266-333.

⁸⁰ Scull, *The Most Solitary*, p. 332.

madness'⁸¹ or 'mansions of misery'⁸² where lunatics were housed away from public gaze, in institutions which were more penal than therapeutic. This general condemnation will be examined later in the thesis in relation to the EMH. He highlighted the condemnatory language used to describe many asylum residents showing how this contributed to the development of eugenics in the early twentieth century.⁸³

Scull also explored the importance of physical space in the containment of those exhibiting madness. Such physical barriers created social settings which reinforced social boundaries between classes and genders.⁸⁴ He stressed that 'the brooding presence of the barracks asylum...dominated both the physical and the symbolic landscape of madness,'⁸⁵ and cited Crichton-Browne's assertion in 1873 that asylums were 'providing convenient storage of heaps of social debris.'⁸⁶

A salient feature of Scull's arguments has been his deep distrust of the psychiatric profession. In *The Most Solitary of Afflictions* he consolidated his arguments about the social control elements of asylums linked to the development of psychiatry as being consciously led by psychiatrists to enhance their power and the importance of their own profession.⁸⁷ By the end of the nineteenth century asylums in Britain became overcrowded and, in Scull's opinion, this had much to do with psychiatry's failure to cure large numbers of sufferers as the profession had enthusiastically promised it could half a century earlier. He has remained critical of the psychiatric profession for the way that it sought to create a powerful and expert position for itself through the control of the mentally ill and for its exclusive dictation of what constituted their mental illnesses.⁸⁸ The role of the professional psychiatrist at the EMH will be examined in the light of Scull's vehement criticism.

⁸¹ He used this phrase in the title of his book: Scull, Andrew, (1979) *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England*, Allen Lane, London.

⁸² Scull, Andrew 'The Insanity of Place, *History of Psychiatry*, vol. 15, no. 4, 2004, p. 422.

⁸³ Scull, *The Most Solitary*, pp. 379-384.

⁸⁴ Scull, 'The Insanity of Place,' p. 414.

⁸⁵ Scull, 'The Insanity of Place,' p. 427.

⁸⁶ Scull, 'The Insanity of Place,' p. 428. Sir James Crichton-Browne (1840-1938) was an influential figure in British psychiatry for many years. He was asylum superintendent in the West Riding County Asylum in Wakefield for 10 years where he conducted hundreds of examinations of the brains of deceased patients. He was co-founder of *Brain* in 1878, the world's first neuroscientific journal.

⁸⁷ See Chapter 5 in Scull. *The Most Solitary*,

⁸⁸ Scull, *The Insanity of Place/The Place of Insanity*, pp. 2-3.

Scull criticised German psychiatrists in general for their use of asylums and their inmates as merely a 'source of pathological specimens for the dissecting table and the microscope'.⁸⁹ However he acknowledged an exception in Emil Kraepelin. Kraepelin, working at the University of Heidelberg towards the end of the nineteenth century and, in the early twentieth, at the German Institute for Psychiatric Research, he studied thousands of psychiatric patients seeking patterns in their pathology.⁹⁰ His research led him to propose that there were two types of madness: *dementia praecox*, a pernicious, permanent and deteriorating illness with little prospect of improvement; and *manic-depressive psychosis*, characterised by mood swings of varying rapidity but with a more promising prognosis.⁹¹ In time Kraepelin's nosology came to be generally accepted both in the West and in colonial India as recognised in psychiatric manuals in Britain and India.⁹²

Scull pointed out that, what he termed 'this theatrical indeterminateness of the concept of insanity',⁹³ had expanded in the nineteenth century so that 'the boundaries of mental disturbance stretched to encompass all manner of difficult, decrepit socially inept, incompetent and superfluous people.'⁹⁴ Such 'deviants,' he argued, were labelled as ill, *mentally* ill, and so being sick they received treatment rather than punishment. Psychiatrists have taken ownership of such treatment as the remit of their profession and their professional power has continued and been consolidated during the twentieth century as new mental illnesses were identified or invented, he argued.

Generally Scull employed a Marxist analysis of the development of asylums. He argued that the establishment of a market economy in the West, and particularly of the market in labour, required a distinction between the able-bodied and non-able bodied poor.⁹⁵ Workhouses had been established under the Poor Law to control

⁸⁹ Scull, *Madness in Civilization*, p. 263.

⁹⁰ Kraepelin produced his first textbook of psychiatry in 1883 and his final edition was published in 1927, the year after his death, and consisted of four volumes.

⁹¹ Scull, *Madness in Civilization*, p. 263.

⁹² See, for example, Overbeck-Wright, Alexander (1921) *Lunacy in India*, Baillière, Tindall and Cox, London and Lodge Patch, C. J. Major (IMS) (1934) *A Manual of Mental Diseases: A Textbook for Students and Practitioners in India*, Baillière, Tindall and Cox, London. The two books illustrate the growth in the influence of German-speaking psychiatrists in the 13 years between their two publication dates.

⁹³ Scull, *The Most Solitary*, p. 392.

⁹⁴ Scull, *The Most Solitary*, p. 392.

⁹⁵ Scull, *The Most Solitary*, p. 35.

those individuals unable or unwilling to survive by their own labour and their equivalents were introduced in India.⁹⁶

In 2015 Scull produced *Madness in Civilization*,⁹⁷ with its subject matter being a cultural history of madness over the last two thousand years. He described how the treatment of madness and the responsibility for its sufferers came to be dominated totally by the medical profession in the first half of the nineteenth century. Yet, he cautioned, society's understanding of madness was as confused as ever. Scull did not deny that madness existed nor that it could cause great distress to its sufferers. However he emphasised that in the twenty first century psychiatry has failed to bridge the gulf between its pretensions and its promises hence 'the roots of schizophrenia or of major depression remain wrapped in mystery and confusion.'⁹⁸

His view of the jostling for professional power by psychiatrists via the state apparatus controlling mental health provision has been challenged in research based on asylum archives by Joseph Melling. Melling has identified what he termed a 'late Whiggism' amongst some historians of British psychiatry, whose attitudes were more benevolent towards psychiatrists in charge of asylums.⁹⁹ The Whiggish vision of science was one of inevitable progress with psychiatrists playing a strategic role in developing a liberal social order. The attraction of this approach has been undermined in recent years by the detrimental impact of austerity and budget cuts in the delivery of improving services.¹⁰⁰ This belief in inexorable progress identified at the EMH will be considered in Chapter 7. However, whatever the background of the observer madness has continued to confuse, to frighten and to threaten many in society and it still stigmatises its sufferers as it has done for centuries.

⁹⁶ For a detailed analysis of the response by the Indian authorities to vagrancy, prostitution, petty crime etc. by whites there see Fischer-Tiné, Harald (2009) *Low and Licentious Europeans: Race, Class and 'White Subalternity' in Colonial India*, Orient Blackswan, New Delhi.

⁹⁷ Scull, *Madness in Civilization*.

⁹⁸ Scull, *Madness in Civilization*, p. 25.

⁹⁹ Melling, Joseph 'Accommodating Madness: New research in the social history of insanity and institutions,' in Melling, Joseph and Forsythe, Bill (1999) (Eds) *Insanity, Institutions and Society*, Routledge, London, p. 14.

¹⁰⁰ See, for example Knapp, Martin 'Mental Health in an age of austerity,' Evidence Based Mental Health, August 2012, vol. 15, no. 3. <http://dx.doi.org.libaccess.hud.ac.uk/10.1136/ebmental-2012-100758> (Accessed 13th August 2018) and Wilkinson, Richard and Pickett, Kate (2018) *The Inner Level: How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Well-being*, Allen Lane, London.

The profession of psychiatry fights back

In the 1970s and 1980s the study of the history of the mentally ill generated an expanding and contentious academic branch of learning. Numerous books and articles by scholars such as Scull, Jones and William Parry-Jones¹⁰¹ laid down a basis for research into an increasingly controversial topic. A flavour of the bitterness engendered in the debate between historians and professionals was indicated by Gerald Grob, an American historian of medicine. Grob wrote of the attack on the legitimacy of psychiatry by, in his opinion, vituperative, dogmatic critics such as Szasz.¹⁰² He viewed the balance between professional autonomy and patients' rights as shifting towards the latter after the Second World War. It was Grob's opinion that opposition to psychiatry had become the province of intellectuals, literary critics and those disillusioned by the Vietnam War. The general public, he argued, could see that there were significant numbers of people with serious long term mental health problems for which they needed treatment and they accepted the remit of the profession to deliver it.

The profession retaliated with letters and articles in medical journals¹⁰³ and in 1991 a history of British psychiatry over the previous 150 years was produced under the editorship of two consultant psychiatrists German Berrios and Hugh Freeman.¹⁰⁴ The articles in their book, written mainly by practitioners but with some contributions from historians covered a wide range of topics. They were generally in praise of the psychiatric profession, the *Great Men*¹⁰⁵ and their institutions, from an unashamedly Whiggish perspective. It was easy to detect the seething anger in the editors' introduction as they derided the revisionist school of Foucault, Scull and others for

¹⁰¹ Parry-Jones, William Llewellyn (1972) *The Trade in Lunacy*, Routledge, London.

¹⁰² Grob, Gerald (Fall 2011) 'The attack on psychiatric legitimacy in the 1960s: rhetoric and reality,' *Journal of the History of Behavioural Sciences*, vol. 47, no. 4, pp. 398-416. DOI10.1002/jhbs.20518.

¹⁰³ See for example Crammer, J. L. (1994) 'English Asylums and English Doctors: where Scull is wrong,' *History of Psychiatry*, vol. 5, p.104. Scull's response came in Scull, Andrew (1995) 'Psychiatrists and Historical 'facts.' Part Two: Re-writing the History of Asylumdom,' *History of Psychiatry*, vol. 6, p. 387. Scull indicated that he had no qualifications in psychiatry, in just the same way the Crammer had no qualifications in history.

¹⁰⁴ Berrios, German H. and Freeman, Hugh (Eds) (1991) *150 Years British Psychiatry*, Gaskell, Royal College of Psychiatrists, London.

¹⁰⁵ This phrase is taken from King, Charles R. 'The Historiography of Medical History: From Great Men to Archaeology,' *Bulletin of the New York Academy of Medicine*, vol. 67, no. 5. September-October 1991, pp. 407-428. King was a physician who wrote of a past tendency, without any pretence of objectivity, to glorify the deeds and times of some medical doctors as great men who had selflessly promoted their own profession for the benefit of all.

their 'verbal pyrotechnics', confrontational approach, their lack of understanding of people with mental illness and their inability to appreciate the gradual improvements in services.¹⁰⁶

Over the three decades following Foucault's seminal *Madness and Civilization* substantial criticism emerged of the psychiatric profession and its exponents. The accompanying challenges to the reality of mental illness had generated a reaction amongst some practitioners. Professional psychiatrists, who had studied the history of their specialism, had, perhaps unsurprisingly, reached different conclusions about the content and value of their discipline than had some professional historians. Berrios and Freeman began their defence of their profession with an attack on what they regarded as the revisionism applied by late-20th century value judgements to the activities of doctors in the completely different conditions of the past. They castigated Scull for his ridicule and condemnation of psychiatrists, and particularly of those interested in psychiatric history, for his lack of experience of clinical work. In response, they wrote that doctors worked on the basis of knowledge and resources of an age, and within the prevailing cultural, political and economic framework then in existence. They promoted the value and importance of a psychiatry which took charge and responsibility for those who, by their irrational behaviour, had transgressed the mores of society, and sought to alleviate suffering by using their professional skills.¹⁰⁷

Another contributor to Berrios and Freeman's work of validation was R.D. Hinshelwood, a consultant psychotherapist.¹⁰⁸ His historical approach was determined by his clinical background rather than by an interpretation of theories of social control. He viewed the previous two centuries in the development of psychiatry as a competition between the psychological and the psychodynamic approaches to it with the latter becoming dominant between the 1890's and the end of the second world war. Hinshelwood regarded this period as one of technological progress and of rapid change which affected all people's lives including those who were mentally ill. He commented that in the late 19th century a scientific psychology was developing in

¹⁰⁶ Berrios and Freeman, *150 Years*, p, xiii.

¹⁰⁷ Berrios and Freeman, *150 Years*, pp. ix to xv. There was no article by Scull in the book.

¹⁰⁸ Hinshelwood, R. D. 'Psychodynamic psychiatry before World War 1, in Berrios and Freeman, *150 Years*, pp. 197-205.

universities influenced by Darwinism which had restricted the grip of religion on the minds of people. Psychiatry was in a state of confusion.

Hinshelwood asserted that psychiatry had become marginalised by the end of the nineteenth century, compounded by its location in asylums, and was isolated geographically and intellectually. Few physical therapies had been developed and the profession was further discredited by those which had such as phrenology and hypnosis, as these were generally regarded as failures. He identified a 'therapeutic pessimism' with admission to an asylum being the only form of treatment for many with a mental illness.¹⁰⁹ Psychiatry appeared to have stalled.

It was the psychodynamic work of Freud and Janet in Europe which gave a creative boost to the psychiatric profession at the beginning of the new century, argued Hinshelwood. Freud's theories, in particular, formed one of the key strands of what Hinshelwood called 'the new psychiatry' commencing around 1905.¹¹⁰ These new medical approaches received criticism from all sides. Thus Mercier, a senior British alienist, condemned them in 1902 as not being materialist enough whilst others argued that discussions around sexual biology were far too practical. A *BMJ* editorial in 1907 castigated psychoanalytical methods for usurping the confessional and being potentially hazardous to patients, but in all cases they were 'dispensable'.¹¹¹ Nevertheless psychoanalysis became of increasing importance to psychiatrists in the West and India after the First World War.¹¹²

The first comprehensive assessment of the historiography of psychiatry has been identified by Robert Houston as the 1985 publication of *The Anatomy of Madness*,¹¹³ a collection of essays edited by W. F. Bynum, Roy Porter and Michael Shepherd following a conference on the history of psychiatry at the Wellcome Institute. Houston, a historian, argued that such historiographies of psychiatry gave a much wider range of historical accounts than was the case in other medical

¹⁰⁹ Hinshelwood, 'Psychodynamic psychiatry,' p. 198.

¹¹⁰ Hinshelwood, 'Psychodynamic psychiatry,' p. 202.

¹¹¹ This was stated in an editorial leader article entitled 'Freud and hysteria,' *BMJ*, 1907, cited in Hinshelwood, p. 203.

¹¹² For a detailed analysis of the growth of psychoanalysis in between the two world wars and how it became virtually 'indispensable' to the point where it 'was called upon to explain the wider problems of civilisation' see Overy, Richard (2010) *The Morbid Age: Britain and the Crisis of Civilization, 1919-1939*, Penguin, London, especially pp.136-174.

¹¹³ Bynum, W.F. Porter, Roy and Shepherd, Michael (1985) (Eds) *The Anatomy of Madness: Essays in the History of Psychiatry*, Wellcome Institute for the History of Medicine, 3 vols., London.

disciplines.¹¹⁴ He summarised the conflict generated whenever the two distinct cultures involved in the separate studies of history and of psychiatry attempted to come together. In language reminiscent of Berrios and Freeman he criticised the ways in which practising psychiatrists ‘delight in consulting across the centuries’ whilst historians would be wary of diagnosing the long deceased.¹¹⁵ In his conclusion he lamented, with wry humour, the role of the professional historian faced with criticism from psychiatrists but made clear where he stood in the debate:

Doing history is easier for clinicians (and bad history simpler still) than is psychiatry for historians (it is, of course, an offence to practise medicine without a licence.)¹¹⁶

In Jordanova’s terms it was useful to be reminded of Houston’s background and prejudices. She pointed out that historians can become isolated in their own discipline, particularly if challenged by other scholars when *doing* history.¹¹⁷

The ‘force-field’ of conflict

Jordanova’s contribution to the understanding of historiography can be developed graphically using force-field analysis, a tool employed in studies of organisational management.¹¹⁸ The purpose of the force-field analysis is to enable a visual representation of the obstacles to organisational change which have led to conflict and inefficiency. The technique can be adapted to display the friction created since the 1960s and 1970s, between the radical historians of psychiatry and psychiatrists themselves (see Figure 2.1). The radical historians were pushing to challenge traditional views of the history of mental illness often denouncing psychiatry as a pseudo-science concerned with consolidating its own professional status and future. Resisting them were practising psychiatrists, including some who were historians of psychiatry, who were opposing the onslaught with a defence of their achievements

¹¹⁴ Houston, R.A. (March 2014) ‘A Latent Historiography? The case of psychiatry in Britain, 1500-1820 in *The Historical Journal*, vol. 57, Issue 1, p. 289.

¹¹⁵ Houston, ‘A Latent,’ p. 308.

¹¹⁶ Houston, ‘A Latent,’ pp. 309-310.

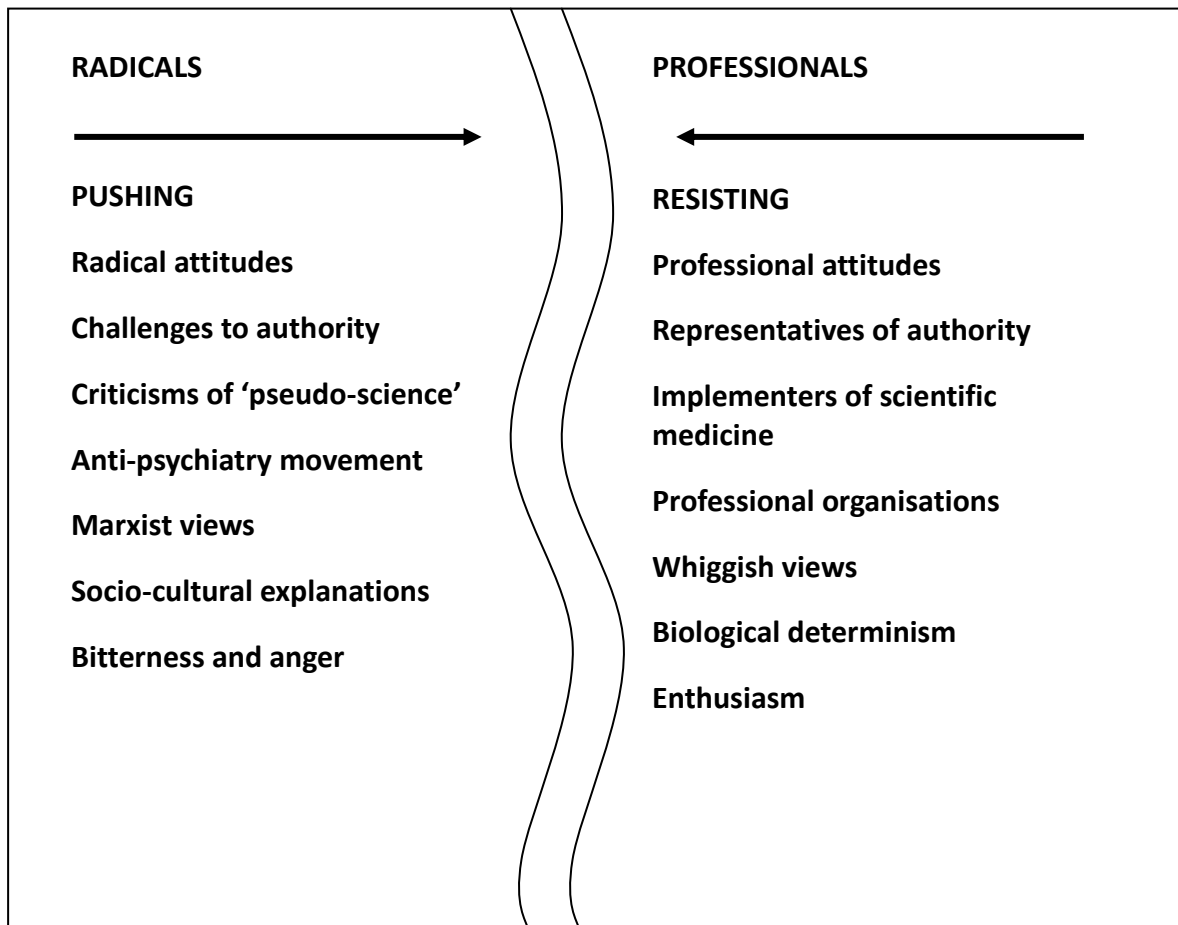
¹¹⁷ Jordanova, *History*, pp. 59-60, 91.

¹¹⁸ Adapted from Johnson, Gerry and Scholes, Kevan (2002) *Exploring Corporate Strategy*, 6th edition, Financial Times Prentice Hall, Harlow, pp. 544-545.

and a Whiggish view of gradual progress in the knowledge and treatment of mental illness. The interface between the two opposed factions was difficult to breach because of the entrenched views on either side. One side was rooted in political and socio-cultural polemic; the other in scientific research and professional pride. Applying this management practice to academic controversy can be a useful practice when comparing their differences.¹¹⁹

¹¹⁹ A solution to such a conflict, if one was sought, might come through skilfully diplomacy, a task, thankfully, beyond the scope of this thesis.

Figure 2.1: A force field analysis of conflict between radicals and psychiatrists



After depicting the conflicts the following section will look in more detail at the 'pushers' and 'resisters' and how their contest was analysed by other academics.

Social control and discounted paradigms

Doing fieldwork, or participant observation, has provided a valuable contribution to the understanding of the lives of patients in institutions. In 1961 Erving Goffman, a Canadian sociologist, produced a study of a psychiatric hospital in Washington D.C. after working incognito as an assistant to a physical education instructor. In his book *Asylums* he observed that most patients had been admitted there compulsorily and for them life was both a humiliating experience and a deprivation of their liberties.¹²⁰

¹²⁰ Goffman, Erving *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Pelican, Harmondsworth, Middlesex, 1968 edition. The original was published in 1961.

He was credited with popularising and perhaps inventing the term *total institution* to describe an establishment where rules moulded and disciplined all aspects of the lives of its residents 24 hours a day and where inmates were normally unable to leave its premises.¹²¹ *Asylums* has been described by an Irish psychiatrist as ‘a text that humanises a dehumanised group of people.’¹²² This key work was influential in the training of mental health professionals in subsequent decades.¹²³

The term ‘the insanity of place’ was used by both Goffman and Scull in their descriptions of psychiatric institutions and their corresponding influence on the public perceptions and misconceptions of those who lived in them. Goffman assessed ‘the social significance of the confusion [the madman creates]’¹²⁴ in society. The sufferers’ mental symptoms were seen as ‘a social infraction and offensive’ and caused ‘organisational havoc’ and trepidation in society.¹²⁵ In Scull’s opinion, such reactionary views legitimated for many the segregated response of the insane asylums in the western world where even the ‘[A]rchitecture itself was moralized’.¹²⁶

Research into the patient’s own perspective was carried out by Porter¹²⁷ and his work was praised by Scull as being ‘history from below,’¹²⁸ in the manner of E. P. Thompson,¹²⁹ in ‘giving a voice to the voiceless.’¹³⁰ Porter did much to popularise the history of medicine in general¹³¹ and of psychiatry in particular.¹³² He regarded Foucault’s work as both radical and unsettling and disagreed with the Frenchman’s declaration that mental illness should be understood as a cultural construct built on psychiatric and institutional practices. Neither could he accept Foucault’s view that

¹²¹ Goffman, *Asylums*, p. 11.

¹²² Mac Suibhne, Seamus (2011) ‘Erving Goffman’s *Asylums* 50 years on,’ *British Journal of Psychiatry*, 198, p. 1.

¹²³ It featured prominently in my own professional social work training, particularly during a placement in a secure unit for adolescents with mental health problems.

¹²⁴ Cited in Scull, Andrew (2004) ‘The insanity of place,’ *History of Psychiatry*, vol. 15, no.4, p. 417.

¹²⁵ Scull, ‘The insanity of place,’ pp. 417-418.

¹²⁶ Scull, ‘The insanity of place,’ p. 424.

¹²⁷ Porter, Roy (1996) *A Social History of Madness: Stories of the Insane*, Phoenix Giants, London.

¹²⁸ Scull, *The Insanity of Place/The Place of Insanity*, p.41

¹²⁹ See Thompson. E. P. (1968) *The Making of the English Working Class*, Pelican Books, Harmondsworth, Middlesex. The original edition was published in 1963.

¹³⁰ Scull, *The Insanity of Place/The Place of Insanity*, p. 51.

¹³¹ Porter, Roy (1997) *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present*, Harper Collins London. The book covered 831 pages.

¹³² See for example the following works by him: Porter, Roy (2002) *Madness: A Brief History*, Oxford University Press, Oxford; (2004) *Madmen: A Social History of Madhouses, Mad-Doctors and Lunatics*, Tempus Press, Stroud, Gloucestershire (originally published as *Mind Forg’d Manacles*, Athlone Press, London, 1987; and with Berrios, German E. (1995) as joint editors *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Athlone, London.

the history of madness was, he paraphrased, ‘an account not of disease and its treatment but of questions of freedom and carnal knowledge and power.’¹³³ Porter dismissed Foucault’s interpretation as simplistic and over-generalised¹³⁴ and he was another career historian who discounted the theory of the *Great Confinement*.

In Porter’s opinion it was wrong to see the rise of institutionalised psychiatry in purely functional or conspiratorial terms. Neither, in his view, was it correct to see the growth of asylums as an inevitable form of social control by the authorities as society became more complex through industrialisation. As an alternative he urged that:

*[T]he asylum solution be viewed less in terms of central policy than as the site of myriad negotiations of wants, rights, and responsibilities between diverse parties in a mixed consumer economy with a burgeoning service sector.*¹³⁵

Some regimes were overly restrictive and even cruel, he acknowledged. However many residents were not there for life and could be discharged, archives revealing that their families often played a dynamic part in this process and had influence on doctors and magistrates.¹³⁶ In the Indian context active familial involvement will be demonstrated in the chapter on the case records of the European Mental Hospital there.

Recent historiographic trends in the history of psychiatry in the twentieth century have been summarised by Volker Hess and Benoît Majerus, based at universities in Berlin and Luxemburg respectively.¹³⁷ They argued that the history of psychiatry in the eighteenth and nineteenth centuries had been covered with authority, coherence and thoroughness. In contrast they observed that there was no such narrative clarity for the twentieth century and that what had been produced had largely missed ‘the impressive transformation of psychiatric treatment.’¹³⁸ They pointed out that some historians have used the nineteenth century paradigms of

¹³³ Porter, Roy (2002) *Madness: A Brief History*, Oxford University Press, Oxford, p. 3.

¹³⁴ Porter, *Madness* p. 93.

¹³⁵ Porter, *Madness* p. 98.

¹³⁶ Porter, *Madness* p. 99.

¹³⁷ Hess, Volker and Majerus, Benoît (2011) ‘Writing the history of psychiatry in the 20th century,’ *History of Psychiatry*, vol. 22, no. 2, pp. 139-145. DOI:10.1177/0957154X11404791.

¹³⁸ Hess and Majerus, *Writing*, p. 139.

institutionalisation inappropriately, as a basis for interpreting the twentieth century history of psychiatry. With recognition of their warnings the interpretation of treatment at the EMH after 1918 will consider in Chapter 7 its relation to the models of the previous century because of their roots in asylum science.

It was their observation that in the second half of the twentieth century, in nearly every European state, psychiatry had detached itself from the earlier model of dominant institutional care. They criticised unspecified historians who continued to use what, in their opinion, was both the essentially nineteenth century model of the psychiatrists' drive for professional dominance over their patients and the model of social disciplining i.e. that institutions were there primarily as an instrument for social and political control.¹³⁹ In opposition to the anti-psychiatrists they called for a narrative of a twentieth century historiography concerned primarily with psychiatry as a science whose purpose was to provide medical help to mentally ill people.

For twentieth century historiography Hess and Majerus pointed to an often bitter divide, another illustration of a force-field, between an interpretation which supported the successes of the 'psychopharmological revolution' and one which championed the development of social psychiatry.¹⁴⁰ In support of their contention they cited scholarship from German-language and French studies of the history of psychiatry in those respective areas. They stressed that most European psychiatric institutions, but especially those in the German-speaking countries, have now been studied in great depth. They argued that writings on the history of psychiatry tended to concentrate on the discipline as a specialist topic whilst failing to place it in a context of other general medical approaches.

The recent historiography of psychiatry for the 20th century has been characterised by Hess and Majerus as containing three elements. Firstly, they identified a distancing from the anti-psychiatry agenda which had been rooted in arguments from the 1970's. They recognised that the Whiggish approach of 'inevitable improvement,' often one proposed by doctors, had been vigorously attacked by critical social scientists citing German scholars. Secondly, they pointed to the emergence in the last thirty years of Science Studies, the interdisciplinary research area that attempts to position scientific expertise in a broad social, historical

¹³⁹ Hess and Majerus, 'Writing,' p. 140.

¹⁴⁰ Hess and Majerus, 'Writing,' pp. 139-145.

and philosophical context. They argued that the Science Studies approach was not concerned with taking 'sides' on the conflicting arguments on the interpretation of psychiatric methods. Rather, its approach was in examining the various ways that psychiatric illnesses have been classified or defined. The third component was the study of patients' records and institutional archives which enabled a measure of recognition of the lives of patients. Archives and case records located psychiatric practice within the context of a complex environment and it also gave some recognition of the role of nurses and other ancillary staff, and of those administrators in charge of the hospitals. The power relationships identified in these historical documents were in keeping with Foucault's views. Hess and Majerus provided an alternative, less partisan approach to the understanding of the historiography of psychiatry in the twentieth century.

It has already been demonstrated that there has been no consensus amongst academics about what constituted mental illness. The contradictions which have arisen from a study of 'medicalized language' and its use by historians of psychiatry have been highlighted by Tomi Gomory, David Cohen and Stuart A. Kirk who analysed the work of seven prominent historians in the subject from the second half of the twentieth century and from the twenty first.¹⁴¹ They pointed to the inability of all seven to define madness without using medical terms and gave examples of how these authors could often contradict themselves in their definitions. As an example of this they commented on how Porter claimed to have written an unbiased account of the history of madness¹⁴² whilst in an earlier work admitting that he had 'necessarily made assumptions about its nature'.¹⁴³ In addition they pointed to the inconsistency of Scull in criticising the psychiatric establishment's negative impact on individuals whilst using the language of psychiatric diagnosis in doing so.¹⁴⁴ Scull's enthusiastic condemnations of therapeutic practice will be considered in the cases of individual *Imperial Minds* resident at the EMH.

¹⁴¹ Gomory, Tomi, Cohen, David and Kirk, Stuart A. (2013) 'Madness or Mental Illness? Revisiting Historians of Psychiatry,' *Current Psychology*, vol. 32, no. 9. DOI 10.1007/S112144-013-9168-3. The chosen seven were Norman Dain, Albert Deutsch, Gerald Grob, Roy Porter, Charles Rosenberg, Andrew Scull and Edward Shorter.

¹⁴² Porter, *Madness*, p.4.

¹⁴³ Porter, Roy (1990) *Mind-Forg'd Manacles*, Penguin, London, p. 15. The original edition was published in 1987.

¹⁴⁴ Gomory et al, 'Madness' unnumbered page.

All the scholarship so far considered has originated from Western academics. One example of a different interpretation comes from the Indian historian Ranajit Guha, who was the founding editor of *Subaltern Studies*.¹⁴⁵ In an article from 1997 he cited the memories of Francis Yeats-Brown, an officer in the elite Bengal Lancers regiment. Yeats-Brown had an agreeable and privileged life with many enjoyable sporting activities and numerous servants to sustain him. However, he had sufficient insight to recognise that the English were an insular grouping set apart from the everyday lives of Indians.

*We English were a caste. White overlords or white monkeys- it was all the same...we were a caste: pariahs to them [the Brahmin caste, the highest Indian grouping], princes in our own estimations.*¹⁴⁶

For Guha, Yeats-Brown represented those imperialists unable to cope with the immensity of India and preferring wherever possible to ignore it and seek the company of like-minded Europeans. Such imperialists could not find their bearings in the colonial environment as its scale was 'unimaginable and uncomfortable,'¹⁴⁷ as perceived by Yeats-Brown. Guha proposed that

*[W]hat made him feel so isolated was not therefore fear predicated on any given object but simply an indefinite and pervasive anxiety about being lost in empire.*¹⁴⁸

Although not a medical man, Guha was in effect, diagnosing the potential for mental distress in an *Imperial Mind*: an inability to cope with or confront the potential for mass opposition to European rule, a sense of isolation and the impact of an alien and unremitting climate. Guha criticised historiography in itself 'with its tendency to

¹⁴⁵ *Subaltern Studies* was a journal established in 1982 to give hitherto marginalised groups in India, such as peasants and labourers, a voice as agents in their own right in the history of India. The word *subaltern* is an allusion to the Italian Marxist Antonio Gramsci's interpretation of power.

¹⁴⁶ Guha, Ranajit (Spring 1997) 'Not at Home in Empire,' *Critical Inquiry*, vol. 23, no. 3, p. 483. www.jstor.org/stable/1344031 (Accessed 8th January 2016) The original reference is Yeats-Brown, *Bengal Lancer*, p. 9.

¹⁴⁷ Yeats-Brown, *Bengal*, p. 9.

¹⁴⁸ Guha 'Not at Home,' p. 484.

misconstrue the existence of anxiety simply as fear.¹⁴⁹ He asserted that some British imperialists were not afraid of Indian opposition as they were so isolated from it, but they were worried about the future, an anxiety which, he said, lacked the precision of fear.¹⁵⁰ Guha asserted that colonial historiography has neglected the role of anxiety in the story of empire and '[I]t is not anxiety but enthusiasm that has been allowed to dominate its [historiographical] narratives.'¹⁵¹ This enthusiasm was 'the very mentality of imperialism itself.'¹⁵² The imperial project was one of triumphalism, of wars won, of engineering and the industrial achievement of Western civilisation through pacification and paternalism. Despite this as Guha observed poignantly, Imperial Minds were 'not at home in empire'.¹⁵³ However comfortable and privileged they were for many Britons, India could not bring inner peace.

The historiography of Western psychiatry became intensely political with entrenched opinions often rooted in the writer's background as a historian or a practitioner in the field of mental illness. There was something of a rapprochement with the creation of the journal *History of Psychiatry* in 1991¹⁵⁴ under the joint editorship of Berrios, the psychiatrist, and Porter, the historian, although it could be argued that the force field has never been breached or removed. The chapter will now consider the place of mental nursing in the historiography of colonial psychiatry, an important yet under researched topic.

The dearth of historical research into psychiatric nursing

In order to determine the contribution of psychiatric nurses in India it was important to explore what has already been written about them in the West from where their profession originated. In her history of nursing in Britain and across the Empire published in 1906 Sarah Tooley, who was not a nurse, described with admiration the current state of the profession in comparison with the first half of the previous century. In her chapter on nursing in asylums for the insane she outlined the almost negligible status of nurses who had once worked in them:

¹⁴⁹ Guha 'Not at Home' p. 485.

¹⁵⁰ Guha 'Not at Home,' p. 485.

¹⁵¹ Guha 'Not at Home,' p. 487.

¹⁵² Guha 'Not at Home,' p. 487.

¹⁵³ Guha 'Not at Home,' p. 487.

¹⁵⁴ See Beveridge, Alan (May 2012) 'Reading about ... The history of psychiatry,' *British Journal of Psychiatry*, 200, p. 431, DOI: 10.1192/bjp.bp.111.107565.

*The 'female keeper' – she rarely received the gracious name of nurse – was up to the forties [the 1840s], and indeed later, a woman of the very lowest type, uneducated, coarse, and brutal. Her only idea of nursing was terrifying the patient, and in extenuation of her diabolical practices it must be remembered that she worked in accordance with the accepted methods of dealing with the insane.*¹⁵⁵

She narrated a history of mental nursing indicating the different kinds of training courses which had been set up to improve professional standards. Thus, she wrote, that by 1906 7,250 nurses had obtained the Medico-Psychological Association's (MPA)¹⁵⁶ certificate in mental nursing after successfully completing a professional training course which in 1906 was for three years. This contrasted favourably with the dire position of the 1840s and enabled her to declare:

*that it takes a person of superior skill and intelligence to make an asylum nurse has been very slowly recognised. She must be tactful and patient to a degree which is angelic, for she is permitted no weapon but moral suasion in the control of a refractory person or for the protection of her person.*¹⁵⁷

There was little evidence that these attributes were recognised by the nursing establishment and, as will be shown in Chapter 6, they were actively ignored in India.

By 1900 a specific body of knowledge, skills and procedures had been established which constituted an embryonic psychiatric nursing profession, according to Elvin Santos and Edward Stainbrook. Writing in 1949 these two historians of medicine and nursing reiterated and developed Tooley's observation that the ending of mechanical restraint on patients led to awareness that there had to be a psychological relationship with the patient rather than the threat or delivery of a

¹⁵⁵ Tooley, Sarah A. (1906) *The History of Nursing in the British Empire*, S. R. Bousefield, London, p. 138.

¹⁵⁶ The MPA was to become the Royal Medico-Psychological Association in 1926 and then the Royal College of Psychiatrists in 1971.

¹⁵⁷ Tooley, *The History*, p. 149.

physical one. Indeed in the view of Santos and Stainbrook it was this concern with the psychological and therapeutic relationship, Toovey's 'moral suasion,' which had constituted the major development in psychiatric nursing since the mid nineteenth century.¹⁵⁸ This, they argued, was a major reason why nurses began to consolidate their role as a vital, though not always appreciated, component of the psychiatric care system.

In Britain in 1885 the MPA produced *A Handbook for Instruction of Attendants on the Insane*,¹⁵⁹ popularly known as *The Red Book*, because of the colour of its cover.¹⁶⁰ The *Handbook* was regarded by Nolan as a milestone in the history of mental nurse education, as it gave to the workers a semblance of scientific credibility and the beginnings of a professional literature.¹⁶¹ It played a key role in contributing to the history and legitimacy of this nascent profession.

Santos and Stainbrook identified a number of training courses for nurses in America and Europe designed to promote the quality of their contribution to care in asylums during the nineteenth century.¹⁶² In 1889 the MPA established a committee to oversee the development of such training schemes, to approve a certificate to reward successful training and to provide a register of mental nurses.¹⁶³ The MPA was beginning to mould and organise a mental nursing profession but one subordinate to and tailored to the needs of alienists.

Further evidence of the development of psychiatric nursing in Britain has been provided by Anne Digby. In her history of the York Retreat she devoted a chapter to nurses, or *keepers* or *attendants* as they were known until the mid nineteenth century. She described them as the 'hidden dimension' of the asylum system and stressed how essential their contribution was to the care and recovery of patients.¹⁶⁴

¹⁵⁸ Santos, Elvin H. and Stainbrook, Edward (1949) 'A History of Psychiatric Nursing in the Nineteenth Century,' *Journal of the History of Medicine*, vol. IV. Part 1, p. 51. At DOI:10.1093/jhmas/IV.1.48 (Accessed 13th October 2016).

¹⁵⁹ Nolan, *A History*, p. 63.

¹⁶⁰ See Royal College of Nursing Archives

http://www2.rcn.org.uk/development/library_and_heritage_services/whats_on/exhibitions/out_of_the_asylum (Accessed 11th March 2017).

¹⁶¹ Nolan, Peter W. (1993) 'A history of the training of asylum nurses,' *Journal of Advanced Nursing*, vol. 18, p. 1198.

¹⁶² Santos and Stainbrook, 'A History,' p. 58.

¹⁶³ For further description of the nurse training courses in English and Scottish asylums see Tooley, *The History*, chapter xv.

¹⁶⁴ Digby, Anne (1985) *Madness, Morality and Medicine: A History of the York Retreat, 1796-1914*, Cambridge University Press, Cambridge, p. 140.

They were developing their own professional history and confirming its authority and independence, as Nolan intimated in the epigraph at the head of the chapter. Thus a training course for its own staff lasting four years was created at The Retreat. Additional examples of a nascent autonomy came in 1893 with the introduction of an identifiable nurses' uniform and in 1900 when a nursing hierarchy was created there with the introduction of ward sisters adopting a system then current in British general hospitals.¹⁶⁵ Digby concluded however that the professionalisation of nursing staff at The Retreat actually reinforced the authority of the medical superintendent as trained nurses were more likely to defer to the authority of the doctor.¹⁶⁶

Traditional histories of nursing have been criticised by Anne Borsay and Pamela Dale for being Whiggish and as such too concerned with professionalisation, too preoccupied with elite figures and national organisations, and too focused on female nurses.¹⁶⁷ They pointed out that mental nurses were never nurses following the Nightingale model¹⁶⁸ and became prisoners of their own institutional context.¹⁶⁹ However they became more recognised in the 1930s as they played a key role in the new physical therapies of insulin coma and E.C.T. treatments. They adopted techniques used by general nurses involved in intensive physical care¹⁷⁰ and so asserted their legitimacy as part of the overall nursing profession.

One of the few histories of mental nursing in the UK was written in 1993 by Peter Nolan, a trained psychiatric nurse turned historian. He was writing a century after the first national training scheme for 'attendants upon the insane' in 1891.¹⁷¹ He felt it an appropriate time to take stock of where psychiatric nursing came from, where it was then and what challenges it might face in the future. Nolan was conscious that his profession lacked a history of its own. He described how its story had been told, if at all, by male alienists and male psychiatrists who often regarded nurses as subordinates employed to carry out their instructions. The 'anti-psychiatry'

¹⁶⁵ Digby, *Madness*, pp. 166-168.

¹⁶⁶ Digby, *Madness*, p. 168.

¹⁶⁷ Borsay, Anne and Dale, Pamela (2015) 'Mental health nursing: the working lives of paid carers from 1800 to the 1900s,' in Borsay and Dale (Eds) *Mental Health Nursing, The Working Lives of Paid Carers in the Nineteenth and Twentieth Centuries*, Manchester University Press, Manchester.

¹⁶⁸ The model stressed the vital importance of a clean and healthy environment to assist the patient's recovery and that nature plays a key role in the person's cure. For full details see Van der Peet, Rob (1995) *The Nightingale model of nursing*, Champion Press, Edinburgh.

¹⁶⁹ Borsay and Dale 'Mental Health Nursing,' pp. 5-6.

¹⁷⁰ Borsay and Dale 'Mental Health Nursing,' p. 11.

¹⁷¹ Nolan, Peter *A History*, p. 151.

movement had challenged what Nolan referred to as the 'received wisdom' of psychiatrists that the history of psychiatry was predominantly theirs. It gave his profession a separate identity and the opportunity to assert its historical and current contribution to the care of the mentally ill.¹⁷² Nevertheless the independence did not attract much interest in research as by 2009 Nolan could only identify six significant historical studies of mental nurses.¹⁷³

The description by Digby¹⁷⁴ of nursing staff as a 'hidden dimension' in nineteenth century mental health care has been supported by an Australian historian Lee-Ann Monk. In her social and cultural survey of attendants in mental hospitals in nineteenth century Victoria, Australia, Monk lamented the paucity of previous research into this group of workers.¹⁷⁵ Those few academics, she asserted, who had considered attendants in their studies had generally dismissed as being recruited from 'the dregs of society.'¹⁷⁶ The implications were that their background made them too difficult to research and so not worth the attempt.

However some historians had begun to view attendants as employees who contributed significantly to asylum care. In her review of psychiatry in colonial Australia Elizabeth Malcolm indicated that Monk had been influenced by David Wright's arguments that twentieth century historians had not sought to examine the myth of the unskilled attendant.¹⁷⁷ Wright wrote of asylum attendants as being ordinary working people who had made rational, occupational choices in their choice of job. Whatever their lowly origins they generally chose to do the work in preference to other types of employment.

It has been argued by Jeanette Mitchell that there was a definite connection between the supremacy of the medical model and the relegation of general and mental nursing to a lower status occupation. This was because, she maintained, 'cure' had become the god and driving force of psychiatry whilst 'care' was less important to psychiatrists. This resulted in caring becoming a mere adjunct to the

¹⁷² Nolan, *A History*, p. 1.

¹⁷³ Cited in Borsay and Dale, Pamela 'Mental health nursing,' p.1.

¹⁷⁴ Digby, *Madness* p.140.

¹⁷⁵ Monk, Lee-Ann (2008) *Attending Madness: At Work in the Australian Colonial Asylum*, The Wellcome Series in the History of Medicine, Rodopi, Amsterdam, pp. 16-17.

¹⁷⁶ Scull, *The Most Solitary*, p. 263.

¹⁷⁷ Malcolm, Elizabeth (2010) 'Psychiatry in colonial Australia: mad women and their attendants in Victoria's asylums, 1848-88,' *History of Psychiatry*, vol. 21, no. 1, p. 98. DOI: 10.1177/0957154X09340296.

medical goal and it was a task which could be done by relatives and friends without the need for training.¹⁷⁸

The imbalance in power between doctors and nurses has been explained by Geertje Boschma, an academic historian and a psychiatric nurse, within a Foucauldian perspective. She supported Foucault's contention that where there was power there was resistance. Nolan has described how male asylum workers in Britain set up associations to represent their own interests.¹⁷⁹ However Boschma argued that the 'hegemonic effect' of a culturally dominant biomedical discourse on mental illness, one which was colluded with by the nursing hierarchy, proved very powerful.¹⁸⁰ Without a strong professional or trade organisation psychiatric nursing has continued to be in a generally subordinate relationship to psychiatrists.

In colonial India the group of workers who later became known as psychiatric nurses were on the fringes of this already marginalised profession of nursing. In her historical study of nurses in India Madelaine Healey identified a moral suspicion attached to nursing because of the intimate personal care it involved and that in some circles nursing was a euphemism for prostitution.¹⁸¹ Her arguments will be discussed in more depth in Chapter 6.

Whilst general nurses in the empire were much praised for their heroism and self-sacrifice, the history of psychiatric nurses in India has been much neglected and requires greater research. There has been a scarcity of primary sources from mental nurses themselves, who were overwhelmingly female, and formal references to them often came from psychiatrists, always male, who had a different professional agenda which required the latter's gender-biased comments to be treated with some caution. This chapter will now progress to more in-depth discussion on the historiography of imperial health and psychiatry.

¹⁷⁸ See Mitchell, Jeanette (1984) *What is to be Done about Illness and Health?* Penguin Books, cited in Nolan *A History*, p. 46.

¹⁷⁹ Nolan *A History*, p. 75-78.

¹⁸⁰ Boschma, Geertje 'Accommodation and resistance to the dominant cultural discourse on psychiatric mental health: oral history accounts of family members,' *Nursing Inquiry*, vol. 14, no. 4, 2007, pp. 268-269. DOI: 10.1111/j.1440-1800.2007.00379.x

¹⁸¹ Healey, Madelaine (2013) *Indian Sisters: A History of Nursing and the State, 1907-2007*, Routledge, New Delhi, p. 47.

Historiography of Imperial health

Until the 1990s limited research had been carried out by historians on aspects of colonial health. What little had been done was dismissed as 'celebratory history' by Shula Marks, a South African-born London-based historian, as if it was there only to praise 'the triumph of science and sewers over savagery and supervision,'¹⁸² with little analysis of the lives of the colonist or the colonised. She observed that there had been few attempts to analyse the lives of ordinary citizens, whether colonisers or colonised. The works of Arnold,¹⁸³ Mark Harrison¹⁸⁴ and others have shifted the debate to considerations of how medicine served as an instrument of colonialism. What became known as tropical medicine from the end of the nineteenth century developed into a specialist scientific discipline originally geared at treating white bodies made inefficient by diseases such as malaria and yellow fever in Asia and Africa. By the end of the nineteenth century Arthur Kleinman proposed that Western medical practitioners had come to believe in a single 'universalizable truth' of their own perception of healthcare taking little notice of non-Western medicine such as the ancient Ayurvedic and Unanic traditions of India.¹⁸⁵

More recently Pratik Chakrabarti, an Indian historian based in Britain, has proposed that the historiography of imperialism and medicine can be viewed in three broad phases.¹⁸⁶ The first academic history writings were from the nineteenth century and regarded imperialism as unquestionably beneficial as it brought to the colonies the rewards of modernity, civilisation and welfare. The second began in the early twentieth century and generally took the opposite viewpoint. A third phase came in the 1960s and subsequent decades as decolonisation took place. It concentrated on the oppressive influences of imperialism and the loss of cultural identities and indigenous medicine. Issues raised by such a model adapted to the study of psychiatry will be addressed in Chapter 3.

¹⁸² Marks, Shula (1997) 'What is Colonial about Colonial Medicine? and What has Happened to Imperialism and Health?' *Social History of Medicine*, vol. 10, no. 2,, p. 205.

¹⁸³ See, for example Arnold, David (1993) *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, University of California Press, Berkeley, USA.

¹⁸⁴ Harrison, Mark (1999) *Climates and Constitutions: Health, Race, Environment and British Imperialism in India, 1600-1850*, Oxford University Press, New Delhi.

¹⁸⁵ Kleinman, Arthur cited in Marks 'What is Colonial?' p. 214. Ayurveda is the traditional form of Indian medicine which has developed over the last 3,000 years. Unani is the mediaeval Islamic form of medicine which has been practised in India since the thirteenth century.

¹⁸⁶ Chakrabarti, Pratik (2014) *Medicine and Empire, 1600-1960*, Palgrave Macmillan, Basingstoke, Hampshire, p. xvii.

Although the study of Western medicine in India made by Arnold did not research specifically the history of psychiatry there, his comments may be considered as relevant by extension to this discipline's status in colonial medicine. Arnold found that Western medicine as a whole was bound up intimately with the nature and aspirations of the colonial state itself.¹⁸⁷ For most of the nineteenth century the work of doctors in India, and this included alienists, was focussed on the military. Their main objective was to ensure sufficient numbers of healthy troops were available to maintain colonial rule. He pointed out that doctors represented the only substantial number of Western-trained scientists based in India. This observation assisted my understanding of Western psychiatry in twentieth century India within the framework of the history of European medicine in the sub-continent. In this context psychiatrists can be regarded as a highly educated elite in colonial India with the ability to project authority and self-confidence in their profession.

He cited the work of Basalla in identifying the spread of European scientific culture in three phases: the growth of European science as it arrived in the colonies; the consequent establishment of 'colonial science' as a development of Western practice which was not inferior to it; and its culmination in the struggle to achieve an independent scientific tradition with local institutions, conventions and honours.¹⁸⁸ Basalla's theories can be applied to the introduction and development of psychiatry to India and the establishment of asylums there on the British model.

Arnold described how colonial medicine in general, and, by association psychiatry as a branch of medicine, needed to be understood as:

*an influential and authoritative vehicle not just for the transmission of Western ideas and practices to India but also for the generation and propagation of Western ideas about India.*¹⁸⁹

To succeed in India, Arnold wrote, with its Ayurvedic and Unanic traditions, practitioners of Western medicine had to compromise and negotiate their own passage between scientific laws and the practicalities imposed by colonial rule over

¹⁸⁷ Arnold *Colonizing* p. 9.

¹⁸⁸ George Basalla, cited in Arnold, *Colonizing*, pp. 15-16.

¹⁸⁹ Arnold, *Colonizing*, p. 291.

an 'alien' society.¹⁹⁰ It was Arnold's opinion that by the 1860s Western medicine felt increasingly secure in its superior knowledge, convinced that most that could usefully be used from indigenous texts and informants had already been harvested.¹⁹¹

Arnold has also analysed the lives of European orphans and vagrants in nineteenth century India. He estimated that in the late nineteenth century nearly half the European population could be classed as 'poor whites,' a term used at the time.¹⁹² In his study of workhouses, orphanages and other institutions for Europeans in India he drew similarities with their counterparts in Britain. He summarised the role of these establishments in an imperial context: 'Europeans were meant to be visible only as a super-race – never aged and infirm, never scantily clad, undereducated orphans in an Indian gutter.'¹⁹³ Removal to an orphanage, or to a workhouse for an adult, would ensure that:

*[I]n this way the illusion of a homogenous white race, affluent, powerful, impeccable, aloof, could be maintained to the satisfaction of the rulers; and, no less important, they would not be 'degraded' in Indian eyes.*¹⁹⁴

The official response had sought to make poor whites invisible to Indians.

Building on the work of Arnold, Collingham has written how a 'web of Britishness was woven round the body,'¹⁹⁵ demonstrated in physical activity, lifestyle, clothing, and dignity and deportment. All these factors were designed to deliver and maintain the prestige required to impose effective and enduring rule over Indians. The British were bringing to India the civilisation of the superior race and exhibiting it daily by their physical appearance; they were on show at all times to their colonial audience. For some Britons this was a source of stress opening up the possibility of mental ill health as will be discussed in Chapter 7. She portrayed this physical and assertive Britishness as an

¹⁹⁰ Arnold, *Colonizing*, p. 293.

¹⁹¹ Arnold, David (2000) *The New Cambridge History of Modern India: Science, Technology and Medicine in Colonial India*, Cambridge University Press, Cambridge, p. 69.

¹⁹² Arnold, 'European Orphans' p.104.

¹⁹³ Arnold, 'European,' p. 114. Most Europeans in India were required to retire officially at 55.

¹⁹⁴ Arnold, 'European,' p. 124.

¹⁹⁵ Collingham, *Imperial Bodies*, p. 92.

essential quality of the imperial ruler and which was 'rule in the British idiom.'¹⁹⁶ As such it had replaced rule in 'the Indian idiom' which had been adopted by the East India Company in the seventeenth and eighteenth centuries as the organisation consciously developed strong links with Indians and Indian culture.

Collingham observed how athleticism in the British was considered an essential prerequisite for white rulers. Physical activity and sports had moulded the elite Englishman in public schools and the universities. This theme was explored by J. A. Mangan who asserted that sports inculcated an ability to observe rules and the public school ethos brought loyalty, comradeship and self-respect to team players. Fair play to the other side in the game was valued.¹⁹⁷ Mary Procida identified that middle class British women in India women also took part in sports including shooting which had the potential extra attribute of use in the defence of the Raj in troubled times.¹⁹⁸ The physical fitness of British men and women was vital in their presentation to Indians although it was an objective which was not always achieved.

Overall the British ruling establishment believed that these qualities of honesty, courage, uprightness and endurance encapsulated their appearance to Indians and justified their presence as colonial rulers from a superior civilisation. Collingham has described how to the colonisers 'proofs' of superiority were found, though only for a limited period, in pseudo-scientific concepts such as phrenology and craniometry.¹⁹⁹ By the end of the nineteenth century imperial rulers began ascribing their position of superiority to a natural phenomenon leading to an accompanying duty to rule Indians. Indians, though, did not necessarily accept this as shown in the detailed demolition of the case for the British Empire in India by the Indian historian and politician, Shashi Tharoor.²⁰⁰

After an examination of the writings of nineteenth century doctors Collingham revealed their real fears of racial degeneration should whites stay too long in the inhospitable tropical climate of much of India or should they marry Indian women. These medical men reserved particular concerns for the future of white children if

¹⁹⁶ Collingham, *Imperial Bodies*, pp. 51-59.

¹⁹⁷ Mangan, J. A. (2001) *The Games Ethic and Imperialism: Aspects of the Diffusion of an Ideal*, Frank Cass, London.

¹⁹⁸ Procida, Mary A. *Married to the Empire: Gender, Politics and Imperialism in India, 1883-1947*, Manchester University Press, Manchester, 2002.

¹⁹⁹ Collingham, *Imperial Bodies*, p. 122.

²⁰⁰ Tharoor, Shashi (2016) *An Era of Darkness: the British Empire in India*, Aleph Books, New Delhi..

they remained in India beyond the age of seven. They risked the negative and immoral impact of the mores of the overwhelming Indian majority.²⁰¹

Building on Collingham's research, Anne Digby, Waltraud Ernst and Projit B Mukharji, recognised the growing prominence of the history of medicine in recent years.²⁰² They wrote how current scholarship on the imperial aspects of medicine was generally from a Eurocentric and modernist viewpoint within a context of European capitalism developing across the globe from the time of the (European) Enlightenment. For the purpose of challenging this there was a need to 'break out of narrow and conventional geo-political boundaries' and engage with different kinds of colonialism, study common and contradictory themes and share their scholarship globally.²⁰³ They acknowledged that distinct and compartmentalised historiographic traditions of medicine have developed in former colonies which have no connection with each other. Hence the model for colonial health might have its building blocks in Britain but the medical practices could vary between the British West Indies and British India and other colonies.

Studies in imperial health such as those by Mark Harrison²⁰⁴ and Biswamoy Pati,²⁰⁵ and by social historians of the Raj such as Collingham, Procida, Benita Parry,²⁰⁶ and Margaret Macmillan²⁰⁷ rarely contained references to mental illness. Whether this was due to their dismissal of the importance of the topic in the colonial history of India or their lack of knowledge or interest in it would be a source of speculation. Nevertheless, despite the acknowledged quality of their scholarship this

²⁰¹ See, for example, Fayer, Sir Joseph (1900) *Recollections of My Life*, Blackwood, Edinburgh. Fayer (1824-1907) survived the Siege of Lucknow in 1857-58 and became the senior British medical officer in India and the Prince of Wales's personal physician. Incidentally, in Fayer's 400 page autobiography he never once mentioned his wife's first name.

²⁰² Digby, Anne, Ernst, Waltraud and Mukharji, Projit B. (2016) (Eds) *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective*, Cambridge Scholars Publishing, Newcastle.

²⁰³ Digby, et al, *Crossing*, p. ix.

²⁰⁴ See for example, Harrison, Mark (September 1992) 'Tropical Medicine in nineteenth century India,' in *British Journal for the History of Science*, vol. 25, no. 3, pp. 299-318; and Harrison, Mark (1999) *Climates and Constitutions: Health, Race, Environment and British Imperialism, 1600-1850*, Oxford University Press, New Delhi.

²⁰⁵ Pati, Biswamoy and Harrison, Mark (2006) (Eds) *Health, Medicine and Empire: Perspectives on Colonial India*, Orient Longman, New Delhi; and Pati, Biswamoy and Harrison, Mark (2009) (Eds) *The Social History of Medicine in Colonial India*, Routledge, Abingdon, Oxon,.

²⁰⁶ Parry, Benita (1972) *Delusions and Discoveries: Studies in India in the British Imagination, 1880-1930*, Allen Lane, The Penguin Press, London.

²⁰⁷ Macmillan, Margaret, (1996) *Women of the Raj*, Thames and Hudson, London.

thesis will focus on the position in the Raj of those distressed *Imperial Minds*, whose lives were generally ignored, and the professionals who cared for them.

The chapter has examined so far the historiography of Western psychiatry and psychiatric nursing with some reference to the physical health of British colonies. It will now turn to a consideration of how this scholarship has influenced the historiography of psychiatry as practised in India and for comparative purposes in other colonies.

Historiography of Imperial psychiatry

Whilst enthusiastic psychiatrists and academic ideologues alike exchanged insults and denunciations over their understanding of and interpretation of mental illness, a key figure, Waltraud Ernst, emerged in current research into its modern history in India. Ernst, an Austrian historian and trained psychologist, was aware of the internecine feuds but chose a middle road of meticulous scholarship over a forty year period. In 1991 she produced the first edition of her groundbreaking *Mad Tales from the Raj* prior to which few historians had studied colonial psychiatry and medicine.²⁰⁸ Those who had, observed Ernst, had usually rooted their studies on a Western model of psychiatry.

Four particular themes have dominated her arguments. These were the pervading nature of white racial superiority; the paucity of previous research into the mental health of poor whites in British India; the way in which India was pathologised and regarded as a diseased environment with an alleged adverse impact on European bodies and minds; and the growth of psychiatry into an international scientific profession. Ernst's key assessments have provided a very useful foundation on which to build the rationale of this thesis. Her studies of the European mentally ill related mostly to the eighteenth and nineteenth centuries but the four themes formed compelling arguments for my research.

Her first theme related to the need by the colonial establishment to protect the distressed *Imperial Minds* from the Indian gaze. The East India Company, the *de facto* rulers of India until the Great Rebellion of 1857-58, sought to establish asylums

²⁰⁸ Ernst, Waltraud *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800-1858*, Anthem Press, London, 2010. The original edition was produced in 1991. Its title echoed the collection of short stories *Plain Tales from the Hills* produced by Rudyard Kipling in 1888.

for Europeans physically away from the Indian population as a means, she argued, to prevent the colonised seeing mentally distressed Europeans who had failed to live up to their official image as members of the superior white race. She illustrated this deep rooted belief by quoting from Henry Dundas, President of the East India Company's Board of Control. In 1793 Dundas feared that 'indiscriminate and unrestrained colonisation' would undermine the general respect which he believed Indians had for the superiority of the English character. It was this European superiority on which the preservation of the empire depended, he stated.²⁰⁹

The Company, Ernst asserted, had reaffirmed this conclusion in 1830 following an inquiry into the feasibility of relocating their existing asylums in India to hill stations. The findings rejected the proposal on three major grounds: the cost, as before railways had been built in India travelling long distances was regarded as being very expensive; the presence of lunatics in the hill stations might have offended the sensitivities of the better class of Europeans and Eurasians who lived there in the 'hot weather';²¹⁰ and more asylums would have meant more mad whites in India for Indians to see. The problem of distressed *Imperial Minds* was, she said, solved elegantly by the Company through repatriation of their 'Indian insanes' as they were termed²¹¹ to their asylum at Pembroke House in Hackney, London opened in 1812.²¹² Those who remained in India and who required hospitalisation were placed in segregated hospitals which were instrumental in keeping those Europeans 'out of sight who were seen to be out of their minds.'²¹³

In her study of the Indian Mental Hospital at Ranchi Ernst explored and criticised the continued overt racial prejudice by European and British professional groups wishing to maintain their privileged position in the medical marketplace.²¹⁴ As

²⁰⁹ Cited in Ernst, Waltraud (1991) 'Colonial Psychiatry: the European insane in British India, 1800-1858,' in Berrios, German and Freeman, Hugh *150 Years of British Psychiatry, 1841-1991*, Gaskell, Royal College of Psychiatrists, London, p. 159.

²¹⁰ Ernst, Waltraud 'Asylum Provision and the East India Company in the Nineteenth Century,' *Medical History*, vol. 42, 1998, p. 484. The 'hot weather' was the period between June and September when the heat in the plains of India was at its most intense.

²¹¹ Ernst, 'Colonial Lunacy p.151.

²¹² Ernst, Waltraud 'Asylums in alien places,' p. 54. When Pembroke House closed in 1870 because of the development of the railways in that part of London the remaining residents were transferred to the Royal Indian Asylum in Ealing.

²¹³ Ernst, 'Colonial Psychiatry': p. 159.

²¹⁴ Ernst, Waltraud (2013) *Colonialism and Transcultural Psychiatry: The Development of an Indian Mental Hospital in British India c. 1925-1940*, Anthem Press, London, especially pp. 6, 8-11, 21. The

evidence she cited the differential in pay and conditions of service when compared to the nearby European Mental Hospital. Further prejudice was illustrated when the European medical superintendent went abroad to a conference and a more junior European doctor was appointed to deputise in preference to a more experienced Indian, even though the white doctor had recently been the Indian's locum.²¹⁵

A second theme concerned the development of Subaltern Studies championed in the 1980s by Indian scholars, some of whom were based in the USA. Subaltern Studies were greatly influenced by Foucauldian paradigms of power relationships in a medical and colonial context. Whilst welcoming the innovation, Ernst argued that the history of individuals was neglected as the discourse was dominated by movements, by hegemonies and by overall colonial identities.²¹⁶ Ernst observed that there were also poor mentally ill white men and women in India who had been subject to social exclusion and discrimination, illustrating that colonialism had a negative effect on more than just the colonised.²¹⁷ Her concern for the fate of individuals contrasted with the impersonal narratives of some scholars.

Vagrancy, destitution and lunacy amongst Europeans in India brought the ruling class into contempt in the eyes of Indians, according to Arnold and so the British sought to make them invisible in workhouses, prisons and asylums, or to repatriate them.²¹⁸ Asylums for Europeans in India were distinct from these other institutions in that they had always taken patients from all social class backgrounds in recognition of the fact that madness, unlike destitution, crossed class boundaries. This indicated, Ernst maintained, that government policy on the development of asylums for Europeans was not linked to its strategy on pauperism.²¹⁹ The British mentally ill were being managed differently to others who might have been classed as showing deviant behaviour.

Indian Mental Hospital also at Ranchi was opened in 1925. It exists today as the Ranchi Institute of Neuro-psychiatry and Allied Sciences and specialises in the treatment of mentally ill offenders.

²¹⁵ Ernst, *Colonialism*, p. 17.

²¹⁶ Ernst, *Mad Tales*, p. xvi.

²¹⁷ Ernst, *Mad Tales*, p. xvi.

²¹⁸ See, for example Arnold, 'European Orphans' pp. 104-127.

²¹⁹ Ernst, Waltraud (1999) "'Out of sight and Out of mind,'" *Insanity in early nineteenth century British India*, p. 252 in Melling, Joseph and Forsythe, Bill (1999) (Eds) *Insanity, Institutions and Society, 1800-1914: a history of madness in comparative perspective*, Routledge, London.

Ernst's third category explored how India had been portrayed as a pathological environment for potential and actual European colonisers.²²⁰ Illness in India was regarded by many Europeans as an inevitable consequence of everyday life there and one which they knew could sometimes be fatal. Tropical illnesses were part of the 'colonial burden,' according to Chakrabarti.²²¹ Ernst had developed this theme in relation to the alleged degeneration of white children in India should they not be able to escape the hostile climate for temperate Europe by the age of seven. It became British medical orthodoxy that by children remaining they risked stunted growth and a debilitated mind, as illustrated by the descendants of the Dutch and Portuguese settlers in India from the seventeenth century, who frequently intermarried with Indians so losing their 'whiteness.'²²² This made the British task of ruling more lonely and selfless as inter-racial sex and friendships were generally condemned.

A fourth theme was the transition in British India from army doctor to alienist to psychiatrist, from a constricted military outlook to an international scientific perspective explored in her *Transcultural Psychiatries*²²³ published in 2010 and summarised in a podcast in 2013.²²⁴ She identified that in the nineteenth century army doctors generally had no special training in psychological medicine. Their priority had been to treat fevers, diarrhoea, cholera and dysentery and so on, diseases which, particularly when of epidemic proportions, had an immediate impact on the fighting efficiency of the army.²²⁵ Ernst suggested that at the turn of the nineteenth century there had been a noticeable shift in power relationships within colonial medical institutions. This she attributed to the management and treatment of

²²⁰ See, for example, Harrison, Mark (1994) *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, Cambridge University Press, Cambridge; Kennedy, Dane (1996) *The Magic Mountains: Hill Stations and the British Raj*, Oxford University Press, New Delhi; Buettner, Elizabeth, (2004) *Empire Families: Britons and Late Imperial India*, Oxford University Press, Oxford.

²²¹ Chakrabarti, *Medicine and Empire*, pp. x – xix.

²²² Ernst 'Out of sight,' p, 253.

²²³ Ernst, Waltraud and Mueller, Thomas (2010) (Eds) *Transcultural Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, c. 1800-2000*, Cambridge Scholars Publishing, Newcastle-upon-Tyne.

²²⁴ See Ernst, Waltraud (30th April 2013) *Colonialism and Transnational Psychiatry in Colonial India*, (Audio Podcast) Retrieved from https://www.academia.edu/8360019/Podcast_on_Colonialism_and_Transnational_Psychiatry_in_British_India (Accessed 24th April 2017).

²²⁵ Ernst, Waltraud 'Doctor-patient interaction in colonial India: a case of "intellectual insanity," ' *History of Psychiatry*, vol. 1, 1990, p. 214. It was not until the early 1920s that most doctors in mental hospitals in India had begun to undertake training in psychological medicine.

the insane becoming subjected gradually to the narrow dictates of medical expertise and an emerging scientific paradigm. Up to this time the blueprint of psychiatry in India had been British-based and linked to colonialism and the 'civilising mission' associated with racial superiority.²²⁶

The spread of European civilisation across the empire led to institutionalised psychiatry becoming essential as colonialism became seemingly permanent.²²⁷ She identified a professional reorientation in the 1920s and 1930s as psychiatry consolidated its scientific knowledge base and became less focussed on that British blueprint.²²⁸ The notion of psychiatry as a universal science enabled Indian psychiatrists to see themselves as part of an international community of experts, worldwide networkers rather than mere colonial servants and collaborators. This outlook also applied to their British counterparts in India. Thus, she argued, that the contemporaneous myth of psychiatry as beneficial to, and an excuse for, empire was replaced by a modern myth of science being universally valid and applicable, culture-free and politically disinterested.²²⁹ Indian psychiatrists now saw themselves as practising modern Western psychiatry on a world stage rather than its colonial variant and this transnational and universalist vehicle was a potential threat to colonialism. The extent to which this scientific liberation contributed to the movement supporting Indian nationalism would be a topic for future research.

Influenced by Foucauldian accounts of psychiatry as a discourse of control and hegemony, Arnold had portrayed medicine and psychiatry in India as 'colonial' medicine and, as such, a component of the tools of empire.²³⁰ Ernst argued that the British colonising of the colonial body, as proposed by Arnold, needed to be readdressed in the light of the emerging science-based medicalisation of body and mind accompanied by the desire of both British and Indian psychiatrists to improve their scientific practice for the benefit of their patients. Colonial psychiatry in the nineteenth century had played an important part in the moral and political justification

²²⁶ Ernst, Waltraud (2009) 'Institutions, people and power: Lunatic Asylums in Bengal, c. 1800-1900,' in Pati, Biswamoy and Harrison, Mark *The Social History of Health and Medicine in Colonial India*, Routledge, Abingdon, Oxfordshire, p. 138,

²²⁷ Ernst 'Asylums in alien places,' p. 50.

²²⁸ Ernst, Waltraud (2011) 'Crossing the Boundaries of "Colonial Psychiatry": Reflections on the Development of Psychiatry in British India, c. 1870-1940,' in *Culture, Medicine and Psychiatry*, vol. 35, p. 540. Doi:10.1007/s11013-011-9233-z (accessed 5th May 2017).

²²⁹ Ernst, 'Crossing the Boundaries,' p. 540.

²³⁰ See Arnold *Colonizing*, pp. 292-294.

of British rule in India.²³¹ She contrasted that with an early twentieth century psychiatry that was developing as a universal science beyond the confines of any one nation state. It was changing from a narrow grouping of colonial servants into a British and Indian profession of an international community of doctors and scientists. The international perspective could be seen clearly in articles in the *Indian Medical Gazette (IMG)*, a monthly journal for medical practitioners in India.

One outcome of this transnational metamorphosis, posited Ernst, was that the debate on the history of medicine and psychiatry changed radically. It had been centred on a critique of colonisation through the lens of medicine which position, she argued, tended to deny political and social agency to individual colonial subjects and, by implication, to the white mentally ill also. Scholarship now questioned what was 'colonial' about colonial medicine and began to take on a greater concern with social history.²³² The logic underpinning this was that the European distressed *Imperial Mind*, although he or she continued to be racially segregated and privileged, had become a patient of a world whose illness transcended colonial boundaries. Her argument made a powerful base for a consideration of patients' treatment at the EMH.

It can be argued that in the 1980s the field of research into psychiatric medicine in the European colonies became dominated by the theories of Frantz Fanon,²³³ a black French psychiatrist, and Ashis Nandy,²³⁴ an Indian clinical psychologist and sociologist. Their concern for the neglected study of powerless colonised subjects, or *subalterns* was praised by Ernst but she criticised their tendency, like Foucault, to explain history at a universal level and as a consequence to neglect 'the mundane minutiae of historical detail'²³⁵ and the issue of diversity in human behaviour which accompanied it. In particular she referred to the work of Nandy as 'mythographies of the oppressed' rather than actual histories of their

²³¹ Ernst Crossing the Boundaries,' p. 538.

²³² Ernst, Waltraud, (2007) 'Beyond East and West. From History of Colonial Medicine to a Social History of Medicine(s) in South Asia,' in *Social History of Medicine*, vol. 20, no3, pp. 509-511.

²³³ Fanon, Frantz (2001) *The Wretched of the Earth*, Penguin Books, London. The original was published in French in 1961. Fanon was from Martinique and practised psychiatry in the French colony of Algeria during its war of independence.

²³⁴ See, for example, Nandy, Ashis (1995) *The Savage Freud and other Essays on Possible and Retrievable Selves*, Princeton University Press, Princeton, New Jersey.

²³⁵ Ernst, *Mad Tales*, p. xii.

everyday life experiences.²³⁶ In her view Foucault had also been guilty of making assumptions in denigrating the experiences of ordinary people.²³⁷

Another academic researching the interface of the problems of madness and its interpretation and treatment in colonial territories was the American historian Richard Keller. He acknowledged the deep influence which Foucault and Edward Said have had since the 1970s on the study of mental health in colonial countries. Keller studied the historiographies relevant to psychiatry in the British and French empires and identified four types which have made a valuable contribution to the understanding of imperial psychiatry.²³⁸

The first concerned the interest of scholars in questions of power, progress and the professional development of this branch of medicine. This Keller attributed directly to the radical assertions of Foucault which undermined the dominant role of Western psychiatry. He recognised the widespread criticism heaped by scholars onto Foucault following his *Great Confinement* theory. However he praised Foucault for stimulating research on such topics as the professionalization of psychiatry, the connection between psychiatry and politics and the importance of gender and race in discourses on mental health. Keller observed that there were failings in such research because of its inherent Eurocentrism and its inability to engage with alternative, indigenous forms of medicine in colonised countries. This led to a second type of historiography developed from the study of Orientalism by Edward Said.²³⁹ Said criticised the Western stereotypes of the Orient which had predominated since classical antiquity and, he said, had become triumphalist generating paternalism and racism. A third type, leaning heavily on Freudian theories of psychoanalysis, was the study of the psychological challenges of the colonial predicament addressing such issues as masculinity, institutionalised violence and social Darwinism.²⁴⁰ His fourth category centred on the question of race which Keller described, in the colonial

²³⁶ Ernst, 'Beyond East and West,' p. 508.

²³⁷ Ernst, 'Beyond East and West,' p. 507.

²³⁸ Keller, Richard (Winter 2001) 'Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962,' *Journal of Social History*, vol. 35, no. 2, pp. 295-326.

²³⁹ Said, Edward W. (2003) *Orientalism*, Penguin Modern Classics, London. The original work was published in 1978.

²⁴⁰ Keller, 'Madness and Colonization,' p. 297.

context, as the paramount category for social analysis.²⁴¹ His findings have proved a useful template for researchers studying the complexities of imperial psychiatry.

The pioneering scholarship of Ernst helped to open up the history of psychiatry in India to other academics. One British historian, James Mills, asserted that the foundations of modern Indian psychiatry were laid down during colonial rule and they continue to have a major influence today. He has proposed that it can be divided into four main periods which will be discussed in detail in Chapter 3.²⁴² Once again the influence of Foucault was acknowledged as Mills refused to call asylum residents 'insane.' This action, in his view, would have been in collusion with the colonial establishment's approach of generally condemning or ignoring those residents of the hospitals and what they had to say.²⁴³ Mills further added to scholarship with his study of the impact of drugs on life in India and how the British sought to limit them.²⁴⁴

The apparent dismissal of asylums as merely places of detention by Shridar Sharma²⁴⁵ and Ernst was criticised by Mills. He disagreed with them and others for their depiction of colonial psychiatry as 'minimally interventionist.'²⁴⁶ Instead, he stressed that asylum regimes resembled the therapy programmes of asylums in Europe implying that as such they were places of planned care and treatment rather than just units of confinement.²⁴⁷ His research also concluded that violence, by which he meant planned physical assaults by invasive treatments such as electroconvulsive and insulin shock therapies, was a central feature of the British colonial psychiatric system.²⁴⁸ Mills's explicit view that violence was at the core of Western psychiatric treatments in India posed challenges for my research at the

²⁴¹ Keller, 'Madness and Colonization,' p. 298.

²⁴² Mills, James (August 2006) 'Modern psychiatry in India: The British role in establishing an Asian system,' *International Review of Psychiatry*, vol. 14, no. 4, pp. 333-343.

²⁴³ Mills, James (2000) *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900*, Macmillan, Basingstoke, p. 2.

²⁴⁴ See, for example, Mills, *Madness, Cannabis*; and Mills, James H. and Barton, Patricia (2007) (Eds) *Drugs and Empires: Essays in Modern Imperialism and Intoxication, c.1500 – c1930*, Palgrave, Basingstoke.

²⁴⁵ Sharma, Shridar (1990) *Mental Hospitals in India*, Directorate General of Health Services, New Delhi, p.52.

²⁴⁶ Mills James H. and Sen, Satadru (2004) 'Introduction' in Mills James H. and Sen, Satadru (Eds) *Confronting the Body: The Politics of Physicality in Colonial and Post-Colonial India*, Anthem Press, London, p. 8.

²⁴⁷ Mills, *Madness, Cannabis* p. 107.

²⁴⁸ Mills James H. 'Body as Target, Violence as Treatment: Psychiatric Regimes in Colonial and Post-Colonial India, in Mills and Satadru *Confronting the Body* p. 96.

EMH. If one accepted, as Mills appeared to, that all such physical psychiatric treatments in the 1920s and 1930s were essentially violent then he was in the very narrow anti-psychiatry sense correct. However, evidence from the medical case notes presented in Chapter 7 indicated that European and Anglo-Indian patients were often consulted about invasive treatments and made choices, respected by their doctors, on whether to accept or refuse them. Additionally many were voluntary patients and so could not be treated compulsorily. Such cases undermine Mills's arguments and his position seems an exaggeration. Ernst challenged Mills's overemphasis on violence²⁴⁹ but stressed that his evidence, as Mills himself acknowledged, was wholly dependent on the content of medical case records with the caveats identified by Andrews.²⁵⁰ However their dispute appeared to have fallen short of the force-field friction between radicals and the Establishment of recent decades.

The value to historians of official statistics collected from the annual reports of asylums for Britons and Indians in India was questioned by Mills. Arising from his archival research at the Lucknow Asylum, a hospital for Indians, he cited discrepancies in the records where, for example, one Indian resident was recorded on different pages as being aged both 27 and 50 and another between 25 and 40.²⁵¹ In addition the application of different classificatory systems used by different doctors undermined the reliability of records for comparison purposes.²⁵² However by developing an awareness of the discourses followed in the creation of the medical notes he asserted that useful information could be gathered for academic study. Ultimately, though he concluded that the notes revealed more about the British psyche of the period than about the mental health of Indians.²⁵³

Mills disputed Foucault's claim that an asylum was

²⁴⁹ Ernst, *Colonialism and Transcultural Psychiatry*, pp. 27-29.

²⁵⁰ Andrews, 'Case Notes,' p. 265.

²⁵¹ Mills, *Madness, Cannabis* pp. 16-17. A perusal of the records of British and Anglo-Indian patients at the European Mental Hospital also found some inaccuracies in birthdates.

²⁵² Mills, *Madness*, p. 21.

²⁵³ Mills, James (2000) 'The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive,' in *Journal of Medical Humanities*, vol. 21, no.3, p, 157.

[A] religious domain without religion – a domain of pure morality, of ethical uniformity... an instrument of moral uniformity and of social denunciation.²⁵⁴

He did not believe that colonial officials including medical superintendents were omnipotent even if they wished to be or thought they were. My research at the EMH challenges Mills's view and shows that the psychiatrists in charge there were extremely powerful in their domain.

Recent scholarship of the British in colonial India has developed from the studies of Guha a concept of empire in itself as a source of permanent anxiety and fear amongst the ruling group.²⁵⁵ 'Could colonialism drive people crazy?' asked Dane Kennedy and he advanced two parallel medico-moral theories to explain the causes and manifestations of mental breakdown amongst both the colonisers and the colonised.²⁵⁶ Kennedy's first theory considered the impact of the climate, environment and the very nature of colonialism itself on the white colonisers. Doctors had devised a clinical diagnosis of a tropical variant of neurasthenia to explain a wide range of symptoms exhibited by Europeans in India and other tropical countries which had become part of Western empires. Kennedy argued that 'civilised peoples,' as Europeans regarded themselves were driven 'crazy' in their colonies by their isolation from modernity, their constant exposure to a primitive and hostile environment and to indigenous, 'uncivilised' peoples.²⁵⁷ Such issues are addressed in detail in Chapters 4 and 5. His second theory emphasised that colonised peoples themselves, non-*Imperial Minds*, became mentally distressed by the imposition of Western civilisation on their traditional ways of life.

In order to explain the impact of Western life on 'uncivilised' peoples the discipline of ethnopsychiatry was devised with its proponents being particularly influential in Africa. Blacks in Africa were viewed by most Europeans as being at a

²⁵⁴—Foucault, *Madness and Civilization*, p. 244, cited in Mills, *Madness, Cannabis*, p. 181.

²⁵⁵ See, for example, Peckham, Robert (2015) *Empires of Panic: Epidemics and Colonial Anxieties*, Hong Kong University Press, Hong Kong. The book is mainly concerned with the perceived or actual threats to colonial rule from such factors as riots, assassination plots and epidemics and infectious diseases and has little comment on the potential for psychiatric disturbances in individuals.

²⁵⁶ Kennedy, Dane 'Minds in Crisis: Medico-moral theories of Disorder in the Late Colonial World,' in Fischer-Tiné, Harald (2016) (Ed) *Anxieties, Fear and Panic in Colonial Settings: Empires on the Verge of a Nervous Breakdown*, Palgrave Macmillan, London, p. 27.

²⁵⁷ Kennedy, 'Minds in Crisis,' p. 32.

lower level of civilisation and, therefore by definition, unable to cope with the 'civilised' existence of Western ideas, technologies and institutions.²⁵⁸ Megan Vaughan, a historian of medicine in Africa, recognised these prejudicial views and wrote that Africans were susceptible to nervous breakdown because they were 'driven mad by "acculturation" and the strains of "modern" society.'²⁵⁹ Where ethnopsychiatry flourished in Africa Jonathan Sadowsky asserted it did so on the basis of Africans being representatives of a race rather than as individual patients suffering from a discrete mental illness and he argued that the power of colonial medicine advanced colonial hegemony.²⁶⁰ As members of civilisationally so-called 'inferior' peoples they were considered intellectually incapable of comprehending the workings and benefits of Western culture.

Ethnopsychiatry appeared to have had little influence amongst practising white psychiatrists in India, though this is not to deny or excuse their racist attitudes. In India much energy was expended on the anthropological categorisation of races, castes and body measurements which had an impact on the census of India.²⁶¹ This lack in importance of ethnopsychiatry may be a result of an inclusive model of colonial rule as by the 1920s Indians were reaching quite senior positions in government and the professions including medicine and psychiatry. Arguments similar to those used in Africa about a 'natural' racial and intellectual inferiority became increasingly difficult to sustain in India because of the growing number of achievements by educated Indians.

A key figure in current scholarship relating to the social history of Europeans in colonial India is the Swiss academic, Harald Fischer-Tiné. Although not a specialist in the history of psychiatry his research on *white subalternity* did relate to many poorer Europeans who became mentally ill and so could be classed as powerless or voiceless.²⁶² He criticised some scholars of empire for employing reductionist models of history and delivering oversimplified explanations. Their

²⁵⁸ Kennedy, 'Minds in Crisis,' p. 35.

²⁵⁹ Vaughan, Megan cited in Kennedy, 'Minds in Crisis,' p. 35.

²⁶⁰ Sadowsky, Jonathan (1999) *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria*, University of California Press, Berkeley, p. 98.

²⁶¹ For a critique of the way in which the census of India took an anthropological approach led by its census commissioner Herbert Risley see Tharoor, *An Era of Darkness*, pp. 120-131.

²⁶² Fischer-Tiné, *Low and Licentious*. In this book Fischer-Tiné considered the lives of proletarian groups which had embarrassed the colonial authorities such as European seamen and white vagrants.

arguments, he maintained, had been based on a flawed but traditional interpretation, rooted in the premise that whites were always powerful and privileged and their promotion of the 'civilising mission' of the Raj had ignored the everyday experiences of poor whites. Fischer-Tiné described them as 'white underdogs' and 'people without history',²⁶³ but a people with often substantial personal connections with Indians. He was highly condemnatory of the proponents of subaltern studies and of feminist historians of South Asian studies, who preferred a binary analysis of colonial history: the oppressing white elite versus the oppressed Indian majority.²⁶⁴ He regarded this as a faulty and simplistic representation which perpetuated the colonial myth of homogeneous racial groups with fixed characteristics such as the portrayal by Francis Hutchins of a white 'middle class aristocracy' in India.²⁶⁵ Fischer-Tiné agreed with Ernst that these 'white subalterns' or white misfits were seen as a threat by and to the imperial authorities and had to be disciplined, re-educated, repatriated or hidden from the view of Indians.²⁶⁶

At this point it is useful for comparative purposes to consider the histories of colonial psychiatry in other parts of European empires. The case records from asylums in other countries can provide useful comparative material, argued Bronwyn Labrum, a historian based in New Zealand. She identified 'webs of empire' in that country linked to the hegemony of Scottish training in psychiatry and the European innovation of kindness and care in treatment.²⁶⁷ Historians have often commented on the numbers and importance of psychiatrists trained at Glasgow, Edinburgh, Aberdeen and St. Andrews Universities who practiced in the colonies and Labrum confirmed their alumni's' significance in New Zealand.

From her research Labrum has developed a concept of 'madness is migration'²⁶⁸ whether the migration was in time or space, was social or cultural, or was internal to the human mind. Whereas her arguments were stimulating they were difficult to follow. It can be argued that a reversal of her idea would provide greater

²⁶³ Fischer-Tiné, *Low and Licentious*, p. 15.

²⁶⁴ Fischer-Tiné, *Low and Licentious*, pp. 4-6.

²⁶⁵ Hutchins, Francis G. (1967) *The Illusion of Permanence: British Imperialism in India*, Princeton University Press, Princeton, New Jersey.

²⁶⁶ Fischer-Tiné, *Low and Licentious*, p. 18.

²⁶⁷ Labrum, Bronwyn (2011) 'Afterword: Madness is Migration – Looking Backward to Look Forward,' in McCarthy, Angela and Coleborne, Catharine (Eds) *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*, Routledge Studies in Cultural History, London, p. 195.

²⁶⁸ Labrum, 'Afterword', p. 193. Emphasis in the original.

insight. Thus the proposal that 'migration was madness' in itself, because of the resultant assaults on *Imperial Bodies* and *Imperial Minds* by climate, isolation, culture and other factors related to migration might have been more easily understood. It is an underlying theme of this thesis that consequences of migration were a cause of mental distress to many Britons who moved to India.

Extensive research has been carried out into the history of psychiatry in the former Dutch East Indies, the current Indonesia, by a Dutch historian, Hans Pols. Pols identified that one of the first discussions of the problems inherent in comparing psychiatric illnesses transnationally came from Emile Kraepelin after his visit to Java in 1904. Kraepelin had proposed that the 'unusual symptomatology' of mental illness amongst the Javanese was because of their lower stage of intellectual development when compared to that of Westerners. Those Europeans who did exhibit a mental illness were often viewed, observed Pols, as degenerate or deviant or retarded and so on a par with 'lesser' races such as the Javanese.²⁶⁹ His studies have produced similar findings to those of Sadowsky in Nigeria. The common theme implied here was that distressed *Imperial Minds* had failed as representatives of a superior civilisation so making themselves by definition inferior to the mentally well.

The bulk of research into the history of psychiatry in colonial India before 1947 has been carried out by Western historians and no comprehensive study of the topic by Indian historians has been identified. However in recent years Indian historians have published numerous works on the subject. Thus Shridhara Sharma has recognised that Indian mental hospitals as they currently existed were entirely a British conception²⁷⁰ and had a function which was custodial rather than curative.²⁷¹ S. R. Parkar et al identified three revolutions in the development of psychiatry in India: the belief that mental illness was sinful and emanated from witchcraft; the advent of psychoanalysis to explain the aetiology of psychiatric disorders; and the development of mental health care in the community away from institutions.²⁷² A number of articles give a broad overview of topics related to psychiatry, for example

²⁶⁹ Pols, Hans August (2006) 'The development of psychiatry in Indonesia: from colonial to modern times,' in *International Review of Psychiatry*, vol. 18, no. 4, pp. 363-370.

²⁷⁰ Sharma, Mental Hospitals in India, p. 131.

²⁷¹ Sharma, S. D. (2004) 'Mental Health: The Pre-Independence Scenario,' in Agarwal, S. P. *Mental Health: An Indian Perspective, 1946-2003*, Elsevier, New Delhi, p. 25.

²⁷² Parkar, S. R., Dawani, V. S. And Apte, J. S. (2001) 'History of Psychiatry in India,' *Journal of Postgraduate Medicine*, vol. 47, no. 1, pp. 73-76 www.jpgmonline.com/text.asp?2001/47/1/73/226 (Accessed 20th January 2012)

Nandini Bhattacharya's study on alcohol in colonial India.²⁷³ Recent studies have been made of psychiatric infrastructures in India such as that by Shilpi Rajpal.²⁷⁴ Alok Sarin, an Indian psychiatrist, observed that medication from the Ayurvedic and the Unanic traditions were used in British asylums in India until the early nineteenth century.²⁷⁵ It is hoped that one day an overall study of the history of psychiatry from an Indian perspective will be compiled.

A protestation came in 2005 from Amit Ranjan Basu, an Indian independent researcher in social sciences and mental health, that the history of Indian psychiatry had been a tale of the unquestioned victory of Western science. He argued that in order to understand fully the history of psychiatry in his country there had to be a precise critique of its relation to colonialism. He credited Ernst and Mills with doing much to change attitudes and praised the work of Nandy and Girindrasekhar Bose. Nandy had argued that colonialism colonised the bodies and the minds of the subjects and changed their culture forever.²⁷⁶ Bose, who was the first Indian to train as a psychoanalyst, projected psychoanalysis beyond narrow colonialism and became respected internationally for his work.²⁷⁷

The concept of an imperial psychiatry has been challenged by Roland Littlewood. He argued that in the nineteenth century and twentieth century before Independence psychiatrists and colonial administrators maintained that mental patients in general, and non-European ones in particular, lacked the 'higher' functions or a sense of personal responsibility to understand and deal with the consequences of their mental illness.²⁷⁸ Their diagnosis, of course, was defined by Western psychiatry. Littlewood identified a contrast between the French and British

²⁷³ Bhattacharya, Nandini (2017) 'The Problem of Alcohol in Colonial India,' *Studies in History*, vol. 33 no. 2, pp. 187-212.

²⁷⁴ Rajpal, Shilpi (2015) 'Colonial Psychiatry in mid nineteenth century India: the James Clark Enquiry,' *South Asia Research*, vol. 35, no. 1, pp. 61-80. DOI:10.1177/0262728014560476.

²⁷⁵ Sarin, Alok (Autumn 2013) 'Rosin Dhunjibhoy is dead,' *Indian International Centre Quarterly*, vol. 40, no. 2, p.106. I had the privilege of sharing a meal with Dr Sarin and his family in Delhi in 2014. His knowledge of the history of Indian psychiatry gave me some valuable insights towards the subject which have been incorporated into this thesis.

²⁷⁶ See for example, Nandy, Ashis (1983) *The Intimate Enemy: Loss and Recovery of Self under Colonialism*, Oxford University Press. Delhi.

²⁷⁷ Basu, Amit Ranjan (1999) *The Coming of Psychoanalysis in Colonial India: The Bengali Writings of Dr. Girindrasekhar Bose*, Enreca Occasional Paper Series – Culture and the Disciplines: Papers from the Cultural Studies Workshops/Tapti Guha Thakurta, no. 5, pp. 36-54. <http://cscs.res.in/dataarchive/textfiles/textfile.2008-08-29.5012712653/file> (Accessed 5th May 2016)

²⁷⁸ Littlewood, Roland (2001) 'Colonialism and Psychiatry,' in Bhugra, Dinesh and Littlewood, Roland (Eds) *Colonialism and Psychiatry*, Oxford University Press, New Delhi, p. 9.

approach to colonial psychiatry. He observed that in the French version the model of colonialism was one of cultural and biological assimilation. The British model however was one of cultural segregation.²⁷⁹

Conclusion

Numerous tomes have been written on the military and political history of the British in India in the twentieth century, the narrative of the 'great' soldiers and the 'great' ministers or viceroys. Raj histories continue to be published and are joined periodically by films and television programmes originating in the West selectively painting the pageantry, the heroism and the occasional hypocrisy in the manner of a historical theme park. There have been fewer studies of the social history of the colonisers and much less on their health. Specialist research into the mental ill health of those who might be classed, perhaps, as the 'less great' men and women who embodied the Raj and served its purposes, are fewer still as identified in the scholarship cited in this chapter.

Chapter 2 has highlighted the bitter conflicts between psychiatrists and historians, the 'pushers' and 'resisters,' over the last fifty years as they analysed power and power relationships, and diagnoses and treatments. It has identified the enthusiasm of psychiatrists, who were often deeply offended by the crusading heroics of historians, as they sought to promote their profession and maintain themselves as the predominant arbiter of mental illness in society. It has portrayed the disputes as an almost impenetrable 'force field' which has rarely been crossed because of the barriers on either side. Historiographies of colonial mental health have repeated the arguments in a colonial setting. The academic debate tended to be at national and international professional levels with the lives of mentally ill individuals often seeming to be lost or forgotten.

Having considered the *doing* of psychiatric history the thesis will next address how Western psychiatry was *done* in India between 1900 and 1947.

²⁷⁹ Littlewood, 'Colonialism and Psychiatry,' p. 11.

CHAPTER 3

Western Psychiatry in India, 1900-1947

[The asylums of India are] a permanent monument of brutal stupidity and of a refusal to look at the rest of the world with any hope of learning from it
Edward Mapother, Medical Superintendent, Maudsley Hospital, London
(1939)²⁸⁰

the aim of the good alienist should be to discharge his patients better, physically, mentally and morally, than they were before.

Major C. J. Lodge Patch, IMS (1934)²⁸¹

Many so-called tropical countries may, in the future, under the guidance of the hygienist, become the heaven of men's dreams, but for the moment, there still remain many areas in the Tropics, with a capital T, where the tortures of hell, like the mycelium of a fungus, sap the moral fibre of the white man and leave him a victim of Tropical Neurasthenia.

Dr Hugh S Stannus (1926)²⁸²

Introduction

The presentation of the historiography in the previous chapter established that there was much academic controversy surrounding the development of psychiatry as a discrete medical discipline. It will now be proposed that the implementation of Western psychiatry in India in the first half of the twentieth century can be divided into three distinct periods of growth. Thus the first will consider the gradual modernisation of the profession prior to the First World War. The second will then emphasise the accelerated period of enthusiastic innovation in treatments and how soon they were introduced to India after their invention in the West. The third period will address how psychiatry coped with the emergency situation produced by the Second World War and by the move towards Independence in 1947. The latter will include an examination of the Bhowe Report which detailed the state of health

²⁸⁰ Bethlem Royal Hospital Archives, Bethlem Museum of the Mind EM-01 Series, Box Number C12/4, Series EM, papers of Edward Mapother. (Unpublished report), p.1.

²⁸¹ Lodge Patch, *A Manual*. p. 326. He later became a Lieutenant Colonel in the IMS.

²⁸² Stannus, Hugh S. 'Tropical Neurasthenia,' Proceedings of an Ordinary Meeting of the Society of Tropical Medicine on 9th December 1926, vol. 20, London, p. 334.

services in India in the mid 1940s. To illustrate these developments classifications of mental diseases used by British alienists in India in each of the three periods will be analysed as vehicles for change. The tropical variant of neurasthenia, whose impact transcended all three periods, will be introduced in a separate section to indicate how relevant medical issues were debated by alienists in their search for treatments for distressed *Imperial Minds* in India. Throughout the chapter references will be made to the impact of climate and isolation on the physical and mental wellbeing of the British in India.

The chapter will begin by introducing the work of the Indian Medical Service (IMS) which played a significant role in providing health services in colonial India in the field of psychiatry and other medical disciplines.

The Indian Medical Service (IMS)

The origins of the IMS were rooted in the East India Company which had established a number of general medical facilities to support British soldiers and their families in India. The IMS was a branch of the Indian Army and as such its doctors were serving military officers subject to military discipline. Its work has been generally ignored by historians and has featured rarely in the force-field battle of colonial historiography.

It can be argued that the development of psychiatry in India within a military setting was a function of the need for efficient organisation and delivery of a service across a huge country. As Ernst has observed there was no large scale confinement of Europeans or Indians during the eighteenth and nineteenth centuries.²⁸³ The Government of India's *Indian Medical Review* for 1938 produced by the Director-General of the IMS, Major-General Bradfield, indicated that there were 11,792 patients of all races in mental hospitals in British India.²⁸⁴ Although they occupied accommodation designed for 8,425 this was not evidence of any mass incarceration of either Europeans or Indians. Instead Bradfield explained the overcrowding as recognition of an improvement in hospital standards of care and a growing public acceptance by Indians of western psychiatry.²⁸⁵

²⁸³ Ernst, *Plain Tales*, *passim*.

²⁸⁴ Bradfield, E. W. C. Major-General (IMS) (1938) *An Indian Medical Review*, Government of India Press, New Delhi, p. 28. The Director-General also held the rank of Surgeon-General which made him the most senior medical officer in India.

²⁸⁵ Bradfield, *An Indian Medical Review*, p. 29.

The limited availability of European doctors in India of whatever discipline made them key figures in Raj communities²⁸⁶ especially in the *mofussil*.²⁸⁷ The IMS was always required to fulfil two roles: to serve the civil community, with priority towards Europeans; and to be part of a military reserve which might be called upon to provide officers for duty in the Indian Army in times of war.²⁸⁸ Those who were alienists had the additional duties of attending to patients in mental hospitals.

The composition of the IMS in the first half of the twentieth century is illustrated in Tables 3.1 and 3.2.

Table 3.1: Officer strength of the IMS (Permanent)²⁸⁹

Year	British	Indian	TOTAL
1912	715	47	762
1914	714	56	770
1918	723	70	793
1920	673	83	756
1926	499	161	690
1930	445	172	617
1935	412	207	619
1939	417	198	615
1943	385	186	571
1946	264	156	410

Table 3.2: Officer strength of the IMS (Temporary)²⁹⁰

Year	British	Indian	TOTAL
1912	0	0	0

²⁸⁶ See, for example, Allen, *Plain Tales*, p. 103.

²⁸⁷ Up-country as opposed to urban.

²⁸⁸ McDonald, Donald (1950) *'Surgeons Twoe and a Barber,' Being some account of the life and work of The Indian Medical Service (1600 – 1947)*, Heinemann, London, p. 194.

²⁸⁹ Adapted from McDonald, *Surgeons Twoe*, p. 270.

²⁹⁰ Adapted from McDonald, *Surgeons Twoe*, p. 270.

1914	0	0	0
1918	19	606	625
1920	16	795	811
1926	4	131	135
1930	0	95	95
1935	0	45	45
1939	0	55	55
1943	174	1809	1983
1946	211	3314	3525

The figures in Table 3.1 and 3.2 indicated the gradual increase in Indian doctors as a result of Indianisation after the First World War. Thus in 1912 94% of the permanent IMS officer corps were British whilst this figure was reduced to 12% in 1946 when temporarily commissioned officers were included. Table 3.2 also showed how Indian doctors were utilised as temporary officers during the emergency situations of both world wars. These Indian doctors were to form the basis of Indian and Pakistani health provision after Independence.

Only two histories of the IMS have been identified and both were by IMS career officers who had reached the rank of lieutenant colonel in their service.²⁹¹ The first came from Dircom Gray Crawford in 1914 and was published in two volumes.²⁹² His aim in the compilation of his history was 'not to make an interesting book so much as to put together a mass of facts'²⁹³ and in that he was most successful. His work took the form of an almost uncritical paean to the service and praised the courage and selfless devotion of officers to their duty and to their medical profession. There were facts about battles and facts about campaigns with considerable detail of the numbers of casualties. The few references to mental ill health mostly concerned the dates of the establishment of the asylums in Madras, Calcutta and Bombay and

²⁹¹ A new medical recruit to the IMS could expect to become a lieutenant colonel after 20 years continuous service.

²⁹² Crawford, Lt. Col., D. G. (1914) *A History of the Indian Medical Service, 1600-1913*, Thacker, London.

²⁹³ Crawford, *A History*, vol. 1, Preface.

brief notes about some of the doctors who had worked there. Facts were dispensed in Gradgrindian fashion but included nothing which related to individual patients.²⁹⁴

The second work came from Donald McDonald who declared that the history of the IMS had been written 'once and for all'²⁹⁵ by Crawford and he adopted accurately the latter's reverential style and copied, with acknowledgement, large chunks of his work. Writing after Indian Independence he was keen to record the achievements of the now redundant IMS. Like Crawford there was little pretence of objectivity. McDonald resolved to tell the story:

*of a service so versatile, so adventurous, so beneficent to humanity and withal so venerable that it would be difficult to find its parallel in the recorded annals of history.*²⁹⁶

He recorded with pride the successes of IMS officers in the discovery that malaria was caused by mosquitoes and in their pioneering treatment of eye and other diseases. He chronicled the development of the IMS and their responsibility for the provision of a civil as well as a military service. He listed all the 59 IMS officers who had died in action between 1705 and 1944. He noted that no IMS officer was ever court-martialled for cowardice and although six IMS officers had fatally wounded others in duels happily no member of the service ever 'allowed himself to be killed in affairs of honour.'²⁹⁷ He named the 28 serving officers killed in the Indian Mutiny²⁹⁸ in 1857-58 and even recorded that the last IMS survivor died in 1925.²⁹⁹ He updated Crawford's facts to include the work of the IMS in the two world wars. Like Crawford, MacDonald made very few references to IMS involvement with patients who were mentally ill and it could be assumed that this lack of coverage reflected his lack of interest in, or respect for, that branch of the service. Perhaps the two 'historians' did not regard IMS alienists as 'so beneficent to humanity.'

²⁹⁴ Crawford, *A History*, vol. 2, p. 400. Thus, for example, he stated that the Madras Asylum was opened on 14th March 1745.

²⁹⁵ MacDonald *Surgeons Twoe*, p. vi.

²⁹⁶ MacDonald, *Surgeons Twoe*, p. vi.

²⁹⁷ MacDonald, *Surgeons Twoe*, p. 102.

²⁹⁸ The events of 1857-58 were referred to as the Indian Mutiny by the British at the time. They are now more often known as the Great Rebellion or the First War of Independence to Indians and modern historians.

²⁹⁹ MacDonald, *Surgeons Twoe*, pp. 120-121.

Crawford and MacDonald succeeded in their goals of providing many details and stories about an organisation to which they had devoted their careers. For them the achievements of the IMS were indisputable but its accomplishments seemed not to have been generally appreciated by post-war military historians of India. Studies of the Indian Army by Philip Mason³⁰⁰ in 1975 and T. A. Heathcote³⁰¹ in 2013 contained no mention of the Indian Medical Service and had very few references to the ill health of soldiers, and none at all concerning the mentally ill. Crawford and MacDonald had never intended to critique the successes or failings of the IMS nor to address issues of race or gender. Such analysis awaits an academic study.

The state of Western medicine in India was surveyed in 1923 by Sir Patrick Hehir, a Major-General in the IMS who had spent most of his life in India and had held many military and civil appointments.³⁰² He described the complex system of the medical profession with its disparate components of the medical services of Government, the independent medical profession in which he included qualified Indian and European doctors and female doctors, and the practitioners of the Indian Ayurvedic and Unani systems.³⁰³ Although more objective than Crawford and MacDonald, Hehir shared their pride in the IMS.

He warned that the IMS was in crisis as young doctors no longer wished to come from Britain in large numbers to practise in India, a position confirmed in Table 3.1. Hehir believed that British recruits were reluctant to apply as they were faced with uncertainties in their future careers if they came out to India.³⁰⁴ Such anxieties had been enhanced by the impact of the official policy of Indianisation which, since the Montagu-Chelmsford Report of 1918³⁰⁵ and the consequent Government of India

³⁰⁰ Mason, Philip (1975) *A Matter of Honour: An account of the Indian Army, its officers and men*, Jonathan Cape, London.

³⁰¹ Heathcote, T. A. (2013) *The Military in British India: The Development of British Land Forces in South Asia, 1600-1947*, Pen and Sword Books, Barnsley.

³⁰² See Hehir, Sir Patrick (1923) *The Medical Profession in India*, Oxford Medical Publications, Henry Froude and Hodder and Stoughton, London.

³⁰³ Hehir, *The Medical Profession*, pp. 2-5.

³⁰⁴ Hehir, *The Medical Profession*, p 1.

³⁰⁵ Edwin Montagu was the Secretary of State for India from 1910 to 1922. Lord Chelmsford was Viceroy of India from 1916 to 1921. A recent appraisal of the Montagu-Chelmsford reforms can be found in Reid, Walter *Keeping the Jewel in the Crown: The British Betrayal of India*, Birlinn, Edinburgh, 2016, pp. 26-34.

Act of 1919,³⁰⁶ encouraged the employment of Indians in all professions including medicine. In addition Hehir had identified a preference amongst those British medical graduates inclined to practise abroad to join other branches of the army, navy or colonial service rather than the IMS.³⁰⁷ This had already been recognised officially in 1913 when Edwin Montagu, the Secretary of State for India, had consulted the British Medical Association about the unpopularity of medical service in India amongst young British doctors. Consequently four principles for the future of the IMS were drawn up and agreed by the Government of India: that IMS doctors should have opportunities for 'interesting' practice; that they should have adequate pay and leave; that there must be increasing opportunities for Indians to enter and to progress in the service; and that conditions of service should be as free as possible from 'friction, irritation and annoyance.'³⁰⁸ The last point referred to the situation which periodically occurred between the British Army's Royal Army Medical Corps (RAMC), who served British regiments in India, and the IMS who combined the dual role of providing medical support to the civilian population and to Indian Army regiments in times of war.³⁰⁹ The friction was an example of an inferiority often felt by IMS officers when they were compared with the RAMC and its predecessors. Hehir delivered a comprehensive appraisal of medical services in India which he believed in 1923 were in a critical stage of its historical development³¹⁰ and he gave his own views about how they could be improved. The decline in the numbers of British doctors in India indicated in Tables 3.1 and 3.2 suggested that the new arrangements still did not prove interesting enough to attract them to leave Britain.

Despite his general thoroughness Hehir's only reference to mental health was to remark that there were no specialist training courses in India which could be compared to those in Britain.³¹¹ This reticence was yet another example from a senior figure in the IMS of his organisation's neglect of psychiatry in British India. In effect he had chosen not to consider the discipline as of sufficient importance in the overall medical profession in India to be included in the subject matter of his book.

³⁰⁶ The Government introduced a scintilla of democracy into the government of India including a measure of local control by Indians of such matters as education, health and agriculture. See Wilson, Jon (2016) *India Conquered: Britain's Raj and the Chaos of Empire*, Simon and Schuster, London.

³⁰⁷ Hehir, *The Medical Profession*, p. 42.

³⁰⁸ McDonald, *Surgeons Two*, pp. 187, 192.

³⁰⁹ McDonald, *Surgeons Two*, p. 187.

³¹⁰ Hehir, *The Medical Profession*, p. 1.

³¹¹ Hehir, *The Medical Profession*, p. 28.

The evidence has shown that alienists lacked champions in the higher echelons of the IMS and their contributions seemed to be regarded as insignificant. After explaining the nebulous position of the IMS in Indian psychiatry attention will now be given to placing psychiatry in the context of colonial history in India by adapting a model devised by the Scotland-based historian James Mills.

An overview of the history of modern psychiatry in India

The earliest record of institutions in India for the care of the mentally ill can be traced back to the 15th century and before that temples and religious institutions may have played a caring role.³¹² An Indian psychiatrist, S. D. Sharma, has observed that mental hospitals in their modern form were entirely a British conception and were first introduced for East India Company soldiers and administrators in the eighteenth century.³¹³

In order to give perspective to the history of modern psychiatry in India from the late eighteenth century to the present day Mills’s framework is summarised in Box 3.1.³¹⁴ His model divided the period into four chronological sections which are outlined below.

Box 3.1: Mills’s overview of Western psychiatry in India

1795-1857	From the establishment of a dedicated unit for ‘mad’ sepoy ³¹⁵ in a military guardroom which had been intended for Indian soldiers who were obviously inappropriately detained there, to the start of the Great Rebellion or Indian Mutiny.
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³¹² Krishnamurthy, K., Venugopal, D. and Alimchandani, A. K. (2000) ‘Mental Hospitals in India,’ *Indian Journal of Psychiatry*, vol. 42, no. 2, p. 127. Temples continue to exist in this role. The present author has visited religious shrines or *dargahs* in India where worshippers pray and consult faith healers in the hope of finding a cure for mental illness.

³¹³ Sharma, S. D, (2004) ‘Mental Health: The Pre-Independence Scenario,’ in Agarwal, S. P. (Ed) *Mental Health: An Indian Perspective, 1946-2003*, Elsevier, New Delhi, p. 25.

³¹⁴ Adapted from Mills, James (August 2006) ‘Modern psychiatry in India: The British role in establishing an Asian system,’ *International Review of Psychiatry*, vol. 18, no. 4, pp. 333-343.

³¹⁵ A sepoy was ‘a native soldier, dressed and disciplined in the European style.’ Yule and Burnell, *The Concise Hobson-Jobson*, p. 393.

1858-1914	From the end of the Great Rebellion and the introduction of Act XXXVI of 1858, the first piece of legislation concerned with the incarceration of Indians whom the British classed as mentally disturbed, to the start of the First World War in 1914.
1914-1947	From the beginning of the First World war until Partition and Independence in 1947, when the British involvement in two world wars stimulated the development of Indianisation in the psychiatric and related medical professions including nursing.
1947-present day	From 1947 to the present day with the consolidation of the Western model of psychiatry promoted and developed by Indian psychiatrists to meet the needs of an independent India.

Whereas the first period did not refer to the earlier asylum provision of the East India Company Mills identified that their initial creation was to meet a military purpose. The Company had opened three asylums in the eighteenth century in India for its servants and soldiers and their dependents: Bombay in 1745, Calcutta in 1787 and Madras in 1794, these three cities being the main centres of British commerce.³¹⁶ A Hospital Board had been established in 1786 to co-ordinate the management of the different strands of the Company's medical activities.

In the early nineteenth century, the first period covered by Mills's model, the Company instigated a policy of repatriating the British mentally ill to the UK if they had not recovered after a year in one of its asylums.³¹⁷ Consequently it had opened its own institution in London in 1818 at Pembroke House in Hackney. This course of

³¹⁶ Crawford, Lt. Col. D. G. (1914) *A History of the Indian Medical Service, 1600-1913*, Thacker, London, pp. 400, 428 and 415.

³¹⁷ Ernst, *Mad Tales* p. 28.

action resulted in a temporary reduction in the numbers of poor, destitute and mentally distressed Europeans in India. In the view of Ernst it was coupled with a less censorious official attitude towards the mentally ill based on the understanding that their affliction could cross class boundaries and affect army officers and gentlemen of standing as well as their social inferiors.³¹⁸

The second stage in Mills's model related to the period after which the British Crown assumed control of India from the East India Company. Following the introduction of the Indian Lunacy Act of 1858 asylums for Indians were constructed across the country. The three opened originally by the Company exclusively for Europeans³¹⁹ developed in the second half of the century with separate residential accommodation for Indian patients. When the Company's administrative functions ceased in 1858 they were replaced by a Medical Board responsible to the Government of India. In 1896 the three provincial medical services based in Bengal, Madras and Bombay were centralised and headed by a Director General of the Indian Medical Service.³²⁰

The original Calcutta asylum for Europeans was damaged on several occasions by cyclones towards the end of the nineteenth century and from 1880 there was much discussion at senior government level about the need for its replacement.³²¹ A hospital solely for Europeans in India had been envisaged for many years.³²² Funding was not forthcoming and as late as 1913 it was still unclear when the new European Mental Hospital would be opened. Thus in March 1913 Colonel Manifold, the Inspector-General of Civil Hospitals for the United Provinces, writing in his annual report on lunatic asylums there, commented on the inadequate and unsatisfactory accommodation for European patients in the Agra Asylum.³²³ A fellow inspector had visited the Agra Asylum and had directed that work must be done to improve the situation but Manifold questioned whether this would cause

³¹⁸ Ernst, *Mad Tales*, p. 29.

³¹⁹ In Bhowanipore (Calcutta), Agra and Lahore.

³²⁰ This information was taken from the unpublished document *Guide to the Records, part ii, Home Department*, National Archives of India, New Delhi, 1977, only obtainable at the National Archives of India.

³²¹ Berkeley-Hill, Owen Lt-Col (IMS retired) (1939) *All Too Human: An Unconventional Autobiography*, Peter Davies, London, p. 241.

³²² There are frequent references to this in, for example, the annual reports on the asylums in the Bengal Presidency in the late nineteenth and early twentieth centuries.

³²³ Government of India (1913) *Report and Returns of the Lunatic Asylums in the United Provinces of Agra and Oudh for the Year 1912*, Government Press, Allahabad, p. 2.

unnecessary expenditure in view of the eventual move to a new hospital site. By May 1915 the proposed improvements had been abandoned as the Government had stated that a European Asylum based at Ranchi had now been agreed upon and the European residents at Agra would be transferred there.³²⁴ Nevertheless it was May 1918 before the hospital at Ranchi received its first patients.³²⁵ By this time modern psychiatry in India was entering Mills's third stage which was characterised by Indianisation in parallel with the development of psychiatry and other related disciplines. It was a time in which the Indian Medical Service became increasingly important in the field of psychiatry on the sub-continent.

The final section in Mills's representation highlighted the extension of colonial psychiatry into the mainstream after Independence as Indian psychiatrists interpreted and implemented Western psychiatry in their own idiom. A new Mental Health Act was introduced in India in 1987 and a series of National Mental Health Programmes were devised with objectives for the extension of mental health services and the promotion of good mental health in all communities.³²⁶ Mills's fourth period is beyond the scope of this thesis.

Having identified the background to the history of psychiatry in India throughout the colonial period and beyond the thesis will now concentrate on the period between 1900 and 1947.

A three stage model of psychiatric development in India, 1900-1947

This thesis has built on the model of Mills by proposing three distinct periods for the development of Western psychiatry in India in the first half of the twentieth century. These are illustrated in Box 3.2 below and will be used as a framework to address the changes in Western psychiatry there.

³²⁴ Government of India, Judicial (Criminal) Department, *Orders of Government, No. 2020/VI – 814 of 1915*, p. 1.

³²⁵ Nizamie, S Haque et al (June 2008) 'Central Institute of Psychiatry: A tradition in excellence,' *Indian Journal of Psychiatry*, vol. 50, no. 2, p. 144.

³²⁶ For an analysis of mental health services in India in the half century after Independence see Khandelwal, Sudhir K. et al (February/March 2004) 'Indian mental health country profile,' *International Review of Psychiatry*, vol. 16 (1-2), pp. 126-141.

Box 3.2: Three stages of psychiatric development in India, 1900-1947

1900-1918	From the turn of the century to the end of the First World War; a period which included a gradual process of modernisation, together with the implementation of the Indian Lunacy Act of 1912 and the consequent responses to the changes in legislation, and to the impact of the war.
1918-1939	From the end of the First World War with the increased interest in mental health generated through new kinds of war casualties, to the opening of the European Mental Hospital in 1918 and on to the late 1930s; a period of more rapid psychiatric innovation and consolidation in a context of growing professional self-confidence and maturity within an international setting.
1939-1947	With imperial psychiatry responding to the emergency demands of the Second World War, to the Bhole Report, and on to Independence in 1947; a period of uncertainty and reaction to unexpected events, allied to the accelerating demands of Indianisation and of Independence.

The gradual process of modernity, 1900-1918

The first period outlined in Box 3.2 related to a time when attitudes to mental illness were slowly changing amongst British alienists in India. The practice of Western psychiatry in India was rooted in Britain and dependent on developments there. Most British and some Indian psychiatrists had trained and qualified in Europe rather than in India. It has been argued by Scull that at the end of the nineteenth century there was a predominantly negative view of mental patients amongst their doctors in Britain. In the context of a growing number of mental patients living in overcrowded

institutions prominent alienists often criticised those for whom they were responsible. Thus Maudsley³²⁷ dismissed his patients as 'especially repulsive characters'³²⁸ and Mercier³²⁹ had written that mental illness arose chiefly in those who had a defective mental constitution which manifested itself in a lack of self-control.³³⁰

A significant date in the history of psychiatry in India was 1905. In that year control of mental hospitals in India transferred from the Inspector-General of Prisons to the Directorate of Health Services heralding a gradual move away from a custodial philosophy to one of care.³³¹ In the same year doctors with an interest in mental illness were appointed as medical superintendents to run mental hospitals under the authority of the Director General of the IMS.³³²

In an attempt to address the specific needs of mental patients in India the first text book of psychiatry in the twentieth century for alienists specifically practising in India was produced in 1908 by Major Ewens.³³³ Ewens had been the medical superintendent of the Punjab Lunatic Asylum in Lahore since 1900 having previously been responsible for various jails in the Punjab from 1896. He included several chapters on criminality and the insane together with 235 case studies, all of which seemed to have been of Indian criminal lunatics. His statement that Indian

*criminals present a far larger proportion of anatomical abnormalities than the ordinary European population, and this is precisely the characteristic anatomy of the lower races*³³⁴

showed his underlying belief in the racial superiority of Europeans, a position shared by many white alienists in India.

Ewens endorsed Mercier's work on the causation of insanity which had concluded that there were two causes of sanity: heredity and stresses. Heredity

³²⁷ Perhaps the most famous alienist of his day. For a brief biography of Maudsley see <http://www.bbk.ac.uk/deviance/biographies/maudsley.htm> (Accessed 26th October 2017).

³²⁸ Cited in Scull, *Madness in Civilization*, p. 295.

³²⁹ Mercier, Charles A. (1895) *Sanity and Insanity*, Walter Scott, London, edition. Available at <https://catalog.hathitrust.org/Record/006645796> (Accessed 18th September 2016)

³³⁰ Cited in Scull, *Madness in Civilization* p. 295.

³³¹ Sharma, *Mental Health* p. 27.

³³² Jagoe Shaw, W. S., (April 1932) 'The Alienist Department of India,' *IMG*, vol. 78, no 4, p. 338.

³³³ Ewens, G. F. W. (1908) *Insanity in India: Its Symptoms and Diagnosis. With reference to the relation of Crime and Insanity*, Thacker and Spink, Calcutta.

³³⁴ Ewens, *Insanity*, p. 247.

could lead to mental illness in a person if, for example, there had been nervous diseases, syphilis or alcoholism in the person's parent. Stresses could be direct if the person had brain tumours or brain injuries or if there were toxins in the blood such as those present in lead or Indian hemp. Indirect stresses, argued Mercier, came from a wide range of factors such as anxiety, over-education, sexual excess and overwork, especially if the person was unsuccessful.³³⁵ For Ewens the key to the understanding of insanity was that it was a loss of self-control.³³⁶ This weakness was, of course, a risk to the display of white racial superiority endorsed by the bulk of the imperial community. Ewens gave his definition of insanity as a

*disease of the brain causing an alteration or impediment of the, mind, and by so doing altering a person's conduct, speech, manner and habits from those of sane people or of himself prior to illness.*³³⁷

Classifications of mental illnesses had been produced throughout the nineteenth century and responded to such factors as the alienists' personal interests, to new discoveries and ideas in medicine and to changes in legislation. Ewens's own classification of mental diseases is given below in Box 3.4. His was a simple taxonomy when compared to those produced later in the century. As such it reflected the limited knowledge at the time of British alienists in India.

³³⁵ Ewens, *Insanity*, pp. 20-22.

³³⁶ Ewens, *Insanity*, p, 9.

³³⁷ Ewens, *Insanity*, p, 7.

A. Congenital

Idiocy, imbecility, weakmindedness and moral imbecility

B. Acquired

1. Mania – acute, recurrent, chronic
2. Melancholia – acute, recurrent, chronic
3. Dementia – acute, secondary, organic etc.
4. Paranoia or chronic systematized Delusional Insanity
5. General Paralysis of the Insane
6. Insanity and Epilepsy
7. Impulsive and Obsessional Insanity
8. Exhaustion psychoses (Confusional Insanity)
9. Toxic Insanity – e.g. alcohol, Indian Hemp, Opium and Morphia, Lead, Cocaine etc.
10. Epochal Insanity
11. Adolescent Insanity (Dementia Praecox)
12. Climacteric
13. Involutional
14. Senile
15. Paralytic Insanity
16. Moral Insanity
17. Insanity with Physical Disease
18. Puerperal Insanity

Ewens made a clear distinction, as proposed by Mercier, between hereditary or congenital mental diseases and those that were acquired through stressful situations or biological cases. Ewens chose to include *dementia praecox* in the same category

³³⁸ Ewens, *Insanity*, p. 29.

as *Adolescent Psychiatry* indicating that the diagnosis covered a wide age range. In this instance he was in agreement with the Swiss psychiatrist Eugen Bleuler who had disliked the term *dementia praecox* because of its suggestion that it was concerned mainly with dementia in older people.³³⁹

In Britain most alienists were based in large mental hospitals with regular and long term access to their patients. However in German-speaking Europe they were normally attached to universities where their clinical research was carried out. In the opinion of Tom Burns, a practising British psychiatrist, modern psychiatry was moulded by three such men: Emil Kraepelin, Bleuler and Sigmund Freud, who were based originally in Germany, Switzerland and Austria respectively.³⁴⁰

Working mainly at the university in Heidelberg Kraepelin studied thousands of asylum patients as he developed his own classification of mental diseases.³⁴¹ He produced an influential textbook *Lehrbuch der Psychiatrie* [Textbook of Psychiatry] which ran to nine editions between 1893 and 1927. In the fourth and fifth editions he created a new classification system introducing the concept of dementia praecox.³⁴² He made the distinction between what he regarded essentially as the two types of madness: dementia praecox and manic-depressive psychosis.³⁴³ The person suffering from the former had little prospect of improvement whilst the latter had a more hopeful diagnosis. Scull argued that Kraepelin's views became clinical orthodoxy amongst institutional psychiatrists whilst emphasising Kraepelin's pessimism and belief in the inevitability of the mental decline in the sufferer from dementia praecox.³⁴⁴ As will be shown below this clinical orthodoxy took longer to be embraced in India than it did in Europe.

The pioneering research of Kraepelin was developed by Bleuler who renamed dementia praecox as schizophrenia in 1908. Bleuler identified that the primary disturbances in schizophrenia were seen in a withdrawal from close relationships

³³⁹ Frith, Christopher and Johnstone, Eve (2003) *Schizophrenia: A Very Short Introduction*, Oxford University Press, Oxford, p. 30.

³⁴⁰ Burns, Tom (2006) *Psychiatry: A Very Short Introduction*, Oxford University Press, Oxford, p. 41.

³⁴¹ Scull, A, *Madness in Civilization* p. 263.

³⁴² Frith and Johnstone *Schizophrenia*, p. 27.

³⁴³ Pols, Hans (June 22nd 2011) 'Emil Kraepelin on Cultural and Ethnic Factors in Mental Illness,' *Psychiatric Times*, at <http://www.psychiatrictimes.com/articles/emil-kraepelin-cultural-and-ethnic-factors-mental-illness> (Accessed 29th September 2016).

³⁴⁴ Scull, Andrew *Madness: A Very Short Introduction*, Oxford University Press, Oxford, 2011, pp. 69-70.

accompanied by disturbances of thinking and mood.³⁴⁵ Unlike Kraepelin he retained his optimism that some patients with schizophrenia, though not all, could be treated successfully.³⁴⁶

These new European ideas were tested in the Dutch East Indies. A study of Dutch colonial psychiatrists by the Dutch historian Hans Pols has found that they saw insanity as a disease of modern civilisation which hardly existed in primitive or less developed societies.³⁴⁷ Kraepelin developed a professional interest in Asia and in 1904 visited the Dutch East Indies spending three weeks at the Buitenzorg mental hospital on the island of Java. Whilst there Kraepelin investigated 100 European and 100 Javanese patients, and 25 patients of Chinese descent.³⁴⁸ He studied the incidence and expression of mental illness amongst the indigenous Javanese and the Chinese and European populations concluding that the symptoms of schizophrenia were less severe in the indigenous population and that they had a better prognosis than the other two races.³⁴⁹ He discovered that tertiary syphilis, was virtually absent among the Javanese population. The rates among European patients were equal to those found in the Western world. Pols identified that Kraepelin had explained this difference by assuming that Eastern brains were less susceptible to syphilis rather than, for example, assuming that the moral standards of Europeans were significantly looser.³⁵⁰

The taxonomy developed by Kraepelin and others began to play an important role in the understanding by alienists of their modernising profession. The traditional nineteenth century approach to ordering mental illness had mania, melancholia, idiocy and dementia at its core. Systems were refined in the earlier twentieth century as knowledge was expanded and discoveries made. Ernst has written extensively on the classification systems of mental disorders.³⁵¹ She admitted that it was difficult to trace the diagnostic practice of individual institutions as little research has been done

³⁴⁵ Frith and Johnstone, *Schizophrenia*, pp. 30-32.

³⁴⁶ Burns, *Psychiatry*, p. 44.

³⁴⁷ Pols, Hans (August 2006) 'The development of psychiatry in Indonesia: From colonial to modern times,' *International Review of Psychiatry*, vol. 18, no. 4, p. 364.

³⁴⁸ Pols, Hans (June 22nd 2011) 'Emil Kraepelin on Cultural and Ethnic Factors in Mental Illness,' *Psychiatric Times*, <http://www.psychiatrictimes.com/articles/emil-kraepelin-cultural-and-ethnic-factors-mental-illness> (Accessed 22nd August 2017).

³⁴⁹ Pols, 'The development of psychiatry,' p. 365.

³⁵⁰ Pols, 'The development of psychiatry,' p. 365.

³⁵¹ See for example Chapter 4 of Ernst, Waltraud (2013) *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, c. 1925-1940*, Anthem Press, London.

on this topic.³⁵² Classifications published in psychiatric textbooks for use specifically in India are discussed in this chapter revealing their authors' interests and prejudices. The replacement by Bleuler of the term *dementia praecox*, originating in the 1850s, with *schizophrenia*, coined in 1908 will be used as an indicator of modernity and awareness of developments beyond Britain.³⁵³

As a step towards modernisation the Viceroy's Council proposed in the autumn of 1911 new legislation on lunacy declaring that it was time 'to bring the law ... into line with the modern English act,' i.e. the Lunacy Act, 1890 as amended by the Lunacy Act, 1891.³⁵⁴ The resulting Indian Lunacy Act 1912 replaced much of the existing legislation which had been on the statute book since 1858 and which, in turn, and had been influenced by the English lunacy acts of 1845. This Indian act of 1912 produced guidelines for the establishment of asylums in the country for both Indians and Europeans and the procedures for their admission. Under the act asylums became licensed by the Provincial Governments for the treatment of mental disorders.³⁵⁵ The legal component of Ewens's volume became obsolete with the passing of the 1912 Act.

One significant provision in the Indian Lunacy Act was the requirement for the first time in India which allowed for uncertified patients, known as 'voluntary boarders,' to be admitted to mental hospitals there. This stipulation was modelled on a Scottish law, the Lunacy (Scotland) Act, 1857.³⁵⁶ The new Indian law enabled mentally distressed adults possessing some insight to seek treatment or respite in hospital without the need for formal compulsory admission and the risk of permanent stigmatisation because of it. Voluntary admissions to English and Welsh mental hospitals did not become possible until the enactment of the Mental Treatment Act of 1930.³⁵⁷ Alienists such as Berkeley-Hill and Jagoe Shaw regarded this as an

³⁵² Ernst, *Colonialism and Transnational Psychiatry*, p. 105.

³⁵³ Ashok, Ahbishekh Hulegar, Baugh, John and Yeragani, Vikram K. (January - March 2012) 'Paul Eugen Bleuler and the origin of the term schizophrenia,' *Indian Journal of Psychiatry*, vol. 54, no. 1, pp.95-96.

³⁵⁴ For further information on the passing of this legislation and its significance in the history of Indian psychiatry see Somasundaram, O. (January 1987) 'The Indian Lunacy Act, 1912: The Historic Background,' *Indian Journal of Psychiatry*, vol. 29, no. 1, pp. 3-14. Its author was at the time the President of the Indian Psychiatric Society.

³⁵⁵ Jagoe Shaw, 'The Alienist Department,' p. 331.

³⁵⁶ Somasundaram, 'The Indian Lunacy Act,' p.9.

³⁵⁷ Jones, Kathleen, (1972) *A History of the Mental Health Services*, Routledge and Kegan Paul, London.

indication that their psychiatry was ahead of England in its respect for patients. The Indian Lunacy Act of 1912 remained the primary mental health legislation until its replacement in 1987.³⁵⁸

Overbeck–Wright’s first text book incorporated the key points of the new legislation and gave advice to practitioners on how it could be interpreted and implemented. He gave three reasons for producing his text: to aid the medical practitioner in India in his dealings with insanity; to give the latter information on relevant legal proceedings; and to bring to his notice the latest discoveries on the causes of insanity. He added with enthusiasm that a new age of discovery had commenced where each year might be likely to bring forward a greater chance of ‘successfully treating the scourge of humanity [insanity] in its various forms.’³⁵⁹

The declaration of Overbeck-Wright’s own limited familiarity with mental disorders was accompanied by a characteristic note of excitement and optimism. He admitted that he had obtained a Medico-Psychological Certificate in 1900 but gained much of his subsequent knowledge through books. At the time of the publication of his *Mental Derangements in India* he had been the medical superintendent of the Agra Asylum for over a year and a specialist to the Medical Department of the Government of India for a similar period. Prior to that he said he had had two years practical experience gained under Dr Reid at the Aberdeen Asylum.³⁶⁰ This narrow curriculum vitae was not uncommon amongst alienists in India in the first quarter of the century.

His horizons of professional knowledge, however, also seemed limited. There were only a few hints, for example, of his awareness of the development of the value psychiatry in the German-speaking world. Thus in his Preface he cited the nine professional authorities whose works he had consulted in the compilation of his textbook: eight were British and the ninth was Craepelin (*sic*).³⁶¹ There was no

³⁵⁸ Nizamie, S. Haque and Goyal, Nishant ‘History of Psychiatry in India,’ *Indian Journal of Psychiatry*, vol. 52 (Suppl. 1) S7-S12, January 2010. At <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3146221> (Accessed 7th October 2016) DOI: 10.4103/0019-5545.69195.

³⁵⁹ Overbeck-Wright, A. W. (1912) *Mental Derangements in India: Their symptoms and treatment*, Thacker and Spink, Calcutta, p. iii. A Major when he wrote his book he was later promoted to the rank of Lieutenant Colonel in the IMS.

³⁶⁰ Overbeck-Wright, *Mental Derangements*, p. iii.

³⁶¹ Overbeck-Wright, *Mental Derangements*, p. iv.

mention of psychoanalysis or Freud, no commentary on the works of Bleuler and only a few references to Kraepelin, of whom he was almost dismissive.

Overbeck-Wright did not give a precise definition of insanity but stated that its cause was due to

*an unstable brain readily drawn into disorder by physical causes, nervous shock or mental strain, and that this instability was transmitted from one generation to another.*³⁶²

However he did give definitions of specific mental illnesses with their symptoms which illustrated his belief in their biological and hereditary causes.

In *Mental Derangements* he disregarded previous classification systems of insanity which had originated from a symptomatological or clinical observational basis, on the grounds that he believed these had now become generally regarded as inaccurate. In their place he used as a working tool a system proposed by a Dr L. C. Bruce in his *Studies in Clinical Psychiatry* in 1906.³⁶³ Overbeck-Wright reported that he thought it was now commonly accepted that the cause of insanity was 'due to an unstable brain readily thrown into disorder by physical causes, nervous shock or mental strain' and this instability was hereditary. He believed that the toxic theory of insanity was then in the ascendant and cited the work of Dr John Macpherson, supported by Bruce, who suggested that the cause of madness would one day be determined as bacteriological. Overbeck-Wright included Macpherson's three causes of insanity through toxæmia in his text i.e. autointoxication through internal instability found in the kidney, the liver, secretions from glands and so on; intoxication from micro-organisms introduced into the body; and voluntary intoxication through alcohol or drugs.³⁶⁴ Unfortunately, he wrote, the theory could never be proved conclusively as it would require the unethical action of introducing toxins, i.e. poisonous substances, into the bodies of healthy humans.

³⁶² Overbeck-Wright, *Mental Derangements*, p. 29.

³⁶³ Dr Lewis Campbell Bruce qualified in medicine at Edinburgh in 1894 and became the medical superintendent at the Perth Asylum. He had a reputation for being independent minded and tactless. Interestingly Bruce failed in his application to join the IMS. Also, see Ernst *Colonialism and Transnational*, p. 121.

³⁶⁴ Macpherson's theory of toxicity being the cause of mental illness devised around 1895 is described in Overbeck-Wright, *Mental Derangements*, pp. 29-31.

Overbeck-Wright adopted Bruce's classification, reproduced in Box 3.4, and declared that he expected all future nomenclatures would be defined in terms of biological toxicity. Ernst has criticised him for his obstinacy in his unquestioning allegiance to Bruce's arrangement and for his dismissal or ridicule of any new ideas which were not based on it, such as those of Freud and Jung.³⁶⁵ Despite his obscurantism Overbeck-Wright's enthusiasm for the value of his profession remained obvious throughout his writings.

Bruce had grouped the different forms of insanity into non-toxic and toxic origins as outlined below.

Box 3.4: Bruce's Classification of Insanity³⁶⁶

I Insanities of non-toxic origin

1. Exhaustion Insanity
2. Insanity resulting from brain anaemia
3. Insanity the result of gross lesion or traumatism
4. Insanity resulting from deprivation of the special senses, particularly sight and hearing.

II. Insanities of toxic origin

Group A – Insanities the result of toxins of metabolic origin

1. Acute Melancholia
2. Insanity associated with deficient, excessive or altered secretion of the thyroid gland.
3. A variety of puerperal insanity.
4. Delusional Insanity

³⁶⁵ Ernst, *Colonialism and Transnational Psychiatry*, pp. 162-163.

³⁶⁶ Overbeck-Wright, *Mental Derangements*, pp. 39-44.

5. Chronic Metabolic Toxaemia (premature senility, chronic brain atrophy).

Group B – Insanities in which there is evidence of bacterial toxins being present in the blood, in which there is always a hyperleucocytosis,³⁶⁷ and in which bacterial agglutinines³⁶⁸ are frequently present in the serum.

1. Excited Melancholia
2. Maniacal Excitement with confusion (Acute Mania).
3. Folie Circulaire
4. Katatonia
5. Hebephrenia
6. Insanity after specific fevers

Group C – Insanities the result of alcoholic and drug toxins

1. Delirium tremens
2. Alcoholic mania
3. Chronic alcoholic insanity
4. Morphinism
5. Cocainism
6. Chronic poisoning by alcohol, ether, chloroform, mercury, iodoform, lead, carbon bisulphide, paraldehyde, Indian hemp and thyroid.

III. Nervous diseases frequently complicated by mental diseases

1. Epilepsy
2. General paralysis
3. Dipsomania

IV. States of mental enfeeblement

³⁶⁷ An unusually large increase in the number and proportion of white blood cells in the blood or the tissues. See <http://medical-dictionary.thefreedictionary.com/hyperleukocytosis> (Accessed 24th August 2017).

³⁶⁸ Agglutinins are [antibodies](#) that cause the red blood cells to clump together. See *Concise Oxford Medical Dictionary* (2015), Oxford University Press, Oxford, p. 17.

1. Idiocy and imbecility
2. The higher imbeciles
3. Secondary dementia
4. Organic dementia

One significant difference between the classifications of Ewens and Bruce is that the latter employed a more scientific approach. Ewens produced a simple list of disorders based on whether they were or were not congenital. Bruce had developed his theory into using sub-divisions of mental disorders. Neither appeared to have much time for the influence of social causes and stress on the causation of mental distress. Bruce promoted the view that mental illness was due to the presence of biological poisons or heredity which, he believed, would be due to biological causes at or before birth.

Overbeck-Wright informed his readership that he preferred the term *Delusional Insanity*, as adopted by Bruce to *Dementia Praecox*, and he cited the authority of the *Medico-Psychological Journal* from January 1912 that dementia praecox was never used to refer to a paranoid illness.³⁶⁹ He was very clear in his belief that dementia praecox could not encompass such conditions he was familiar with e.g. paranoia, katatonia and hebephrenia as proposed by Kraepelin because the first had a completely different origin to the second and the third, as the last two stemmed from 'bacterial toxaeemias'.³⁷⁰ He described Kraepelin's research in this specific field as 'unsound' and an 'error' whilst acknowledging that the German's work had some scientific merit.³⁷¹ Overbeck-Wright's confidence and independence of thought came from his personal observations and treatment of both European and Indian patients at the Agra Mental Asylum and his 'great scientific interest and zeal in this specialised branch of medicine' was praised by the Inspector-General of

³⁶⁹ Overbeck-Wright, *Mental Derangements*, pp. 152-153.

³⁷⁰ Overbeck-Wright, *Mental Derangements*, p. 152.

³⁷¹ Overbeck-Wright, *Mental Derangements*, pp. 183-184 and 191 respectively.

Hospitals in 1913.³⁷² Whether his students at the Lucknow and Agra Medical Schools were misled by his bias can only be the subject of speculation.

There were indications that Overbeck-Wright had developed an awareness of what was later named transcultural psychiatry.³⁷³ For example:

*.....if an ordinary Indian female of Northern India voluntarily appeared in public with her head uncovered one would consider it strong presumptive evidence of mental derangement, though one would think nothing of a European woman doing so.*³⁷⁴

He had learnt through experience of India that sociocultural issues had an impact on the interpretation of mental illness. It was a lesson to his medical students on the importance of recognising that there were cultural differences between Europeans and Indians in their different presentations of mental disorder. It can also be interpreted as an indication of the racialised landscape in which European alienists were practising in colonial India, a theme which was constant in their writings throughout colonial rule.

The First World War generated new interest in mental diseases and forced the authorities to confront their own prejudices about what constituted mental distress. In May 1918 the *IMG* published the Army Council Instructions 462 and 1171 announcing a new *Nomenclature of Mental Diseases*, which had to be 'strictly adhered to' by Army medical officers including the Indian Medical Service, when they were assessing someone's mental state.³⁷⁵ The military classification is given below in Box 3.5 and has more in common with the nomenclature of Ewens than of Bruce. The Army categorisation below showed the objective comfort with precision preferred by the military, which meant that it did not always fit easily with the subjective interpretations of mental symptoms.

³⁷² Government of the United Provinces of Agra and Oudh, Manifold, Col O. C. (1914) *Report and returns for the United Provinces of Agra and Oudh for the Year 1913*, Government Press, Lucknow, p. 3.

³⁷³ For a discussion on transcultural psychiatry see, for example, Fernando, Suman (1991) *Mental Health, Race and Culture*, Macmillan, Basingstoke, p. 3.

³⁷⁴ Overbeck-Wright, p. 101.

³⁷⁵ Unattributed, 'Nomenclature of Mental Diseases.' (May 1918) *IMG*, vol. 53, no. 5, p. 184.

Box 3.5: Army Council Nomenclature of Mental Diseases, 1917/18

1. Idiocy (variety to be stated)
2. Imbecility
3. Feeblemindedness
4. Moral imbecility
5. Mania (acute, intermittent, chronic)
6. Melancholia (acute, intermittent, chronic)
7. Maniacal-depressive insanity
8. Mental stupor
9. Delusional insanity (acute or chronic)
10. Psychasthenia (obsessional insanity)
11. Acute delirium
12. Insanity associated with infective diseases
13. General paralysis of the insane
14. Confusional insanity synonym, exhaustion psychosis
15. Insanity due to alcohol (acute or chronic)
16. Dementia praecox
17. Dementia (primary or secondary)

One difference from Ewens's categories was that the Army had no place for puerperal insanity which would perhaps be of irrelevance to the overwhelmingly male component of the combatants and their physicians. Another was that the military was struggling to come to terms with the wider public awareness in the field of mental illness because of the traumatic impact of what became popularly known as *shell shock*. As a consequence there was no reference to it in the Army classification of mental diseases for 1917-18.

The initial view of the military and medical hierarchies that explanations could be understood in terms of eugenics theories were shaken when educated middle

and upper class officers began to demonstrate similar symptoms.³⁷⁶ At the beginning of the First World War it was thought that shell shock was caused by the physical effects of exploding shells. Sufferers were initially regarded by senior army officers as cowards or evaders of their duties and therefore a potential threat to morale and military discipline. Gradually, though, it was realised that the combatants were suffering from psychological disorders which could be treated by psychotherapy away from the stresses of the battlefield. Peter Leese observed that because of their background officers were generally shielded from the taint of dishonour, cowardice and insanity. The official medical history of the war dedicated a whole chapter to the issue and gave details of the numbers diagnosed with traumatic neurasthenia and how they were treated. Its editors recognised 'a severe mental disability which rendered the individual affected temporarily, at any rate, incapable of further service.'³⁷⁷ Nevertheless some medical officers continued to believe that a number of men presenting with these symptoms were malingerers.³⁷⁸

As the war progressed, and then in its aftermath, the British public of all classes became more accustomed to the sight of once physically fit young men who now suffered from some form of psychological disorder or in the words of Janet Oppenheim were 'unmanned men' exhibiting 'manly nerves.'³⁷⁹ Tracey Loughran has observed how, as a result of the hostilities, thousands of doctors across Britain were suddenly confronted by the fragility of the human mind, in a way no previous medical generations had been before, by thousands of mentally distressed invalided soldiers from the full range of class backgrounds.³⁸⁰ She argued that shell shock 'overturned the hereditarian discourse of asylum psychiatry, and increased awareness of psychodynamic theories and techniques.'³⁸¹ It would lead to innovative approaches by some alienists forced to address the new and unexpected challenges. One

³⁷⁶ Leese, Peter (2002) *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War*, Palgrave Macmillan, Basingstoke.

³⁷⁷ MacPherson, Maj-Gen, Sir W. G. et al (Eds) (1923) 'Neurasthenia and War Neuroses,' *History of the Great War: Medical Services, Diseases of the War*, vol. II, HMSO, London, pp. 1-67. The quote comes from p.1.

³⁷⁸ Downing, Taylor (2016) *Breakdown: The Crisis of Shell Shock on The Somme, 1916*, Little, Brown, pp. 90-94.

³⁷⁹ Oppenheim, Janet 'Shattered Nerves': *Doctors, Patients, and Depression in Victorian England*, Oxford University Press, New York, 1991, p. 152 and Chapter 5.

³⁸⁰ Loughran, Tracey (2009) 'Shell Shock and Psychological Medicine in First World War Britain,' *Social History of Medicine*, vol. 22, no. 1, pp. 79-95.

³⁸¹ Loughran, 'Shell Shock,' p. 80.

outcome of the war was that changes in the attitudes of European society resulted in the need to handle mass emotions on a rational basis. Doctors in the West concerned with mental disorders shifted away from moral exhortation towards more practical chemical or surgical methods.³⁸²

This awareness of a new kind of mental distress and diagnosis reached India as Indian troops returned from the trenches of Europe. As members of the IMS British alienists had been directed to serve in conflicts in East Africa and Mesopotamia and some in France. They dealt with officers and men who had suffered psychological trauma there which required treatment on their return to India. An official Government of India report commented, for example, on the 14.78% overcrowding of the European patients which was caused by the increased number of 'British military insanes' admitted to asylums there.³⁸³ In 1917 70 European soldiers were admitted to Yeravda from the war in Mesopotamia as it was not possible to return them directly to England. The report said that many improved rapidly when removed from conflict and were able to be repatriated to England after a comparatively short time.³⁸⁴ The Army's response represented the official attempt at recognition of the changing world of mental distress, which had been observed during the First World War but had not been fully understood.

Some alienists in India maintained an awareness of the possibility of feigned insanity by malingerers, particularly amongst private soldiers. In a rare contribution to a professional journal Overbeck-Wright outlined the case of an Indian *sepoy* whose condition puzzled him but whom he eventually identified as a malingerer. The *subadar*³⁸⁵ told him that some Indian soldiers had the ability to simulate symptoms of mental or physical illness to avoid duties.³⁸⁶ Twenty years later Lodge Patch dedicated a whole chapter in his manual to feigned insanity illustrating how difficult it

³⁸² Leese, *Shell Shock*, pp. 180-181.

³⁸³ Government of Bombay (1918) Lyons, R. W. S., Surgeon-general *The Triennial Report of the Bombay (Yeravda) Asylum for 1915-1917*, p. 114.

³⁸⁴ Government of Bombay (1918) *Triennial Report* p. 115.

³⁸⁵ An Indian soldier in the Indian Army, roughly equivalent to captain.

³⁸⁶ Overbeck-Wright, Alexander (September 1915) 'A Case of Malingering,' *IMG*, vol. 61, no. 9, pp. 334-335.

was to maintain such a state particularly where physical punishment was introduced.³⁸⁷

One consequence of the First World War in Britain was the development of psychological treatments in response to the unprecedented trauma affecting so many apparently previously healthy adults.³⁸⁸ There were proportionately fewer psychological casualties in India and consequently a lesser impact on the psychiatric services needed when the four years of war were over.

Here my model differs from the work of Mills by proposing a new period beginning in 1918 rather than 1914. It is my contention that the new era in the history of psychiatry began not as Mills suggests in 1914 but in 1918 with the opening of the European Mental Hospital. This created a European space for managing European facets of the imperial project. It was a venue where innovations in physical, biological and psychological techniques were implemented in a modernistic atmosphere of enthusiasm and scientific research free from the demands of wartime emergencies. The conflict had generated new knowledge which led to consideration of alternative treatments. After the end of hostilities alienists in India could resume peacetime activities and, for Europeans and Anglo-Indians, practice in a new hospital.

Innovation and self-confidence, 1918-1939

The second period postulated in Box 3.2 began with the opening of the EMH in May 1918 shortly before the end of the war. It was intended solely for people suffering from a mental illness who were regarded as of European or Anglo-Indian origin. The definition of European was broad and included persons of Jewish, Armenian, Russian and white American origin as well as those from the British Isles and the European mainland. It was the only mental hospital in India intended solely for people of European heritage and natives of Asia or Africa were not eligible for admission.³⁸⁹

³⁸⁷ Lodge Patch, *A Manual*, Chapter XI. He gave the examples of two British officers who had successfully fooled their Turkish captors into releasing them because of their convincing mimicry of mental illness. He praised their pertinacity in the face of physical cruelty from the Turks.

³⁸⁸ Overy, Richard (2010) *The Morbid Age: Britain and the Crisis of Civilization, 1919-1939*, Penguin, London, pp. 143-144. Overy observed that 120,000 war veterans received war pensions for psychiatric disabilities and 6,000 remained as permanently insane.

³⁸⁹ Berkeley-Hill, Owen Major (IMS) (January 1924) 'The Ranchi European Mental Hospital,' *Journal of Mental Science*, vol. 70, no. 288, p. 69. Major Berkeley-Hill, later Lieutenant-Colonel, was the

The EMH was originally built to house 92 male and 86 female patients³⁹⁰ in wards eventually named after key figures in Western European psychiatry such as Conolly, Freud, Jung, Maudsley and Kraepelin. By May 1936 it had 239 patients.³⁹¹ During its existence it always had a slightly larger proportion of male to female residents. The hospital had a huge catchment area, being 2,100 miles across covering the whole of the northern part of British colonial India, from present day western Pakistan to the whole of Myanmar (Burma). The hospital was never used for serving British soldiers until the Second World War as they were treated in military hospitals and were likely to be returned to the UK.³⁹²

When the EMH was opened in 1918 the 62 residents of the Bhowanipore asylum, all of whom European, were transferred there, as were the 35 Anglo-Indian patients of the mixed race Berhampore asylum. The precise interpretation of the admission criteria became problematic for the authorities. The Bihar and Orissa provincial government objected to the admission of 31 Indian Christians as they were clearly neither European nor Anglo-Indian. The central government, which controlled the hospital, ruled that the Indian Christians should be admitted as their 'habits were those of Europeans' and the hospital authorities accepted all but three of them.³⁹³ This was an interesting example of government compromise by determining eligibility for admission to the EMH on social and cultural grounds rather than simply racial ones. Intriguingly, it was reported the following year that three of the patients never returned to Berhampore but were not living at the European Mental Hospital either.³⁹⁴ The reports over the next few years never identified their whereabouts.

In 1921 Overbeck-Wright produced an updated edition of his original textbook with much coverage of the new legislation, including copies of the relevant legal documents associated with it, and instructions on how it was to be implemented by doctors, magistrates and the Army. He listed 21 asylums in India and Burma, five of

medical superintendent of the European Mental Hospital from October 1919 until his retirement in October 1934.

³⁹⁰ Berkeley-Hill, 'The Ranchi European,' p. 69.

³⁹¹ See Central Institute of Psychiatry (CIP) Archives Mr B C DVD 015 ANC Roll 21 A620-O-M.

³⁹² Hoare, Philip (2001) *Spike Island: The Memory of a Military Hospital*, Fourth Estate, London, p. 158.

³⁹³ Government of Bengal (1921) O' Kinealy, Lt Col F., *Triennial Report of the Lunatic Asylums in Bengal for the Years 1918, 1919, 1920*, Government Press, Calcutta, p. 3.

³⁹⁴ Government of Bengal (1922) Heard, Maj. Gen., R., *Annual Report of the Mental Hospitals in Bengal for the Year 1921*, Government of Bengal, Calcutta, p. 3.

which had separate wards for Europeans and the remaining 16 were solely for Indians.³⁹⁵ The majority of these had been established after 1858 in line with the new legislation of that year.³⁹⁶ His manual was illustrated with detailed case studies relating to his patients and those of other alienists in India and Britain. He showed a strong awareness of issues of race and culture stressing the importance of promptly identifying a new patient's caste and station in life. He continued to prefer the classification of mental diseases compiled by Bruce as he had in 1911. There was no reference to Kraepelin and nothing about psychoanalysis. He did make a passing though disparaging acknowledgement of the *Freudian school* and declared Freud's theories of sexuality to be 'utterly wrong.'³⁹⁷ These omissions and critical dismissals of psychological innovations which were already three decades old represented conservatism and self assuredness in Overbeck-Wright and an inability to accept new approaches in his practice.

The passing of the Indian Lunacy Amendment Act, 1922 permitted the term 'lunatic asylum' to be replaced by 'mental hospital.'³⁹⁸ Hence the European Hospital was only termed an asylum between 1918 and 1921 being renamed the European Mental Hospital in an action praised by the Surgeon-General of the Government of Bombay, Lt-Col D, McCoy as a sign of 'the progress of the infant science of Psychiatry' in India and one which 'will encourage workers to take a scientific interest in their works'.³⁹⁹

Another classification of mental diseases was published by W. S. Jagoe Shaw in 1925 in his *A Handbook of Mental Diseases* for use in India.⁴⁰⁰ He was in turn the medical superintendent of the Punjab Asylum in Lahore, the Burma Asylum in Rangoon and the Central Hospital for Mental Diseases in Yeravda. From 1912 to 1926 he was the senior IMS officer of what he described as the 'Alienist Department of India,' a term he himself invented. He stated that he had produced a thin volume

³⁹⁵ Overbeck-Wright, *Lunacy in India*, Appendix IV, p. 395.

³⁹⁶ Mills, 'Modern psychiatry in India' p. 334.

³⁹⁷ Overbeck-Wright, A. W. (1921) *Lunacy in India*, Baillière, Tindall and Cox, London, p. 79.

³⁹⁸ Jagoe Shaw, W. (April 1932) 'The Alienist Department of India,' *Journal of Mental Science*, vol. 78 no. 321, pp. 338-339.

³⁹⁹ Government of Bengal, McCoy, Lt Col D. (1923) *Annual Report of the Mental Hospitals in Bengal for the Year 1922*, Government Press, Calcutta, p. 11.

⁴⁰⁰ Jagoe Shaw, W. S. (1925) *A Handbook of Mental Diseases: For the use of students and medical practitioners in India*, Butterworth (India), Calcutta.

deliberately as standard texts on the topic were often too large and too expensive for the private library.

With some passion Jagoe Shaw declared that negative, stereotypical language could perpetuate myths about his patients, reinforcing the widespread stigma associated with their mental illness. He wished to end the use of the word 'mad' as a synonym for 'insane,' and he preferred to keep the use of 'insane' to indicate that someone had been certified under the Indian Lunacy Act. In common parlance, he wrote, 'mad' was equated, especially in Indian conditions, with 'rabid' as in 'mad dog.' He criticised the use of 'lunatic; or 'lunacy,' which was still extant in legal documents in India and Britain, preferring the less provocative term 'mental disorder.'⁴⁰¹ It would be difficult to determine the impact of Jagoe Shaw's crusade for a more sensitive vocabulary but it indicated his intellectual defence of his patients' misfortune.

Jagoe Shaw argued that there were two causes of insanity or disorder of the mind. The first were predisposing causes such as heredity or a previous mental breakdown. The second were either physical exciting causes such as poisons like cocaine or alcohol, or mental exciting causes such as a failure to adjust to the environment or prolonged mental stresses. His classification of mental diseases⁴⁰² is reproduced in Box 3.7 and each section was accompanied by a case study.

Box 3.6 Jagoe Shaw's classification

1. Manic-Depressive Insanity (Recurrent and Periodic Psychoses)
2. Confusional Insanity (Exhaustion Psychosis)
3. Alcoholic and other Toxic Psychoses
4. Dementia Praecox
5. General Paralysis of the Insane or Dementia Paralytica
6. Mental Disorders associated with organic disease and injury of the brain, including epilepsy.
7. Senile and Arteriosclerotic Psychoses

⁴⁰¹ Jagoe Shaw, *A Handbook*, pp. 18-20.

⁴⁰² Jagoe Shaw, *A Handbook*, pp. 21-25 and *passim*.

- 8 Symptomatic Psychoses
- 9 Paranoia or Delusional Insanity
10. The Psychoneuroses, or Borderland States.
11. Idiocy and Imbecility (States of Defective Mental Development) or Amentia

In many ways Jagoe Shaw's classification was a return to the simplicity of Ewens's. However he built on the work of Mercier and Ewens and gave greater attention to the stress experienced by the individual in India in a challenging environment. Jagoe Shaw had not adopted the term schizophrenia for dementia praecox, which may be an indication of its lack of use in India in 1925.

An important contribution to the knowledge of mental health services in colonial India came in Jagoe Shaw's descriptions of the layout and construction of an ideal mental hospital to which he dedicated a whole section in his *Handbook*.⁴⁰³ When at Rangoon he had advocated a 'pavilion' or a 'block' arrangement for a new mental hospital there and the Colonial Office subsequently accepted his designs for mental hospitals in Mombasa and Accra.⁴⁰⁴ It was this plan which prevailed at the EMH.

He advocated that 'Europeans and persons of European habits' should not be treated in the same hospitals as Indians which was 'not on any grounds of sentiment, but because the accommodation and amenities necessary for the one are unsuited to the other.'⁴⁰⁵ This was an admission of racial discrimination justified by cultural differences. At Yeravda he sought to make conditions as little prison-like as possible with suitable employment and games, dances and concerts etc. He replaced the terms 'keeper,' and 'warder,' with less custodial sounding ones such as 'nurse,' 'overseer,' and 'attendant.' European nurses and attendants were rewarded financially for passing professional exams. This proved unsuccessful in the case of Indians, he said, because of their poor standard of education.⁴⁰⁶ Jagoe Shaw's innovative hospital designs and sympathetic approach to patients and staff illustrated

⁴⁰³ Jagoe Shaw, *A Handbook*, Appendix 3.

⁴⁰⁴ Jagoe Shaw, 'The Alienist,' p. 332.

⁴⁰⁵ Jagoe Shaw, 'The Alienist,' p. 333.

⁴⁰⁶ Jagoe Shaw, 'The Alienist,' p. 333.

his enthusiastic commitment to the promotion of his profession within the colonial setting.

A professional controversy embroiled Jagoe Shaw after identifying what he affirmed was the 'peculiarly great incidence' of dementia praecox amongst the Parsi community, a grouping of only 100,000 people but a commercially significant one which had been consistently loyal to the British for two centuries.⁴⁰⁷ He attributed this degeneracy to the intermarriage of close relatives in what was already a small community. The issue was discussed by doctors in several editions of the *BMJ* in 1928⁴⁰⁸ and echoed the debates on eugenics which were taking place in Europe. He was one of a number of British alienists in India who felt their views important enough to publish them irrespective of, and possibly unaware through naivety of, any political consequences.⁴⁰⁹

This interest in the intellectual decline of races displayed by Jagoe Shaw was common in India and Europe amongst scientists, politicians and lay people between the two world wars.⁴¹⁰ The degeneracy theory had been given official credence by a Parliamentary Select Committee on Colonisation⁴¹¹ appointed by the House of Commons in March 1858. Reporting in 1859 it had been asked to consider whether the climate of the Indian plains presented an insuperable barrier to permanent colonisation by whites. The report observed that the Portuguese race, which had begun to settle Goa in the sixteenth century, had died out after the third generation through a combination of miscegenation and adverse climate. A key issue was that their racially purity had been diluted by intermarriage. The Select Committee concluded that whites would not survive three generations living in India⁴¹² and this

⁴⁰⁷ Jagoe Shaw, W.S. (1928) 'The Heredity of Dementia Praecox, *BMJ*, (1928) no. 3534, pp. 566-568.

⁴⁰⁸ Jagoe Shaw, 'The Heredity of Dementia Praecox, pp. 566-568. For a fuller discussion on this topic see Ernst, *Colonialism and Transnational*, pp. 11-14.

⁴⁰⁹ Berkeley-Hill's journal articles which produced wholesale condemnation of the Muslim and Hindu religions were banned by the Government of India in 1919 because of the danger of provoking unrest during a time of political agitation.

⁴¹⁰ For a fuller description of this topic and its impact in Europe see Overy, *The Morbid Age, Chapter 3*, pp. 93-135.

⁴¹¹ Fischer-Tiné, *Low and Licentious*, p. 50.

⁴¹² Cited in Hutchins, *Illusions*, p. 61.

statement is repeated frequently in popular writings and medical textbooks during the time of the Raj.⁴¹³

After 1918 it was possible to identify a time of therapeutic optimism amongst alienists in India. This was compared by Leonard Smith to the period in England and Wales after the passing of the 1845 lunacy legislation.⁴¹⁴ One such similarity was the new legislation in India which offered scope for innovative approaches in the treatment of the mentally distressed who, as non-compulsory patients, could develop a different kind of working relationship with their doctors. Such enthusiasm led to the creation of organisations promoting the profession, including the Indian Psychoanalytical Association, an Indian branch of the British Medical Association⁴¹⁵ in 1922 and the Indian Psychological Society in 1926⁴¹⁶ were formed. New treatments such as the use of injections of cardiazol and insulin coma therapy were introduced soon after their development in continental Europe.⁴¹⁷

Another example of the influence in India of Kraepelin came in 1922 when he engaged in correspondence with Berkeley-Hill at the EMH and involved him in an international study on the incidence of neurosyphilis among non-white people. Berkeley-Hill's contribution was to devise a questionnaire which he sent to British psychiatrists in India and other colonies and then to collate their responses.⁴¹⁸ Kraepelin planned to visit India in December 1926 to carry out research at the Punjab Mental Hospital in Lahore. He had two study projects: to determine whether the incidence of mental illness in the country was different to that in Europe; and to

⁴¹³ See, for example, Hunter, George Yeates (1873) *Health in India: Medical Hints as to who should go there: and how to retain health whilst there and on returning home*, Thacker Spink, Calcutta, p. 25. For an academic discussion of the topic see Brendon, Vyvyen (2005) *Children of the Raj*, Weidenfeld and Nicolson, London especially Chapter 2, pp. 41 – 67.

⁴¹⁴ Smith, Leonard, (2014) *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838-1914*, Palgrave Macmillan, London p. 10. The term 'therapeutic optimism' was taken from Smith.

⁴¹⁵ Hartnack, Christiane (1987) 'British Psychoanalysts in Colonial India' in Ash, Mitchell G, and Woodward, William R. (Eds) *Psychology in Twentieth Century Thought and Society*, Cambridge University Press, New York, p. 237.

⁴¹⁶ See *IMG* (March 1928), vol. 63, no. 3, p. 157. The *Indian Journal of Psychology* was first produced, as a quarterly journal, in January 1926.

⁴¹⁷ Nizamie H. S. and Goyal, Nishant (January 2010) 'History of Psychiatry in India,' *Indian Journal of Psychiatry*, no. 52 (Suppl. 1) pp. 3-4. DOI: 10.4103/0019-5545.69195 (Accessed 20 01 12).

⁴¹⁸ Hartnack, 'British Psychoanalysts' p. 237.

identify the frequency of syphilis, general paresis⁴¹⁹ and syphilis of the brain.⁴²⁰ The visit never took place because of his death in October of that year.

A medical text book, produced in 1934, brought a more open, philosophical and scientific approach to its readership. Its author was Major C. J. Lodge Patch, the medical superintendent of the Punjab Mental Hospital in Lahore.⁴²¹ The manuals of Ewens, Overbeck-Wright and Jagoe Shaw gave the impression of idiosyncratic late Victorian or Edwardian pioneers travelling through new territory, heavily dependent on their personal experience but frequently sceptical of new ideas. In contrast Lodge Patch's manual had a fresh, contemporary outlook reflecting, perhaps, the fact that he was younger and his medical training had not taken place over thirty years earlier. He chose not to classify mental illnesses in tabular form rejecting the oversimplification which this could bring.

His first chapter was entitled *Psychology* and it began with a section on consciousness which, he said, 'is never absolutely still. It flows continuously through life.' In asserting his modernity Lodge Patch drew an analogy between consciousness and a cinema film 'where the background may remain the same but the actors are always moving.'⁴²² He gave details of the research of Bleuler, acknowledging the latter's creation of the term *schizophrenia*, with which he felt comfortable and used in his practice. He took his readers through a wide range of mental illnesses giving case examples from his work in the Punjab Mental Hospital. He described symptoms, treatments and medication which had sometimes not been discovered or implemented when the manuals of his predecessors in India had been compiled. Throughout the book there were references, sometimes critical, to eminent doctors and their interpretations of mental disorder which enabled him to muse on the peculiarities of the human mind. Despite his progressive approach he still used the word *alienist* to describe his profession in 1934.

⁴¹⁹ Paresis is a condition of muscle weakness associated with nerve damage or disease. It can also mean an inflammation of the brain in the later stages of syphilis. Overbeck-Wright dedicated a chapter to General Paralysis of the Insane (GPI) and its links with syphilis in *Lunacy in India* including relevant case studies.

⁴²⁰ Lodge Patch, I.C. (June 1987) '50 Years Ago – Psychiatry in Lahore,' *Bulletin of the Royal College of Psychiatrists*, vol. 11, p. 190. At <http://pb.rcpsych.org/content/pbrpsych/11/6/189.full.pdf> (Accessed 29th September 2016)

⁴²¹ Lodge Patch, *A Manual*.

⁴²² Lodge Patch, *A Manual*, p.7 for both references.

Lodge Patch also exhibited conservatism in his wariness of accepting some innovatory methods of treatment. He welcomed the exciting possibilities of what he called 'the new school of psychology,' which he attributed to Freud and his dissenting disciples Jung, Adler and Wundt and he recognised and admired their pioneering research. However he told his readers he preferred to approach what he called the 'true psychoses (i.e. the states of insanity)' by means of an 'older and more constructive form of psychology.'⁴²³ Even so he explained to his readers that, for example, he had refrained from describing the psychoneuroses of hysteria and neurasthenia, and the anxiety and obsessional neuroses because of their modernity. For all Lodge Patch's receptivity of new ideas the inference was that the diagnoses and treatments of these diseases were experimental and might not prove of long term value to medical men.⁴²⁴ His enthusiasm was a cautious one.

Lodge Patch extolled firm views on the role of the hospital and the patient's family in the treatment of the mentally ill. He stated that some people in India, whether European or Indian, were not prepared to let their spouses go into hospital unless they could be with them or play a major role in their recovery.⁴²⁵ He disagreed with this believing that a person was more likely to recover when treated in the presence of strangers, as he or she would not become the centre of attention. Instead the patient would become only one discrete unit surrounded by many more individuals with similar illnesses without the distracting influence of family members. Every recoverable case, he maintained, would be cured much more speedily in a mental institution than at home because '[I]n a hospital he has no necessity to think for himself and he need not think too much of himself,' thus clearing the mind as an aid to recovery.⁴²⁶

His advice to practitioners was that incurable and chronically ill patients, although they must never be told that they were in this hopeless condition, should be kept separate from those who had a chance of recovery. Those patients diagnosed as manic depressive, he said, often had some insight into their condition and so their fellow patients might exert recuperative pressure on them by example, with a strong

⁴²³ Lodge Patch, *A Manual*, p. 3.

⁴²⁴ Lodge Patch, *A Manual*, p. 4.

⁴²⁵ In my visits to India I observed that relatives of a patient in a general or psychiatric hospital, especially when from a rural area, will spend many hours at their kin's bedside often living close by until the person is discharged.

⁴²⁶ Lodge Patch, *A Manual*, p. 292.

chance of encouraging self improvement in habits, cleanliness and attitude. These pronouncements were recognition of the efficacy of peer support groups in encouraging the recovery from mental illness.

Throughout his book Lodge Patch stressed the importance of learning and developing diagnostic and treatment skills via constant observation of patients. He gave the example of how a wise physician and mental nurse could note a patient's remissions and relapses and then study the person's environment and life in order to discover the reasons behind improvements or deteriorations.⁴²⁷ He concluded by giving the readership his views on the qualities needed for the ideal alienist. Such a practitioner must have knowledge of all classes of mankind, be able to take a broad point of view whilst maintaining a surplus of tact, be frank and honest in expressing opinions and be optimistic and cheerful in order to encourage patients. Finally he, and he did not seem to expect alienists to be female, must demonstrate conduct and lifestyle beyond reproach. All these attributes were essential in order 'to discharge his patients better, physically, mentally and morally, than they were before.'⁴²⁸ Whilst he may have lacked some of the charisma of his predecessors in India Lodge Patch presented as a proponent of psychiatry who was prepared to accept, sometimes cautiously, new methods of treatment. His ultimate professional aim was to have 'relit the torch of reason from the dying embers of a few broken minds.'⁴²⁹ His thoughtful text book encouraged constructive reflection amongst its readers rather than providing them, like some alienist authors, with precise instructions on therapeutic delivery.

Many of the primary sources consulted in this thesis originated from the practical work of alienists in India and because of this their objectivity has to be questioned. For comparative purposes it has been possible to study reports produced by Edward Mapother, the medical superintendent of the Maudsley Hospital in London, following his two visits to India⁴³⁰ and Ceylon⁴³¹ in 1937 and 1938. As the leading figure in British psychiatry Mapother had been invited personally by Dr S. T.

⁴²⁷ Lodge Patch, *A Manual*. p. 317.

⁴²⁸ Lodge Patch, *A Manual*. p. 326. See epigraph at the head of this chapter.

⁴²⁹ Lodge Patch, *A Manual*. p. 325.

⁴³⁰ Bethlem Royal Hospital Archives, Bethlem Museum of the Mind EM-01 Series, Box Number C12/4, Series EM, papers of Edward Mapother. (Unpublished report).

⁴³¹ Mapother, Professor Edward (1938) *Report on Present Arrangement of Mental Disorders in Ceylon and Suggestions for Reorganisation*, Ceylon Government Press, Colombo. Available at the Bethlem Royal Hospital Archives.

Gunasekara, the first Sinhalese medical director of Ceylon, to report on the state of mental health services on the island.⁴³² His comments on what he found there were most critical but accepted by the island's government. His report on Ceylon was published but most of his recommendations for Ceylon were not implemented because of the demands of the Second World War.

Much embarrassment to the Government of India was saved by Mapother's agreement in advance of his visit to the mainland, to keep his report on Indian mental hospitals confidential. It has never been published. His critical tone was summarised in his introduction:

*It would be difficult for the most jingoistic to affirm that, in the matter of provision for mental disorder in India, the British 'bearing of the white man's burden' has been quite adequate.*⁴³³

This somewhat clumsy and verbose understatement was quickly followed by blunt condemnation of the state of mental health services and many of its doctors. It may be that because he knew his report would be private he felt he could criticise so severely the Indian situation he encountered. He wrote of asylums in India as 'a permanent monument of brutal stupidity'⁴³⁴ and of the 'wretched provision for the insane in India.'⁴³⁵ He felt that some of the money spent on the construction of the new imperial capital, New Delhi, would have more usefully diverted into funding mental health provision in the country. He had visited seven mental hospitals in India and denounced most medical men as ignorant and indifferent in their mental health practice.⁴³⁶ The IMS system of promotion of its doctors on the grounds of length of service rather than merit he described as 'scandalous.'⁴³⁷

Mapother produced a factual comparison of the numbers of beds in 'institutions for mental conditions' in the London County Council area and in India.

⁴³² Mills, James H. and Jain, Sanjeev (2009) 'A Disgrace to a Civilised Community,': Colonial Psychiatry and the visit of Edward Mapother to South Asia, 1937-8,' in Mooney, Graham and Reinartz, Jonathan (Eds) *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting*, Rodopi, Amsterdam, p. 223.

⁴³³ Mapother, *Report*, p. 1.

⁴³⁴ Mapother, *Report*, p. 2.

⁴³⁵ Mapother, *Report*, p. 2.

⁴³⁶ Mapother, *Report*, p. 10.

⁴³⁷ Mapother, *Report*, p. 11.

Thus London with a population of 4.4 million had 10 'institutions for mental conditions' with 22,000 beds, whilst India with its 276 million people had 19 with 9,608 beds. He stated in his report that there was no difference between Britain and India in the incidence of 'mental disorder and mental defect' which made the underprovision of resources in India inexcusable.⁴³⁸

By the time of Mapother's visit in 1938 the title *psychiatrist* was now in common usage in India. His report contained very personal comments on individual psychiatrists. Thus he praised Berkeley-Hill, whose portrait can be seen in Appendix 4, as 'by far the ablest man that there has yet been in Indian psychiatry,' and as the man responsible for developing the EMH up to standards comparable with the West.⁴³⁹ This was tempered by Mapother's criticism of him as 'imaginative rather than orderly' and of his lack of tact. He described Berkeley-Hill as

*a bitter controversialist with a dangerous wit who scored so successfully off his official superiors that they retired him as soon as possible.*⁴⁴⁰

Mapother had developed the Maudsley Hospital and the Institute of Psychiatry in Britain by the exercise of much perseverance and diplomacy.⁴⁴¹ The approach of Mapother to his work has been described by Katherine Angel as a belief in scrupulous fact gathering. He used rigorous quantitative evaluation methods at the Maudsley, which he regarded as crucial in his aim to ensure that psychiatry became a reputable branch of medicine.⁴⁴² It was in this context of focussed professional dedication that Mapother regretted that Berkeley-Hill's embarrassing publications and personal behaviour reinforced the 'usual view that mental specialists are themselves abnormal' and so causing damage to their profession.⁴⁴³

It was the conjecture of Mills that Mapother may have been seeking to re-establish an Orientalist colonial order, in the Saidian sense, by stressing the

⁴³⁸ Mapother, *Report*, p. 3.

⁴³⁹ Berkeley-Hill's portrait can be seen at Appendix 4.

⁴⁴⁰ Mapother, *Report*, p. 47.

⁴⁴¹ Angel, Kathleen (2003) 'Defining psychiatry: Aubrey Lewis's 1938 Report and the Rockefeller Foundation,' in Angel, Katherine, Jones, Edgar and Neve, Michael (Eds) *European psychiatry on the eve of war: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s*, Wellcome Institute, London, pp. 40-42

⁴⁴² Angel, 'Defining psychiatry' p. 49.

⁴⁴³ Mapother, *Report*, p. 47.

dominance and superiority of Western psychiatry when compared to the Indian approach. Mills viewed the report as patronising in a number of ways, one of which was the author's comments that Indian medical students should go to Britain for their psychiatric training. However another more pragmatic interpretation would be that, since the training facilities in India were virtually non-existent, as Hehir had found in 1923, education in Britain was the only feasible option to stimulate the profession. Whichever viewpoint was accepted Mills was certain that if Mapother had been 'empire building' it was for his own institution, the Maudsley Hospital, rather than for any notion of imperialism or patriotism.⁴⁴⁴

No other evidence has been found of a contemporary analysis of Indian mental health services by someone not based in the country. Mapother was not constrained by the military discipline imposed on serving IMS officers and neither was he a politician or a diplomat. His views were those of the universal scientist who believed passionately in the future of his profession. He could criticise without fear of reprisals from an embarrassed or angry military hierarchy.

As the twentieth century progressed psychiatry in India became less focussed on Britain by developing an international dimension. More Indians were being employed in senior positions and Western and Indian psychiatrists began to see themselves as part of an international community of scientists and doctors,⁴⁴⁵ something strongly advocated by Mapother. Ernst has written that psychiatry in nineteenth century India has regularly been perceived as linked to the British civilising mission of empire and of colonial control.⁴⁴⁶ This undertaking was reinforced, she maintained, by the pathologisation of India as a diseased environment with a harmful impact on the British mind and body owing to the self-sacrifice of imperial duty which it required.⁴⁴⁷ However, Ernst argued, the needs of empire became less relevant as the profession developed and

⁴⁴⁴ Mills and Jain, 'A Disgrace,' p. 238.

⁴⁴⁵ Ernst, Waltraud (2011) 'Crossing the Boundaries of 'Colonial Psychiatry': Reflections on the Development of Psychiatry in British India, c. 1870-1940,' in *Cult Med Psychiatry*, no. 35, p 540.

⁴⁴⁶ Ernst, 'Out of sight,' p. 263.

⁴⁴⁷ Ernst, 'Out of sight,' p. 258.

*[T]he myth of psychiatry as benefit and excuse of empire came to give way to the myth of science as universally valid and applicable, culture free and politically disinterested.*⁴⁴⁸

By 1939 psychiatry in India had matured into a modern scientific discipline but one which was then challenged by the demands of war.

The years of emergency and through to Independence, 1939 to 1947

In her study of India during the Second World War Yasmin Khan has argued that at the beginning of the war Europe's troubles seemed far distant and removed from India.⁴⁴⁹ She asserted that senior army officers and government officials believed that India was insulated from the ideological struggles of the West and that Indians would rally to the Crown in loyalty against the imperial enemy as they had 25 years earlier. Few Europeans were prepared for the stresses associated with maintaining imperial control in the face of growing Indian nationalism within and the approaching Japanese menace without. The evidence in this chapter has identified that there had been some neglect of psychiatry in the IMS since the First World War and so it was to the credit of the Government that they valued the role of psychiatry in wartime and were planning ahead in anticipation of soldiers suffering mental distress as the hostilities against Japan intensified. As the war approached India geographically the Government of India accepted that, as in the First World War the physical casualties would be augmented by the mental ones. In December 1942 it sought to recruit psychiatrists into the Army requesting some to come out of retirement indicating official recognition of the value of psychiatry in wartime.⁴⁵⁰ They advertised through existing medical networks by writing to current psychiatrists, medical schools and hospitals.

A confidential, unpublished file indicated that the Government regarded the response from only seven potential recruits as quite poor. Most of those who did

⁴⁴⁸ Ernst, 'Crossing,' p. 540.

⁴⁴⁹ Khan, Yasmin (2015) *The Raj at War: A People's History of India's Second World War*, The Bodley Head, London, p. xi.

⁴⁵⁰ The information in this and the next paragraph is taken from Confidential files held at the National Archives of India – Office of the Director-General, IMS, Recruitment Section (Branch – 2), File No. 16-3-1/43-R-2. (Accessed 22nd November 2013).

show an interest indicated they required certain conditions to be allowed, such as not serving beyond the boundaries of India. Berkeley-Hill, now retired, was one of the seven and he requested that he be made a full colonel and receive extra expenses for rejoining the IMS. With characteristic immodesty he reminded the Director-General that any further information which his office might require from him could be found in his autobiography '*All Too Human*, copies of which can be found in most club libraries in India.' The minutes in the file recorded that Berkeley-Hill's application was discussed at the highest level and the senior IMS hierarchy were unanimous in their decision not to employ him. He had been 'adversely reported several times' during his career and although he was recognised as an able psychiatrist he was rejected as 'perhaps a trifle too unconventional to serve harmoniously with the Army.' This was not revealed in the official letter of response on the 18th May 1943 from the Director-General who thanked him for his interest but said 'we ought to give the youngsters a chance first.'

In October 1943 the Government of India appointed a Health Survey and Development Committee with the remit to make a broad survey of the present position in regard to health conditions and health organisation in British India, and make recommendations for future developments. It was chaired by Sir Joseph Bhore, a professional administrator, who had entered the Indian Civil Service in 1902 and held several senior posts in a variety of government departments. The Bhore Report was commissioned in time of war and in anticipation of a post-war India which was likely to become independent at an unspecified time in the near future. It contained numerous tables comparing health care in India with the situation in England and Wales, the USA and other countries, and almost universally the statistical results were markedly inferior. The final part of the Bhore Report was published in 1946.⁴⁵¹

Bhore and his committee emphasised that because of the war they were unable to travel around India to take evidence or to visit experts and health facilities abroad. For the same reason some statistics were out of date or unobtainable. Lt Colonel M. Taylor, the medical superintendent of the EMH, was asked to visit the

⁴⁵¹ Government of India, (1946) Bhore Report. See http://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report_VOL-1.pdf The Bhore Report, (1946) (Accessed 30th September 2016).

most important mental institutions in the country, not just those treating European patients, and report back on what he found. Taylor reported that they were working at an extremely low level of efficiency and that:

*the majority of the mental hospitals in India are quite out of date, and are designed for detention and safe custody without regard to curative treatment. The worst of them, the Punjab Mental Hospital, the Thana Mental Hospital and the Nagpur Mental Hospital, savour of the workhouse and should be rebuilt.*⁴⁵²

Taylor was equally critical of medical staffing arrangements stating that:

*seven of the largest mental hospitals in India have men appointed as Superintendents at salaries that a first class mechanic in Tatas Works would scorn, six of them have little or no experience or training in psychological medicine. The subordinate medical staff are also untrained in psychiatry.*⁴⁵³

Taylor's contribution was reproduced in full in volume three of the Report.⁴⁵⁴ He found that medical training standards were reasonable at Bangalore and the EMH but elsewhere considerable investment was needed to improve the skills of doctors and nurses and the quality of the mental health care they delivered. Whilst Taylor had a professional interest in the improvement in mental health services and would welcome new resources as a senior figure in psychiatry in India his stern criticism deserved attention. There was no evidence that Taylor had seen Mapother's condemnatory reports of the mental health system in India produced only a few years earlier. However, Taylor's comments reached a similar conclusion though expressed in much less flamboyant language. These internal and external psychiatrists both agreed, being displeased with what they had found.

⁴⁵² Bhore Report, vol.1, p.131. The Tata company was the major producer of steel in India.

⁴⁵³ Bhore Report, vol.1, p.131.

⁴⁵⁴ Bhore Report http://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report-3.pdf (Accessed 30th September 2016)

The final report contained ten pages of recommendations.⁴⁵⁵ Those for *Mental Disease and Mental Deficiency* came in the section entitled *Health Services for Certain Important Diseases* which included twelve other diseases such as malaria, tuberculosis, cholera, leprosy and hook-worm. That it did not merit its own chapter suggested that mental illness was considered by the Government of India of much lesser importance than physical illness.

The Bhole Report highlighted deficiencies in numerous aspects of public health provision and the prevention of disease but gave mental health little priority. The report came almost at the end of nearly three and a half centuries of British involvement in India and was the last official account of imperial health provision in India before Independence. In essence it indicated the failings of colonial health provision as the Raj neared its end.

An understanding of the development of Western psychiatry in India in the first half of the twentieth century has been assisted by the use of the three time periods. The issue of tropical neurasthenia in India, however, transcended this periodisation and its significance will now be considered.

The creation of neurasthenia and tropical neurasthenia

Neurasthenia was a term which had been invented in the 1850s in America to describe a set of symptoms with the common, underlying factor of excessive fatigue. Its leading proponent was George Beard, a New York physician, who in 1869 wrote a brief article in a Boston medical journal entitled *Neurasthenia or nervous exhaustion*.⁴⁵⁶ He described it as a 'morbid condition' characterised by a 'want of strength in the nerve,' leading to a wide range of mental and physical symptoms: 'dyspepsia, headaches, paralysis, insomnia, anaesthesia, neuralgia, rheumatic gout, spermatorrhea in the male and menstrual irregularities in the female,' together with a feeling of weakness and general malaise.⁴⁵⁷ Beard developed his work on neurasthenia writing scholarly articles for the medical press and more populist ones for the general public. In 1881 he published his *American Nervousness* where he

⁴⁵⁵ See Bhole Report, vol. 2, pp. 137-218. http://www.nhp.gov.in/sites/default/files/pdf/Bhole_Comittee_Report_Vol2.pdf (Accessed 30th September 2016).

⁴⁵⁶ Jackson, *The Age of Stress*, p. 25.

⁴⁵⁷ Cited in Jackson, *The Age of Stress*, pp. 25-27.

promoted his belief that neurasthenia was inextricably linked to the rise of American civilisation.⁴⁵⁸ He specified five modern conditions which predisposed citizens to an increase in functional nervous disorders: the introduction of steam power; and of the press; and of the telegraph; developments in the sciences; and the increasing education and employment of women.⁴⁵⁹ Beard was proud that he had identified the first, all-American disease, a disease created by American modernity as its response to the expanding industrial civilisation in the New World. Neurasthenia quickly crossed the Atlantic and was adapted for European needs as shown in publications from the 1880s by doctors such as William Smout Playfair, a leading and influential London practitioner in the second half of the nineteenth century who specialised in women's illnesses.⁴⁶⁰

Hilary Marland has described neurasthenia as 'a wastepaper basket diagnosis'⁴⁶¹ because of its catchall definition. In an article about Playfair, she observed that he was absolutely emphatic in his opinion that, for females, neurasthenia was a disorder which only affected ladies of standing who exhibited 'high culture and delicacy' of feeling and in clever, emotional and excitable ones but not in the fanciful.⁴⁶² Neurasthenia was a gradual and incipient disorder linked to obstetric occurrences.⁴⁶³ Playfair was a former member of the IMS and had been the Professor of Surgery in Calcutta and it was possible that he had developed these views whilst treating British women in India. Many of his female patients in London hospitals who, as he observed regularly, were working class women who were overworked, strained and ill fed and this affected their physical and mental health. Because of their humble origins poor uneducated women were unlikely to develop neurasthenia, he believed, as they lacked the level of civilisation and sensitivity which its symptoms implied.

One medical practitioner who specialised in the health challenges faced by Europeans in the tropics was Sir Andrew Balfour who was to become the Director of the London School of Hygiene and Tropical Medicine. Balfour wrote that many of

⁴⁵⁸ Cited in Jackson, *The Age of Stress*, p. 26.

⁴⁵⁹ Jackson, *The Age of Stress*, p. 26.

⁴⁶⁰ See Gijswijt-Hofstra, Maijke and Porter, Roy (Eds) (2001) *Cultures of Neurasthenia: From Beard to the First World War*, Editions Rodopi B. V. Amsterdam.

⁴⁶¹ Marland, " 'Uterine Mischief', W. S. Playfair and his Neurasthenic Patients," in Gijswijt-Hofstra and Porter *Cultures of Neurasthenia*, p. 117.

⁴⁶² Marland, " 'Uterine Mischief' ," p. 123.

⁴⁶³ Marland, " 'Uterine Mischief' ," p. 129.

the illnesses formerly attributed to the climate were now shown by scientific discovery to be caused by parasites, unhygienic surroundings and the persistent abuse of alcohol. In 1921 he wrote in a textbook on this topic that '[T]here can be no doubt that the nervous system is that on which the chief stress of a tropical climate falls.'⁴⁶⁴ He emphasised that stimulation of the senses would normally lead to depression and when the latter was exaggerated the outcome would be neurasthenia.⁴⁶⁵ Balfour maintained that neurasthenic illnesses were determined by climatic conditions such as the humidity, excessive temperatures and the electrical phenomena caused in the atmosphere. His status as an expert authority reinforced the medical view that neurasthenia had now become a tropical disease.

It was perhaps not surprising that an illness with so many and so varied symptoms should cause confusion amongst medical practitioners and also highlight some uncomfortable political issues. The last quarter of the nineteenth century saw rapid imperial expansion by the Europeans and Americans in Africa and Asia. Kipling had already written of the problems facing the USA and its soldiers and administrators as a new colonial power in his 1899 poem *The White Man's Burden*.⁴⁶⁶ Doctors became much exercised by the unsuitability of whites to live and work or fight away from their temperate homelands. As a response to this the term *tropical neurasthenia* was coined in 1905 by Major Charles E. Woodruff, a US Army surgeon who had served in the Philippines during his country's war with Spain in 1898. Woodruff's theory was originally developed as an explanation for the neurasthenic symptoms experienced by American colonisers in the Philippines but the term also crossed to Europe where it was enthusiastically taken up as an extension of debates about the suitability of the tropics for white settlement.

For Woodruff natural selection meant that white men could never survive in the tropics for any length of time. In his 1909 book *Expansion of Races*⁴⁶⁷ he declared that temperate northern climates enabled whites to become the fittest and

⁴⁶⁴ Balfour, Andrew (1931) "Personal Hygiene in the Tropics and Minor Tropical Sanitation," in Byam, W. and Archibald, R. G., (Eds) *The Practice of Medicine in the Tropics by many authorities*, Oxford Medical Publications, Henry Frowde and Hodder and Stoughton, London, p. 5.

⁴⁶⁵ Neurasthenia originates from the Greek, meaning "nerve weakness."

⁴⁶⁶ Kipling, Rudyard *Rudyard Kipling's Verse: Definitive Edition* (1960), Hodder and Stoughton, London, p 323-4. The poem was subtitled *The United States and the Philippine Islands*.

⁴⁶⁷ See Kennedy, Dane 'Diagnosing the Colonial Dilemma: Tropical Neurasthenia and the Alienated Briton,' in Ghosh, Durba and Kennedy, Dane (Eds) (2006) *Decentring Empire: Britain, India and the Transcolonial World*, Orient Longman, Hyderabad, India, pp. 160-161, 172, 176.

most developed race from a civilisational perspective and this drove them to colonise the rest of the world which was less gifted physically and mentally. He accepted that there was an obvious paradox between the superior race striving for domination of the tropics and their physiological weakness which prevented it from populating them.⁴⁶⁸ However he reconciled this by pointing out that the white race should assume a supervisory role in ruling the darker races, as this was in the latter's best interests and of civilisation as a whole. He believed that every white person who had spent more than a year continuously in the tropics would almost certainly be neurasthenic as he or she could never acclimatise to such conditions. Woodruff generated much respect amongst some of his scientific peers as, through his 1905 *actinic radiation* theory he was applying the principles of modern physics to the traditional anxieties of many whites about life in the tropics.⁴⁶⁹ He appealed to others because his theories seemed to justify the racial superiority of the white races and, by extension, the argument for eugenics.

Tropical neurasthenia had been employed by Woodruff to describe certain symptoms he had observed which were associated with Europeans living in tropical settings such as colonial India, the Far East and Africa. In her study of tropical neurasthenia Anna Crozier observed that the topic was embraced by physicians with such seriousness that by 1913 tropical neurasthenia even formed the topic of the presidential address by Sir Havelock Charles at the annual meeting of the Society of Tropical Medicine and Hygiene in London in October of that year.⁴⁷⁰ An article in the *BMJ* that year named it as the chief reason, ahead of malaria, cholera and dysentery, for Europeans being invalided from British tropical possessions.⁴⁷¹ A member of the Indian Medical Service for 25 years Charles eventually became the

⁴⁶⁸ See Kennedy Dane (1990) "The perils of the midday sun: climatic anxieties in the colonial tropics," p. 123 in McKenzie, John M. (Ed) *Imperialism and the natural world*, Manchester University Press, Manchester, pp. 118-140.

⁴⁶⁹ Quoted in Johnson R. (2009) 'European Cloth and "Tropical" Skin: : Clothing Material and British Ideas of Health and Hygiene in Tropical Climates. *Bulletin of the History of Medicine*, pp. 530-560. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3400508/#_fn-groupid2377320title (accessed 2nd January 2016). In 1905, Woodruff published *The Effects of Tropical Light on White Men*, arguing that debilitating photochemical effects of the sun's rays (actinic rays) damaged 'white' skin even if it were clothed in protective wool, or cotton.

⁴⁷⁰ Crozier, Anna (2009) 'What was Tropical about Tropical Neurasthenia? The Utility of the Diagnosis in the Management of British East Africa,' *Journal of the History of Medicine and Allied Sciences*, p. 531, doi:10.1093/jhmas/jrp017 (Accessed 19th April 2014).

⁴⁷¹ Cited in Greenwood, Anna (March 2011) 'The strange history of tropical neurasthenia,' *The Psychologist*, vol. 24, no.3, p.226.

most senior medical officer in India and was later personal doctor to King George V for 18 years.⁴⁷²

The subject of his address to the society was the suitability of the white man for the tropics and the impact which this might have for his offspring if they were born and raised there.⁴⁷³ Charles began by stating his professional medical recommendation on the character and, therefore, the suitability of people to serve the Raj. He declared that 'the best kind of man'⁴⁷⁴ for the tropics was

*the good ordinary type of Britsher with a clear head 'well screwed-on,' an even temper, not over intellectual, who can take an interest in things around, not unduly introspective, one who can work hard and find pleasure in it, capable of bearing exposure to the sun; one who will practice temperance in all things, with self-control and common sense – meaning that such an one inherits no liability to that neuropathic disposition which requires only a light exciting cause to develop active mental trouble.*⁴⁷⁵

Thus for Charles the *Imperial Mind* had to be disciplined, enthusiastic and in a healthy body. Such characteristics took precedence over intelligence. He did not give his audience his opinion on what the 'best kind of woman' would be for the Indian Empire.

During the nineteenth century the British in India had coined the phrases *Punjab head, Bengal head or Burmah head*, depending on where they were living or serving, to describe a general malaise which they believed was caused by the hostile climate. In medical language it was also known as 'tropical inertia' or 'tropical amnesia.'⁴⁷⁶ There were frequent references to these terms in contemporary

⁴⁷² Maj Gen Sir Havelock Charles became the head of the IMS. He was named after General Sir Henry Havelock who had been killed in action in the Indian Mutiny/Great rebellion in 1858, the year of Charles's birth. See his Obituary in *BMJ*, Nov 3rd 1934, vol. 2 (3852), pp. 838–839.

⁴⁷³ Charles, Havelock (November 1919) 'Neurasthenia and its bearing on the decay of Northern peoples in India,' in *Transactions of the Society of Tropical Medicine and Hygiene*, vol. VII, no. 1. pp 2-21. The key points from his address were covered in *BMJ* (March 1914) vol.1, 2278, pp. 727-728.

⁴⁷⁴ Havelock, 'Neurasthenia,' p. 3.

⁴⁷⁵ Havelock, 'Neurasthenia,' p. 3.

⁴⁷⁶ Kennedy, Dane (1990) "The perils of the midday sun: climatic anxieties in the colonial tropics," in McKenzie, John M. *Imperialism and the natural world*, Manchester University Press, Manchester, p. 123.

memoirs identifying the affliction which was viewed as an inevitable, though usually temporary, but recurring irritant accompanying imperial duty in the tropics.⁴⁷⁷ In his Presidential speech Charles recalled his own experience of *Punjab Head* and linked it to the primary causes of neurasthenia which were

[T]he humidity and the sun, with its light and heat which produce an abnormal condition of the body characterised by lowered pulse-rate and tension, an irritable heart, lessened respiratory function owing to deficiency of intake and rarefaction of the air, extra work thrown on the liver, followed by continued congestion, and atonic dyspepsia⁴⁷⁸ leading to chronic auto-intoxication.^{479 480}

Charles urged those who selected men for service in India to take greater care in their task. It was vital to choose 'the fit man and the right man,'⁴⁸¹ one who will have less of a liability to contracting neurasthenia. In summary Charles stressed that the empire needed practical, moderate and modest men. He did not consider the role of women and he discounted bureaucrats who were good at passing exams because 'character is of far more value than mere learning in those who have to rule foreign races.'⁴⁸²

His pen picture of the ideal *Imperial Minds* for colonial service gave medical endorsement at the highest level to the commonly held British belief from Victorian times onwards in amateurism and fair play, physical toughness, devotion to duty and quick decision making with ruthlessness, when it was deemed necessary, by men on the spot. It also repeated the popular suspicion of the intellectual and of the London-based administrator or politician. Such gentlemanly qualities were nurtured in the

⁴⁷⁷ See, for example Macleod, R. D. (1938) *Impressions of an Indian Civil Servant*, H. F. And G. Witherby, London; and Darling, Sir Malcolm (1966) *Apprentice to Power: India 1904 -1908*, Hogarth Press, London.

⁴⁷⁸ Atonic dyspepsia: 'A condition characterised by a loss of tone in the digestive organs, with little or no appetite, often a loathing of food, and even sometimes nausea.' See <http://medical-dictionary.thefreedictionary.com/atonic+dyspepsia> (accessed 30th November 2015).

⁴⁷⁹ Auto-intoxication: "Poisoning by a toxin formed within the body." See *Oxford Concise Medical Dictionary*, p. 68.

⁴⁸⁰ Charles, *BMJ* (28th March 1914) p. 727.

⁴⁸¹ Charles, 'Neurasthenia' p. 10.

⁴⁸² Charles, *BMJ* (28th March 1914) p. 728.

British public school system which produced the vast majority of the army officers and senior civil servants who ran India.⁴⁸³

Charles alluded to Woodruff's theory of actinic radiation and outlined how the climatic conditions lower the power of bodily resistance and made the individual liable to disease. He added that a white person may work under great strain in temperate zones but the sympathetic climate will allow ample opportunity for recovery. However for those in the tropics who were predisposed there may be no such respite with the consequence of a mental breakdown attributable to neurasthenia. He believed that as neurasthenia was on the increase in the civilised world it followed that its tropical variant would also increase inevitably. He described how the life of a Government of India civilian⁴⁸⁴ could be very strenuous as he was likely to have superabundant energy, to be adventurous and daring, often facing danger. Whereas temperate climates may be more kind to him '[E]very white man is not fitted for tropical life – certainly, many are totally unfitted.'⁴⁸⁵ Charles registered a serious warning that the strains of modern living were

*breeding a race of neuropaths who naturally cannot resist the strain of the conditions on which they have to live in the tropics*⁴⁸⁶

and such unhealthy factors could lead to a deteriorating effect on the nervous system⁴⁸⁷ Kipling had given a fictional description of this in his 1890 short story *At the End of the Passage* about the death of an engineer, who was based at a remote railway station, through mental breakdown following excessive strain brought on by overwork, isolation and the intense heat.⁴⁸⁸ Kipling's enormous popularity in the sub-

⁴⁸³ See Mangan, *The Games Ethic*, *passim*. This collection of attributes became known as the *Punjab Style* from its development in the warlike region of the Punjab gradually conquered by the British in the first half of the nineteenth century. Its physical embodiment was seen in Henry and John Lawrence the heroes of the Sikh wars and the Mutiny/Great Rebellion who were lionised in the writings of Rudyard Kipling and others.

⁴⁸⁴ The term 'civilian' was used to describe a senior, predominantly British, member of the ICS.

⁴⁸⁵ Charles, 'Neurasthenia' p.10.

⁴⁸⁶ Charles, *BMJ*, p. 728.

⁴⁸⁷ Charles, *BMJ*, 29th March 1914, p. 727.

⁴⁸⁸ See, for example, Kipling, Rudyard 'At the End of the Passage,' a short story originally published in 1890, at <http://www.telelib.com/authors/K/KiplingRudyard/prose/LifesHandicap/endpassage.html> (Accessed 2nd November 2017).

continent ensured that his audience there would have recognised the stressed Briton struggling in an unpleasant environment.

To address such concerns a debate was initiated in the *BMJ* by the Bishop of Singapore in 1926 asking why so many Europeans living in the tropics were affected by nervous breakdowns and why they sometimes committed suicide.⁴⁸⁹ The medical superintendent of the state lunatic asylum at Angoda in Ceylon, L. D. Parsons responded with an explanation of the causes of tropical neurasthenia which he declared were: the excessive and unaccustomed stimuli of the tropics such as the heat, the light and flies; the strange languages and customs combined with the appalling moral atmosphere faced by the Europeans to which they are unaccustomed; the inability of some whites to take things easy and their tendency to display anxiety; and what he termed the ridiculous customs regarding food, dress and the hours of work.⁴⁹⁰ The stress factors associated with the environment and with British culture in India will be analysed in Chapters 4 and 5.

The controversy continued in November 1926 when Major Hugh Acton, IMS, and Professor of Bacteriology, Pathology and Helminthology⁴⁹¹ at the School of Tropical Medicine and Hygiene in Calcutta read a paper to the Medical Section of the Asiatic Society entitled 'Neurasthenia in the Tropics.' It was later published in the *IMG*⁴⁹² giving tropical neurasthenia a scientific grounding. Acton declared that neurasthenia was '*real ill health*'⁴⁹³ [Acton's emphasis] and not a form of shirking as believed by some of his medical colleagues and large numbers of the general public. If the patient is not believed when explaining his or her illness he might resort to quack remedies advertised in the press which will only prolong suffering.⁴⁹⁴ Acton stated that the exciting cause of neurasthenia is a depression of the function of certain endocrine glands, especially the thyroid. In his address he spent much time outlining the predisposing causes of the illness. He told his audience that

⁴⁸⁹ The debate is considered in detail in Kennedy, Dane (1990) 'The perils of the midday sun: climatic anxieties in the colonial tropics,' in McKenzie, John M. (Ed) *Imperialism and the natural world*, Manchester University Press, Manchester, pp. 118-140.

⁴⁹⁰ Parsons, L. D. (22nd May 1926) *BMJ*, no. 3411, p. 884.

⁴⁹¹ Helminthology is the study of parasitic worms (helminths). See *Oxford Concise Medical Dictionary* p. 346.

⁴⁹² Acton, Major Hugh (January 1927) 'Neurasthenia in the Tropics,' *IMG*, pp. 1-8.

⁴⁹³ Acton, 'Neurasthenia,' p.1.

⁴⁹⁴ Adverts for medicines with incredible claims could be found regularly in copied of newspapers or journals such as the *Calcutta Review* and the *Indian Planters Gazette*, which were widely read by the British in India.

*[T]here is a greater tax on the body as the result of the continued high atmospheric temperature and the excess of humidity*⁴⁹⁵

which required considerable perspiration to maintain body temperature at 98.4°F. 'Eastern races,' he stated, recognised this and countered it by rarely eating a meal during the heat of the day unlike the custom of the colonial rulers. European clothing, with its numerous layers and such items as starched collars, added to the overheating of the body. He criticised Indian cooks for consistently preparing spicy and greasy meals which were irritants to European stomachs.

To their detriment, Acton remarked, Europeans tended to indulge in excessive exercise in the hot weather rather than relaxing in the heat and this was particularly ingrained in the neurasthenic. As neurasthenia developed 'there is a general loss of tone and a feeling of not being up to the mark.'⁴⁹⁶ This could lead to excessive introspection and, for example, a fear by the person that they might be suffering from a serious heart problem or cancer of the abdomen, whereas the problems related to indigestion and an inappropriate diet. In both sexes a morbid anxiety can develop and this, in conjunction with heat, could lead to a reduction in or ending of sexual activity. Both men and women might become claustrophobic and lose confidence, and there was a real risk of depression. Acton's description in essence highlighted the threats to the *Imperial Mind*, which sought to maintain a European lifestyle against all the negative stresses by which he or she was confronted.

The scientific nature of the debate intensified when The Far Eastern Association for Tropical Medicine held their congress in 1927 in India. Berkeley-Hill read a paper entitled *Mental Hygiene of Europeans in the Tropics*.⁴⁹⁷ He lamented the fact that whereas tropical hygiene was a well developed branch of medicine mental hygiene had received little consideration. He defined the latter as:

⁴⁹⁵ Acton, 'Neurasthenia,' p.1.

⁴⁹⁶ Acton, 'Neurasthenia,' p. 3.

⁴⁹⁷ Berkeley-Hill, Owen Lt Col (IMS) (1927) 'Mental Hygiene of Europeans in the Tropics,' in *Transactions of the Far Eastern Association for Tropical Medicine*, Seventh Congress, held in India, December 1927, vol. 1, Thacker's Press and Directories, Calcutta, 1929, pp. 289-399.

*the improvement of the mental health of the community by a close and critical study of social habits with a view to eradicating factors which lead to mental ill-health.*⁴⁹⁸

He added that 'the concern of mental hygiene may be said to be the promotion and preservation of right and efficient living.'⁴⁹⁹ His comments embraced a form of social psychiatry as will be seen in some of the medical records considered in Chapter 7.

Berkeley-Hill spoke of his disappointment that the majority of books on tropical medicine contained little or no references to tropical psychopathology of Europeans in the tropics. However he cited at length the works of Pieter van Brero and Heinrich Scheube, Dutch and German doctors respectively.

He outlined the work of van Brero on *Tropenkoller*, which can be translated as tropical madness. Van Brero had worked at the State Asylum of Lawang in Java in the Dutch East Indies for a number of years. Van Brero pointed out that tropical madness was rare amongst Europeans who lived in agreeable conditions in the tropics. However he said it was 'common among those who live lonely lives deprived of the usual amenities of civilisation.'⁵⁰⁰ Climate could be a factor in *Tropenkoller* and when this was related to loneliness and discomfort a neurosis could develop amongst some Europeans. When the neurosis was added to the excesses in *Baccho et Venere*⁵⁰¹ this would lead inevitably to mental degeneration.

Van Brero identified neurasthenia as a neurotic disorder characterised by high blood pressure and auto-intoxication due to constipation. In addition, he wrote, alcoholism, arthritis and 'over-work,' whether mental or physical, were also factors in its causation. He considered that very hard mental work was the commonest cause of tropical neurasthenia 'especially among those who will not realise that the capacity for mental strain is lowered by long residence in hot countries.'⁵⁰²

Berkeley-Hill also cited the work of Scheube, who was famous for his research on beriberi. In his 1896 work *Diseases of Tropical Countries*, Scheube wrote that long residence in a tropical climate resulted in a poor sleep pattern and

⁴⁹⁸ Berkeley-Hill 'Mental Hygiene,' p. 390.

⁴⁹⁹ Berkeley-Hill 'Mental Hygiene,' p. 390.

⁵⁰⁰ Cited in Berkeley-Hill 'Mental Hygiene,' p. 390.

⁵⁰¹ A Latin phrase meaning excesses of alcohol and sex. Cited in Berkeley-Hill 'Mental Hygiene,' pp. 390-391.

⁵⁰² Cited in Berkeley-Hill 'Mental Hygiene,' p. 391.

nervous irritability and when the latter was coupled with chronic malaria the outcome was neurasthenia, a mental disorder common amongst Europeans in hot countries. Scheube cited the work of a fellow German professor, Carl Mense, who was of the opinion that the morbid emotional state was a mixture of hate and affection. Berkeley-Hill, as a trained psychoanalyst pointed out that that this coincided with the Freudian concept of the ambivalence of these emotions. Mense went on to say that in his view a large percentage of Europeans who chose to go to the tropics were already 'eccentric' and it was owing to the existence of an inherent abnormality of temperament that they left their homeland in the first place.⁵⁰³ From his own experiences Berkeley-Hill believed that mental disorder was more common amongst Europeans in hot countries than at home, although he accepted it was not a popular perception amongst the English. Such an *Imperial Mind* would have failed to meet Charles's ideal of the 'good ordinary type of Britisher.'

The medical discussion continued in the *IMG*. In 1928 Lt Col J. W. D. Megaw, a professor of Tropical Medicine at the Calcutta School of Tropical Medicine, described tropical neurasthenia as a state of exhaustion of the nervous system with overwork and 'worry' being its chief causes. He added that malaria, dysentery and other tropical diseases lowered the vitality of the nervous system so making it more liable to exhaustion. Climate was also a factor, he said, as the tone of all body tissues was lowered by prolonged existence in unfavourable climatic conditions.⁵⁰⁴ Megaw also criticised the dangers to Europeans in India of drinking alcohol excessively as it could lower body vitality, and for their obsession with maintaining the same kind of diet as they would have had in Britain which was a recipe for digestive disorders. Because of the dearth of white women in India and the custom of army officers not marrying before their thirties many Britons remained unmarried. Like Acton he warned that this enforced bachelorhood might also be a cause of neurasthenia as 'normal' male sexual activity was important for the maintenance of good mental health. Also like Acton he believed that some pressures on the community were self-imposed culturally.

⁵⁰³ Cited in Berkeley-Hill 'Mental Hygiene,' p. 391.

⁵⁰⁴ Megaw, Lt Col J. W. D. (March 1928) "Tropical Neurasthenia," in *IMG*, vol. 63, no. 3, pp. 150-1.

However Megaw did not believe that conditions in the tropics merited the addition of the word 'tropical' to neurasthenia. Whilst emphasising that each case should be judged on its merits it was

*likely that in most cases a reformation in the habits of life would bring about a cure just as certainly as in other countries.*⁵⁰⁵

When conditions 'cannot be mended' the patient should be sent to a 'cheerful and healthy' locality such as a hill station but preferably back to Europe.

In the opinion of Millais Culpin, a professor of tropical medicine and a psychotherapist, the use of the phrase 'tropical neurasthenia' was a misnomer and should be discontinued promptly.⁵⁰⁶ He disputed the view that there was something intrinsic in the tropics, which meant that mental breakdown was inevitable for Europeans. He believed that people in the tropics had 'nervous troubles' as elsewhere. The key, he argued, lay in the psychological examination of would-be tropical residents.

There was, therefore, a substantial amount of information on tropical neurasthenia, with contrasting viewpoints, in professional journals and the minutes of medical conferences, and so on. The diagnosis was also covered in newspapers. It was not the remit of this thesis to analyse the extent of the general public's knowledge of the condition but a random perusal of British newspapers revealed that neurasthenia appeared regularly in police and coroners' reports. Thus in 1927 the *Hull Daily Mail* reported the suicide in Karachi of Flight-Lieutenant Porter of the RAF. He had cut his throat after suffering from 'neurasthenia and melancholia for the past eight weeks.'⁵⁰⁷ The *Tamworth Herald* reported in 1935 the death of Mr John K Clegg who had shot himself in his car. He had been invalided out of the ICS in Ceylon having 'suffered from tropical neurasthenia brought on by malaria.'⁵⁰⁸ Coroners were often reported as giving the cause of suicide as neurasthenia and it

⁵⁰⁵ Megaw, 'Tropical,' p. 151.

⁵⁰⁶ Culpin, Millais (1933) 'An Examination of Tropical Neurasthenia,' *Proceedings of the Royal Society of Medicine*, Section of Tropical Diseases and Parasitology, vol. 26, no. 7, p. 917/53.

⁵⁰⁷ 'Air Officer's Suicide,' *Hull Daily Mail*, 20th May 1927, p. 11. *British Library Newspapers*, tinyurl.galegroup.com/tinyurl/5A8pz0. (Accessed 1st September 2017)

⁵⁰⁸ 'Man Shot Dead in His Car,' *Tamworth Herald*, 5th January 1935, p.9. *British Library Newspapers*, tinyurl.galegroup.com/tinyurl/5AgJ7. (Accessed 1st September 2017)

may be that the newspaper reading public were made aware of the condition, though from this negative perspective.

Whereas the tropical version of neurasthenia was debated at major international conferences by senior clinicians from many countries there was surprisingly little coverage of it in the classifications of mental diseases and in the text books written for India by experienced alienists for aspiring alienists and general practitioners. Overbeck-Wright covered it in a single paragraph in 1921 and remarked that a few months' rest, a change of climate with treatment would generally produce a perfect recovery with an infinitesimal danger of relapse.⁵⁰⁹ Jagoe Shaw gave a slightly longer coverage remarking on the similarities to the early symptoms of General Paralysis of the Insane but with the key difference being that the neurasthenic exhibited insight into his or her condition and would actively seek treatment.⁵¹⁰ It could be that neither thought the illness, in Acton's words, to be 'real ill health' for consideration by military medics. Lodge Patch in 1934 was equally reticent on the subject and he described the stresses of overwork and climate without reference to a diagnosis of neurasthenia. He had however embraced schizophrenia and one of his chapters was entitled 'Dementia Praecox or Schizophrenia.'⁵¹¹ His apparent lack of concern with neurasthenia may be an indication of Kennedy's view that the diagnosis was already faltering in the 1930s.⁵¹²

Crozier concluded that tropical neurasthenia became a useful tool in the management of empire as it became an 'entirely rational means of filtering, regulating, and managing the behaviour of British colonial personnel.'⁵¹³ It meant that colonial officials demonstrating difficult or bizarre behaviour could be categorised as ill and removed, as patients in need of rest and treatment. David Gilmour gave the example of one British district magistrate who shot and killed a village headman and was certified as insane and eventually transferred to Broadmoor Hospital in Britain. Such removals from public life in India were important in preventing further embarrassment to the imperial project. For Tom Lutz neurasthenia was a fashionable disease and being diagnosed as suffering from it

⁵⁰⁹ Overbeck-Wright, *Lunacy*, p. 201.

⁵¹⁰ Jagoe Shaw, *A Clinical Handbook*, p. 188.

⁵¹¹ Lodge Patch, *A Manual*, p. 92.

⁵¹² Kennedy, Dane 'Diagnosing the Colonial Dilemma: Tropical Neurasthenia and the Alienated Briton,' in Ghosh and Kennedy *Decentring Empire*, pp.180-181.

⁵¹³ Crozier, 'What was Tropical,' pp. 526-528.

was a 'badge of cultural advancement'⁵¹⁴ and so any shame felt by the displaced person could consequently be minimised.

In the opinion of the American historian Barbara Sicherman neurasthenia became a highly elusive, protean concept that might attack any organ or function.⁵¹⁵ It was an umbrella term, according to the Dutch historian Marijke Gijswijt-Hofstra, which had been originally an affliction of the elite and educated. After the First World War it became 'desocialised' or 'democratised' whilst the numbers suffering from it rose as a consequence of that conflict.⁵¹⁶ She interpreted it as a malady of over-excitement and its diagnosis therefore no longer regarded as implying a fundamental lack of willpower in its sufferer.⁵¹⁷ Its very vagueness could reduce the shame of too close an identification with mental illness.

Adding to the work of Gijswijt-Hofstra, Kennedy found that tropical neurasthenia accounted for a significant number of colonists being invalided home from Asia and Africa. He argued that it was best understood as a socially constructed disease. Doctors emphasised an interplay between the physiological and neurological effects of the tropical climate and the cultural and psychological impact of colonial life.⁵¹⁸ The life of the coloniser could thus be regarded as having to sustain at all times a permanent balance of these factors or risk a descent into tropical neurasthenia.

Kennedy maintained that tropical neurasthenia had three functions. Firstly, its diagnosis enhanced the psychiatric profession by fitting it into a medical dimension and so enabling doctors to claim an expertise and an authority. Medical practitioners could give their patients a scientifically determined label for a vague set of symptoms which, nevertheless, were very real for the sufferer. Secondly, the diagnosis stressed the racial dimension, reinforcing the differences between coloniser and colonised. Unless educated in the West and living a Western lifestyle Indians could not, by

⁵¹⁴ Lutz, Tom 'Neurasthenia and Fatigue Syndrome,' in Berrios, German and Porter, Roy (1995) (Eds) *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders*, Athlone Press, London p. 536.

⁵¹⁵ Sicherman, Barbara (1977) 'The Uses of a Diagnosis: Doctors, Patients and Neurasthenia,' *Journal of the History of Medicine and Allied Sciences*, vol. XXXII, no. 1, p. 33.

⁵¹⁶ Gijswijt-Hofstra, Marijke 'Introduction: Cultures of Neurasthenia from Beard to the First World War,' in Gijswijt-Hofstra, Marijke and Porter, Roy (Eds) (2001) *Cultures of Neurasthenia: From Beard to the First World War*, Rodolpi, Amsterdam, p. 22.

⁵¹⁷ Gijswijt-Hofstra p. 21.

⁵¹⁸ Kennedy, 'Diagnosing' p.157.

definition of Western doctors, be neurasthenic. Thirdly, the diagnosis gave the illness a social context identifying the sufferer as a member of the colonial regime rather, as proposed by a fellow American historian Warwick Anderson, than someone who had chosen to reject or had actually failed in their imperial role.⁵¹⁹ The creation of tropical neurasthenia sought to reassure British colonisers that any emotional unease they felt in the colonial environment was explicable in somatic terms.⁵²⁰ In spite of the wishes of the imperial establishment Kennedy identified that much of the medical literature concerning the disease could be read as the colonists' alienation from colonial life.⁵²¹ Their hardships were real enough for many and imbued the community with a sense of self-sacrifice in the name of duty as will be shown in Chapter 4.

Neurasthenia and its tropical variant as medical terms are rarely used today in Europe and North America. It was excluded from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) in 1980 and it is found in the World Health Organisation's International Classification of Diseases ICD-10 under 'F48: Other Neurotic Diseases.'⁵²² It was Kennedy's conclusion that the demise of tropical neurasthenia after the Second World War proved his point that it existed only as part of the colonial enterprise. It ceased to be valid when colonialism lost favour as a system of rule. One historian has suggested that neurasthenia may now have been reassigned in modern medicine to victims of chronic fatigue syndrome or ME.⁵²³

Colonial migration and mental asylums

Large scale white colonisation of India had been actively discouraged and prevented by the East India Company and from the mid nineteenth century onwards by the British Government.⁵²⁴ The key reasons for this were identified by Arnold⁵²⁵ and

⁵¹⁹ Kennedy, 'Diagnosing,' pp. 158-159.

⁵²⁰ Ghosh, Durba and Kennedy, Dane 'Introduction,' in Ghosh and Kennedy *Decentring* p. 13.

⁵²¹ See Kennedy, 'Diagnosing,' p. 158.

⁵²² See World Health Organization *International Classification of Diseases (ICD)* <http://apps.who.int/classifications/icd10/browse/2016/en#/F40-F48> (Accessed 30th December 2014)

⁵²³ Greenwood 'The strange history' p. 226. ME is formally known as myalgic encephalomyelitis.

⁵²⁴ See James, Lawrence (1997) *Raj: The Making and Unmaking of British India*, Little, Brown, London.

⁵²⁵ Arnold, 'European Orphans' pp. 104-127.

Ernst⁵²⁶ as mass migration would have opened the potential for an embarrassment to the British and a threat to their prestige from anti-social groups of Europeans such as vagrants, the destitute and the insane, who could bring the ruling race into contempt. The official response was to make them invisible through such measures as deportation or admission to a mental hospital: 'Out of sight ... out of mind,' as Ernst termed it.⁵²⁷ Whilst Kipling mooted the idea of British colonisation of Kashmir by whites and Eurasians⁵²⁸ there was no evidence to suggest that mass white settlement was seriously contemplated by the British government in the nineteenth and twentieth centuries.

In a recent study of mental hospitals in the British Caribbean Leonard Smith found no evidence that asylums were constructed in the empire as part of an imperial central plan but established instead that the decisions to build them were taken locally.⁵²⁹ Research by Angela McCarthy and Catherine Colborne on Australia and New Zealand has produced similar results.⁵³⁰ Scull believed that the reason for this was that colonial administrators were neither rich enough nor sufficiently well organised to initiate an imperial *Great Confinement* in the manner suggested by Foucault,⁵³¹ a finding endorsed by Ernst.⁵³²

Labrum has studied mental hospitals for Europeans in the British colonies of Australia, Canada and New Zealand which later became the white dominions. She found that there was segregation by gender with white males working on the hospital farm or in its gardens and white females restricted to 'ladylike' mainly indoor occupations such as sewing.⁵³³ McCarthy and Colborne used medical case notes from the nineteenth and twentieth centuries in the asylums set up by the colonial

⁵²⁶ Ernst, 'Out of sight and out of mind' pp. 245-267.

⁵²⁷ Ernst, 'Out of sight and out of mind', p. 251.

⁵²⁸ Gilmour, David (2002) *The Long Recessional: The Imperial Life of Rudyard Kipling*, John Murray, London, p. 74. Kipling made this the subject of two short stories in 1889. By *Eurasians* Kipling meant white people born in India, possibly of mixed racial heritage and working class, people who might become servants or soldiers.

⁵²⁹ Smith, *Insanity, Race and Colonialism*, p. 13.

⁵³⁰ McCarthy, Angela and Colborne, Catharine (2012) 'Introduction: Mental Health, Migration and Ethnicity,' in McCarthy, Angela and Colborne, Catharine (Eds) *Migration, Ethnicity and Mental Health: International Perspectives, 1840-2010*, Taylor and Francis (Routledge), Abingdon, Oxon, *passim*.

⁵³¹ Scull, Andrew (April 2008) book review of Mahon, Sloan and Vaughan, Megan (Eds) *Psychiatry and Empire* in *Social History of Medicine*, vol. 21, no. 1, pp. 411-413.

⁵³² Ernst, Waltraud (2009) 'Institutions, people and power: Lunatic Asylums in Bengal, c. 1800-1900,' in Pati, Biswamoy and Harrison, Mark (Eds) *The Social History of Health and Medicine in Colonial India*, Routledge, London, p. 136.

⁵³³ Labrum, 'Afterword: Madness is Migration, p. 194.

authorities in Australasia. Their implication that insanity follows inevitably with the physical displacement of the body to an unfamiliar and even hostile setting bears comparison with India. They pointed out that not all white migration from Europe led to madness and institutionalisation, and that admission to mental hospitals occurred generally after a reasonably lengthy period of settlement.⁵³⁴ This will be confirmed later as evidenced by an analysis of medical records at the EMH.

In her study of lunatic asylums in the nineteenth century Sally Swartz has identified themes common to similar institutions across the British Empire. She argued that particular asylums had their own strong identities determined by their colonial context. Thus local politics, culture and geography had a strong influence in shaping mental health services in each colony. Whilst there was a legislative framework for regulation the individual colony was mostly left to run the affairs of its mental health provision.⁵³⁵ In India medical superintendents of mental hospitals were key figures in delivering services and influencing Government of India policies as shown by Berkeley-Hill in the EMH, Jagoe Shaw in Lahore and Overbeck-Wright in Agra.

Conclusion

This chapter has shown how Western psychiatry in India developed between 1900 and 1947 and how it was implemented for its European residents. It considered the role of the IMS as a combined military and civil state psychiatric service responsible for delivering treatment to distressed *Imperial Minds*.

A new approach to the study of the subject has been added with the adaptation into three time periods of a model by Mills. The first was characterised by a gradual expansion of the discipline culminating in the Indian Lunacy Act of 1912 and a reaction to the mental stresses created by the First World War. The second period started in 1918 when the first mental hospital solely for Europeans was finally opened. There followed in the 1920s and 1930s an era of enthusiasm amongst individual alienists which saw practical innovation and experimentation as they expanded their scientific knowledge base. Psychiatry in India began to look beyond

⁵³⁴ McCarthy and Colborne, 'Introduction: Mental Health,' p. 3.

⁵³⁵ Swartz, Sally (2010) 'The Regulation of British Colonial Lunatic Asylums and the Origins of Colonial Psychiatry, 1860-1864,' *History of Psychology*, vol. 13, no. 2, pp. 160-162 and pp. 171-172. DOI: 10.1037/a0019223 (Accessed 23rd January 2015)

its British origins towards an internationalist agenda. The final phase was a response to the wartime emergency and the approaching end of British rule as imperial achievements in mental health were highly criticised by Mapother and the Bhole Report.

As an illustration of the progress of Western psychiatry in the colony the changing classification of mental diseases in the textbooks devised specifically for use in India was analysed across these three time periods. The use of such primary resources highlighted a move away from heredity to the recognition of physical and mental responses to stress as a major cause of psychiatric illness. The transition from the diagnosis of dementia praecox to one of schizophrenia was identified as a marker of this modernisation.

The phenomenon of neurasthenia transcended the three time periods and was significant in all and its importance to the development of Western psychiatry in India has been emphasised. The chapter showed how from the mid nineteenth century middle and upper class Americans and Europeans had adopted it to justify class, gender and racial differences. In the Indian context its tropical variant became a useful diagnosis with its legitimation of the mental stresses faced by distressed *Imperial Minds* engaged in the colonial project.

Having given the background to the practice of Western psychiatry in India this thesis will now turn to the mental challenges facing those charged with maintaining British rule in India.

CHAPTER 4

Climate, boredom and isolation: stress factors of daily living for the British in colonial India

[The British woman] is called upon, year after year to face that pitiless destroyer of youth and beauty – the Punjab hot weather.

Maud Diver (1909)⁵³⁶

The army wife was not expected to do anything or be anything except a decorative chattel or appendage of her husband. Nothing else was required of her whatever.”

Elizabeth Vere Birdwood, (1931)⁵³⁷

So the one solitary man lived the veritable life of a hermit, shut off from almost all communication with the outer world and the amenities which make life worth the living.

Indian Planter's Gazette (1915)⁵³⁸

Introduction

The purpose of this chapter is to develop the idea that the geographical and meteorological environments were significant sources of potential mental stress, and actual distress, to many Britons in colonial India. It will maintain that particular stress factors were detrimental to the efficiency of colonial rule. The epigraphs above each introduce one of the trinity of climate, boredom and physical and social isolation, which could produce mental distress amongst European residents enhancing the risk of mental illness. Their impact on distressed *Imperial Minds* will be analysed in turn.

In order to develop an understanding of the challenges faced by them evidence will be provided from the contemporaneous writings of novelists and diarists and the professional assessments of medical practitioners of the period, together with academic analysis. The chapter will explain why some *Imperial Minds* in India were unable to cope successfully with the mental stresses they encountered

⁵³⁶ Diver, Maud (1909) *The Englishwoman in India*, Blackwood, Edinburgh, p. 28.

⁵³⁷ Cited in Allen, Charles (1985) *Plain Tales from the Raj*, Century Publishing, London, p. 153.

⁵³⁸ Editorial *Indian Planters' Gazette*, 9th September 1915.

when administering, defending or just living in the country whilst serving the interests of the Raj.

A definition of stress

A knowledge of stress is a key component in the understanding of a variety of disciplines such as psychology, physiology, ecology and engineering. Before considering the impact of stress on the British in colonial India it is important to understand what is meant precisely by the concept in this thesis.

The prominent figure in scientific research into the causes of stress, and its impact on humans and animals, for 40 years from the 1930s onwards was Hans Selye, a Canadian-Hungarian endocrinologist.⁵³⁹ In 1936 Selye proposed that stress represented the generalised response of an organism to environmental demands. He argued that not all stress was harmful and at a moderate level it had a protective and adaptive function.⁵⁴⁰ However more intense stress could generate pathological changes and even lead to death. Selye termed the actual environmental factor which produced stress as a *stressor*. He mischievously gave a populist description to illustrate the confusion, ambiguity and flexibility in the use of the word *stress*. 'Everybody knows what stress is and nobody knows what stress is,' he said identifying the growing popular awareness and use of the word.⁵⁴¹

There has been much criticism of Selye's model both for its description of stressors as abstract entities divorced from their social and political context, and from a particular time and place, and because of its emphasis on the physiological i.e. biological causes of stress.⁵⁴² The sociologist Cecil Helman summarised this censure and noted that stress could arise from positive experiences which were specifically life changing such as promotion or the birth of a child. In 1971 the World Health Organisation declared that stress and the diseases resulting from it

⁵³⁹ Selye was nominated 17 times for a Nobel Prize but was unsuccessful on every occasion. See <http://www.nobelprize.org/nomination/archive/show.php?id=10093> (Accessed 2nd February 2017). Selye's nominations were in the 'Physiology or Medicine' category.

⁵⁴⁰ Helman Cecil G. (1990) *Culture, Health and Illness, An Introduction for Health Professionals*, Butterworth-Heinemann, Oxford, p. 249.

⁵⁴¹ Cited in Jackson, *The Age of Stress* p. 268.

⁵⁴² See for example, Jackson, *The Age of Stress* pp. 146-157.

represented 'an unsuccessful attempt on the part of the body to deal with adverse factors in the environment.'⁵⁴³

In their recent psychiatric textbook designed for medical students, John Geddes, Jonathan Price and Rebecca McKnight defined stress, in biological terms, as 'a force from the outside world acting upon an individual,'⁵⁴⁴ which can lead to psychological disturbance, and stated that it was a phenomenon that everyone today will have experienced. This force or perceived threat, known as a *stressor*, produces a reaction to that stress which is a normal physiological event. However if the reaction is prolonged, too intense or atypical the stress can become abnormal and problematic for sufferers.⁵⁴⁵ Whether stimulating or traumatic it tends towards physical and mental instability. It is this effect of psychological tension which will be used as an explanation of stress as portrayed in this thesis.

An historical study of stress has been made by Mark Jackson, a British-based historian of medicine.⁵⁴⁶ The strength of his arguments was compounded by his interdisciplinary approach and his skill in linking together history, sociology and various branches of science in a coherent explanation. Providing evidence from archaeological research Jackson showed that it was not only a modern phenomenon. Thus the presence of 'transverse Harris lines' on the long bones of children whose bodies were excavated in ancient and mediaeval graves indicated the impact of environmental and nutritional instability. Scientific research revealed that they had suffered stress from trauma and anxiety in their young lives.⁵⁴⁷ Jackson developed the argument that stress on individuals in America and Europe was intensified in the late nineteenth and early twentieth centuries because of a growing sense of personal and social mobility. This became more evident as the rate of sociocultural, technological and political change appeared to accelerate.⁵⁴⁸ Such psychosocial illnesses as neurasthenia, work-related fatigue and the shell shock of the First World War, with the clinical attempts to explain and combat them, alerted the general public to such diseases of 'modern civilisation.'

⁵⁴³ WHO cited in Helman, *Culture*, p. 250.

⁵⁴⁴ Geddes, John, Price, Jonathan and McKnight, Rebecca (2012) *Psychiatry*, Oxford University Press, Oxford, 4th edition, p. 263.

⁵⁴⁵ See Geddes et al, Chapter 23: 'Reactions to stressful experiences,' in *Psychiatry*, pp. 263-283.

⁵⁴⁶ Jackson, *The Age of Stress*.

⁵⁴⁷ Jackson, *The Age of Stress*, p. 266.

⁵⁴⁸ Jackson, *The Age of Stress*, p. 266.

A fictional account of the dangers inherent in a modern civilisation came in 1909 from the novelist E. M. Forster in his short story, *The Machine Stops*.⁵⁴⁹ He wrote about a dystopia set in a future where all human needs are provided and controlled by the omniscient and omnipotent *Machine*. Forster portrayed an anonymous world where, because of some unspecified environmental catastrophe, people lived underground as isolated individuals sheltered from all discomfort and decision making but were then confronted with the consequences of what he termed the 'accelerated age'.⁵⁵⁰ It was a world in which 'Humanity, in its desire for comfort had over-reached itself' and had been 'strangled in the garments that [Man] had woven'.⁵⁵¹ As it became clear that the *Machine* was dying those who were aware of this previously inconceivable possibility began to confront a terrifying stressor. There were some aspects of this 'accelerated age' in India where the needs of the British upper and middle classes were met by Indian servants, protecting them from menial tasks and from contact with the wider population. The British represented the rapid changes in the West even if, as will be shown, their society in the East was essentially conservative. Power and privilege could not, of course, fully protect pampered imperialists from the weather, particularly in the days before widespread air-conditioning.

Psychiatrists in British India did not have access to modern research on such topics as depression, alcoholism or Post-Traumatic Stress Disorder. They did, however, recognise some of the predisposing, precipitating and perpetuating causes of stress associated with the harsh climate, personal boredom or geographical isolation encountered by some of the European population and offered advice and treatment. Having built an understanding of what stress is the chapter will now consider its link with the climate, the first of the trinity, in an Indian setting.

The impact of climate on mental stress

The European preoccupation with climate was deeply rooted and numerous academic studies have confirmed that it was a permanent source of concern in their

⁵⁴⁹ Forster E.M. (1987) 'The Machine Stops' in *Collected Short Stories*, Penguin, Harmondsworth, Middlesex, pp. 109-146.

⁵⁵⁰ Forster, 'The Machine Stops', p. 137.

⁵⁵¹ Forster, 'The Machine Stops,' pp. 138 and 145.

lives in India in the eighteenth and nineteenth centuries.⁵⁵² The climate in much of the Indian sub-continent was perceived by many Europeans in colonial India to be alien and hostile and associated with diseases which were often life threatening. Examples are given below of the traumatic impact felt by some Britons living in India.

From the beginning of the East India Company's involvement in India in 1600 this threat of ill health and the consequent mortality rates became an obsession for the British in India. In his survey of British cemeteries in colonial India Theon Wilkinson highlighted the fragility of the lives of new arrivals there.⁵⁵³ Numerous letters and diaries exist recording the misery and rapidity of the decline and death of Europeans confronted by the harsh environment. One such account came from the Reverend James Covington who travelled from England to Bombay in July 1690. He wrote that of the 24 who arrived with him 20 had died by the time the monsoon rains had ended the following month.⁵⁵⁴ In 1692 Calcutta had a European population of around 800 but 100 of them died that year from the various fevers.⁵⁵⁵ Covington noted pessimistically that many Europeans did not survive two years in India and that the 'common Fatality [from fever] created a Proverb among the English there that *Two Monsoons are the age of man*.'⁵⁵⁶ A century later in Calcutta out of a total European population of 1200 over one third died in one year in the months between August and the end of December.⁵⁵⁷ In comparatively healthier places such as Madras of 30 army ensigns arriving there from England in 1775 only 16 were alive in 1780. Five years was regarded as the acclimatisation period necessary for the European to become "salted" or seasoned i.e. to have a good chance of survival.⁵⁵⁸

The fear and the shock of a sudden death were summed up by Sophia Goldborne, a resident of Calcutta, in 1785:

⁵⁵² See for example Harrison, Mark (1994) *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, Cambridge University Press, Cambridge; Kennedy, Dane 'Perils of the Midday Sun: Climatic Anxieties in the Colonial Tropics,' in Mackenzie, John M, (1990) (Ed) *Imperialism in the Natural World*, Manchester University Press, Manchester, pp. 118-140; and Chakrabarti, Pratik (2014) *Medicine and Empire, 1600-1860*, Palgrave MacMillan, Basingstoke.

⁵⁵³ Wilkinson, Theon (1976) *Two Monsoons*, Duckworth, London,

⁵⁵⁴ Wilkinson, *Two Monsoons*, p. 1.

⁵⁵⁵ Wilkinson, *Two Monsoons*, p. 1.

⁵⁵⁶ The Reverend James Covington (1690) quoted in Wilkinson, *Two Monsoons*, unnumbered page in preface. (Emphasis in the original.)

⁵⁵⁷ Wilkinson, *Two Monsoons*, p. 2.

⁵⁵⁸ Wilkinson, *Two Monsoons*, p. 6.

*Funerals are indeed solemn and affecting things in Calcutta ... for as it often happens in the gay circles, that a friend is dined with one day and the next day is in eternity – the feelings are [intensified], the sensations awful, and the mental question, for the period of interment at least, which will be tomorrow's victim?*⁵⁵⁹

Such heartfelt observations from another century showed that the British in India had never been far from illness and death and became deeply rooted in the psyche of the colonists. The presence of numerous cemeteries across the sub-continent served as a permanent reminder of their mortality as British rule persisted.⁵⁶⁰

In her research Waltraud Ernst has identified how the East India Company was aware of the impact of climate on the mental health of its employees from the early eighteenth century. She quotes from the records of the Medical Board of Madras in its correspondence with the government of that Presidency in 1818. The Board commented that:

*In England and other cold countries, attacks of Insanity, generally arise from sudden reverses of fortune, keen disappointments, and other causes of deep mental depression, but in this country it is otherwise, here the attack may at almost every instance be traced to exposure to the sun; hard living and other irregularities, by exciting the action of the heart and blood vessels, and producing unusual determination to the head.*⁵⁶¹

Doctors in Madras were concerned that the 'deleterious operation of the climate' was observed in the progress of mental illness.⁵⁶² Ernst has wryly observed how the Company elegantly solved the difficulties presented by European lunatics in India

⁵⁵⁹ Dutta, Krishna (2015) *Calcutta: A Cultural and Literary History*, Supernova. New Delhi, p. 76.

⁵⁶⁰ The Christian cemeteries and memorials in India are being meticulously recorded by the British Association for Cemeteries in South Asia (BACSA).

⁵⁶¹ Cited in Ernst, Waltraud 'Colonial Lunacy policies and the Madras Lunatic Asylum in the Early Nineteenth Century,' in Pati, Biswamoy and Harrison, Mark (Eds) *Health, Medicine and Empire: Perspectives on Colonial India*, Orient Longman, New Delhi, 2006, p. 148.

⁵⁶² Ernst "Colonial Lunacy," p. 148.

from 1817 with its policy of repatriation by transferring the problem to Britain to their own asylum, Pembroke House, Hackney in London.⁵⁶³

The records of the public asylums in India had long given evidence that doctors associated the climate with pre-empting mental illness amongst whites. It could even be responsible for their illness. Thus, for example, in the causes of insanity section of the records of European patients admitted to the Bengal Asylum in 1867 two were specified as suffering from sunstroke: one from exposure to the sun, another from 'climatic disease.'⁵⁶⁴

In her work on the history of the British in India Elizabeth Collingham explained how the European experience of India was 'intensely physical.'⁵⁶⁵ She demonstrated how the British body was central to the colonial experience and the clothes worn by the imperial rulers became a trope for the Raj.⁵⁶⁶ The 350 year period of British involvement in India was always an intensely physical one. The long sea journey could take up to three months before the opening of the Suez Canal in 1869 and four to six weeks afterwards. Seasickness was frequent and passengers had an introduction to the relentless heat. On disembarkation in India the smells, heat and poor hygiene there presented a genuine challenge to their *Imperial Bodies*.⁵⁶⁷ With exposure to insect bites and physical diseases such as malaria and cholera the challenge could prove to be a fatal one. Whilst accepting Collingham's findings it will be argued that the British experience of India was also an intensely mental one, as the newly arrived *Imperial Minds* were faced with the challenges of races and religions, cultures and environments unlike anything they would have experienced at home. For some the failure to cope would ultimately result in mental breakdown.

The medical orthodoxy throughout the nineteenth century, observed Collingham, was that the heat of the Indian climate over-stimulated the organs of the

⁵⁶³ Ernst "Colonial Lunacy," p. 151.

⁵⁶⁴ IOR/V/24/1724-27, European Lunatic Asylum Report for the Year 1867, Calcutta, 1868. For a consideration of this issue in the mid nineteenth century see Goodman, Sam "A Great Beneficial Disease": Colonial Medicine and Imperial Authority in J.G. Farrell's *The Siege of Krishnapur* (2015) *Journal of Medical Humanities*, no. 36, pp. 141-156.

⁵⁶⁵ Collingham, *Imperial Bodies*, p. 1.

⁵⁶⁶ This topic is explored in depth in Johnson, Ryan (Fall 2009)'European Cloth and "Tropical" Skin: Clothing Material and British Ideas of Health and Hygiene in Tropical Climates,' *Bulletin of the History of Medicine*, vol.83, no.3, pp. 530-560. DOI: 10.1353/bhm.0.0252 (Accessed 3rd January 2016).

⁵⁶⁷ Collingham, *Imperial Bodies*, p. 1.

body leading to sluggishness and congestion.⁵⁶⁸ She found that the accepted view was that different climates were regarded as producing different constitutions in people. She maintained, therefore, that climate consequently became a significant explanatory tool in the European encounter with the Orient.⁵⁶⁹ Thus the superiority of the white colonist races could be explained and justified in terms of climate. Many Europeans believed that their temperate climate produced a strong, independent type of person, full of manly vigour considered ideal qualities for those who had important positions in a tropical empire. In contrast, though, for Bengalis their climate bred, allegedly, sloth in mind and body as the fertility of the soil made life much easier than in cooler countries.⁵⁷⁰

The fundamental importance of the weather to Europeans had been recognised in guides for those visiting India. In 1836 the London-based publishing house, John Murray, produced their compendium for British travellers touring the Indian sub-continent and they gradually developed a reputation for reliable description and sound recommendation.⁵⁷¹ They went on to publish guides covering most of the world and their first edition solely for India was issued in 1859. In time the British had compartmentalised the climate into precise seasons. Thus Murray's authoritative manual for India in 1904 declared peremptorily that there were three seasons of weather in India: the *cold weather* lasted from 15th October to 15th March; the *hot weather* from 15th March to 15th June; and *the rains* from 15th June to 15th October.⁵⁷² The seasons featured strongly in the novels and memoirs associated with British India, with the *cold weather* being regarded as a delightful respite from the intensity of meteorological excesses.

To illustrate the intensity of the *hot weather* Margaret MacMillan in her study of imperial women quoted from the diaries published in 1884 of Mrs E. A. King, the wife of an Indian civil servant in Allahabad in northern India. Mrs King deliberately placed her thermometer in the full sun one day in June in the early 1880s and it read

⁵⁶⁸ Collingham, *Imperial Bodies*, p. 2.

⁵⁶⁹ Collingham, *Imperial Bodies*, p. 25.

⁵⁷⁰ Collingham, *Imperial Bodies*, p. 25. This theme has been further developed by Sinha, Mrinalini (1995) *Colonial Masculinity: The 'manly Englishman' and the effeminate Bengali' in the late nineteenth century*, Manchester University Press, Manchester.

⁵⁷¹ See The John Murray Archive at the National Library of Scotland <http://digital.nls.uk/jma/index.html> Accessed 17th December 2015.

⁵⁷² *The Imperial Guide to India*, John Murray, London, 1904, p. 2.

169°F (76°C).⁵⁷³ Perhaps unsurprisingly Mrs King recorded that '[M]y head often feels as if it were fried,' her version of Charles's *Punjab Head*. Temperatures varied and were cooler in the mountainous areas of the Himalayas but in large parts of India the daytime temperatures could reach 80°F (27°C) during the *cold weather* which could falsely lead newcomers to believe that this was the start of the *hot weather*. In the actual *hot weather* temperatures in the regions around Karachi and in Bengal were often around 90° to 100°F (32° - 38°C) but the humidity could be 100%.⁵⁷⁴ Across the Plains of central India and in the North West the heat was drier but temperatures could often reach 110°F (43 °C) and above. Government officials and their families, and the more prosperous Europeans could relocate for several months to hill stations in order to avoid the *hot weather* in the plains. Those who remained because their duties or lack of income made such an escape impossible faced the full force of the unrelenting heat.

The dangers in a young wife's new life when she came to India for the first time to be with her husband were explained with blunt clarity by Maud Diver.⁵⁷⁵ Diver was a British-Indian novelist and author of a guide intended for the newly married Englishwoman.⁵⁷⁶ If she escaped the heat and spent her summers in the temperate hill stations she ran the risks of temptation by engaging in amateur theatricals or from the charming military man on leave, as depicted in the short stories of Kipling.⁵⁷⁷ If she chose to spend the summers with her husband on the plains she was 'called upon year after year, to face that pitiless destroyer of youth and beauty – the Punjab hot weather.'⁵⁷⁸ She will then encounter inevitably

*her monotonous round of life from May to October – five red hot interminable months including the merciless furnace of June and July.*⁵⁷⁹

⁵⁷³ MacMillan, *Women of the Raj*, p91.

⁵⁷⁴ Information on temperatures in this paragraph was taken from MacMillan, *Women of the Raj*, pp. 90 – 91.

⁵⁷⁵ Maud Diver (1867-1945) was born in India, the daughter of an Indian army officer. She spent her early childhood in India, was educated in England but returned to the sub-continent and married an Indian Army officer herself.

⁵⁷⁶ Diver, Maud (1909) *The Englishwoman in India*, Blackwood, Edinburgh.

⁵⁷⁷ Diver, *The Englishwoman*, p.21. Kipling's Mrs Hawksbee was the scandalous fictional female personification of this risqué lifestyle.

⁵⁷⁸ Diver, *The Englishwoman*, p. 28.

⁵⁷⁹ Diver, *The Englishwoman*, p. 30.

To this menace Diver, giving the benefit of her personal experience, alerted her readership to the stressful impact on female *Imperial Minds* of the lifestyle of a young Englishwoman coming to India for the first time. She wrote that

[I]t is a known fact that the Indian climate, the artificial life its hot season entails, the long railway journeys, and the continuous shifting from place to place, from which few Anglo-Indians⁵⁸⁰ are exempt, tends to promote an astonishingly rapid waste of nerve tissue; and it is this fact which renders long residence in India more injurious, as a rule, to women than to men. It is this same waste of nerve force which lies at the root of much of the restlessness and irritability, in certain temperaments, and, in others, that curious slackness – mental and moral – of which the Anglo-Indian woman stands accused.⁵⁸¹

Diver had clearly recognised that stress, this ‘waste of nerve force,’ was linked to the climate and was associated with a risk of mental debilitation.

Practical health advice for young British women was given by Kate Platt, one of the first female British doctors in India, who had been the Principal of the Lady Hardinge Medical College and Hospital for Women in Delhi. In 1923 she produced her guide and like Diver she warned the young white female traveller of the perils of the climate despite modern inventions designed to moderate its effect.

Those who have had no experience of tropical heat find it difficult to realise the discomforts of a hot weather in the plains. The long days, passed in the semi-obscurity of the bungalow, doors and windows closed, with perspiration streaming down the face and body. The wakeful, airless nights, with vain attempts to find a cool spot on which to lay the head, render life almost unendurable even with the alleviations of electric fans and ice.⁵⁸²

⁵⁸⁰ In this context *Anglo-Indian* refers to those of direct British ethnic origin who lived and worked in India and retained strong family connections with the home country.

⁵⁸¹ Diver, *The Englishwoman*, p. 8.

⁵⁸² Platt, Kate *The Home and Health in India and the Tropical Colonies*, Baillière, Tindall and Cox, London, 1923, p. 4.

She was concerned that the unprepared young woman fresh from Britain would fail to cope with the shock of the tropical climate and risked mental distress.

European doctors recognised the dangers to white bodies and minds. In his first Indian psychiatric textbook Alexander Overbeck-Wright, medical superintendent of the Agra Asylum wrote that sunstroke, of which *heat apoplexy* was considered a form, was the most common reason given by relatives to the doctor for an attack of insanity.⁵⁸³ He warned his readership that sunstroke was rarely a cause of insanity on its own as in the majority of cases alcohol abuse played a large part in the onset of the mental illness. Where the latter occurred the condition was properly known as *sun traumatism*⁵⁸⁴ and the sufferer might show symptoms such as high fever, vomiting, headaches and delirium, and an intolerance of light, sound and movement. A lengthy period of debility could occur with long term effects such as memory loss, deafness, tremor, amblyopia, epilepsy and insanity.⁵⁸⁵

The climate as a direct cause of admission to mental hospitals was recognised by Overbeck-Wright in a survey he carried out into the admissions to the Agra Asylum of both British and Indian patients between 1908 and 1913. He identified a large rise in the number of patients each year from a minimum in January to a maximum in July and falling to a minimum in December. In his view this could only be explained by the effects of the hot weather and the corresponding fall in admissions due to the relief brought on by the rains. He noted that the *hot weather* in 1913 was unusual in being extremely mild and, because of this, the admissions dropped. Overbeck-Wright maintained that physical factors such as the climate played a 'tremendous part in the aetiology of mental derangements,' and one which he believed was often understated by his medical colleagues.⁵⁸⁶ His detailed scientific research reinforced both the medical and the widely held popular belief by the British in India that its climate was a major contributor to mental distress and admission to hospital.

⁵⁸³ Overbeck-Wright, *Mental Derangements in India* p. 292.

⁵⁸⁴ Sun traumatism was first described in the late nineteenth century by Sir Patrick Manson, a Scots pioneer of tropical medicine.

⁵⁸⁵ Overbeck-Wright, *Mental Derangements*, p. 293. Amblyopia is an impairment of vision in one eye that does not have a physical cause.

⁵⁸⁶ Overbeck-Wright, *Lunacy in India*, p. 6.

In his fiction and journalism Kipling had written prolifically about all classes of the European community in India and especially of the common soldier for whom he had much respect. In a letter from Lahore to his aunt in June 1886 Kipling related how three soldiers had died the previous night from heat apoplexy and that there had been a funeral nearly every day for a fortnight. He found that at midnight it was 97°F (36C) in the guardroom verandah and the soldiers slept upright for fear of contracting heat apoplexy which they regarded as a potentially fatal condition.⁵⁸⁷ Kipling, however, was delighted that his own bedroom never reached more than 86°F (30C) as six men, *punkah wallahs*,⁵⁸⁸ were working the fans in relays to keep it relatively cool for him.⁵⁸⁹ Although they would not have known the term British soldiers were aware that they were never far from the stressor of climatic intensity.

There were numerous diaries and letters published by middle class Britons concerning their Indian experiences but there are few extant written by private soldiers. This paucity of sources can be seen in the bibliographies of military historians such as T. A. Heathcote⁵⁹⁰ and Philip Mason.⁵⁹¹ One such memoir, however, by Private Frank Richards, of the Royal Welch Fusiliers, gives rare insight into the lives of British Other Ranks.⁵⁹² He joined up in 1901 aged seventeen and a half and served in the Boer War before seeing continuous service in India and Burma between 1902 and 1909. In terms of the climate Richards echoed Kipling's observations of 20 years earlier. He spent the summer of 1906 with his regiment in Agra in the plains of India. He recorded that temperatures in May and June of that year averaged between 116F (47C) and 120F (49C), and occasionally reached 125F (52C). At midnight the temperature was sometimes 107F (42C). He related how the *punkahs* over soldier's beds were used 24 hours a day in an attempt to seek some respite from the torrid heat.⁵⁹³

⁵⁸⁷ Cited in Carrington, Charles *Rudyard Kipling: His Life and Work*, Macmillan, London, 1955, p. 75.

⁵⁸⁸ Yule and Burnell, *The Concise Hobson-Jobson*, p. 356. Originally a large leaf of the Palmyra family used as a portable fan. Later it became a large fixed and swinging fan to agitate the hot air. The *wallah* was a person of low status who operated the *punkah*.

⁵⁸⁹ Cited in Carrington, Charles, *Rudyard Kipling: His Life and Work*, Macmillan, London, 1955, p. 75.

⁵⁹⁰ Heathcote, T. A. (2013) *The Military in British India: the Development of British Land Forces in South Asia, 1600-1947*, The Praetorian Press, Barnsley.

⁵⁹¹ Mason, Philip (1974) *A Matter of Honour: An account of the Indian Army, its officers and men*, Jonathan Cape, London.

⁵⁹² Richards, Private Frank (2003) *Old Soldier Sahib*, Naval and Military Press, Uckfield, Sussex, a reprint of the original 1936 edition.

⁵⁹³ Richards, *Old Soldier Sahib*, p. 221.

Like his fellow soldiers Richards had a fear of heat apoplexy having suffered himself, becoming dangerously ill with a body temperature of 106.8F (42C). He described the fate of one soldier who only reluctantly agreed to go into hospital after a night when he had been unable to sweat, which Richards indicated was the first symptom of heat apoplexy. His comrade's body temperature reached 110F (43.C) and he then died in less than an hour despite being rubbed all over with ice.⁵⁹⁴ In that summer of 1906 Richards records that his battalion lost 50 to 60 men through heat apoplexy within one month.⁵⁹⁵

The experiences of British soldiers written in their personal memoirs often gave much insight into the relentless physical and mental threats facing them even before they reached a battlefield. Baden-Powell, who later reached the rank of lieutenant-general, and had served in India from 1876 to 1884, was aware of the impact of the climate on his soldiers. In his memoirs of service there he wrote of the threat of sudden disease, death and rapid burial and that '[M]en half-mad with heat are apt to shoot themselves.'⁵⁹⁶

A generation later than Baden-Powell, Reginald Savory, a British officer who served in a Sikh regiment for over thirty years including in both world wars, recalled that:

*[I]n mid-April something happens. The wind drops, the sun gets sharper, the shadows go black and you know you're in for five months of utter physical discomfort. Mentally you have to battle against this heat. Physically you try and shut it out. Heat, light, headaches – right up to September. You think it's never going to finish.*⁵⁹⁷

From much experience Savory believed that for some Europeans physical and mental suffering was inevitable and some would cope better with it than others. Gradually modern technology began to bring some respite to the sufferers from intense heat. From the 1920s the availability of electric fans slowly replaced the

⁵⁹⁴ Richards, *Old Soldier Sahib*, p. 225.

⁵⁹⁵ Richards, *Old Soldier Sahib*, p. 86.

⁵⁹⁶ Baden-Powell, Robert (1915) *Indian Memories: Reflections of Soldiering, Sport etc.*, Herbert Jenkins, London, p.90.

⁵⁹⁷ Allen, *Plain Tales*, p.118.

manually operated *punkahs* and brought some relief to those who could afford them.⁵⁹⁸ The writer and senior member of the Indian Civil Service (ICS) Penderel Moon wrote that before air conditioning the hot weather had to be suffered like a 'toothache.'⁵⁹⁹ Describing a journey to the North West Frontier in 1941 Fraser Noble, another member of the ICS, recalled that:

*At Lahore... I breakfasted well and four rupees bought myself a place in an air-conditioned compartment on the Frontier Mail. I was thankful for this, for up to Rawalpindi, whenever the door was opened, a blast of hot air from the furnace of the Punjab rushed in on us, and the external door handles scorched our hands.*⁶⁰⁰

Despite the relief it provided it seemed that modern technology could not always compensate for the weather.

The attitude of the British to life in India prior to 1800 had been guided by their belief in monogenism i.e. that Man was the same all over the world having originated from the same source. In his study of how the Indian climate impacted on the British bodily constitution Mark Harrison pointed out that some medical practitioners in the eighteenth century believed that Europeans in India would in time adapt physiologically to their new environment. Some doctors predicted that whites would gradually develop blacker skin over the generations and take on the characteristics of the indigenous population.⁶⁰¹

By the nineteenth century the Indian environment, observed Ernst, was generally regarded as having a pathological effect on Europeans living there.⁶⁰² She identified a 'solar myth' that had developed amongst the British in India as they came to believe that the excessive heat could be the direct cause of a wide variety of

⁵⁹⁸ Jones, Robin D. (2007) *Interiors of Empire: Objects, Space and Identity within the Indian Sub-continent c. 1800-1947*, Manchester University Press, Manchester, p. 52. Jones commented that the earliest models of fans resembled the propellers of First World War fighter biplanes.

⁵⁹⁹ Allen, Charles (1985) *Plain Tales from the Raj*, Central Publishing, London, , p. 118

⁶⁰⁰ Noble, Fraser (1997) *Something in India: A memoir of service in the Frontier Province*, Pentland Press, Bishop Auckland, Co. Durham, , p. 35.

⁶⁰¹ Harrison, Mark (1999) *Climates and Constitutions: Health, Race and Environment and British Imperialism in India, 1600-1850*, Oxford University Press, New Delhi, pp.11, 219.

⁶⁰² See Ernst, Waltraud (1994) 'Out of sight, and out of mind: insanity in early nineteenth century British India,' pp. 245-267 in Melling, Joseph and Forsythe, Bill (Eds), *Insanity, Institutions and Society, 1800-1914: a social history of madness in comparative perspective*, Routledge, London.

illnesses such as prickly heat,⁶⁰³ heatstroke and depression. In addition, unacceptable or unusual actions such as adultery and manslaughter and the insubordination of soldiers could be attributed to it. My research confirmed that the contemporary writings of Britain in India supported Ernst's findings outlined in Chapter 2 that for Europeans the Indian climate had become a trope for physical and mental illnesses as well as for the anti-social and immoral behaviour associated with it. Indeed her 'solar myth,' which had originally related to her studies of early nineteenth century India, had become in everyday life in the Raj a factor of belief with regards to the 'rapid waste of nerve tissue,' the 'heat apoplexy' or the risk of becoming 'half-mad' with the heat.' Writers and their European colonial readership recognised that the hostile climate could lead to mental distress, one of the fundamental arguments of this thesis.

In 1931 the tropical medicine professor Balfour introduced a concept which he called *racial acclimatisation*.⁶⁰⁴ He identified two contrasting arguments held by contemporaneous doctors of tropical medicine on this topic. On the one hand there was the view that, provided insanitary conditions were removed, then a white man could live and work in the tropics and produce healthy and virile children. Evidence to support this came from the successful establishment of a white community in Queensland, Australia. In contrast the predominant and contradictory view was that the white man could never labour out of doors in the tropics and if he tried to he and his offspring would inevitably degenerate. Balfour pointed out that the latter viewpoint was essentially an assumption with no clear evidence to support it.

In his study of 'white subalternity' in colonial India Harald Fischer-Tiné has argued that in official medical discourse India and its people became pathogenic factors which gave rise to insanity and crime.⁶⁰⁵ However he contended that the widespread belief that India's harsh climate was inimical to the white body played only a small role in the reluctance of the British authorities to allow large scale emigration to India. As early as 1792 Charles Grant, who had served the East India Company in India and eventually became its chairman, warned the Company that large numbers of poor white settlers in India would worsen relations with the natives.

⁶⁰³ Defined in Yule and Burnell, *The Concise Hobson-Jobson* as 'A troublesome cutaneous rash in the form of small red pimples, which itch intolerably,' p. 256.

⁶⁰⁴ Balfour, 'Personal Hygiene,' p. 5.

⁶⁰⁵ Fischer-Tiné, *Low and Licentious*. p. 258.

In addition it would be detrimental to the esteem of the 'ruling race.'⁶⁰⁶ It can be argued that Grant's exhortation dominated British policy on settlement in India for the next 150 years. Fischer-Tiné maintained that throughout their connection with India the British ruling elite in India feared the growth of a *lumpenproletariat* and its threat to white racial superiority.⁶⁰⁷ In his view class and race were more important factors than weather when mass migration was being considered by the British and Indian governments.

Having discussed the impact of the hostile climate on the mental health of some Britons consideration will now be given to another major risk factor which contributed to the distress of some *Imperial Minds*: the boredom of life in India.

The impact of boredom on mental stress

*For heaven's sake let us be common-sensible and tell the truth. The majority of European women in India have nothing to do. Housekeeping is proverbially easy, there is seldom any urgent need for economy...*⁶⁰⁸

These words came from the autobiography of Flora Annie Steel, who spent 20 years in India as the wife of a civil servant covering an area of the Punjab over half the size of Yorkshire which contained only a handful of Europeans.⁶⁰⁹ Because of the cultural and physical isolation there was always a danger of 'nothing to do.' She observed that the European woman had 'few companions of her own sex, no shop-windows to look at, no new books to read, no theatres, no cinemas; above all, in many cases , an empty nursery.'⁶¹⁰ Children were often absent from middle class British families having been sent home around the age of seven.⁶¹¹ This was in keeping with the then accepted medical advice that white children in the tropics risked ill health and actual degeneration if subjected to the effects of the climate throughout their childhood. In addition there was the fear that white children might be influenced

⁶⁰⁶ Fischer-Tiné, *Low and Licentious*, p. 46.

⁶⁰⁷ Fischer-Tiné, *Low and Licentious*, p. 53.

⁶⁰⁸ Steele, Flora Annie (1929) *The Garden of Fidelity: Being the Autobiography of Flora Annie Steele*, Macmillan, London, p. 122.

⁶⁰⁹ Steele, *The Garden*, *passim*.

⁶¹⁰ Steel, *The Garden*, p. 123.

⁶¹¹ The reasons for their removal is discussed in detail in Brendon, Vyvyan (2005) *Children of the Raj* Weidenfeld and Nicolson, London,

negatively by Indian children who were more considered more sexually advanced and who might pass on to them a shameful and socially embarrassing *chi-chi* accent.⁶¹²

Steel had prodigious energy and countered the isolation of the remote posting with her husband by providing services to Indians. Despite having no medical training she set up a clinic and treated her patients with Western medicines and herbal remedies she had learnt in Scotland. Like Diver she used her experience to co-author a guide to British housewives in India⁶¹³ which included detailed recipes, treatments for common ailments and advice for managing servants. It was important that the imperial housewife occupied herself in running the home as the Raj itself should be run and, although housekeeping may have been 'proverbially easy' she pronounced, 'an Indian household can no more be governed peacefully, without dignity and prestige, than an Indian empire.'⁶¹⁴ Linking the governance of India to the responsibilities of everyday life may well have seemed a stressful responsibility to the young wife faced with ruling her small corner of the Raj.

In her work on the madness of European women in the late nineteenth century Indrani Sen has written of the stress factors inherent in their gender role within the Raj. She argued that these stresses were linked to women's social context and came through marriage, housework, family responsibilities and their gender's subordinate social status. Women suffered particularly, she asserted, through the dominant policy from the mid nineteenth century onwards of the importance of developing and maintaining an imperial aloofness from Indians. In practice such a policy remained in place in many parts of India until the 1930s. This meant, said Sen that the middle class European woman 'was allotted a circumscribed existence that kept her alienated from the surrounding culture.'⁶¹⁵ For political, racial and moral reasons she was expected to distance herself from contact with Indians, with the exception of her servants.

⁶¹² See Brendon, *Children*, p. 136. *Chi chi* was a highly offensive term of racial abuse used by whites about Anglo-Indians during the Raj.

⁶¹³ Steel, Flora Annie and Gardiner, Grace (1898) *The Complete Indian Housekeeper and Cook: Giving the Duties of Mistresses and Servants the General Management of the House and Practical Recipes for Cooking in all its Branches*. Facsimile edition edited by Crane, Ralph and Johnston, Anna Oxford University Press, Oxford, 2010.

⁶¹⁴ Steel and Gardiner, *The Complete Indian Housekeeper* facsimile edition, p.18.

⁶¹⁵ Sen, Indrani (May-June 2005) 'The Memsahib's "Madness": The European Woman's Mental Health in Late Nineteenth Century India,' *Social Scientist*, vol. 33, no. 5/6 p. 23.

The way of life highlighted by Sen was lived by Elizabeth Vere Birdwood on her marriage in 1931 to an officer of Probyn's Horse, an elite Indian Army cavalry regiment. She was the sixth generation of her family to live in India and was familiar with the role expected of her:

*[T]he army wife was not expected to do anything or be anything except a decorative chattel or appendage of her husband...It didn't even matter if she wasn't beautiful, so long as she looked reasonable and dressed reasonably and didn't let her husband down by making outrageous remarks at the dinner table.*⁶¹⁶

In effect Birdwood's life had been dictated by her upbringing. In that sense she was born to the role of the *memsahib* and to be the ruler of her imperial Indian household.

In a similar vein, Barbara Wingfield-Stratford, a novelist and aristocrat who spent several years in India, wrote in 1922 how the *hot weather* was 'a heat that saps the vitality and dulls the brain,' and was the 'cause of a limp depression that steals over most people in this season.'⁶¹⁷ Like Diver she noted that the emptiness of the average woman's existence led to 'a certain moral flabbiness,' which often led to a married woman acquiring a 'boy' i.e. a young officer with whom she could flirt and go out riding.⁶¹⁸

The mental risks from having 'nothing to do' were presented as a serious threat to her female readership by Diver. She warned them that there would be little mental stimulus and few intellectual pastimes and so religious or charitable works might be needed to occupy their time. She stressed how vital it was to have an absorbing hobby to remove the risk of boredom or frivolity or of 'moral danger' which accompanied their lives as 'even the more seriously inclined succumb for a while to the irresistible charm, the lightness and brightness, and irresponsibility of colonial social life.'⁶¹⁹ Without a hobby

⁶¹⁶ Cited in Macmillan, p.180.

⁶¹⁷ Wingfield-Stratford, Barbara (1922) *India and the English*, Jonathan Cape, London, p. 18.

⁶¹⁸ Wingfield-Stratford, *India and the English*, pp. 36-38. This was a phenomenon frequently found in Kipling's short stories.

⁶¹⁹ Diver *The Englishwoman*, p. 17.

*the long lonely hours, during which the door of her husband's office tent is hermetically sealed to her, will hang very heavily on her hands.*⁶²⁰

The novels of Diver and other British Indian novelists such as Alice Perrin regularly featured female stereotypes of both the strong heroic wife whose forebears have supported imperial men in India for generations and, in contrast, the feeble, inept but beautiful woman who is unable to support her husband and her Empire.⁶²¹ In fiction British Indian readers recognised the heroic female as the role model to which white women should aspire. The pretty but ineffectual woman was a liability and embarrassment to the white community and a threat to their Empire. She was someone whose inability to cope might risk the prestige of the Raj and make her another victim to India.

The unsatisfactory and frustrating lives of British women were also sometimes recognised by male authors. In 1927 the novelist and journalist Edward Thompson, who spent nearly 15 years in India, wrote in his fictional account of the approaching inevitability of the end of British rule that:

*[H]ilda at Darjeeling wondered if there were any country where it was so useless and ineffective to be a woman. ... The men she knew were busy all day, and every day, in work that was steadily, inexorably, building their minds away from her.*⁶²²

Thompson showed much sympathy for Indian nationalism whilst simultaneously recognising that Britons favouring Independence faced the contradictions and stresses inherent in their roles in representing the Raj. It was a form of cognitive dissonance to be endured by progressive white colonists. Thompson had recognised that white men had physical and mental tasks with which to absorb their time whilst white women often had little activity to occupy their minds.

⁶²⁰ Diver *The Englishwoman*. p. 32. It is hard to believe that Flora Annie Steel would have allowed her husband's tent door to be 'hermetically sealed' from her.

⁶²¹ See, for example, Diver, Maud (1912) *Captain Desmond V.C.*, Blackwell, Edinburgh, 1909 and Perrin, Alice *The Anglo-Indians*, Methuen, London.

⁶²² Thompson, Edward (1938) *An Indian Day*, Penguin, Harmondsworth, p186.

As Steel and Diver indicated imperial wives had a role to play in supporting their husbands with the tasks of empire. Mary Procida has challenged the notion that women had little to do and had no purpose other than as a decoration for and companion for her husband. Procida described Anglo-Indian⁶²³ women as active assets in imperial politics and administration though their role has not always been recognised for the importance it contained. Procida accepted Diver's view that British Indians were members of one imperial community and she stressed that husbands and wives worked together for the common, imperial cause. She argued that:

*..the imperial family did not segregate husbands and wives in gendered spheres, but rather united men and women in an imperial partnership centred on governing the Raj.*⁶²⁴

Procida contended that women could influence their husbands through discussion at the dinner table. Although the core of the memsahib's daily life was her husband's work she could acquire a sound knowledge of local affairs and administration and he might confide in her or ask her advice. She might become by proxy his imperial representative to Indians in his absence 'on tour' in his district. To illustrate their commitment to the Raj a significant number of European women actually gave their occupation in the 1881 Census of India as the same as their husbands. The enumerators were much irritated by this and altered their employment category to 'housewife'⁶²⁵ though their personal assertion was often repeated in subsequent censuses. Whilst accepting Procida's arguments that some white women might have achieved intellectual stimulation through discussions with their husbands and by acting as his substitute it can also be argued that others lived unfulfilling lives and were prone to mentally unhealthy thoughts of uselessness and low self esteem. In some people this could lead to depression and even admission to hospital.⁶²⁶

⁶²³ In this context Procida used the term *Anglo-Indian* to refer to the British in India and was a name used by them about themselves.

⁶²⁴ Procida, Mary A. *Married to the Empire: Gender, Politics and Imperialism in India, 1883-1947*, Manchester University Press, Manchester, 2002, p. 29.

⁶²⁵ Procida, *Married to the Empire*, p. 45.

⁶²⁶ For a clinical discussion on the possible outcomes of low self esteem see Geddes et al *Psychiatry*, pp. 33-34 and 422-424.

Two fifths of the land mass of India and a quarter of its population were ruled semi-autonomously by princes.⁶²⁷ Their links to the Indian government were via British agents. One such was Sir Edward Wakefield, the political agent in the princely state of Gujarat in the 1930s, recalled in his memoirs the boredom which he and his wife experienced:

*In the evenings lacking anything better to do, we would sit indoors watching lizards stalking their prey... Lack of exercise, the enervating climate and the absence of any social life had a depressing effect on both of us.*⁶²⁸

The numbers of whites in the nominally independent princely states was typically very small. For some of them the lack of stimulation was a permanent challenge to their mental and physical wellbeing. Letters to the Wakefields from England about their children 'brought occasional gleams of sunshine into the drab monotony of our lives,' but, joyful as those letters were, they quickly reminded them of their exile from their family. They sometimes coped with this by betting on the odds of errant moths escaping the lightning tongues of the lurking lizards.⁶²⁹ Their unintended interest in wildlife may well have helped preserve their sanity.

For others boredom was filled by alcoholism,⁶³⁰ which could lead to a decline in their mental health and even suicide. For others there was the risk of physical temptation and what at the time was regarded as immorality. Charles Allen, who was born in India in 1940 to a British-Indian family, and spent many years of his adult life living and working there, has pointed out that extra-marital affairs were common, especially in the army, but discretion was vital. Vere Birdwood recalled that whereas

⁶²⁷ Read, Anthony and Fisher, David (1997) *The Proudest Day: India's Long Road to Independence*, Jonathan Cape, London, pp. 476-477. There were 562 princely states in total.

⁶²⁸ Wakefield, Sir Edward (1966) *Past Imperative: My Life in India 1927 to 1947*, Chatto and Windus, London, pp. 153-154.

⁶²⁹ Wakefield, *Past Imperative*, p. 154. Incidentally, Wakefield calculated the odds as 6 to 4 against the moths.

⁶³⁰ For descriptions of drunkenness in both British man and women in India see, for example, Edwardes, Michael (1969) *Bound to Exile*, Redwood Press, London, pp. 18-19 and 66-67 and Vernede, R. V. (1996) (Ed) *British Life in India: An Anthology*, Oxford University Press, New Delhi, pp. 163-174.

there was a certain tolerance on such matters it was never acceptable for an officer to have an affair with the wife of an officer from the same regiment.⁶³¹

Private Richards has so eloquently described the life of the common soldier which, outside of warfare, was often tedious. Regular parades, military exercises and sports maintained a high level of fitness which helped them cope. Such activities were usually carried out in the early morning before the day became too hot. Unlike their officers ordinary soldiers were unable to afford ponies or indulge in other sports or hunting activities apart from occasional football games. Neither did they have their officers' opportunities to take part in the active social life of middle class Europeans in military stations. Instead many soldiers often spent their days confined to barracks with little activity in the *hot weather* unless they were engaged in wars, training or other military activities. Indian village shops and bazaars were often out of bounds to them.⁶³² Brothels were tolerated periodically despite temporarily being closed down by overzealous or evangelical officials, a topic covered in much detail by Kenneth Ballhatchet.⁶³³

In order to alleviate boredom many private soldiers played and invented card and board games, often associated with gambling, as Richards recalled from his experience. Some of his comrades he described as *bun-punchers* or *char wallahs* because of their habit of drinking char or tea all day and every day.⁶³⁴ Others drank beer excessively, referring to it as 'neck oil' or 'purge' boasting proudly that they could imbibe greater quantities in India because of the permanent sweating of their body in the intense heat.⁶³⁵ Military manoeuvres and wars came, even if life threatening, as a much needed relief for many.

As a senior officer Baden Powell was conscious of the threat of boredom on officers and soldiers. He observed, and resented, that the British in India were generally regarded by those in Britain as 'a frivolous lot.' He believed strongly that soldiers had to be occupied consistently in sport, military training or other physical activities and he ensured that these took place for those under his command. He himself indulged in amateur dramatics both acting and painting scenery.

⁶³¹ Elizabeth Vere Birdwood cited in Allen, *Plain Tales*, p. 154.

⁶³² Allen. *Plain Tales*, p. 157.

⁶³³ Ballhatchet, Kenneth (1980) *Race, Sex and Class Under the Raj*, Weidenfeld and Nicolson, London.

⁶³⁴ Richards, *Old Soldier Sahib*, p. 217.

⁶³⁵ Richards, *Old Soldier Sahib*, p. 223.

*We worked hard, almost desperately, at theatricals and the like, fighting against the ennui which is the breeding ground of sickness.*⁶³⁶

Baden Powell kept meticulous records of the prevalence of diseases and devised strategies to tackle them. These included the construction of a bakery and a dairy and the provision of flavoured soda water. His intention was to prevent his soldiers buying 'risky' food and drink from Indians and so courting ill health.⁶³⁷ He had no doubts that the best preventative measure against disease in India was 'plenty of work, occupation and exercise' as it was 'the ennui that kills.'⁶³⁸ General and private thus held similar views on the dangerous consequences of too much boredom.

A third factor carrying the risk of mental ill health was isolation which will now be discussed in the following section.

The impact of isolation on mental stress

The British ensured a physical separation between the life of the official elite and Indians by the planning and construction of civil stations or military cantonments away from the indigenous population across the whole of India. Research completed by Anthony King has shown how rigid racial segregation was normally in force in these locations and Indians, apart from servants, were not permitted to live there.⁶³⁹ King gave a variety of reasons for such separation. It ensured a high degree of racial segregation between white and Indian communities whilst ensuring an element of physical protection in times of tension and conflict. It maintained a measure of supervision of and control over Indians.⁶⁴⁰ In addition questions of sanitation were also important with colonial settlements, or stations, often being built deliberately for practical and symbolic reasons on higher ground, away from the risks of water or air which were generally believed to have been contaminated by Indians.⁶⁴¹ In King's

⁶³⁶ Baden Powell, *Indian Memories*, p. 92. There are photographs of him acting in plays in Simla, the summer capital of imperial India, during the *hot weather*. See, for example, Allen, *Plain Tales*, p. 132.

⁶³⁷ Baden Powell, *Indian Memories*, p. 100.

⁶³⁸ Baden Powell, *Indian Memories*, p. 106.

⁶³⁹ King, Anthony (1976) *Colonial Urban Development: Culture, social power and environment*, Routledge and Kegan Paul, London. King argued that the term *station* derives from the Latin for 'standing place' or 'residence' and in this sense is only used in colonial or ex-colonial countries.

⁶⁴⁰ King, *Colonial Urban Development*, pp. 39-40.

⁶⁴¹ King, *Colonial Urban Development*, p. 131.

view the separation provided a comfortingly familiar and easily recognisable environment, one which enabled 'psychological and emotional security in a world of uncertain events.'⁶⁴² It represented, of course, a self-imposed isolation from Indians and was repeated across India even in quite small settlements.

Following the 1915 quote from the editor of the *Indian Planters' Gazette (IPG)* at the head of this chapter it has been made clear that for some the business of empire meant social and physical isolation. The *IPG* was a weekly newspaper for the British who managed plantations, often located in remote areas, for tea, coffee, indigo etc. Its editor regretted that whereas tea plantations had been introduced to Assam in the previous century by intrepid, hard-working Europeans such enterprising people were now few in number. He lamented the fact that there were no memorials 'raised to these heroes, who in many cases sacrificed their lives for the cause,' i.e. the cause of bringing modern British agricultural techniques and capitalism to secluded and 'uncivilised' north eastern India. This editorial was reproduced in a 1922 edition to highlight the contrast with the present day when, as its editor proudly proclaimed, the plantations were now prosperous and well run.⁶⁴³

This self-imposed segregation by many of the British in India had not always been the official response to their rule in India. Until the early nineteenth century many East India Company officials adopted Indian ways, learnt local languages and often married Indian women. As the century progressed, however, the belief in a white racial and civilisational superiority took precedence and was accompanied by a social and cultural distancing from Indians.⁶⁴⁴ Whereas most Europeans lived in the larger towns and cities for some British representatives of the Raj geographical and the accompanying cultural isolation were inevitable. As ICS officers they could be posted to a remote town or to a semi-autonomous princely state as an administrator or political agent. In his history of the ICS David Gilmour has identified that the average size of a district, in which there might be only a handful of Britons, was 4,430 square miles and at the beginning of the twentieth century its average

⁶⁴² King, *Colonial Urban Development*, p. 39.

⁶⁴³ Editorial *Indian Planters' Gazette*, 9th September 1922.

⁶⁴⁴ See, for example Collingham. *Imperial Bodies*, Chapters 1 and 2 and Hutchins, *Illusions of Permanence*, *passim*.

population was 931,000.⁶⁴⁵ Employment as the owner of or as a manager of a tea or coffee plantation would normally require location in a remote area such as Assam or in the Himalayan foothills reinforcing geographical isolation and an almost inevitable lack of regular European contact.

In her study of the politics of race and sexual morality in twentieth century colonial cultures Ann Stoler described this rigid restriction on the mixing of races as 'making empire respectable.'⁶⁴⁶ She pointed out that medical opinion stressed the importance of physical separation of the races for good health including the separation of communities.⁶⁴⁷ The type of segregation found in British settlements in India described by King was depicted by Stoler as a 'cordon sanitaire,' a boundary around European enclaves and European homes, a 'routinised protection of their physical health and social space' from the Indian gaze.⁶⁴⁸ It can be argued from Stoler's proposal that a mental separation from Indian culture and conversation was also a consequence of making the Raj superior. It was also a further example of conformity to the norm of white society and taking precedence over the risk of loneliness.

In her study of racial segregation in colonial India Durba Ghosh has described how the colonial rulers from the early nineteenth century came to fear that liaisons between white men and Indian women would endanger the 'whiteness' of their rule. In their view an increase in the number of mixed heritage children would reduce the purity of the ruling elite and so undermine its authority. The impact was a self-imposed distancing of Britons and Indians which was widespread across India and another factor in the isolation of ruler from ruled.⁶⁴⁹

In outlying districts, or *mofussi*⁶⁵⁰ with few English speakers cultural isolation was almost inevitable. The Briton could be posted to a remote town or princely state as an administrator or political agent or be employed as a manager of a tea or indigo

⁶⁴⁵ Gilmour, David (2005) *The Ruling Caste: Imperial Lives in the Victorian Raj*, John Murray, London, p. 89.

⁶⁴⁶ Stoler, Ann L. (1989) 'Making empire respectable: the politics of race and sexual morality in 20th century colonial cultures,' *American Ethnologist*, vol. 16, pp. 634-660.

⁶⁴⁷ Stoler, 'Making empire respectable,' p. 652.

⁶⁴⁸ Stoler, 'Making empire respectable,' p. 652.

⁶⁴⁹ Ghosh, Durba (2006) *Sex and the Family in Colonial India*, Cambridge University Press, Cambridge, pp. 1 and 255.

⁶⁵⁰ The 'provinces' as opposed to the large cities, or rural localities of a district, from Yule and Burnell, *The Concise Hobson-Johnson*, p. 275.

plantation. The claustrophobic lives on a small European station in a remote part of Burma were recorded in the novel *Burmese Days* by George Orwell.⁶⁵¹ Orwell, who was born in India, had been a police inspector in Burma in the 1920s and wrote from his experience of such communities. Their social life was centred around the European Club and Orwell noted with disapproval its prejudiced social mores and the self-imposed barriers against developing links with educated Indians and Burmese.

As another example of mofussil life, John Rowntree, a forestry officer in Assam from 1929 to 1947, recounted his experiences there living with the many hill and jungle tribes who spoke a huge variety of languages. He was isolated like the planter in the epigraph at the head of the chapter but, overall, he enjoyed his time in India perhaps because he befriended Indians of mixed heritage and took an interest in local people and their customs. He did however recall the loneliness of Christmas, and the dangers from rogue elephants and driving cars in the monsoon rains.⁶⁵²

For some Britons in India the isolation actually intensified after the First World War with the introduction of Indianisation as described by R D Macleod in his memoirs. Macleod had been a civil servant in the United Provinces of Agra and Oudh between 1910 and 1934. He recalled that three quarters of stations were small and only consisted of a handful of Europeans. As more Indians gradually moved into senior judicial, administrative and medical posts from the early 1920s onwards the proportion of Europeans in such posts began to decline. From his experience he wrote that Europeans could not develop much companionship with Indians because the latter's customs and outlook were different to their own.⁶⁵³ To accompany Indianisation the Government of India placed pressure on racially exclusive social clubs to admit Indians as members. For many Europeans this was a shocking encroachment on what Sinha has termed their 'colonial public sphere,' their choice to remain aloof from Indians even where geographical remoteness already ensured an element of isolation.⁶⁵⁴

⁶⁵¹ Orwell, George (2009) *Burmese Days*, Penguin, London. The original work was published in 1934.

⁶⁵² Rowntree, John (1981) *A Chota Sahib: Memoirs of a Forest Officer*, Tabb House Press, Padstow, Cornwall. *Chota* means small or insignificant.

⁶⁵³ Macleod, R. D. (1938) *Impressions of an Indian Civil Servant*, H. F. and G. Witherby, London, pp. 133-134.

⁶⁵⁴ Sinha, Mrinalini (October 2001) 'Britishness, Clubbability, and the Colonial Public Sphere: The Genealogy of an Imperial Institution in India, *Journal of British Studies*, vol. 40, no. 4, p. 515.

The lives of white colonists with mental health problems in other parts of the British Empire have been studied recently and can be considered for comparative purposes. Catherine Coleborne has researched medical case records of white settlers in asylums in Australia and New Zealand and addressed the extent to which colonial mental institutions and colonial societies intersected and reinforced notions of colonial social identities.⁶⁵⁵ She recorded that an Inspector-General of Asylums in New South Wales observed in 1880 that the male colonists were probably more socially isolated than their female counterparts. He further commented that the male residents showed a marked tendency to be introspective, suspicious, distrustful and selfish when they could not fall back on associates and families. In the comparable society of New Zealand white male asylum residents who had experienced disappointments and failures at work demonstrated severe alienation and had a tendency towards suicide.⁶⁵⁶ Although there are numerous differences between white colonial societies in India and Australasia white residents of both suffered geographical isolation. Coleborne's observations of distressed *Imperial Minds* gave some insight into the lives of Europeans in India when issues of physical isolation were being considered.

Finding ways to cope

There were many ways that Britons tried to cope with the heat, boredom and isolation as will be discussed in this section. In order to avoid the perils of the hot weather in the plains the British sought out the cooler climate of the hills and from the 1820s began to develop hill stations which soon became popular resorts which were to be likened to Scarborough, Bath and Brighton.⁶⁵⁷ In 1864 one such hill station, Simla, 7,000 feet above sea level, became the summer capital of the Indian Empire when for the five hottest months of the year the Viceroy and his Government relocated from Calcutta, a distance of 1,200 miles. The climate was temperate and the scenery reminded many officials and soldiers of the Scottish Highlands. A historian of Simla Pamela Kanwar has written how the settlement provided an

⁶⁵⁵ Coleborne, Catharine (2015) *Insanity, Identity and Empire: Immigrants and institutional confinement in Australia and New Zealand, 1873-1910*, Manchester University Press, Manchester , p. 14.

⁶⁵⁶ Coleborne, *Insanity, Identity and Empire*, p. 61.

⁶⁵⁷ See Wright, Gillian (1991) *Introduction to Hill Stations of India*, Twin Age, Hong Kong.

escape from the heat and also the native culture of the plains. She pointed out that it enabled the British to leave behind the relative isolation of district or cantonment where the only refuge could be found in their clubs.⁶⁵⁸

In 1891 the Surgeon-General for Bombay Sir William Moore praised the value of hill stations not only

*as exciting a sanitary effect on the body but also on the mind: the freedom from the harass of daily work and the change of scene and society, tending to raise and exhilarate the spirits, depressed by the continued influence of the heated plains.*⁶⁵⁹

Away from the restrictions imposed upon them by duty the British middle class could engage in personal activities and relationships which might be impossible elsewhere. They could indulge in hunting with hounds, in creating gardens and shops and on other activities associated with English country gentlemen and women so much missed in the hostile Indian climate. They constructed Tudor-style buildings reminiscent of the Home Counties or mock baronial castles inspired by those in the Scottish Highlands. Kennedy describes the escape:

*[T]o these cloud-enshrined sanctuaries the British expatriate elite came for seasonal relief not merely from the physical toll of a harsh climate but from the social and psychological toll of an alien culture.*⁶⁶⁰

Kennedy stressed how the hill stations played a key role in ‘the social reproduction of the British ruling elite.’⁶⁶¹ They were able to combine a playground with the serious business of running the empire. Using examples similar to the ones above, Kennedy, has described the heat in India as not merely a source of discomfort but actually “a trope for all that was alien and hostile about the tropics.”⁶⁶² The hill stations offered a public space where private interests could be pursued away from the restrictions of

⁶⁵⁸ Kanwar, Pamela *Imperial Simla: The Political Culture of the Raj*, Oxford University Press, New Delhi, 4th edition, 2009, p. 3.

⁶⁵⁹ Quoted in Kennedy *Magic*, p. 31.

⁶⁶⁰ Kennedy *Magic*, p. 1.

⁶⁶¹ Kennedy *Magic*, p. 13.

⁶⁶² Kennedy, *The Magic*, p. 19.

the public gaze which was a permanent obligation upon the imperial masters in the plains or cities.

Furthermore, non-conformity was a way that Britons could overcome boredom and isolation. In her autobiography Steel gave examples of her assistance to her husband with his official duties. She appointed herself as the first female inspector of schools in the Punjab. Her exuberant lifestyle dedicated to imperial duties showed how she coped constructively with the stresses of imperial life.

In order to expand her argument that in many ways British women did not always conform to the stereotypes of their gender in Britain Procida made references to firearms. Although administered by a civil power the British Raj was essentially a heavily armed military regime with the vast majority of its male representatives trained to use firearms. Many women kept guns as potential protection against wild animals and some were actively involved in hunting and shooting. Ultimately, though, there was what Thomas Metcalf has described as 'an enduring legacy of fear'⁶⁶³ of the repeat of the unexpected violence of 1857-8 and rifles might be needed against rebellious natives. Thus:

*[T]he gun exemplified literal and metaphysical potency as both the actual instrument of British conquest and dominance in India and the symbol of Western mastery over colonial peoples.*⁶⁶⁴

In Procida's view the gun reinforced this role of the memsahib as racially superior to Indians as:

*[W]omen's use of firearms was ... primarily for engaging with the empire, a means not only of demonstrating their support for the imperial undertaking but also of integrating themselves into the symbolic and practical politics of the Raj.*⁶⁶⁵

⁶⁶³ Metcalf, Thomas R. (1995) *The New Cambridge History of India, iii, pt.4, Ideologies of the Raj*, p. 244.

⁶⁶⁴ Procida, *Married to the Empire*, p.138.

⁶⁶⁵ Procida, *Married to the Empire*. p.158.

The presence of armed white women was thus recognition of the uncertainty of the future, a preparation for potential violence which was an ever present stressor in itself. In her opinion middle class women were unavoidably involved in the administration of India. Procida provided powerful arguments explaining the role of middle class British Indian wives as actively, though somewhat discreetly, supporting their husbands in running the empire. Their houses could not be the oases of privacy and domesticity they would have been in Britain, as, being inhabited by white representatives of government whether official or not, they were explicit symbols of the Raj. In other words, their homes were a 'branch office in the business of empire.'⁶⁶⁶ If her husband was away 'on tour' she might have been required to make proxy decisions on his behalf, on behalf of the empire in her 'branch office'. Nevertheless the conventional image of the bored middle class Raj wife has persisted. She would have had numerous servants to carry out domestic tasks. In a small station there would be a permanent round of dinner parties and socialising at the club with the same Europeans. There would have been ample opportunity for some women to support community activities and influence, subtly or otherwise, male imperial business.

The unanimity of purpose implied by Procida had earlier been challenged by David Arnold. He emphasised that nearly half of the European population in India were 'poor whites,' a term which was used at the time. As a demographic they mostly originated as serving or retired soldiers and sailors and their dependents became the main providers of a semi-skilled workforce in such fields as shop workers, untrained midwives and teachers, clerks and so on.⁶⁶⁷ They were also the major source of orphaned and mixed heritage Anglo-Indian children and of vagrants, convicts and lunatics.⁶⁶⁸ This generally working class section of the British in India, the official Anglo-Indian community, maintained its loyalty to the colonial establishment despite the weakening of their physical connections to the motherland. They were rewarded with priority employment in such as the Posts and Telegraph service and the railways and, of course, where necessary, admission to the EMH rather than to a mental hospital intended for Indians only.

⁶⁶⁶ Procida, *Married to the Empire*. p. 60.

⁶⁶⁷ Arnold, 'European Orphans' pp. 104-127.

⁶⁶⁸ Arnold, 'European Orphans,' p. 105.

Significantly, many Britons thrived in these circumstances engaging in constructive activities and enjoying their time in India. The permanent exhilaration and insecurity of life for some whites in India was described by Ian Stephens in his autobiography. Stephens became a journalist on *The Statesman*, a daily newspaper based in Calcutta and was its editor from 1942 until 1951. He was fully aware of the coexisting contradictions of excitement and uncertainty, of success and failure.

*Life in India still enchanted me: the colour and human warmth of it; the astounding scenic and social contrasts of being poised perpetually on a knife-edge between enjoyment and disaster; the size of everything, the bigness of the opportunities, yet the awareness of sudden death, of earthquakes, flood and tempest, lethal diseases, riots always lurking near.*⁶⁶⁹

Stephens enjoyed the intellectual stimulation of wartime Calcutta, especially when American soldiers arrived with a refreshing and non-conformist attitude towards India and Indians. However he also met some young British officers and NCOs fresh from Britain who coped less well with the new mental, physical and cultural challenges with which they were suddenly confronted. They were the last generation of Britons required to do so.

Furthermore, the diaries of those middle class men who lived in India are concerned predominantly with the joys and tragedies and heroism of military service or the more mundane experiences of civil servants, businessmen or planters. For those with sufficient money there was polo.⁶⁷⁰ Shooting or *shika*⁶⁷¹ enabled men, and sometimes women, to test their skills against wildfowl, deer, bears and the rapidly dwindling population of tigers.⁶⁷² Perhaps more tedious were the rituals associated with calling cards and formally visiting members of the British community when being at a new station and a failure to conform risked social ostracism. The

⁶⁶⁹ Stephens, Ian (1966) *Monsoon Morning*, Ernest Benn, London, p. 12.

⁶⁷⁰ Yeats-Brown, *Bengal Lancer*, pp. 70-83.

⁶⁷¹ Hunting and shooting of wild animals.

⁶⁷² See Special Collections, Leeds University Library LIDDLE/WW1/AFE/07 – the papers of Dr Alexander Cameron (1889-1932). Each year Dr Cameron filled pages of his diary with lists of what he had shot keeping annual totals for comparative purposes. His greatest triumph was a black bear but he never killed a tiger.

process was gently mocked by Dennis Kincaid, a writer and member of the ICS, in the 1930s as a quaint Edwardianism.⁶⁷³

Throughout the nineteenth and early twentieth centuries numerous writings frequently demonstrated self sacrifice, and the unquestioned duty of empire together with a respect for the warrior races of the North West Frontier and distrust of the more effeminate and politically scheming Bengalis.⁶⁷⁴ According to Mrinalini Sinha the real test of British masculinity was in their 'chivalric' protection of white women from Indian men.⁶⁷⁵ It was this reverence for British females by British males, she argued, which was a cause of the terrible revenge wreaked on Indians for the events of the Great Rebellion of 1857.⁶⁷⁶ It appeared, however, that there was little space or time for men to discuss their own feelings and contemporary diaries rarely revealed deep introspective thought at least until the final years of the Raj.⁶⁷⁷

Beyond the bravado and heroism there were often references to suicides or mysterious deaths which had been attributed as accidents but may have been self-inflicted. A description of an accidental demise might have spared distress or shame to the relatives, whilst also seeking to preserve intact the myth of white superiority.⁶⁷⁸ As an example of this Dr Alexander Cameron of the IMS performed an autopsy in December 1908 on an Indian Army captain who was suspected of having died 'an unnatural death' by poison. No evidence was found of this and so no official cause of death by suicide was recorded, though Cameron suspected that this had been the case.⁶⁷⁹ A missionary doctor in south India in the 1920s, Dr A. Butterworth, wrote in his memoirs of his despair at the numbers of suicides of people he knew and his sympathy for their pain:

⁶⁷³ Kincaid, Dennis (1973) *British Social Life in India, 1608-1937*, Routledge and Kegan Paul, London, 2nd edition, p. 315. The book was originally published in 1938.

⁶⁷⁴ See for example, Sinha, *Mrinalini Colonial Masculinity: The 'manly Englishman' and the effeminate Bengali' in the late nineteenth century*, Manchester University Press, Manchester, 1995.

⁶⁷⁵ Sinha, *Colonial Masculinity*, p. 51.

⁶⁷⁶ Sinha, *Colonial Masculinity*, pp. 47-48.

⁶⁷⁷ For example, Trevelyan, Humphrey (1972) *The India We Left*, Macmillan, London. The reflection of retired civil servants and soldiers after 1947 were normally in praise of their selfless duty rather than personal self-analysis.

⁶⁷⁸ Kipling wrote several short stories of such 'accidental' deaths.

⁶⁷⁹ See Special Collections, Leeds University Library LIDDLE/MW1/AFE/07 – the papers of Dr Alexander Cameron (1889-1932).

*[O]nly too many of my European acquaintances in India have died by their own hands, and I do not remember a single case where a motive will be assigned.*⁶⁸⁰

Suicide was a recurrent theme in letters and diaries and it seemed that awareness of its potential and occurrence was widespread amongst Britons in India.

Allen observed that for ordinary soldiers mental illness had no place in the army vocabulary and a breakdown could be treated as military indiscipline, possibly resulting in a court martial.⁶⁸¹ However officers might be diagnosed with the less stigmatising and more acceptable illness of neurasthenia.⁶⁸² Further evidence of 'unnatural death' was provided by Allen who gave examples of soldiers shooting themselves either because of the heat or because of bad news received from home. The easy access to guns in British India may have been a major cause in the numbers of deaths by accidents or suicide. He wrote of one 'young boy' who hung himself after only two weeks in India; and of a 17 year old soldier who believing he was being tormented by NCOs, 'drove himself insane' and then blew his brains out.⁶⁸³ In common parlance of the day they were said to have gone 'doolally'.⁶⁸⁴

Conclusion

The findings in this chapter concerning the impact of the trinity of the climate, of boredom and of geographical and physical isolation on health illustrated a deep rooted fear of life in India amongst some Europeans, as well as a resignation that it had to be endured in the pursuit of imperial duty. From the early days of the East India Company's involvement in India its climate presented a challenge to Europeans within a diseased environment which damaged Western minds and bodies which could lead to insanity and crime. Thus the weather was officially bad for European physical and mental health as recognised by numerous medical men

⁶⁸⁰ Butterworth, A. (1923) *The Southlands of Siva: Some Reminiscences of Life in South India*, John Lane, The Bodley Head, London.

⁶⁸¹ Allen, *Plain Tales* p. 123.

⁶⁸² Allen, *Plain Tales* p. 157.

⁶⁸³ Allen, *Plain Tales* p. 166.

⁶⁸⁴ Allen, *Plain Tales* p. 157. Deolali is a town near Bombay where soldiers who were mental patients awaited a ship to take them to psychiatric hospital in England. It gave its name to 'doolally' or 'doolally tap,' phrases used by soldiers to refer to someone who was, or was behaving as if they were, mentally disturbed.

and by those who lived there and experienced it daily. The chapter has also introduced the idea of stressors to explain the risk of mental ill health encountered by those Britons delivering the imperial project. The high temperatures could be punishing to body and mind alike. Boredom, isolation and fear of the natives could cause mental distress. The arguments have shown that it was believed by Europeans living in India that the relentless heat could demoralise them, could demotivate both their men and women, could degenerate their children and could destroy their soldiers. Whereas the elite and some members of the middle class could enjoy their privileges with support from numerous servants, those further down the white social hierarchy might not. The numbers who hid their depression with alcohol, whose suicides were officially and euphemistically termed as accidents or who went 'doolally' will never be known. The ones who entered a mental hospital ward for Europeans were the more seriously ill and amongst the most problematic for the authorities.

Life in India with the sometimes unbearable climate, the risk of boredom and the possibility of social and physical isolation were significant factors in presenting great challenges to Europeans. They could also contribute to the danger of mental ill health. The next chapter will address the impact of cultural factors on the stresses facing *Imperial Minds*.

CHAPTER 5

A culture under stress: cultural pressures facing the British in colonial India

Each culture provides its members with ways of becoming ill, of shaping their suffering into a recognisable illness entity, of explaining its cause, and of getting some treatment for it.

Cecil G. Helman (1990)⁶⁸⁵

The European in India was a sojourner, who, after spending his working years in India, looks forward to retiring to that other country which is real home.

*Indian Statutory Commission Report (1930)*⁶⁸⁶

Introduction

This chapter will aim to extend our knowledge of the mental health of the British in colonial India by examining how the culture associated with the white community became a source of stress for some of its members. It will argue that there were substantial stresses inherent in the culture of the British in colonial India which always presented a risk of developing into mental illness. Within the context of British imperialism it will demonstrate how British society in India, already reactionary, was resistant to change and increasingly divorced from the values and objectives of Britain. The stress factors confronting the Raj will be identified and explained using an adaptation of the *cultural web*, a model used in the understanding of organisational structures. Traditional research has concentrated on the *burra*⁶⁸⁷ *sahib*, and his wife the *memsahib*, the middle or upper class representatives of colonial power. More recent scholarship has been influenced by subaltern studies

⁶⁸⁵ Helman, Cecil G. (1990) *Culture, Health and Illness, An Introduction for Health Professionals*, Butterworth-Heinemann, Oxford, p. 230.

⁶⁸⁶ *Indian Statutory Commission Report (1930)* Cmd. 3568, 1, 47-48, London cited in Arnold, David (January 1983) 'White Colonization and Labour in Nineteenth Century India,' *Journal of Imperial and Commonwealth History*, vol. xi, no. 2, p. 134.

⁶⁸⁷ A senior sahib, European head of an important department. See *The Concise Hobson-Johnson*, p. 64.

and 'low and licentious Europeans,' the ordinary soldiers and the poor and destitute whites in India.⁶⁸⁸ This chapter adds to the debate about the British in India by highlighting the interlocking aspects of their culture which were based on racial superiority and the need to maintain imperial prestige. It will consider the consequent mental stresses involved in being members of the ruling race and being part of an ethnic minority albeit a privileged one in a foreign land.

The two epigraphs at the head of the page set the tone for this chapter: how the British in India constructed their responses to illness; and that, in the end, how their time in India was a preparation for their eventual retirement to Britain. The chapter will now consider the stressors in British Indian society.

Stress within the socio-cultural context

Having considered the definitions of stress in the previous chapter and how it relates to environmental factors, this chapter will turn the focus to stress in the socio-cultural context. To understand how culture can be a contributing factor, it must first be defined. Culture is a many sided concept which makes it difficult to define and to paraphrase Selye's comment on stress in the previous chapter, everybody knows what culture is but nobody knows what *it* is.⁶⁸⁹ Terry Eagleton has attempted a definition of *it* with four different meanings: a body of artistic and intellectual work; a process of spiritual and intellectual development; the values, customs, beliefs and symbolic practices by which men and women live; and a whole way of life.⁶⁹⁰ In recent times culture has been determined in popular language by, amongst others, Gerry Johnson and Kevan Scholes as 'the way we do things around here.'⁶⁹¹ For the purposes of this thesis the meaning of *culture* will be taken as an amalgam of Eagleton's third and fourth definitions with that of Johnson and Scholes.

A scholar who related culture and stress was Cecil Helman. He added to scholarship by arguing that stress represented an inadequate or unsuccessful adaptation to change by the individual faced with changing life circumstances. Such a stressor emerged amongst the British in India as the demands for independence

⁶⁸⁸ See, for example, Fischer-Tiné, *Low and Licentious*.

⁶⁸⁹ Cited in Jackson, Mark *The Age*, p. 268.

⁶⁹⁰ Eagleton, Terry *Culture*, Yale University Press, New Haven, USA, 2016, p. 1.

⁶⁹¹ Johnson, Gerry and Scholes, Kevan *Exploring Corporate Strategy*, Pearson Educational, Harlow, Essex, 6th edition, 2002, p. 229.

intensified during the twentieth century portending a new political hegemony but one without them at its head.

In Selye's model stress represented a pathological response to environmental demands, including the cultural background of the individual. Helman indicated that culture helped to shape a recognisable language of distress, as stress is specific to the culture in which it is found. In addition, he observed, culture's opinion of itself, its world view, can have a positive impact where it was optimistic, or negative where fatalistic.⁶⁹² It is a tenet of this thesis that the latter situation prevailed soon after the First World War.

There has been criticism of Selye's work because of its preoccupation with the physiological causes of stress and Helman and Jackson both cited research which emphasised the importance of psychological factors.⁶⁹³ Individuals react differently to stressors and it is impossible to predict accurately how individuals may react psychologically to events. Other critiques of Selye arose from his belief that stressors were abstract and not, as is now generally accepted, directly related to the economic and political forces impacting on the person and his or her community. The foundations for Selye's work were laid after 1918 and the extent to which the research carried out by Selye and his followers would have been familiar in colonial India is not known, although alienists there such as Overbeck-Wright and Lodge-Patch indicated in their textbooks an awareness of stresses generated by shellshock and battlefield psychoses and neuroses.⁶⁹⁴ It is now necessary to explore the British culture in India before showing how this related to experiences of distress.

Towards the end of the nineteenth century medical texts emphasised the combined influence of heredity and environmental circumstances as precipitating factors in attacks of insanity. One such British alienist who promoted this link was Mercier⁶⁹⁵ who, in his text book on mental illness published in 1902, asserted that insanity was a function of only two variables, these being heredity and stress.⁶⁹⁶ It was Mercier's contention that there were two forms of stress: direct and indirect. The former was of the kind caused by a blow to the head or another pressure such as a

⁶⁹² Helman, *Culture*, p. 255.

⁶⁹³ Helman, *Culture, Culture*, p. 250; and Jackson, *The Age*, pp. 179-180.

⁶⁹⁴ Overbeck-Wright, *Lunacy* and Lodge Patch, *A Manual of Mental Diseases*.

⁶⁹⁵ For an assessment of the significance of Mercier in the history of British psychiatry see Berrios, and Freeman *150 years of British Psychiatry*, pp. 183 and 193.

⁶⁹⁶ Cited in Jackson, Mark *The Age* pp. 40-41.

brain tumour. Indirect stresses came from fevers or major physiological changes which, in his view, made women particularly susceptible. However, indirect stresses could only produce insanity in those predisposed to it through an inherited nervous instability.⁶⁹⁷

Having established the links between stress and mental illness it is now necessary to combine them with culture.

British culture in colonial India

In his work on the social, political and cultural processes governing colonial Indian urban development, the sociologist Anthony King constructed the argument that, in colonial countries, there existed three types of culture relating to that of the dominant power.⁶⁹⁸ The *first culture* was that of the metropolitan society whose values and institutions were taken out to the empire by colonial rulers who were mainly middle class. The *second culture* was that of the indigenous, peripheral colonised society comprising in India a wide range of races, religions and lifestyles and King used the term as an aid to understanding his model, whilst recognising India's great diversity. The *third culture* was the initial product of the contact in India between the selected elements of these first and second cultures.⁶⁹⁹ The first culture initially delegated the rules of governance and lifestyle to be implemented and monitored by the third. The third was centred around the institutions of government from which power emanated including the education system, the process through which colonial laws were instigated and enacted, the dominant ideologies, cultural artefacts and so on. For the purpose of this chapter the culture of the British in India will be regarded as an example of King's third culture.

It can be argued that some aspects of this third culture were accepted by, and even exploited or adapted by the second, particularly the elite members of Indian society. Such acknowledgements would include items of Western dress, the English language, the national railway system and admissions to the medical and other professions, all of which changed little after Independence. Despite these assimilations, aspects of this third culture remained exclusive to the ruling white

⁶⁹⁷ Cited in Jackson, Mark *The Age*, p. 38.

⁶⁹⁸ King, *Colonial Urban Development* pp. 41-66.

⁶⁹⁹ King, *Colonial Urban Development*, p.65

group. Hence the social and political ideologies of racial and civilisational superiority, and the stereotypical perceptions of 'natives,' remained largely unique to third culture members whilst their colonial power existed.

It was King's contention that, inevitably, the third culture came to reflect increasingly the values of its own colonial society rather than those of the metropole, as the latter developed in different ways and in different directions through its changing circumstances. However these values were a source of tension and became increasingly irrelevant and anachronistic in British India as changes came through modernisation and democracy in Britain, especially after the First World War. A policy of Indianisation had been official British Government policy since 1910.⁷⁰⁰ The measures were introduced gradually and irreversibly and their implementation threatened the comfort, privileges and the very future existence of the British in India. The reforms were generally unpopular amongst them and caused the viceroy, Lord Irwin, to confide to the secretary of state for India in 1927 his concerns about the 'excessive Indianisation of the medical teaching staff' as he felt that continued British supervision was needed over the students.⁷⁰¹ Many British-Indians believed that Indians were incapable of ever ruling themselves and running their own affairs. So, as late as January 1939, only eight years before Independence, the viceroy, Lord Linlithgow, thought that Indian self-government was so remote it was not worth discussing.⁷⁰²

The third culture generated its own interpretation of historical events, its own historical perspective and its own emotions and traditions. As a means of reinforcing its ethos the community developed its own stories, its own rituals and its own symbols which were defended fiercely in order to emphasise and preserve the differences of ruler from ruled. Examples of how such factors contributed to an understanding of the third culture will be discussed later in this chapter in the section concerned with the *cultural web*.

The ruling elite of British India has been depicted by Hutchins as a middle class aristocracy which gave them an 'illusion of permanence'.⁷⁰³ He argued astutely

⁷⁰⁰ See Reid, *Keeping the Jewel* pp. 26-34.

⁷⁰¹ Borthwick Institute, University of York, *Papers of the Earl of Halifax as Viceroy of India, 1926-1931*, No. 3 - 'Letters to and from the Secretary of State for India,' Vol. II, no, 36, 24th August 1927.

⁷⁰² Reid, *Keeping the Jewel*, p. 128.

⁷⁰³ Hutchins, *The Illusion*, p. 101.

that the British, whatever their status, were mutually dependent in order to maintain control of India whilst perpetuating the myth of superiority. To preserve British prestige under the Indian gaze a form of solidarity, even if sometimes superficial, had to be maintained by all whites to ensure the continuation of the colonial hegemony. This 'illusion of permanence,' argued Hutchins, pervaded British imperialism and persuaded many of its white representatives that a permanent Raj seemed a practical possibility.⁷⁰⁴ The ruling class, which he termed the 'official class' in India, were drawn from a small number of public schools with a similar elitist ethos. As public schoolboys, he argued, they retained the basic attitudes they had acquired there until middle age when most retired home to Britain. This ensured that many civil servants and army officers in India thought and acted in comparable ways. However, in his study of the ICS Clive Dewey concluded that ICS men were prisoners of the values they had absorbed in their youth.⁷⁰⁵ In other words they had strength as a group from uniformity but as a whole could have had difficulty in coping with change.

One element which united the ennobled viceroy and the common soldier alike was their 'whiteness,' a union which would not have existed in Britain. Hutchins identified an 'extraordinary confraternity of feeling among Englishmen and an extraordinary sensitivity to criticism of any of their number.'⁷⁰⁶ In other words, he wrote, the upper class Briton could not dismiss a vulgar lower class compatriot as he or she might have done in Britain because the pretensions of both rested on the shared bond of their perceived white racial superiority. It was a kinship which was 'distasteful but unmistakable,'⁷⁰⁷ though nevertheless essential to the middle and upper classes. That distaste was illustrated by Humphrey Trevelyan, a member of the ICS and later a diplomat whose family had Indian connections going back to the 1820s. He recalled a general from the Brigade of Guards in Government House, Ootacamund saying to him 'I cannot help thinking that these people who go into dinner ahead of me are the wretched people who put up little bungalows round my

⁷⁰⁴ Hutchins, *The Illusion*, p. xii.

⁷⁰⁵ Dewey, Clive (1993) *Anglo-Indian Attitudes: The Mind of the Indian Civil Service*, Hambledon Press, London, p. vii.

⁷⁰⁶ Hutchins, *The Illusion*, p. 113.

⁷⁰⁷ Hutchins, *The Illusion*, p. 111.

place in Hampshire.⁷⁰⁸ To the general they might be rich businessmen but they were a lesser breed of men than civil servants. As a tactician the eminent military leader knew that success required a united front and, to paraphrase Hutchins, the white population as a whole were a low lying island of Britons in a tidal Indian sea and they would survive or drown together.⁷⁰⁹

The extent to which the British in India were culturally homogenous needs to be addressed here for the sake of clarity. There are numerous references from the British in India themselves to being members of a single community. Thus in 1909 Maud Diver, who had been born in India to a British Indian family, made her frequently quoted remark that all 'English men and women in India are, as it were, members of one great family, aliens under one sky.'⁷¹⁰ In her reminiscences of life in India Jill Cartwright, who had been born in Kashmir and was the daughter of a senior British Indian police officer, entitled a chapter 'One Great Family,' where she revelled in the camaraderie and *esprit de corps* she experienced there.⁷¹¹ The modern scholarship of Harald Fischer-Tiné criticised this uniformity as simplistic and 'a colonial myth ... [with] ... a long afterlife.'⁷¹² Mrs Cartwright like many of her fellow colonists may have been guilty of nostalgia in her old age whilst choosing to exclude unpleasant memories.

Maintaining British prestige amongst the Indian population was a permanent feature of the British-Indian lifestyle and a concept often commented upon by scholars. A key study of this by Ballhatchet highlighted the belief amongst the colonial authorities that the continuation of British rule depended on its ability to preserve the image of the British rulers as civilised, controlled, disciplined, rational and well-meaning. These were all functions of a belief in their civilisational and racial superiority in contrast to the inferior 'natives.'⁷¹³ Such attributes applied to both British men and British women, arguably giving females a higher status than they might have held generally in Britain.

Comparisons were drawn by Hutchins between the British rulers of India and those of the former Soviet Union as both monolithic, bureaucratic hierarchies. They

⁷⁰⁸ Trevelyan, Humphrey (1972) *The India We Left*, Macmillan, London, p. 112.

⁷⁰⁹ Hutchins, *The Illusion*, p. 113. This sentence is an augmented version of Hutchins' words.

⁷¹⁰ Diver, Maud *The Englishwoman*, p. 33.

⁷¹¹ Cartwright, Jill *The Garlands of Ranpur*, (1998) Pentland Press, Bishop Auckland, pp. 23-34.

⁷¹² Fischer-Tiné, *Low and Licentious*, p. 1.

⁷¹³ Ballhatchet, *Race, Sex and Class*, pp. 123-159.

each maintained a rigid ordering of their societies by making social rank crucial for advancement.⁷¹⁴ In the Soviet Union this was achieved through such methods prescribed by the organisation and discipline of the Communist Party and in India by the Warrant of Precedence.⁷¹⁵ Both societies chose different forms of correction for its dissidents. For British-Indians it could be ostracism by exclusion from community activities. As a member of the Indian Imperial Police in George Orwell had been aware of how the British-Indian community could turn against their non-conformists.⁷¹⁶ This was the subject of his novel *Burmese Days* where the main character was driven to suicide by the claustrophobic pressures, obscurantism and arrant racism of his compatriots in a small and remote British station.⁷¹⁷ The need to maintain prestige could be stressful as well as frustrating.

The British-Indian establishment sought to protect white children, many of mixed heritage, from the Indian gaze by creating schools in more remote areas such as the Himalayan foothills. In her study of European families in India Elizabeth Buettner researched their schools, many of which were run by church organisations and intended for lower and middle class British and Anglo-Indian children in India.⁷¹⁸ A vocational education was often provided which foresaw boys moving to employment on the railways, in the army or in trade and girls to become servants to middle class white families. The intention was to draw them into the ruling hierarchy, though with a lower status. The two world wars forced some upper class families to send their children to schools in India because of the impracticalities and dangers of them travelling to Britain. In Buettner's view this disrupted barriers and brought British children into close contact with their Anglo-Indian peers,⁷¹⁹ but by then the Raj was nearly over.

In order to reinforce their British identity the British in India established a way of life dedicated to recreating the memory of living in the mother country. The

⁷¹⁴ Hutchins, *The Illusion*, pp. 201-202.

⁷¹⁵ King, Anthony D. *Colonial Urban*, pp. 241-243. The Warrant of Precedence is discussed later in this chapter. A sample of this ordinance is given in Appendix 1.

⁷¹⁶ Taylor, D. J. (2004) *Orwell: The Life*, Vintage, London, pp. 73-82.

⁷¹⁷ Orwell, George (2009) *Burmese Days*, Penguin, London. The original was published in 1934. A station was a centre of British population, often on the edge of an Indian town. As a term it is still used today. I remember being told that one psychiatrist in Ahmedabad was 'off station' as he was away from work on leave.

⁷¹⁸ Buettner, *Empire Families*, *passim*.

⁷¹⁹ In addition to Buettner this topic is considered in some detail in Brendon, Vyvyan (2005) *Children of the Raj*, Weidenfeld and Nicolson, London, especially in Chapter 8. pp. 213-240.

everyday artefacts of life in Britain, however, such as European foods, fashions, books and newspapers could not easily be obtained. The community had to adapt what was available. Thus curries prepared for the British palate became part of the diet of many, an example of acculturation showing that the British did make some concessions to the lifestyle of the majority. They became members of a highly artificial society and one that was 'so tightly knit that it exerted a compelling pressure on all its members.'⁷²⁰ The creation of an inexact replica of Britain under Indian conditions fostered 'self-pity and dissatisfaction,'⁷²¹ contended Hutchins, and was itself a source of stress. It can be argued that this was a society with a selective memory, as some of its members were unsuited or unable to cope with the inexorable changes in the West and focussed on what was familiar to them trying to ignore approaching Independence and their own demise.

The replication of Britain in colonial houses was intended to evoke memories of home whilst anchoring the British imperial presence in India.⁷²² The spatial arrangements of their interior design have been studied by Robin Jones who found that the British sought to maintain a physical separation from Indians as one way to prevent the emergence of a hybrid culture.⁷²³ However, these intentions were undermined by the domestic arrangements which required, because of the climate, numerous doors, small windows and high ceilings, together with the presence of a larger number of servants than would have been likely in Britain. European visitors often remarked on the idiosyncratic and uncomfortable nature of these very un-British homes.⁷²⁴ The Raj did not reproduce cosy Edwardian parlours on the sub-continent and this perpetual discomfort could be regarded as a permanent cause of anxiety. The hill stations may well have given a semblance of the Home Counties with mock Tudor houses or Victorian churches and gone some way to placate homesickness. Yet their attempts to recreate England reinforced the artificiality of their society. Thus, for example, in the absence of slates, their roofs were covered in locally sourced materials such as corrugated iron and sounded most foreign in the

⁷²⁰ Hutchins, *The Illusion*, p. 101.

⁷²¹ Hutchins, *The Illusion*, p. 101.

⁷²² Jones, Robin D. (2007) *Interiors of Empire: Objects, Space and Identity within the Indian Subcontinent, c. 1800-1947*, Manchester University Press, Manchester, pp. 60-61 and pp. 220-221.

⁷²³ Jones, *Interiors of Empire* p. 220.

⁷²⁴ Jones, *Interiors of Empire* pp. 1-2.

rain. They served incongruously as playgrounds for chattering monkeys, something which would not normally be seen in Buckinghamshire or Hertfordshire.⁷²⁵

A working class approach to describing life in India came from Private Richards who recorded tales of the tedium of everyday life in barracks and the excitement of campaigns. He recalled meeting a white man, aged about 90, who had settled in the country after serving in the East India Company's army from 1837. The old man, who wore Indian clothes and spoke Hindustani, had made a comfortable life as a 'bacon wallah' selling his meat each winter to British soldiers.⁷²⁶ Despite having 'gone native' he was respected by ordinary soldiers for the service he provided to them and not seen as a threat to their racial identity.

The superficial uniformity of British-Indian culture was designed to impress and awe its colonial subjects as an embodiment of collective strength. In reality it was a veneer attempting to hide the differences in social class, a thin covering embracing the mental stresses inherent in the psyche of the anxious minority. What was evident, however, was the underlying fear of another uprising of the kind which shocked the British in 1857 and 1858. The uncertainty of their situation was highlighted by the journalist and historian Michael Edwardes, who came from a British-Indian family. He observed that the memory of that great horror was always near the surface.⁷²⁷ Yet many of the British convinced themselves that their community was, in Buettner's words, a 'permanent impermanence,' as service in India became a family business passing through generations of the same families.⁷²⁸

In his *Culture and Imperialism* Said gave a post-modern interpretation of culture as being about Western domination, or globalisation as it is now called. He identified cultures as being part of a hierarchy of sophistication with some being more sophisticated than others. To Said culture was dynamic and changing. It was a flexible system of values and outlook on the world which people lived by, and by which they defined their identities and negotiated their lives. Said recognised cultures as humanly made structures implying authority and participation. He

⁷²⁵ See, for example, Bhasin, Raaja (2011) *Simla, The Summer Capital of British India*, Rupa Publications, New Delhi, and Kanwar, Pamela (2009) *Imperial Simla: The Political Culture of the Raj*, Oxford University Press, New Delhi, 2nd edition. The author of the thesis can verify the activities, irascible behaviour and sharp teeth of the monkeys in Simla.

⁷²⁶ Richards, *Old Soldier*, p. 86. A *wallah* was a person of a particular occupation. It was a term often used dismissively.

⁷²⁷ Edwardes, Michael (1963) *The Last Years of British India*, Cassell, London, p.15.

⁷²⁸ Buettner, *Empire Families*, p. 1.

contended, with acknowledgment to Foucault, that those in power in the West created, dominated and disseminated the language associated with rule and power.⁷²⁹ It ensured that they internalised linguistically their belief in white superiority and Eastern inferiority.

The work of the Raj and of similar imperial regimes was implemented by those whom Said called 'decent people'. In effect, they were given permission by those in authority to believe that native peoples must be subjugated and ruled for their own good. These 'decent people,' a term he used without irony, were permitted in their implied if imagined job description 'a protracted, almost metaphysical obligation to rule subordinate, inferior or less advanced peoples.'⁷³⁰ Such specifications were turned into derogatory language towards non-white races and absorbed and used by those in the colonial authorities to justify imperial power and their racial superiority.⁷³¹ It can thus be argued that the 'ordinary' colonist enabled the empire to continue because of his or her subordination to the parent state, imperial Britain. Whether this was through a common interest or the inability to conceive of any alternative was irrelevant.

It was proposed by the historian D. K. Fieldhouse that the cornerstone of empire rested on the mental attitude of the colonist.⁷³² He argued that the success of the imperial project depended on what the latter was prepared to cope with, whether this was the environment, the risk of revolt and so on. Said asserted that cultures were 'benevolent in what they include, incorporate and validate but less benevolent in what they exclude and demote.'⁷³³ The grand notions of the Raj rested for their success on the combined mundane experiences and commitment of Europeans lower down the social hierarchy, the individuals who were physically closer to Indians and who personified the empire to them.

⁷²⁹ Said, Edward (1994) *Culture and Imperialism*, Vintage, London, p. 132.

⁷³⁰ Said, *Culture and Imperialism*, p. 10.

⁷³¹ Said, Edward (2003) *Orientalism*, Penguin Books, London, (original 1978), *passim*, but especially pp. 207, 231-234, 262.

⁷³² Cited in Said, *Culture*, p. 11.

⁷³³ Said, *Culture*, p.15.

Culture and stress of the British in India

The links between mental health, race and culture have been studied by the Sri Lankan born psychiatrist Suman Fernando.⁷³⁴ He argued that, following the influence of the anthropologist, W. H. Goodenough in the 1950s, culture became defined as a social concept or 'something out there.'⁷³⁵ In addition, thirty years later, wrote Fernando, R. G. D'Andrade introduced the idea of culture having a psychological state i.e. it was something 'inside' the person or persons who embraced it. Fernando absorbed both these external and internal components when applying Eagleton's definition of culture as 'a unique way of life.'⁷³⁶ He accepted that because of its multiple definitions 'culture' was an imprecise term but was a useful concept for explaining the non-physical influences that determined their behaviour, attitudes and way of life.⁷³⁷ In terms of British India this meant a withdrawal by the individual from Indians and a pride in his or her distinct racial and cultural difference. The social and psychological aspects of this topic will be explored in more depth later in the chapter.

Much of Fernando's clinical career has been concerned with ethnic minorities who have been forced to leave their homelands through economic and political upheavals, or simply with the basic need for survival. The British who lived there were, as has already been shown, an ethnic minority in India. The British diaspora across the Indian sub-continent had once been an adventure bringing with it the chance of great riches. After 1858 many still sought wealth and comfort but their role as economic migrants changed for many to a self-determined position in bureaucratic administration and military pacification. Their rewards were moral and, as described by Collingham, the early nineteenth century *nabob*, the flamboyant, effeminate and wealthy East India Company employee, was transformed into the early twentieth century *sahib*, the sober and bureaucratic representative of the

⁷³⁴ See Fernando, Suman (2010) *Mental Health, Race and Culture*, Palgrave Macmillan, 3rd edition, Basingstoke, Hampshire, and Fernando, Suman (2014) *Mental Health Worldwide: Culture, Globalization and Development*, Palgrave Macmillan, Basingstoke, Hampshire.

⁷³⁵ Goodenough, W. H., (1957) and D'Andrade, R. G. (1984), both cited in Fernando, *Mental Health, Race*, p. 10.

⁷³⁶ Fernando, *Mental Health, Race*, p. 9. See also Eagleton, Terry (2000) *The Idea of Culture*, Blackwell, Oxford, p. 26.

⁷³⁷ Fernando, *Mental Health, Race*, p. 26.

Crown.⁷³⁸ Their sense of duty and self-sacrifice began to prevail with the potential for increased stress.

Organisational culture and its links to what has now been defined as institutional racism have been addressed by Fernando.⁷³⁹ Institutional racism has been defined as

*that which, covertly or overtly, resides in the policies, procedures, operations and culture of public or private institutions - reinforcing individual prejudices and being reinforced by them in turn.*⁷⁴⁰

Fernando argued that organisational culture could be viewed as a racist culture, where people adhered to a tradition and acted in unison for a particular purpose. The outlook of the British in India as a group, or an organisation, and which was institutionally racist would meet this criteria.

Another way of explaining the impact of the change from King's first culture to his third was to employ the modern concept of *cultural bereavement*. It was first proposed in 1990 by the psychiatrist Maurice Eisenbruch to assist with the understanding of the impact of the stresses faced by refugees following their loss of family and homeland.⁷⁴¹ The application of this concept to the British in India viewed the latter as an ethnic minority thousands of miles from home and lamenting the loss of their life in their homeland. They had tried to recreate physically a British ambience in the hill stations and to reproduce what they missed from home. Whilst some thrived on the privileges that came with being part of a middle class aristocracy others found the experience stressful. As Richards remarked ordinary soldiers might feign mental illness in order to be repatriated to Britain. He wrote of one soldier who achieved his goal of admission to hospital by running naked outside a church on a Sunday when officers and their wives were leaving it. After 12 months in an asylum

⁷³⁸ Collingham, *Imperial Bodies*, p. 3.

⁷³⁹ Fernando, *Mental Health, Race*, p. 11, The term was initially defined by the Macpherson Inquiry into the murder of Stephen Lawrence in 1999. Fernando discussed the arguments around the institutional racism debate including the suggestion that the culture of psychiatry itself is institutionally racist.

⁷⁴⁰ A. Sivanandan, Director, Institute of Race Relations, cited in *The Guardian*, <https://www.theguardian.com/uk/1999/feb/24/lawrence.ukcrime7> (Accessed 22nd November 2017)

⁷⁴¹ Eisenbruch, M. (Dec. 1990) 'The cultural bereavement interview: a new clinical research approach for refugees,' *Psychiatric Clinics of North America*, vol. 13, no. 4, pp. 715-35.

in Britain he married and settled down to a steady job in London apparently cured. Sometimes he was sure, he wrote, that they were actually insane or may have become so as part of their pretence.⁷⁴² In this context cultural bereavement may be viewed as a pathological form of homesickness.

The notion that migrants have experienced multiple and unique stresses that could have an impact on their mental wellbeing has been developed by the psychiatrists Dinesh Bhugra and Matthew from the work of Eisenbruch.⁷⁴³ Such pressures can include the loss of cultural norms and social support systems, adjustment to a new culture and changes in identity and the very concept of self. Whereas their findings were aimed at present day psychiatrists dealing with current migration situations they can help with an understanding of the historical stresses faced by the British in India who were engaged in recreating a Western culture in an Eastern land. The white community, both the elite and the 'ordinary,' were trying to maintain a political system to the best of their ability which London threatened to hand over to an independent India. It could be argued that many Britons grieved for their homeland but for a Britain that had long since changed and continued to do so. Their predicament was intensified following the Montagu-Chelmsford reforms but the deadline for their implementation was never determined until 1947, only a few months from Independence. For many Britons this ongoing threat to their official and privileged status, their culture, their existence, must have seemed a source of permanent anxiety.

The British in India had developed and sustained a narrow, inward looking culture. Their inability or unwillingness to adapt it as circumstances changed was a potential stressor as the community fought to defend what became increasingly indefensible, both morally and politically. They aspired to self-preservation, spurned intermarriage and deliberately restricted contact and relationships with Indians. It can be argued that the British in India were a cultural diaspora, an ethnic and religious minority transposed from the edge of the European continent to the heart of Asia. In effect they were at the centre of a force field being pressed on all sides adding to their stress.

⁷⁴² Richards, *Old Soldier*, pp. 155-159.

⁷⁴³ Bhugra, D., and Becker, M. A. (2005) 'Migration, cultural bereavement and cultural identity.' *World Psychiatry*, 4(1), 18–24.

Having discussed issues of cultural stress for the British in India the chapter will now illustrate these in more depth using the diagrammatical tool known as the *cultural web*.

The cultural web

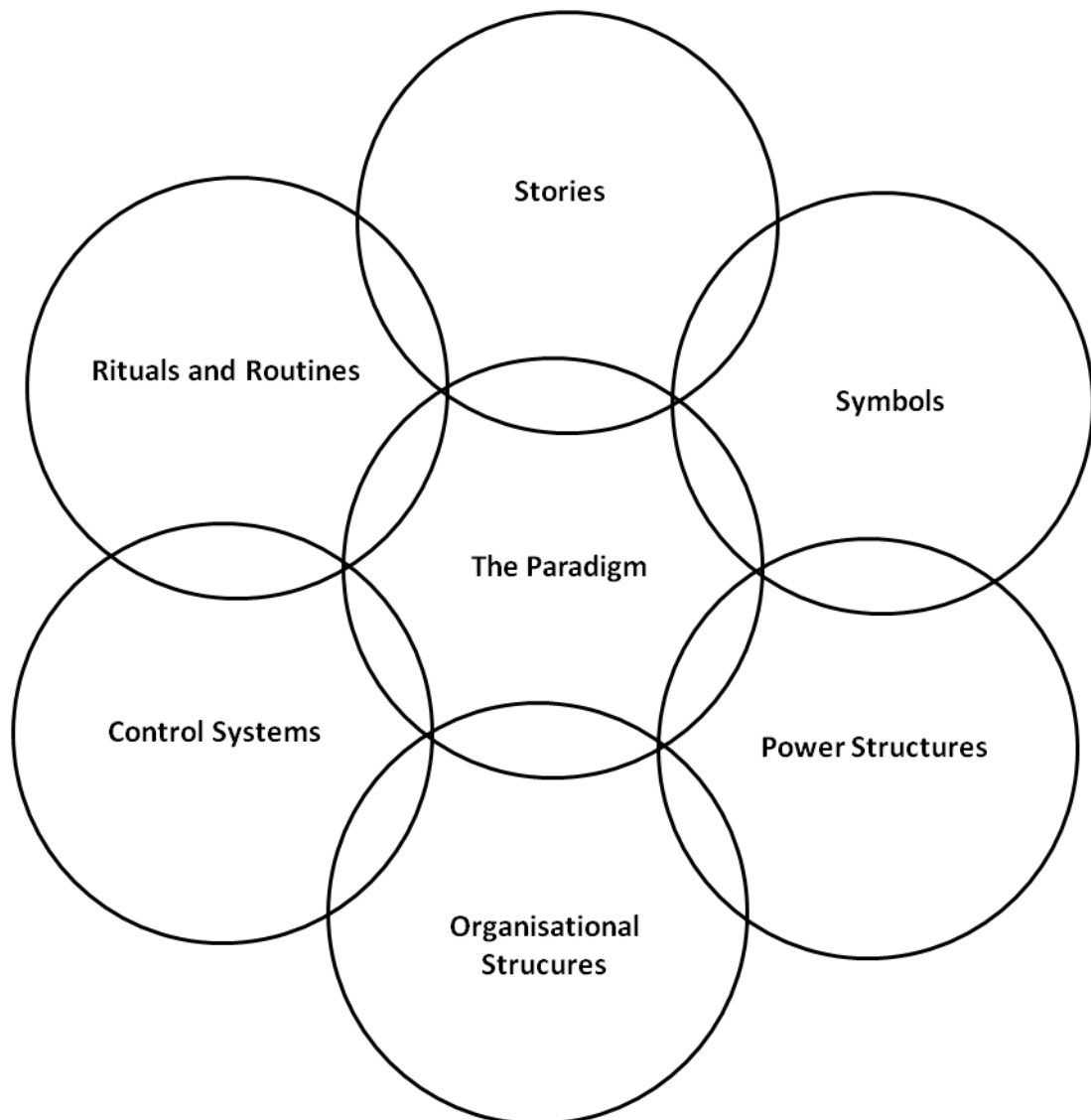
The *cultural web* was devised originally in the 1980s by Gerry Johnson, a British professor of strategic management as a descriptive and analytical device to help understand the relationship between strategy and organisational culture.⁷⁴⁴ It can be used to inform the debate about the cultural stresses surrounding the British in India and illustrate how they were unable to adapt to the many changes surrounding them. It was designed to be used in the study of organisational change as a way to facilitate future improvements in working relationships. The arguments in this chapter so far have shown that, although heavily delineated by class, the British in India sought to act as a homogenous community with a universal culture linked by its whiteness. Race transcended class for this dimension of the imperial project. For the purposes of this chapter the British in India will be regarded as being part of an organisation, an entity defined as a 'systematic arrangement for a specific purpose',⁷⁴⁵ in this case for the maintenance of their Raj.

The web is represented graphically by a central circle with six interlocking circles around its perimeter. The basic *cultural web* is introduced graphically in Figure 5.1 and the broad definitions of its seven components are outlined below in Box 5.1. A completed version will be constructed in Figure 5.2.

⁷⁴⁴ For further information on the *cultural web* see Johnson, Gerry and Scholes Kevan (2002) *Exploring Corporate Strategy*, Pearson Education, Harlow. Essex, 6th edition pp. 229-236, and Johnson, Gerry and Scholes, Kevan (2001) *Exploring Public Sector Strategy*, Pearson Education, Harlow, Essex, pp. 300-314.

⁷⁴⁵ *The Shorter Oxford English Dictionary* (1987) vol. 2, Oxford University Press, Guild Publishing, London, p. 1462.

Figure 5.1: The Cultural Web⁷⁴⁶



At the core of the cultural web is a *paradigm* or a set of assumptions about what an organisation or community is there to do and the reasons for its success in the past. It was this ‘taken for grantedness’ which acted as a filter enabling the members of the organisation to make sense of their world both internally and externally. Johnson and Scholes wrote that the paradigm could provide shorthand for identifying the successes of the organisation or community as well as a way of understanding complex situations. However change may be problematic, or even impossible, if the

⁷⁴⁶ From Johnson and Scholes, *Exploring Public Sector Strategy*, p. 305.

culture reinforced past achievements whilst being resistant to change.⁷⁴⁷ The elements of the web are introduced below in Box 5.1

Box 5.1: Elements of the Cultural Web defined⁷⁴⁸

Section	Description
Paradigm	The <i>paradigm</i> was the set of assumptions about the community which were held in common and taken for granted by its members.
Routines	The <i>routines</i> referred to how members of the community behaved towards each other, and to how different parts of it were linked together. These routines illustrated the ‘way we do things around here’, which at their best lubricated the workings of the community. However, they could also signify a ‘taken-for-grantedness’ about how things should happen which was extremely difficult to change and which was highly protective of core assumptions in the paradigm.
Rituals	The <i>rituals</i> of community life indicated what was important in the community. They reinforced ‘the way we do things around here’ and signalled to the community, and outsiders, what was especially valued.
Stories	The <i>stories</i> told by members of the organisation to each other, to outsiders, to new recruits, and so on, embedded the present in the community history and recalled important events and personalities. They also warned of the unconventional people who deviated from the norm.

⁷⁴⁷ Johnson and Scholes, *Exploring Corporate Strategy*, pp. 534 and 562

⁷⁴⁸ Adapted from Johnson and Scholes, *Exploring Public Sector Strategy*, p. 304.

Symbols	The <i>symbols</i> of the community were a shorthand representation of its nature and were seen in forms of clothing and imperial architecture.
Power Structures	The <i>power structures</i> were strongly associated with the key constructs of the paradigm. The most powerful groupings in the community were likely to be the ones most associated with core assumptions and beliefs about what was important.
Control systems	The formalised <i>control systems</i> emphasised what was important in the community and measured and controlled its achievements through rewards and honours and by physical elements of control such as the Army and the police.
Organisational structures	In turn, the formal <i>organisational structures</i> , or the more informal ways in which the organisations work, were likely to reflect power structures and, again, delineate important relationships and emphasise what was important in the community.

Application of the cultural web in colonial India

The paradigm at the centre of this specific web, which has been argued throughout this thesis, was that the British represented allegedly a racially superior civilisation and one which was there to help the Indian population gradually rise to the expectations of their masters. The ultimate goal was the eventual achievement of self-government by the colonised. There was no realistic master plan and no strategic blueprint until just a few months before Independence. The ICS and the humble white clerk, the colonel and the ordinary soldier, and their respective wives, each had their role in maintaining a united front of white superiority and paternalism,

or in other words racism and exploitation. The assumptions in the paradigm were generally recognised and taken for granted by most of the white community, though there was no consensus around a time scale.

The unity was never complete. Some individuals were a permanent embarrassment to the established order. There was the *loafer*, defined by H. J. A. Hervey, who worked in the Indian Telegraphs Department, as ‘the stone-broke vagrant pauper’⁷⁴⁹ who might flaunt his whiteness. This was an action which Fischer-Tiné has called the racial dividend,⁷⁵⁰ and might be used, for example, where a member of the ruling race might assert his whiteness over an Indian policeman and so escape the consequences of breaking the law which an Indian would never be permitted to do. There were the missionaries who might be motivated by spiritual rather than political outcomes and whose piety might not fit well with institutional racism.⁷⁵¹ There were the visiting MPs who were satirised by Kipling and others for their rapidly acquired self-styled expert knowledge of India following a brief visit.⁷⁵² There were the intellectuals such as E. M. Forster⁷⁵³ and Edward Thompson whose critical writings based on their experiences in India might be quite influential in Britain and challenged or ridiculed the status quo.

The web depicts tightly interlocking sections around the central paradigm. If any of the components were to be detached the whole would be at risk of imminent collapse. In historical terms it portrays some of the key factors relating to British culture in India. Thus if the British had ceased to believe in their stories of their heroism and well-intentioned paternalistic rule, their symbols of the King-Emperor, the military parades and distinctive clothing would become irrelevant and their authority would be undermined. If their power structures and control systems ceased to function, as in 1947, then the Raj’s authority would be ended permanently.

⁷⁴⁹ Hervey, H. J. A. (1913) *The European in India*, Stanley Paul, London, p. 95. The term ‘loafer’ was in common usage amongst the British in India to describe one of their own race who was a vagrant or beggar and did not conform to the expectations of the majority of Europeans there.

⁷⁵⁰ Fischer-Tiné, *Low and Licentious*, p. 375.

⁷⁵¹ For further information on this topic see Hasan, Mushirul (2013) *Faith and Freedom: Gandhi in History*, Niyogi Books, New Delhi, especially Chapter 7.

⁷⁵² See, for example, the poem ‘Pagett M.P.’ in *Rudyard Kipling’s Verse*, pp. 26-27.

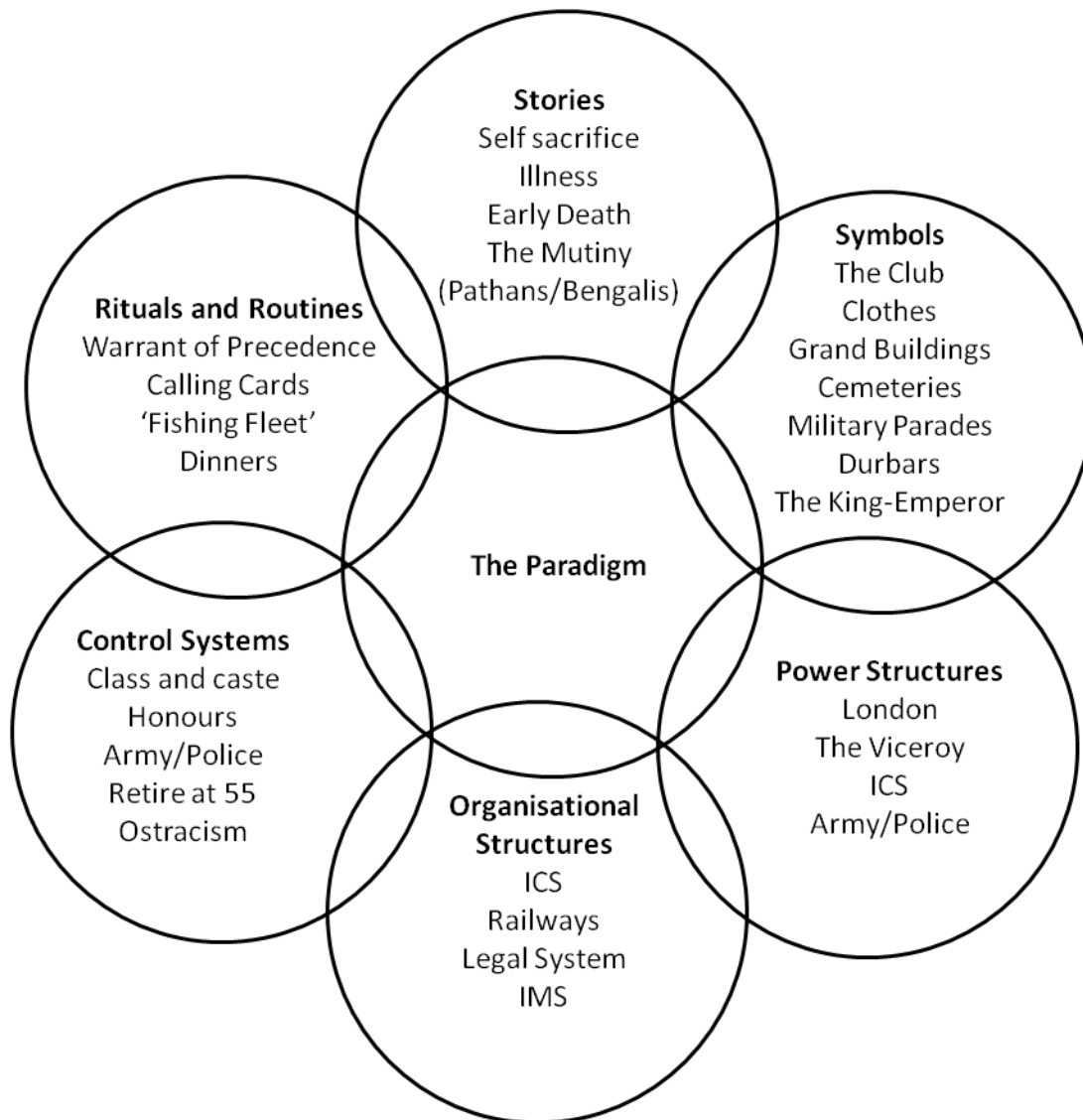
⁷⁵³ See, for example, Forster, E. M. (1985) *A Passage to India*, Penguin, Harmondsworth, Middlesex. The original was published in 1924. His novel was particularly criticised by the community because of its general portrayal of British officials as bigoted and uncultured.

In addition the web also demonstrated how the British could not manage changes to their position in India. The assumptions about themselves were conservative ones which rested on their notions of imperial power. They had successfully campaigned against the Ilbert Bill of 1883, which would have allowed more Indian judges to preside over British men and women. However the Montagu-Chelmsford reforms initiated in 1911, and their offshoots, were endorsed by different parties in British government in the subsequent decades. The impact of these changes were assessed by the historian Judith Brown who described the period between 1914 and 1947 as amongst the most turbulent periods in the history of India. Looking back at those years she observed that there was a significant dynamic pervading the sub-continent during this period of unprecedented change.⁷⁵⁴ Although the reforms were disliked by viceroys and wives of railwaymen alike change was inexorable as it was what London desired. As such the reforms were a threat to the British in India who had to implement changes which many of them did not want and many of them thought unworkable.

Having provided an interpretation of how the cultural web can be applied to the context of the British in India, this chapter will now delve deeper into the analysis and explore its different components and its application as a tool for understanding. A completed cultural web will be shown in Figure 5.2. Each circle is populated by random examples which illustrate the element under investigation and some of which could also be accommodated in other circles. The content of the circles is not intended to be exhaustive.

⁷⁵⁴ Brown, Judith M. (1999) *India: The Oxford History of the British Empire*, vol. 4, Oxford University Press, Oxford, p. 421.

Figure 5.2: A cultural web for British culture in India



The paradigm

Whilst it is impossible to cover every aspect of the lives of British-Indians it is the contention of this chapter that there were common assumptions which their community made about itself and its colonial role. Evidence for this can be provided

in the fictional works of Diver and Kipling, and the innumerable memoirs⁷⁵⁵ of those who represented the Raj in India.

There was a general view amongst the British community that they were doing 'good,' that they were selflessly undertaking a 'civilising mission'⁷⁵⁶ as they shouldered the 'white man's burden.'⁷⁵⁷ Their objective was to raise the level of Indian civilisation from the decay which it had undergone in previous centuries. The intention was that, with British direction, India would one day achieve independence as a dominion within the British Empire, though it was taken for granted that this would not be in the foreseeable future. The basis for this assumption was that the British were superior to Indians in race, intellect and civilisation and, by definition, were therefore vital to the governance of the country for decades ahead. The purpose of imperial rule became that of a paternalistic Raj governing their subjects in the latter's best interests even if Indians did not always appreciate or understand or accept the motivation behind it. The Raj was *Ma Bap*,⁷⁵⁸ and Indians were frequently referred to as children, undisciplined and often mischievous, but immature people who were thought to relish and indeed welcome the firm and fair hand of British control.

Underpinning this paradigm was the inherent fear that another uprising on the scale of 1857-58 could emerge at any time with catastrophic consequences for the community. The periodic Nationalist opposition to the Raj, which was met with actual or threatened violent repression by the occupying power, as at Amritsar in 1919, maintained British trepidation. The British were a garrison community and their permanent defensive status was a source of stress for the whole European population. They presented an insular culture, based on the need for self-preservation and the status quo which conflicted more and more with the policy demands of London. With some exceptions they were unable to embrace change, as

⁷⁵⁵ See, for example, Lawrence, Sir Walter R. (1929) *The India We Served* Cassell, London and McMunn Sir George (1934) *The Living India: Its Romance and Realities*, G Bell, London.

⁷⁵⁶ For a critical description of the 'civilising mission' see Fischer-Tiné and Mann, *Colonialism*. The term, originally French, was coined to justify colonialism from a colonial perspective.

⁷⁵⁷ 'The White Man's Burden' in *Rudyard Kipling's Verse*, pp. 323-324. The poem was written in 1899 and concerned the American acquisition of the Philippine Islands as Kipling welcomed the United States joining the white family of colonial countries.

⁷⁵⁸ This is defined by Yule and Burnell, *The Concise Hobson-Jobson*, p. 254 as 'You, my Lord, are my mother and father!' This is an address from a native, seeking assistance, or begging release from a penalty, or reluctant to obey an order.'

to do so would have been to admit the untenability of their future position and anticipate the end of their culture and their very existence.

In stressing the importance of this paradigm it has to be stated that it would not have applied prior to the early nineteenth century. Before this the ethos of the East India Company, the foremost British authority on the sub-continent, was one driven by commercial exploitation. Their territorial expansion and frequent wars were designed to sustain this drive for profitability and prevent competition from rival colonial powers. Their energetic search for profits did not prevent the nabobs from marrying Indian women and taking an active interest in Indian culture. As the nineteenth century progressed, and particularly after 1858, the sahibs began to presume their presence was indefinite, an existence mixing commercial success with the need to 'improve' India and Indians whilst remaining aloof from them.

In his contribution to the debate about a civilising mission Harald Fischer-Tiné argued that there was an 'external mission' directed at the Indian population at the same time there was an 'internal' one geared at poor white residents.⁷⁵⁹ The latter have been termed by the Indian scholar, S. P. Mohanty, as an 'awkwardly intermediate class'⁷⁶⁰ whose very existence threatened British prestige. An 'internal' mission was needed, emphasised Fischer-Tiné:

*to safeguard the legitimacy of an imperial enterprise jeopardised by the confrontation of the Indian population with the dropouts of European society.*⁷⁶¹

The internal mission was thus essential in supporting the external one. The implementation of both objectives remained a continued source of stress as the British sought to maintain their image as a superior race with all the contradictions and paradoxes over which they presided. It was Fischer-Tiné's conclusion that the civilising mission became the sole ideology of British colonialism in India.⁷⁶²

⁷⁵⁹ Fischer-Tiné, Harald (September 2005) 'Britain's other civilising mission: Class prejudice, European 'loaferism' and the workhouse-system in colonial India,' *The Indian Economic and Social History Review*, vol. 42, no. 3, p. 298. DOI 10.1177/001946460504200302.

⁷⁶⁰ Mohanty, S. P. (July 1989) 'Kipling's children and the color line,' *Race and Class*, vol. 31 no. 1, p. 30.

⁷⁶¹ Fischer-Tiné, 'Britain's other,' p. 298.

⁷⁶² Fischer-Tiné and Mann, *Colonialism*, p. 24.

This self-styled civilising role, or burden in Kiplinesque terms, became embedded in the imperial psyche. In recognition of its depth Said argued that Britain stayed in India because it had massively reinforced notions of a civilising mission.⁷⁶³ In addition Bill Ashcroft and Pal Ahluwalia concluded that by the late nineteenth century the British had erected an edifice of community, which was so hugely confident, authoritative and self-congratulatory that its centralising of European life and its complicity in the civilising mission could not be questioned.⁷⁶⁴

Recent scholarship however has challenged the idea of a British civilising mission. Jon Wilson contended that there was no systematic vocation to advance Indian civilisation but instead its objectives were far more chaotic and anxiety-provoking. Wilson added:

*[F]rom beginning to end, it was ruled by individual self-interest, by a desire for glory and a mood of fear, by deeply ingrained habits of command and rarely any grand public reason.*⁷⁶⁵

He emphasised that the consequences were erratic and uneven governance whose end result was the chaos that colonial rulers left in 1947.

In summary, the paradigm on which the above cultural web was constructed was based on the assumptions held by British-Indians across the class divides that they were there, selflessly, to guide and educate Indians until one day in the distant future the latter would be able to rule themselves. In the semi-permanent interim there was a commonly held view and a deep anxiety that vigilance was always required as another great rebellion might occur at any time. The individual components of the cultural web will now be addressed in turn.

Rituals and Routines

This section represented the daily behaviour of and actions within the community, which signalled conduct that was acceptable and that which was not. Rituals and

⁷⁶³ Said, Edward Culture and Imperialism, pp. 129-133 and passim,

⁷⁶⁴ Ashcroft, Bill and Ahluwalia, Pal (2001) *Edward Said*, Routledge, London, p. 87.

⁷⁶⁵ Wilson, *India Conquered*, p. 9.

routines indicated what was expected to happen in given situations and what was valued by the community.

The generosity and hospitality of her own community was praised by Diver, proud of her long family connections with India. In her 1909 guide for the Englishwoman newly arrived in India she observed that India was '[T]he Land of the Open Door'⁷⁶⁶ and 'the land of dinners, as England is the land of five o'clock teas,' a country where bachelors often dropped in, guests would stay for weeks and meals were made for friends or strangers with little notice.⁷⁶⁷ She advised the newcomer that entertaining fellow Europeans was an important part of the middle class hostess's life in India. The latter, of course, would preside over the stories of the Raj being told over the dinner table. Advice to the hostess needing guidance on the recipes to use or the correct etiquette to employ could be consulted in one of the many manuals created for just these purposes. The popularity of these manuals was shown by the success of that by Steel and Grace Gardiner whose volume first published in 1898 had run to ten editions by 1921.⁷⁶⁸

In addition to text books on how to manage menus and seating arrangements proper social etiquette was decreed from the centre. In Raj government and military circles it was codified in the *Warrant of Precedence*. This was an elaborate instrument listing 175 separate roles which were classified into 61 basic positions.⁷⁶⁹ Thus the Viceroy was ranked at number 1, Lieutenant Generals and the Chief Commissioner of Delhi at 20 equal, the Civil Superintendent of Clothing Factories 44. The Controller of Printing, Stamps and Stationery at 46 was ranked 13 places above an army major. Wives were given the ranking of their husbands. The ranks attached to positions were well known and determined, for example, the degree of social etiquette and respect to which the postholder was entitled. Although the warrant only applied to holders of official government positions it was also influential in determining the social importance of non-officials such as businessmen and planters. It became the bible of every British hostess from the middle of the nineteenth century until 1947 and its details and nuances were frequently discussed

⁷⁶⁶ Diver, *The Englishwoman*, p. 49.

⁷⁶⁷ Diver, *The Englishwoman*, p. 55.

⁷⁶⁸ Perhaps the most popular was Steel and Gardiner (1898) *The Complete Indian Housekeeper*.

⁷⁶⁹ King, Anthony D. *Colonial Urban*, pp. 241-243. Part of the Warrant is reproduced in Appendix 1.

in the Viceroy's Council.⁷⁷⁰ The Army recognised the authority of the Warrant but also had its own esoteric customs. The rituals and routines associated with the Warrant emphasised what was important to the community and how its members were expected to behave.

The pride of Diver and many others in imperial achievements was not always shared by outsiders to the community. A criticism of the culture of the British in India came from Lionel Fielden. He was from a wealthy and privileged background in Britain and after military service in the First World War who held a series of posts including cabinet secretary for the first Labour government before joining the BBC in the late 1920s. In 1935 Fielden was appointed the first Director General of the incipient All India Radio. He moved to Delhi and in his autobiography gave a damning indictment of British cultural life in India.⁷⁷¹ He portrayed the British in India as:

*the conglomeration of English officials and their wives – the most ignorant, insensitive, arrogant and stupid conglomeration that the world has ever produced.*⁷⁷²

Fielden mocked the British in India for their houses, furniture, guests, food and conversation, all of which he said were identical. He recounted how he was required to join in the rituals and routines of dinner every evening and how he was forced to wear full evening dress despite the heat. He had to be seated at the table in the order determined by his salary and so always sat with the same people, an example of the rigidity of the Warrant of Precedence in practice. He wondered how any human being could stand it and he wanted to scream at the falseness and absurdities of the culture it represented where

*[N]ot a book was read or owned, in those trim respectable bungalows, not a play had been seen, not a note of music was known, never was there even an echo of real laughter.*⁷⁷³

⁷⁷⁰ Macmillan, *Women of the Raj*, p. 41.

⁷⁷¹ Fielden, Lionel (1960) *The Natural Bent*, Andre Deutsch, London.

⁷⁷² Fielden, *The Natural*, p. 179.

In summary, he wrote

*it was though one was shut up with a crowd of actors in an outdated pageant, a dusty, fusty representation of Versailles*⁷⁷⁴

and as such unaware and uninterested in the population it ruled, making the Raj, a sad spectacle of a 'third rate tyranny'.⁷⁷⁵ To Fielden the British were cultural philistines who ignored India changing around them and protected themselves from it with arcane and absurd rituals and routines.

Those British visiting India without the long family tradition of service there were often critical of the customs which they encountered. The writer, Paul Scott, came to India as a serving soldier during the Second World War viewing the British from a different political background and identified similar attitudes to those of Diver and Perrin. Scott did not accept Diver's view that the British were heroically saving India with their courage and paternalism. Instead he was scathing about the community's racist attitudes, its insularity and its indifference towards and ignorance of India and its people. He wrote of the constant negativity of Britons and their self-pitying pronouncements which sought to justify their existence and served as a form of imprisonment and exile from the world beyond the Indian Empire.⁷⁷⁶

One ritual was regarded as particularly ridiculous by Scott and other newcomers. He mocked the custom which he regarded as an archaic Edwardian practice that required a Briton newly arrived at a colonial station for the first time to leave his or her calling card at European homes in the settlement. The occupant would then decide whether or not to invite the new arrival to dinner. The refusal not to cooperate was a recognised snub to the community, as was a refusal not to invite him or her to afternoon tea or dinner. Scott regarded this ritual as bizarre and as

⁷⁷³ Fielden, *The Natural*, p. 179.

⁷⁷⁴ Fielden, *The Natural*, p. 179. Fielden the outsider was treated with suspicion by the establishment of British India. His post was opened by the police and the Head of CID told him that India was no place for 'Left Intellectuals.'

⁷⁷⁵ Fielden, *The Natural*, p. 179.

⁷⁷⁶ Moore, Robin (1990) *Paul Scott's Raj*, Heinemann, London p. 23.

'fossilised nonsense.'⁷⁷⁷ However it played an important role in preserving British traditions and giving some semblance of continuity to their community.

Ever since the British first came to India in the seventeenth century there had been a considerable imbalance between the numbers of white males and white females. In 1901⁷⁷⁸ and 1921,⁷⁷⁹ for example, the ratios were, respectively, 2.6:1 and 2.5:1. In part because of this officers were often refused permission to marry by their colonel until the age of 30.⁷⁸⁰ An early example of single women coming to India in search of marriage was identified by Anne De Courcy in 1671 when the East India Company paid for 20 women to go to Bombay to find a husband.⁷⁸¹ The journey time to India was reduced from two months to less than four weeks with the opening of the Suez Canal in 1869 and the trip became safer and more comfortable as the quality of ships improved. By the end of the nineteenth century it was common for large numbers of European women to travel to India 'husband-hunting.' The 'Fishing Fleet,' as they became known would sail out to India in September as the weather cooled, to attend a whirlwind of balls and social activities over the following few months. For many the goal of marriage was achieved and life as a memsahib began. Those 'fisherwomen' who were unsuccessful were unkindly deemed 'returned empties' and went back to Britain as singletons, though there was the possibility of a return the following season.⁷⁸²

The British in India clung to the security of their rituals and routines which political radicals like Fielden and Scott regarded as outmoded and farcical. The community did not wish to alter the way it operated and was highly protective of its underlying mission to Indians. However the British in India did not wish, or were unable, to change what they took for granted, which was in itself a stressor, whether or not they were able to recognise it.

⁷⁷⁷ See Moore, *Paul Scott's Raj*, p. 24.

⁷⁷⁸ See Government of India (1902) Census Commissioner of India, Census for 1901, Vol. 1, Table VII, p. 399-400. At <https://archive.org/details/cu31924071145704> (Accessed 11th November 2017).

⁷⁷⁹ See Government of India (1922) Census Commissioner of India, Census for 1921, Vol. 1, Table XV, pp. 184-186. At <https://archive.org/details/cu31924014522746> (Accessed 11th November 2017).

⁷⁸⁰ Allen, *Plain Tales*, p. 63.

⁷⁸¹ De Courcy, Anne (2012) *The Fishing Fleet: Husband-Hunting in the Raj*, Weidenfeld and Nicolson, London, p. 2.

⁷⁸² De Courcy, *The Fishing Fleet*, p. 3. Ms De Courcy did not find evidence that any of the young women suffered from mental illness, at least whilst in India. She told me that for many it was an exciting experience with a successful outcome of marriage. (From personal email conversation.)

The illustration of these rituals and routines has helped with the understanding of British culture in India and some of the inherent stresses it presented. Their customs helped to unite and sustain their community, Diver's 'one great family.'⁷⁸³

Stories

Stories are another part of the paradigm which reveal an important part of one's culture. This section concerns the *stories* which members of the community told to each other, to visitors from abroad, and to those new recruits who had just come to India. The sagas celebrated the heroic myths created by important events and personalities and were implanted deep into the community's history. They also served as a warning to any critical or non-conforming newcomers who might threaten to deviate from the norm.⁷⁸⁴

The vision of the colonial purpose was proffered at the highest level. Speaking in 1904 at the apogee of British power in India the viceroy, Lord Curzon declared

*[T]o me the message is carved in granite, it is hewn out of the rock of doom – that our work is righteous and it shall endure.*⁷⁸⁵

These sentiments reverberated throughout the community at all levels. On one of the lower rungs was Mrs E M Becher, who was interviewed in 1976 by the Centre for South Asian Studies at Cambridge University. She went out to India in October 1929 to join her husband who worked on the railways. Mrs Becher had never envisaged the British leaving India and believed that Independence had come too soon for India. She expressed her justification for the Raj quite simply and sincerely:

*[W]e regarded it as a sacred trust to help the backward races. We felt we were there to help the underprivileged.*⁷⁸⁶

⁷⁸³ Diver, *The Englishwoman*, p. 33.

⁷⁸⁴ See Kincaid, *British Social Life*, Allen *Plain Tales*, and Vernede, *British Life*, for examples of stories told by individual Britons in India.

⁷⁸⁵ Cited in Edwardes, Michael (1965) *High Noon of Empire: India under Curzon*, Eyre and Spottiswoode, London, p. 247.

⁷⁸⁶ Interview with Mrs E. M. Becher *Centre for South Asian Studies, Cambridge University, 1976*, Audiotape 006, located at <http://www.s-asian.cam.ac.uk/archive/audio/collection/e-m-becher/> (Accessed 26th November 2015.)

Mrs Becher spoke without irony but with some disappointment that British achievements were not generally appreciated outside British India.

The Great Rebellion 1857-58, or the Indian Mutiny as it was always known to the British in India, came as a great shock and left a permanent and deep impression on the community. No accurate estimate of the numbers of deaths of Europeans has been made though one historian, Rosie Llewellyn-Jones has suggested that between 1,000 and 1,500 white non-soldiers were killed.⁷⁸⁷ Official and individual attitudes right up until the approach of Independence retained an underlying fear of recurrence. A chronicler of British-Indian social and cultural life, Charles Allen was born in India and had family connections with India going back to 1799. He wrote that the bitter memories left behind by the Mutiny were never healed.

*[I]t forced the two communities apart and created a Mutiny mentality – a refusal to trust the Indian – that the British never quite shook off.*⁷⁸⁸

The practicalities of this mistrust were highlighted by the novelist, translator and great sympathiser with Indian nationalism, Edward Thompson. He spent over 20 years in India and observed in doggerel that the crucial difference between rulers and ruled was that: 'Whatever happens, we have got/The Maxim gun, which they have not.'⁷⁸⁹ It was a cynical but accurate observation on the coloniser's need for protection.

The standard version of the 'Mutiny' narrative persisted until the end of the Raj. The stories of British heroism in the face of 'native' conspiracies and evil plotters became accepted as fact. This 'repertoire of tropes' has been described by Karen Wagner as the '*Mutiny*'- *motif* dominating the collective memory of the British and becoming an essential part of colonial culture and imperial identity.⁷⁹⁰ She argued

⁷⁸⁷ Llewellyn-Jones, Rosie (2008) *The Great Uprising in India, 1857-58, Untold Stories, Indian and British*, Boydell Press, Woodbridge, Suffolk, p. 56. The first census of India took place in 1870, over ten years after the rebellion. At that time there were 212 million 'Asiatics' and just under 90,000 Europeans and Americans. It is a reasonable assumption that the number of whites in India in 1857-58 was of a similar order. See Llewellyn-Jones, *The Great Uprising*, p. 4.

⁷⁸⁸ Allen, Charles (1977) *Raj: A Scrapbook of British India, 1877-1947*, Book Club Associates (Andre Deutsch), London, p.11.

⁷⁸⁹ Thompson, Edward cited in Hutchins *The Illusion*, p. 118.

⁷⁹⁰ Wagner, Karen (February 2013) "'Treading upon fires": The 'Mutiny- Motif and Colonial anxieties in British India,' *Past and Present*, no. 218, p. 169, doi:10.1093/pastj/gts026. Accessed 15th December 2016).

that this 'Mutiny'- motif was a rallying cry for the Raj, 'an invocation of jingoistic sentimentality' which became a guiding principle for the maintenance of British rule.⁷⁹¹ The stories told in the British homes and clubs in India were of fearlessness and pride tempered with some relief that the Indian Army was well armed.

As an illustration of how the community saw itself, tales of past events and the people who took part in them were portrayed consistently in the novels of British India. Many of the stories which the British told about themselves are included in fiction written by members of their community. One such novel by Diver was typical of the genre. In her *Captain Desmond V.C.*⁷⁹² the eponymous hero married Evelyn, a beautiful but feckless woman recently arrived from England, who preferred the comfortable lifestyle of the Simla or Murree hill stations to the hardships of the North West Frontier. Evelyn was befriended by a senior policeman who was devious and ingratiating and could never be trusted like a true Briton because he had Indian blood in him. Evelyn was murdered by a religious fanatic and after a year's compassionate leave Captain Desmond married Honor, his friend and secret admirer, who had a clearer grasp of the imperial vocation as befitted the daughter of a general and the sister to four Indian Army Officers. This very moralistic novel asserted that the British in India must stay together to pursue their courageous civilising mission for the benefit of Indians. In turn they must never collude with those of mixed heritage as they were inherently unable to hold British values however much they tried. Underlying all Diver's fiction was a constant foreboding that actual violent challenge to the British presence was never far away.

Similarly, in another novel Diver summed up the impact of the tradition of service of several generations of British families in India. With great reverence for her heroes and heroines she declared that 'their names become a legend that passes from father to son, because India does not forget' emphasising the continuity of what she called the Raj's great purpose.⁷⁹³ To reinforce the importance of Europeans keeping their own company Diver described the plight of 'poor little Miss Delawny' sitting out at a dance as no white man dared to be her partner as she was 'cafe au lait', a dismissive and racist euphemism for her mixed heritage.

⁷⁹¹ Wagner 'Treading,' p, 170.

⁷⁹² Diver, Maud (1907) *Captain Desmond, V.C.* Blackwood, Edinburgh.

⁷⁹³ Diver, Maud (1921) *Far to Seek a Romance of England and India*, Houghton Mifflin, Boston, USA, p. 139.

The contempt for Anglo-Indians⁷⁹⁴ or Eurasians was a reality and not just fictional. The writer and member of the ICS, Dennis Kincaid commented in the 1930s on the exaggerated ways in which they sought to imitate British dress and mores with 'almost masochistic obsequiousness' but knowing they could never be respected by the 'True Whites.'⁷⁹⁵ Nevertheless he reminded his readers of Kipling's warnings of the traps which were set for young unmarried officers by young Eurasian women in collusion with their mothers seeking to ensnare a white husband. Kincaid observed that

*[T]hey were as painfully aware of their colour as of their whiter neighbours' disdain, which they, hating as they did all even darker than themselves with pathological ferocity, could not but acknowledge in their heart of hearts to be justified.*⁷⁹⁶

It would be difficult to argue that Diver's novels constituted great literature, but her books were well read amongst British-Indians and went into many editions in her lifetime. They were romantic novels of a *Ma Bap* nature, the concept that the British were the parents of their childlike Indian subjects. They were self-congratulatory and politically conservative, with Indians usually appearing as generally committed to the British cause, sometimes ruthless agitators or often simply loyal but virtually anonymous servants. Their common theme was that India needed Britain's civilising mission despite the sometimes fatal or uncomfortable outcome possibly awaiting its white proponents. Mangan identified her novels as:

*stoical in the face of the foolish ingratitude of the ruled, certain of the moral and material benefits they conferred, secure in the strength of their cultural superiority, courageous in their firm suppression of the incomprehensible uprisings of the native.*⁷⁹⁷

⁷⁹⁴ In this context *Anglo-Indian* means of mixed British and Indian heritage and this is synonymous with *Eurasian*,

⁷⁹⁵ Kincaid, *British Social Life*, p. 238.

⁷⁹⁶ Kincaid, *British Social Life*, p. 238.

⁷⁹⁷ Mangan, *The Games Ethic*, p. 51.

Similarly, the literary compositions of Alice Perrin shared the same themes as those of Diver, but were even more explicit in their racial discrimination. The popularity of *The Anglo-Indians*⁷⁹⁸ went into three editions in the first two months after publication in 1912. Perrin lamented the plight of the British who, when they retired home to Britain, found it hard to adapt to a culture and a lifestyle where they were misunderstood or ignored by their new neighbours. As early as 1873 Hunter had written of Britons who had retired home from India were prone to 'mental morbidity' and he urged them to travel for several months before finally settling back in the home country. He forewarned the returnee that the 'big man in India was by no means necessarily a big man at home.'⁷⁹⁹ The Britons had returned home having served their empire and sometimes could not cope with the indifference of their compatriots in Folkestone or Cheltenham.

Many scholars have likened the hierarchy of the British in India to the caste system of Indians with the ICS members at the pinnacle as were Brahmins to Hindus.⁸⁰⁰ Both Diver and Perrin frequently made references to the British as being members of a caste whose rules and regulations they must not break if they wished to continue governing with the respect of Indians. At the same time, like Kipling before them, they praised the courageous Pathans and mocked the effeminate Bengalis.⁸⁰¹ Scholars such as Margaret MacMillan and Benita Parry have studied their novels and regarded these as representative of the values, attitudes and prejudices of the British in India from 1900 to Independence.⁸⁰² Their research presented further evidence of the conservatism and isolation of the colonial periphery when compared to the changing metropole, particularly in the aftermath of the First World War.

Health, or more accurately, ill health was a permanent topic of conversation in the clubs, over the dinner tables and in correspondence to friends and families back home in Britain.⁸⁰³ The plethora of medical and self-help health manuals was an

⁷⁹⁸ Perrin, Alice (1912) *The Anglo-Indians*, Methuen, London, *passim*.

⁷⁹⁹ Hunter, p. 90.

⁸⁰⁰ For one study see Dirks, Nicholas B. (2001) *Castes of Mind: Colonialism and the Making of Modern India*, Princeton University Press, Princeton, USA. ICS members were often referred to as 'the Heaven-born, to emphasis their equivalence to the Brahmins in the Indian caste structure.

⁸⁰¹ Allen, pp. 169 and 206 respectively.

⁸⁰² See, for example Macmillan, *Women of the Raj*; and Parry, Benita (1972) *Delusions and Discoveries: Studies on Indian the British Imagination*, Allen Lane The Penguin Press, London.

⁸⁰³ See, for example, Sinha, 'Britishness.'

indication of this and they have been researched in detail by Indrani Sen.⁸⁰⁴ She found that they had been targeted predominantly at white men whilst guides for white women were more concerned with housewifely and home nursing duties. It was Sen's finding that these publications tended to reinforce colonial race, class and gender ideologies.⁸⁰⁵ It seemed clear that Britons in India would have recognised this as they concentrated on maintaining their health in order to maintain their separate and privileged lifestyle.

To add to potential health hazards came the risk from snakes and other wild animals.⁸⁰⁶ Death was an omnipresent factor in European life in India as witnessed by the numerous graveyards which still survive across the sub-continent.⁸⁰⁷ The stories of illness and death were related within the community and emphasised, with a certain pride and resignation, the self-sacrificing nature of their service to the Raj.

Symbols

Symbols existed as a distinct visual representation of the community. At the level of the individual they could be seen in the dress code. The British community in India were symbolised by the club together with the ubiquitous and practical bungalow. At the national level there was the creation of the purpose-built imperial capital of New Delhi with government buildings in a grand classical style symbolising British power and civilisation.⁸⁰⁸

Every British settlement, or station, in India with more than a few Europeans had its own social club. It has been argued that clubs were oases of white colonial culture which sought to reproduce the comforts of Britain in a colonial and often tropical setting.⁸⁰⁹ Until the final days of the Raj their membership was mostly European-only with white women normally not allowed to be full members with voting rights. One writer in 1927 described the club as an institution as 'peculiarly British,'⁸¹⁰

⁸⁰⁴ Sen, Indrani (2010) 'Memsahibs and Health in Colonial Medical Writing, c. 1840 to c. 1930,' *South Asia Research*, vol. 30, no. 3, pp.253-274. Doi:10.1177/026272801003000303 (Accessed 20th October 2016).

⁸⁰⁵ Sen, 'Memsahibs' p. 269.

⁸⁰⁶ MacMillan, *Women of the Raj*, pp. 78-101.

⁸⁰⁷ The cemeteries have been catalogued by the British Association for Cemeteries in South Asia (BACSA).

⁸⁰⁸ For a general overview of British colonial architecture in India see Morris, Jan with Winchester, Simon (1986) *Stones of Empire: The Buildings of the Raj*, Oxford University Press, Oxford.

⁸⁰⁹ Sinha, 'Britishness, Clubbability,' p. 489.

⁸¹⁰ H. R. Pankridge, the historian of the Bengal Club, cited in Sinha 'Britishness,' p. 490.

which by the beginning of the twentieth century had become the centre of European social life in India.

Membership of the club was not compulsory but not joining presented a risk of ostracism from the community. One soldier who served in India from 1914 to 1947 remarked that:

[I]f you didn't belong to the Club you were an outcast. Some people refused to kowtow to all these things and refused to belong to the Club, intellectuals very largely ... Either you were a rebel, and a courageous rebel, who didn't belong to the Club, or else you were a social outcast who wanted to join the Club but couldn't get in.⁸¹¹

Lower-middle and working class Europeans had their own clubs. These were often based around their types of jobs such as railwaymen or businessmen and were of a lower social status. Anglo-Indians were sometimes allowed into these clubs but often they started their own if refused membership.

The club was the symbol for and centre of British imperialism in a British Indian community. However Leonard Woolf, who was a member of the Ceylon Civil Service from 1904 to 1911, said that its members were not always conscious of this. He described the Kandy Club in central Ceylon as having a 'curious air of slight depression, but at the same time exclusiveness, superiority, isolation,' but it was gloomy and located in a building he regarded as sordid. It lacked the comforts and luxuriousness of London clubs but had the same exclusivity of composition with only the 'best people' as members and, therefore, no Sinhalese, only whites.⁸¹²

Public buildings in India were built as showpieces of British civilisation and power. Whether they were governor's palaces, railway stations or prisons, or the entirety of the new imperial capital of New Delhi, they were, in the words of Ernst, the

⁸¹¹ Lt-Gen Ronald Savory cited in Allen, *Plain Tales*, pp. 97-98.

⁸¹² Woolf, Leonard *Growing: An Autobiography of the Years 1904-1911*, Hogarth Press, London, 1969, p. 135.

*bricks-and-mortar manifestations of patriotic pride and self-satisfaction: symbols of the assumed benefits of an allegedly superior and rational, enlightened civilisation.*⁸¹³

It was asserted by Jan Morris that the observer could detect in them the ‘mingled emotions of British imperialism, at once so arrogant and so homesick.’⁸¹⁴ The buildings represented power and authority but also hinted at a sadness amongst the community as some members might have preferred them to have been in the Home Counties or the borders of Scotland. That sadness was given visual status in the ubiquitous cemeteries which numbered around 1,300 in the colony and whose monuments were often substantial.⁸¹⁵

The magnificence of the imperial design also extended to lunatic asylums as illustrated by the Palladian elegance of the original Calcutta Asylum of 1787.⁸¹⁶ The European Mental Hospital was built in 1918 in a modern, colonial style with light, villa-style blocks unlike the massive Victorian edifices of British mental hospitals.⁸¹⁷

Earlier in this thesis references were made to the pathologisation of India and the apparent inevitability of Europeans there acquiring tropical diseases. The notions of what constituted the correct protective clothing changed over the centuries of colonial involvement with the tropics. In the view of Collingham tropical clothing highlighted the vulnerability of the white occidental body when confronted by the Indian climate.⁸¹⁸ At the beginning of the twentieth century new materials were developed which became the essentials for ‘tropical kit,’ items which were thought to give protection from the harsh effect of sunlight on unacclimatised white skin.⁸¹⁹

European clothing symbolised its wearer as a representative of the Raj however lowly in the social hierarchy its model might be. One scholar of symbolism and imperial domination emphasised that ‘[D]ress became a visual marker for

⁸¹³ Ernst, ‘Out of Sight,’ p. 246.

⁸¹⁴ Morris, *The Stones*, p. 11.

⁸¹⁵ See the BACSA site for further details <http://www.bacsa.org.uk> (Accessed 20th November 2017)

⁸¹⁶ See Appendices 2 and 3

⁸¹⁷ See Appendix 3.

⁸¹⁸ Collingham, *Imperial Bodies*, p.91.

⁸¹⁹ For a description of the materials used and the philosophy and science behind the creation of ‘tropical kit’ see Johnson, Ryan (Fall 2009) ‘European Cloth and “Tropical” Skin: Clothing Material and British Ideas of Health and Hygiene in Tropical Climates,’ *Bulletin of the History of Medicine*, vol. 83, no. 3, pp. 530-560.

distinctions of race, gender and social rank.⁸²⁰ The experiences of Mr E A Jenkins who arrived in India in 1934 aged 22 to be a clerk with Cox and King's, the travel agent showed the risks which could be associated with wearing it. His tasks involved booking people and export equipment on ships destined for Europe. He was based in Bombay and spoke of the tension in 1937-38 following political agitation by Indian nationalists. On three or four occasions he was dragged out of his car by demonstrators who knocked off his topi and told him to remove his tie, both symbols of the Raj. Each time he was stopped he complied with the wishes of those he had encountered. They required him to shout 'Quit India' and 'Jai Hind',⁸²¹ which were the main Nationalist slogans. He told his interviewer that if Europeans behaved sensibly in front of the mob they would not be harmed.⁸²² To some, therefore, the consequences of wearing clothing which, in effect, was an imperialist uniform, could become a source of stress because of the reactions it might generate.

Power Structures

Power structures were significant and this section portrays where the power was, relating to hierarchies and who had the most influence on decision making. Power rested ultimately with the government in London via the secretary of state for India. The viceroy was the monarch's representative in India and, as such, was in a very powerful position in the governance of India. Communications across the empire improved⁸²³ after the First World War enabling London to take a greater interest in everyday affairs in the colony. The telegraph and airmail facilitated much quicker communication between London and India and led to a reduction in power and decision making by the Government of India. The voluminous correspondence between Lord Irwin, the viceroy from 1926 to 1931 and the secretaries of state for India illustrated clearly the latter's commanding position.⁸²⁴ The penultimate viceroy

⁸²⁰ Helen Callaway cited in Johnson, 'European Cloth,' p. 553.

⁸²¹ Hindi for 'Long live India!' or 'Victory to India!'

⁸²² Taped interview with Mr E A Jenkins, British Library Audio tape F19/11 – 2. (Accessed 5th November 2015)

⁸²³ Airmail services across the Empire developed after 1919. The first airmail service directly linking India, from Karachi, to London began in 1929. For a brief history of the postal service of Imperial Airways see <http://www.nzstamps.org.uk/air/external/eastern/easternroute.html> (accessed 23rd February 2017).

⁸²⁴ Borthwick Institute, University of York, *Papers of the Earl of Halifax as Viceroy of India, 1926-1931, passim*. Incidentally, these records contain a copy of the first airmail letter from a monarch to a

Lord Wavell wrote in his memoirs how he was restrained from acting against Gandhi and other Indian nationalists without consultation and a final decision from London.⁸²⁵

The viceroy assisted by his council, which included some Indians, presided over a bureaucracy run by almost 1,000 civil servants in the ICS. They were supported by thousands of Indian clerks. The ICS played a key role in administering the law across India outside the princely states.⁸²⁶ If matters could not be agreed through discussion or jurisprudence then there was the possibility of enforcement through the police or, exceptionally, via the Army.

As well as the ICS there were national systems for such services as posts and telegraphs and forestry which were linked to local and central government. Anglo-Indians were guaranteed jobs on the state railways and posts and telegraphs until the 1920.⁸²⁷

Organisational Structures

This part of the web represents the structure of the British community in India. It relates to the lines of power and influence, sometimes unwritten, that indicate whose contributions to running the organisation were most valid. The numerical composition of the British administration was complete by 1900 and had changed little by the time of Independence⁸²⁸ and much of its framework remains in existence in modern India.⁸²⁹ At the head of the organisation in India was the Viceroy, always a lord, who was appointed by the monarch and in most cases originated from the landed aristocracy of Britain. He was assisted by the Viceroy's Council containing six

viceroy dated 21st December 1926. There is a noticeable absence of material in these papers relating to mental illness amongst the British in India.

⁸²⁵ Moon, Penderel (1973) (Ed) *Wavell, The Viceroy's Journal*, Oxford University Press, London, p. 61.

⁸²⁶ The princely states comprised two fifths of the territory and one quarter of the total population of the Indian sub-continent. They were outside the direct jurisdiction of British India and very few Europeans were based there. See Singh, Hira 'Colonial and post-colonial historiography and the princely states: Relations of power and rituals of legitimation,' p. 15 in Ernst, Waltraud and Pati, Biswamoy (2007) (Eds) *Indian Princely States: People, princes and colonialism*, Routledge, London.

⁸²⁷ For a recent analysis of railways in British India see Prasad, Ritika (2015) *Tracks of Change: Railways and Everyday Life in Colonial India*, Cambridge University Press, Cambridge.

⁸²⁸ Gilmour, David (2005) *The Ruling Caste: Imperial Lives in the Victorian Raj*, John Murray, London, *passim*. Gilmour provides an organisational structure of the ICS in tabular form on pages xxiv and xxv.

⁸²⁹ Guha, Ramachandra (2008) *India After Gandhi: The History of the World's Largest Democracy*, Pan Macmillan, London, pp. 756-764. The ICS was renamed the Indian Administrative Service or IAS in 1947.

Members plus sixteen officials, some of whom were Indians. The Members were each responsible for a department of government. Their responsibilities were unevenly distributed and in his assessment of the Council Gilmour observed that sometimes individual Members had to be assisted by their peers to prevent a mental breakdown threatened by pressure of work.⁸³⁰ On a par with the Members Council were the governors or lieutenant governors of the British-controlled provinces. The implementation and management of their decisions was the responsibility of the Indian Civil Service.

The career of a typical ICS man was chronicled by R D Macleod who, between 1910 and 1934, served in the United Provinces of Agra and Oudh.⁸³¹ The geographical size of the local administrative unit was the district which, across India, each averaged 2,200 square miles and had an average population of just under a million. To give a comparative picture of the large size of a district he compared it the average English county at the time which covered 1,000 square miles and had a population of 762,000.⁸³²

He wrote that as the retirement age was 55 for most government officials in India and because many women and children left the *moffusil* for half the year middle age predominated. The effect of this, remarked Macleod, was 'a hard practical society uninspired by the imagination of youth nor softened by the sentiment of old age.'⁸³³ This lack of diversity had an unhealthy impact on the culture of the British in India. As the external influences on cultural development were denied, he said,

*the sahib runs a grave danger of becoming absorbed in his own immediate interests to the exclusion of all others and eventually furnishing one more example of the popular idea that every man retired from India is a philistine and a bore.*⁸³⁴

This narrow outlook of many of the British middle class in India was acquired during their years of education. In his study of the ICS Dewey depicted British civil servants

⁸³⁰ Gilmour, p. 230.

⁸³¹ Macleod, R. D. (1938) *Impressions of an Indian Civil Servant*, H. F. and G. Witherby, London.

⁸³² Macleod, *Impressions*, p. 16.

⁸³³ Macleod, *Impressions*, p. 136.

⁸³⁴ Macleod, *Impressions*, p. 156.

as prisoners of the values which they had absorbed at public school from where they were almost exclusively drawn.⁸³⁵ This was corroborated by J. A. Mangan in his examination of the games ethic and the British Empire. Mangan cited the views of J. E. C. Weldon, the headmaster of Eton from 1881 to 1895. Weldon stressed that Britain's brand of imperialism, which he regarded as superior to that of other European colonial powers, depended on physical strength, religion, promptitude but above all 'character' wherein honesty overcame pride, arrogance and intolerance.⁸³⁶ Whilst Weldon praised the ethics of the public schoolboy he warned of the standards of the scholarship boy. The latter, coming from a lower social class, would always be seeking personal advancement whereas the public schoolboy was imbued with the values of teamwork and self-sacrifice, qualities which were so vital for colonial rule. The personality developed was reflected in Charles's 'good ordinary type of Britsher'⁸³⁷ who would not let the side down.

Another unsettling period for the community came after the First World War when there was a reduction in the number of Britons seeking entry to the ICS. Only 5 Britons could be recruited to the ICS in 1935 and, between 1936 and 1939 to keep up the British complement, the Government had to introduce a system of appointment⁸³⁸ rather than through competitive examination as had been the only means of entry since 1855.⁸³⁹ This was attributed by D. C. Potter in his study of the ICS to the uncertainty about the future of the service.⁸⁴⁰ It was a practical example of the decline of the British community and a potential stressor as it was an indication that the end of the Raj was approaching but with no specified deadline for the finale of the Indian Empire.

Control Systems

This section in the graphic portrays the way in which the British controlled their Raj. It also illustrates what was important in the community and how success within it was rewarded and measured. After 1858 the British colonial establishment, having learnt lessons from the causes of the Great Rebellion, chose not to continue with their

⁸³⁵ Dewey, *Anglo-Indian Attitudes*: p. vii.

⁸³⁶ Mangan, *The Games Ethic*, p.36. Weldon was speaking in 1894-5.

⁸³⁷ Charles, 'Neurasthenia,' p. 3.

⁸³⁸ Moore, *Paul Scott's Raj*, p. 41.

⁸³⁹ Gilmour, *The Ruling Caste*, p. 43.

⁸⁴⁰ Cited in Moore, *Robin Paul Scott's Raj*, Heinemann, London, p. 41.

policy of removing corrupt or despotic regimes in the princely states. The effect, according to the American social anthropologist Nicholas Dirks, was to make India an ethnographic state where caste became the determinant factor in the imperial understanding and control of its population. He argued that colonialism itself was a cultural project of control. The 1901 Census of India incorporated a hierarchy of castes with official categorisation that some castes took precedence over others.⁸⁴¹ The intended effect was to disunite the Muslim and Hindu communities who had rebelled together against their colonial masters in 1857-8 and pursue a policy of divide and rule by promoting rivalries amongst different castes and religions.⁸⁴²

In conjunction with this strategy the British found ways to control its own community and its Indian subjects by incorporating them into the structure of the Raj with rewards such as knighthoods and other honours. To illustrate this the historian David Cannadine outlined how from the 1880s the British sought to create rule and authority which included Indians in the state but on the basis of a rigid social stratum that generally kept the races apart. One way to do this was to create new orders of chivalry which became eagerly sought by Indian princes and British soldiers and bureaucrats conscious of their status.⁸⁴³ The rewards became a promise of formal recognition by the Crown for particular achievements or just for continued loyalty to the Raj.

In Said's opinion the British saw their representatives in the imperial community as 'dynamic, individualistic, egalitarian, modernising.' Cannadine argued that they were actually 'enervated, hierarchical, corporatist, backward.'⁸⁴⁴ No doubt to Said those Britons who ran the Indian Empire were decent folk but they were existing within a community which was conservative, officially and unashamedly unequal and with no plans for it ever to become otherwise. It was an unjust society which Cannadine saw as:

⁸⁴¹ Dirks, 'Castes of Mind,' pp. 43-52.

⁸⁴² For an analysis of the impact of 'divide and rule' see Tharoor, Shashi (2016) *An Era of Darkness: The British Empire in India*, Aleph Books, New Delhi, especially Chapter 4, pp 119-174. Tharoor is an Indian historian and politician who is highly critical of British rule in India.

⁸⁴³ Cannadine, David (2001) *Ornamentalism: How the British Saw Their Empire*, Oxford University Press, New York. Two examples were the Most Exalted Order of the Star of India for men and Order of the Crown of India for women.

⁸⁴⁴ Cannadine, *Ornamentalism*, p. 4.

*characterised by a seamless web of layered gradations, which were hallowed by time and precedent, which were sanctioned by tradition and religion, and which extended in a great chain from the monarch at the top to the humblest subject at the bottom.*⁸⁴⁵

It was a system in which much energy, from British and Indian alike, was expended in achieving recognition at the expense of agitation or complaint.

The clubs which the Europeans established can also be regarded as part of the control system of the Raj. The smaller ones, particularly in the *mofussil*, actively encouraged European women to attend in order to maintain the prestige and exclusivity of the white community there. Another reason for this apparent integration of the sexes, argued Sinha, was that their presence was a measure of control to prevent the threat of women engaging in activities away from their menfolk which might portray the community in a bad light.⁸⁴⁶ Interracial affairs and friendships might have been tolerated but interracial ones were not.

Evidence has shown that poorer and potentially embarrassing whites were placed under European control to attempt to remove them from the sight of Indians. Orphanages were regarded by Arnold as the starting point for 'a lifetime's cycle of institutions.' He pointed out that many 'unseemly whites' such as paupers, the sick, including the mentally ill or the aged, and 'fallen women' were protected in a variety of European establishments, often in isolated areas, managed by Europeans.⁸⁴⁷ Retirement to Britain at 55 ensured that Indians rarely saw Britons in physical and mental decline.

Conclusion

This chapter has demonstrated how the British in India represented a conservative and artificial society and were an ethnic minority culturally distinct from the motherland and from indigenous Indians. It has utilised King's model of three cultures in the colonial context to demonstrate the growing gulf between the British community in India and at home in Britain. It has examined the links between race

⁸⁴⁵ Cannadine, *Ornamentalism*, p. 4.

⁸⁴⁶ Sinha, 'Britishness,' p. 501.

⁸⁴⁷ Arnold, 'European Orphans,' p. 113.

and culture and how they both became sources of stress for some Britons in India. The British in India created their own literature of heroes and heroines to reinforce their uniqueness as a 'superior' entity, the members of 'One Great Family.' This supposed cultural homogeneity was maintained to give an impression of unity which was shown to be superficial, a rigid class system equivalent to Indian castes whose common thread was the 'whiteness' of their bodies.

The concept of a *cultural web* was employed centring on the paradigm that the British were naturally 'superior' and were present and necessary in India to guide Indians towards a better, Western-inspired civilisation and on to Independence in the distant future. The web illustrated how the construction of British culture in India meant it was unable to adapt to the demands of the metropole and to approaching Independence. Whilst many enjoyed their colonial lifestyle they were ultimately sojourners awaiting an escape to a deserved retirement in Britain.

So far this thesis has identified the nature of Western psychiatry as practised in India and analysed the stresses faced at the level of the British community overall. The next two chapters will move to concentrate on individuals: those who worked in the nursing and psychiatric professions, and how the latter related to and treated their patients, the distressed *Imperial Minds* who could not cope mentally with their role in empire.

CHAPTER 6

A 'hidden dimension': nursing distressed British Imperial Minds in colonial India, 1900 - 1947.⁸⁴⁸

*No place is too remote, no climate too deadly for the nurse to ply her ministrations. Like the soldier she obeys the call of duty and, if need be, gives her life in the cause.*⁸⁴⁹

Sarah A. Tooley (1906)

Introduction

This chapter will consider aspects of psychiatric nursing and its development as a profession in colonial India by concentrating on the care of European mental patients there. A key theme will be the apparent lack of interest in mental nursing by the nursing establishment in India. There is an absence of an academic history that focuses solely on psychiatric nursing in India. Consequently this chapter is much dependent on the writings of doctors there which, with some exceptions, were often patronising and perfunctory in their references to nurses, whom they often considered as servants. Observations are necessarily cautious as the voice of the nurse (usually female) was often silent or spoken with reverence for, or deferentially towards, the doctor in charge (always male). Evidence will be provided of the significant hardships linked to the nursing role and to the high moral and physical standards demanded of them by psychiatrists. White nurses shared the climatic extremes of India with their fellow Europeans and were often required to travel great distances in their work. Nolan has produced a history of mental health care in the UK from the viewpoint of the nurse and many of the topics he highlighted have a parallel in the development of psychiatric nursing in India and its inherent weakness.

The term *mental nurse* became the official title of the job in the UK in 1923 with the setting up of the Supplementary Register for Mental Nurses under the

⁸⁴⁸ The 'hidden dimension' was a term used initially by Anne Digby to describe the contribution of asylum attendants to the care of mental patients. See Digby, *Madness, Morality,* p. 140.

⁸⁴⁹ Tooley, *The History of Nursing*, preface, page unnumbered.

General Nursing Council⁸⁵⁰ and it was in common usage in India in the same year.⁸⁵¹ Mental nurses began to refer to themselves as psychiatric nurses in the 1940s.⁸⁵² The terms *psychiatric nurse* or *mental nurse* will be used in general to refer to those, excluding doctors, who were employed to work with psychiatric patients, and who provided personal and practical physical care to them, with varying levels of skill, responsibility and remuneration.

This chapter will examine the current knowledge of the history of psychiatric nursing in India in the half century leading to Independence. It will consider, with vigilance, the numerous statements written by alienists indicating, and sometimes dictating, the qualities which they believed were essential for nurses in psychiatric hospitals. In addition it will explore comments by nurses themselves about their work which, although scarcer, do give insight into their profession and add to our knowledge of everyday life for mental nurses at the EMH.

The development of the mental nursing profession

The Trained Nurses Association of India (TNAI) was founded in 1908 to promote the profession across the country. Its publication, the *Nursing Journal of India (NJI)*, was first issued in 1910 in conjunction with the Association of Nursing Superintendents of India. The 1931 TNAI Handbook lists key dates in its development and catalogues the various civil, military and religious bodies that employed nurses in India.⁸⁵³ It indicated that there were nurse registration schemes for Madras and Burma but not one which covered the whole of the sub-continent. There were two significant omissions from the handbook: reference to male nurses being one, and the almost complete absence of any information on mental nursing the other. All the references to nurses were made in female terms and there was no entry to suggest that men could join the association. There were 24 pages listing all the hospitals in India, except mental hospitals, giving their addresses, the numbers of staff divided into the categories of European, Anglo-Indian and Indian, and the salaries of matrons,

⁸⁵⁰ Nolan, *A History*, p. 6.

⁸⁵¹ See Butcher, F. (April 1923) 'Mental Nursing in Private Practice,' *Nursing Journal of India*, vol. XIV, no. 4, pp. 89-92.

⁸⁵² Nolan, *A History*, p. 6.

⁸⁵³ The Trained Nurses Association of India (1931) *Handbook*, TNAI, Madras. The Handbook cost 12 annas plus 4 annas postage.

nurses and ancillary workers and so on.⁸⁵⁴ The single reference to mental hospitals covered one third of a page on the final page of text as if it was an afterthought. It simply listed ten mental hospitals in India for which 'information has been received' but unlike other hospitals no further details were given.⁸⁵⁵

From the evidence, or more precisely from the lack of it, in the handbook the conclusion can be drawn that the nursing establishment in India had little interest in mental nurses and their development or in the institutions where they worked. A perusal of the *NJI* confirmed this indifference although more articles relating to mental illness began to appear as the 1930s progressed. One criterion for membership of the TNAI was that the applicant had to have trained successfully for three years in a general hospital.⁸⁵⁶ This would automatically exclude many who worked as nurses or attendants in mental hospitals resulting in minimal representation in a professional body. Despite their absence from the TNAI it was possible to find some information from other sources.

Overall the views of some psychiatrists on what they wanted from their nurses seemed clear but what the mental nurses themselves were saying was not. One stratagem in the search for the nurses' voice in this thesis was an analysis of the contents of the *NJI*. From its inception the leadership of the TNAI was exclusively female, middle class, Christian and British, factors which were clearly reflected in the articles contained in its journal. From its inception the *NJI* had a transnational focus with regular news items and articles about nursing in the white British Empire and the USA. In 1912 only four years after its creation the TNAI affiliated to the International Council of Nurses becoming the first association of nurses outside Europe and North America to do so.⁸⁵⁷ It was represented at multinational nursing conferences in Europe and the USA and its delegates reported back in the *NJI*.

The tone of the articles written by nurses in their journal was characterised by pride in their work but also by modesty, anonymity and deference to the medical profession. The journal maintained an intimate and amateur style and, in its first 15 years could be read like a family newsletter circulating across India to a small

⁸⁵⁴ TNAI, *Handbook*, pp. 82-105.

⁸⁵⁵ TNAI, *Handbook*, p. 184.

⁸⁵⁶ *NJI*, vol. xxviii, no. 12, December 1937, p. 303.

⁸⁵⁷ Fitzgerald, Rosemary 'Making and Moulding the Nursing of the Indian Empire: recasting Nurses in Colonial India,' in Powell, Avril A. and Lambert-Hurley, Siobhan (Eds) (2006) *Rhetoric and Reality: Gender and the Colonial Experience in South Asia*, Oxford University Press, New Delhi, p. 207.

community of nurses, most of whom had qualified in the UK. It had ceased publication in June 1919 because of the lack of someone willing to be its editor and was revived in March 1920 when a volunteer came forward. There were regular references to Christianity and the Bible and it was clear that the readership was predominantly Christian and regularly attended church services. Thus there were monthly homilies with a religious theme entitled 'For the Quiet Hour.' Each monthly edition gave the names and addresses of new members and annually full lists of its members were published, including the names of those whose subscriptions had lapsed. Members in India were advised of their colleagues' returns to the UK and were kept informed of the career progress and eventual retirement of those who had gone home to work in British hospitals.

As the 1920s progressed the membership of the TNAI began to include women of Anglo-Indian and Indian origin and from the late 1920s each copy of the *NJI* began to include a page in Hindi. In September 1931 the *NJI* published what seemed to have been its first article by an Anglo-Indian when Miss Lavinia Mewa Raw, a Public Health Nurse at Jubbulpore, wrote about why she had chosen nursing as a career.⁸⁵⁸ A photograph printed with the article confirmed her mixed racial heritage. The International Congress of Nurses for 1933 was held in Paris and Brussels and for the first time one of the delegates was an Indian. Group photographs of TNAI and other conferences became regular features in the *NJI* from the mid 1920s. The official photo accompanying the TNAI annual conference in 1934 showed, for the first time, all the nurses present sitting on chairs or standing.⁸⁵⁹ In previous years Indian nurses had always been shown sitting on the ground in front of the European nurses. Such conspicuous physical changes were an indication of the growing numbers and importance of non-European nurses in India.

Between 1918 and the early 1930s there were very few references in the *NJI* to any form of mental nursing. There were however articles about psychology. In 1921 Col. Summer, a civil surgeon in Simla, wrote an article on the workings of the mind and of psychological phenomena and how these might impact on the work of

⁸⁵⁸ Mewa Raw, Lavinia G. (September 1931) 'Why I chose nursing as a profession,' *NJI*, vol. xxii, no. 9, pp. 229-233.

⁸⁵⁹ Presidential Address, TNAI Conference (January 1935), *NJI*, vol. xxvi, no. 1, pp. 5-6.

nurses.⁸⁶⁰ The following year an article, originally from the *British Nursing Journal*, by a British nurse, M. M. G. Bielby, appeared entitled 'Practical Psychology: Thought Transference.'⁸⁶¹ She advised that '[T]he work of a nurse entails continuous recognition of the destructive force of thought on three planes of existence: physical mental and moral.'⁸⁶² A nurse can with '[S]trong thoughts of peace or consolation create an atmosphere of serenity about the object of the thought'⁸⁶³ to the benefit of the patient. Such articles reflected the growing importance in India of the use of psychological techniques as therapeutic tools.

In 1923 a major and unattributed article was published in the *NJI* entitled 'Indian Nursing – Its past and future.'⁸⁶⁴ At eight pages it was uncharacteristically long for this publication and it recalled with pride the past work of nurses in India and the challenge of an exciting future. It echoed Tooley's themes of duty and self-sacrifice highlighted in the epigraph at the start of this chapter. As with so many articles in the *NJI* it praised the inspiration of Florence Nightingale and raised her to an almost saintly status.⁸⁶⁵ Interestingly, there was no reference at all to mental nursing or mental hospitals. For the remainder of the 1920s there averaged only one or two articles in the *NJI* each year which related to mental nursing. It routinely published the names and addresses, usually hospital workplaces, of its qualified nurse members in India of whom very few had connections with mental health services.

The nursing profession in India appeared to be growing in self-confidence from the early 1930s judging by the scope of the articles in the *NJI* and by the rise in the membership of the TNAI. The latter had gone from 147 in 1919,⁸⁶⁶ to 650 in 1933 and 1,021 in 1937.⁸⁶⁷ In 1930 a Student Nurses Association was instigated and

⁸⁶⁰ Summer, Colonel IMS, untitled article in *NJI*, vol. XII, no. 6, June 1921, pp. 13-19.

⁸⁶¹ Bielby, M. M. G. (July 1922) "Practical Psychology: Thought Transference," *NJI*, vol. XIII, no. 3, pp. 53-54. The original article had appeared in the *British Journal of Nursing* (April 1922) vol. 68, 22nd, p. 248.

⁸⁶² Bielby, 'Practical Psychology, p. 53.

⁸⁶³ Bielby, 'Practical Psychology,' p. 54.

⁸⁶⁴ Anonymous (January 1923) *Nursing Journal of India*, vol. XIV, no. 1, pp. 28-35.

⁸⁶⁵ The reverence for her continues today in India. In 2014 I visited two different nurse training schools in India and in the offices of both their Deans there was a large photograph of Florence Nightingale and a bust of her garlanded with fresh flowers.

⁸⁶⁶ *NJI* (March 1920) vol. xi, no. 1.

⁸⁶⁷ The last two figures are from *NJI* (July 1937) vol. xxv111, no.7.

its members made regular contributions to the journal.⁸⁶⁸ For the first time the TNAI was able to employ a full time paid secretary in 1935.⁸⁶⁹ Its journal became bigger with a wider variety of articles including description of practical nursing techniques. Between 1910 and 1930 it had changed from an informal social magazine to the early stages of a modern, professional journal with a definite commitment to strengthen the discipline and improve work standards.

In March 1931 the *NJI* contained a review of a text book on mental nursing by Elizabeth Macaulay which had been published in Britain the previous year.⁸⁷⁰ The reviewer was D. Porter, the Matron of the Government Mental Hospital in Madras. She highlighted Macaulay's belief that the essence of mental nursing was that the nurse must have a 'Sympathetic Spirit' and the other key qualities of 'Patience, Perseverance, Forbearance, Tact and Truthfulness.' Porter added practical advice from her own experience: 'a nurse who is foolish enough to placate an insane patient with a prevarication will, if discovered, lose respect.' Porter praised the usefulness of the book because, she stated, as most nurses in India who cared for the mentally ill in India were either midwives or general trained nurses, it would enhance their practice giving them greater insight into mental illness. Porter's endorsement of the manual was an admission of the lack of practical training in mental health of most nurses in India.

Later in 1931 came a rare reference to male nurses. In November Mrs Watts, a British nurse, wrote about the opposition which there had been in her profession to registering men officially as nurses. She said that impetus had come during the First World War when male nurses were needed to work on wards for injured soldiers. She was in favour of male nurses and believed they had a role to play in mental and military hospitals and in sanatoria for patients with tuberculosis.⁸⁷¹ Mrs Watts based her opinions on the physical strength of men and their consequent abilities to cope with potential violence.

By the early 1930s the TNAI had set up four standing committees to promote nursing across the country. They were required to report back each year at the

⁸⁶⁸ See *NJI* (January 1931) vol. xxii, no. 1.

⁸⁶⁹ *NJI* (January 1935) vol. xxvi, no.1, p. 6.

⁸⁷⁰ Macaulay, Elizabeth L. (1930) *A Textbook of Mental Nursing*, The Scientific Press, Faber and Faber, London, reviewed in *NJI*, March 1931, p.76. Macaulay was then Matron of the Kent County Mental Hospital in Maidstone.

⁸⁷¹ Watts, Mrs E. A. 'Male nurses and nursing,' *NJI*, (September 1931) vol. xxii, no. 11, pp. 286-291.

conference but the minutes showed that they did not always achieve this target. One of the groups was for Mental Nursing and Hygiene and its convenor in 1933 was Miss J. L. Masters, who had been a nurse at the mental hospital in Yeravda.⁸⁷² In the list of TNAI members for 1935 there were only two based in mental hospitals.⁸⁷³ There were only five members in her Mental Nursing and Hygiene committee, only one of whom was based in mental hospitals, and there was little evidence to suggest that it produced much work.

An indication of issues facing mental nurses came in Miss Masters's committee report for 1933. She emphasised that employees in mental hospitals were under an obligation not to mention the names of their patients to others outside those hospitals because of the stigma of mental illness which might become permanently attached to them. A factor in this injunction was the tightly knit community of British India, as the identification of a distressed *Imperial Mind* would have been relatively easy with the networks of clubs, letter writing and general gossip. She also believed that this requirement might hold back the development of professional nursing across India, as it could limit case discussions and the shared knowledge which could be gained from them.⁸⁷⁴ Her fears were proved correct as the *NJI* reported in September 1936 that the committee on Mental Nursing and Hygiene had become dormant citing the 'Medical Rule of Reticence' which prevented the discussion of patients under treatment.⁸⁷⁵

The issue of retirement was also addressed by Miss Masters. In 1938 she informed the *NJI* that she had been required to retire compulsorily by the government having reached the age of 55. She was concerned that 'youthful nurses' would not have the experience of 'elderly' ones, that is those aged 55 or over. She challenged this requirement for public servants which had been in force since the eighteenth century. In her experience mental patients

⁸⁷² See 'Reports of 23rd Annual Conference of the TNAI at Bangalore,' *NJI*, (December 1933) vol. xxiv, no. 12, pp. 368, 376.

⁸⁷³ List of current TNAI members, *NJI*, (June 1935) vol. xxvi, no. 6.

⁸⁷⁴ Report of the Committee for Mental Nursing and Hygiene, Convenor Mrs J. Masters, *NJI*, (December 1933) vol. xxiv, no. 12, pp. 367-368.

⁸⁷⁵ *NJI*, (September 1936) vol. xxvii, no. 9, p. 177.

*call for great patience and quiet reserve and sympathy too, to gain their friendship and trust. These qualities are not easy for young souls to acquire.*⁸⁷⁶

In her two articles Miss Masters articulated some of the specific skills which identified mental nursing as a separate discipline and one distinct from general nursing. However it was not until 1991 that the Indian Society of Psychiatric Nursing was formed to promote the specialist discipline of this profession nationally.⁸⁷⁷ As Nolan has argued, if mental nurses had developed their own history sooner the establishment of their profession may have been quicker and they may have challenged their subordination to doctors earlier.⁸⁷⁸

From a detailed perusal of the *NJI* over 25 years of its publication it can be argued that a summary of the views of TNAI members in the 1930s was presented by Miss Frodsham in her address to its annual conference in 1935. With much politeness, she outlined the three main problems for her profession in India. The first was that the selection and dismissal of nurses was always in the hands of men, that is male doctors. She asserted that female nursing superintendents ought to have the power to do this. Her second issue was that hospitals might lose their reputations with the public simply if one nurse 'goes astray,' if she demonstrated some culturally unacceptable behaviour. Her third problem was that nurses lacked the courage to challenge the first two⁸⁷⁹ Unfortunately it seemed that Miss Frodsham's radical insights were never seriously addressed in the remaining years of the Raj.

Whilst some nurses may have held challenging views their leadership were deeply immersed in traditional matters affecting the Empire. The TNAI delegate to the 1937 International Congress of Nurses in London, for example, reported back to her readers about more than the conference proceedings. She witnessed the Coronation of George VI and wrote three pages on the royal procession through the capital. In an article uncharacteristically long for the *NJI* she described, with great imperial fervour, such items as a full list of the army regiments who took part in the

⁸⁷⁶ *NJI*, (January 1938) vol. xxix, no. 1, p. 3.

⁸⁷⁷ See Indian Society of Psychiatric Nursing website www.ispnindia.org (accessed 27th August 2015)

⁸⁷⁸ Nolan, *A History*, p. 1.

⁸⁷⁹ *NJI*, (January 1936) vol. xxvii, no 1, p. 8.

parade and the precise order in which they processed.⁸⁸⁰ The correspondent wrote that she knew her patriotic readership would be delighted to receive these detailed descriptions of the royal event. Whether or not this was the case the prominence in the journal of this unashamedly jingoistic article was an indication of the importance of events in the metropole for European nurses in their colonial setting.

Further research is needed to determine how many qualified mental nurses there were in British India. The *BMJ* reported in 1923 that there appeared to be a 'total absence of nurses with any recognized qualification for nursing mental cases,'⁸⁸¹ in the sub-continent. In October 1936 the *NJI* reported that nine sisters from the European Mental Hospital sat the Royal Medico-Psychological Association's exam. All had passed and three had gained distinctions.⁸⁸² A survey of TNAI members from 1918 to 1937 indicated that it had never had any members recorded as working in the European Mental Hospital.⁸⁸³ The *NJI* in November 1937 declared that, with the exception of the European Mental Hospital, there were no nurses in India who had trained in mental nursing, although in some hospitals lectures were provided. The implication was that this training depended on the interest shown by individual medical superintendents. Whatever the correct figure for the number of qualified mental nurses in India it seemed that it was very low.

The significance of mental health matters to general nurses received greater attention with the evolution of the mental hygiene movement. From the early 1930s the professional mental health journals in India were regularly publishing articles about it. The January 1934 edition of *NJI* had several articles on mental hygiene and how the concept could assist the nursing role. One by Agnes Dunn, who was not based in India, cited the work of Clifford Whittingham Beers, who was credited as the founder of the American mental health hygiene movement in 1908.⁸⁸⁴ Beers had stressed that the most work of the movement was in 'the waging of an educational war against the prevailing ignorance regarding insanity'⁸⁸⁵ and that prevention was

⁸⁸⁰ *NJI*, (September 1937) vol. xxviii, no. 9, p. 237.

⁸⁸¹ *BMJ*, (December 1st 1923) vol. 2 no, 3283, p. 1066.

⁸⁸² *NJI*, (October 1936) vol. xxviii, no, 10, p. 192.

⁸⁸³ Information obtained by the present author through a perusal of copies of the *NJI* between those dates.

⁸⁸⁴ Szasz, *The Manufacture of Madness*, pp. 157n and 343. Beers had been institutionalised several times after 1900 suffering severe depression and paranoia. He spent over three years as a resident of American asylums.

⁸⁸⁵ Cited in Dunn, Agnes 'Mental Hygiene,' *NJI*, vol. xxv, no. 1, January 1924, p. 19.

its most effective cure. Dunn explained how nurses could not care adequately for their patients' physical illnesses without knowing how to apply the principles of mental hygiene on a daily basis. With much optimism and obvious pride in her vocation she looked forward to the day when professional nurse practice

*will be interpreted as the care of the patient in his mental, physical and social relations in sickness and in health.*⁸⁸⁶

The device of this 'person centred practice' has now entered the current practitioner's toolkit⁸⁸⁷ showing clear roots in the mental hygiene movement. Dunn showed much prescience, as it is generally accepted today by the medical, nursing, social work and allied professions that it is the circumstances of the 'whole' person which need to be addressed.

The status of nurses and their role in India was felt to be of sufficient importance and interest to be discussed at the TNAI annual conference in 1936. A paper was presented on this theme by Miss Winter who, as the Nursing Superintendent at the Lady Hardinge Medical School Hospital in Delhi was a key figure in the profession in India. Once again there was no reference to mental illness or mental nursing⁸⁸⁸ and this apparent lack of interest by the nursing establishment generated professional interest abroad. In 1937 an official request was issued to the TNAI by the International Council of Nurses in Geneva for information about the progress of mental nursing in India. The response published in the *NJI* admitted that developments were slow but that the TNAI was striving to raise standards in that field. The article contained few facts about mental nursing though it recorded, somewhat incongruously, that in 1923 three male overseers at the Central Mental Hospital in Yeravda and two trained nurses at an unspecified location had passed exams guided by the MPA's *Red Book* and they were given Rs25 per month as a proficiency award. The TNAI reported that social work and psychiatric social work

⁸⁸⁶ Dunn, 'Mental Hygiene,' p. 20.

⁸⁸⁷ Burns, *Our Necessary Shadow*, p. 182. The concept of a 'person-centred approach' owes much to the *anti-psychiatry* movement of the 1960s and 1970s.

⁸⁸⁸ Cited in *NJI* (December 1936) vol. xxvii, no. 12, p. 272. The *Red Book* was the training manual for mental nurses in the UK.

courses had been set up.⁸⁸⁹ The reception of this response in Geneva is not known and it was not covered in copies of the *NJI* over the next few years.

From the early 1930s the frequency of articles on matters relating to mental ill health had increased. Their subjects included puerperal insanity, child behaviour, aspects of psychology and how to tell the difference between manic depression and schizophrenia. The factual information provided would have raised awareness amongst general nurses of the practical skills which mental nursing brought to these topics.

An indication of the TNAI's increased self-confidence came as the *NJI* entered new territory in June 1938 when its Editorial announced that

*[W]e are glad to be able to publish our long promised double number dealing entirely with the work of Men Nurses.*⁸⁹⁰

The TNAI had 20 *Men Nurses* in its membership. Of these 17 were described as 'Local' implying that they were Indian or Anglo-Indian and three as 'Overseas' which suggested they may have been in the military. To illustrate the innovation photographs were published in the special issue of some of the men. The editor declared that there was 'a crying need for men nurses in the mental hospitals and their work calls for special ability and training.'⁸⁹¹ It was an indication of the TNAI's growing awareness of the importance of men to the future of the profession that they chose the unusual step of producing an edition larger than usual dedicated to this topic.

The senior members of the TNAI showed confidence consistently in the value of their profession and its work in India but were concerned that there was no single record of its achievements. They realised, as Nolan was to assert, that a definitive history would give nurses greater credibility and authority in the world of health care.⁸⁹² In her presidential address to the TNAI in November 1934 Miss Chadwick lamented the fact that the nursing service 'does not have a name amongst

⁸⁸⁹ Editorial, (April 1937) 'Mental Nursing in India' *NJI*, vol. xxviii, no. 4, pp. 90-91.

⁸⁹⁰ Editorial, (June 1938) *NJI*, vol. xxix, no. 6, p.149.

⁸⁹¹ Editorial, (June 1938) *NJI*, vol. xxix, no. 6, p.153.

⁸⁹² Nolan, *A History*, p. 1.

Governments of India' and that it was 'a subordinate medical service.'⁸⁹³ In addition, archival analysis of annual reports of government inspections of mental hospitals over the previous thirty years revealed that they did little to enhance the status of mental nurses in India.⁸⁹⁴

To address this recognised lack of a record of events the editors of the *NJI* made several appeals through their journal for someone to write a history of nursing in India. However the first was not compiled until Alice Wilkinson's book in 1958.⁸⁹⁵ She had been the nursing superintendent at St Stephen's Hospital in Delhi from 1916 to 1938 and was President of the TNAI from 1940 to 1947.⁸⁹⁶ Her slim volume consisting of only 116 pages was an uncritical paean, in the manner of Tooley, to the struggles and fortitude of the nursing profession in India over the previous three centuries. The inspirational actions of Florence Nightingale, who encouraged the development of nursing in India, featured strongly in her history.⁸⁹⁷ The book contained only one and a half pages relating to psychiatric nursing and this was located in the chapter entitled *Mental Nursing*. Much of that chapter referred to the survey of mental health provision carried out in 1946 by the then Medical Superintendent of the EMH Lt Col Taylor as part of his contribution to the Bhore Report.⁸⁹⁸

The Bhore Report had found for nursing staff '[I]nadequate numbers and insufficient training alike [which] contributed to make the standard of service of an extremely low order.'⁸⁹⁹ Another of her references from the report related to the lack of post-qualification training of doctors in psychological medicine but there was no reference to mental nursing. Wilkinson made no comment on what appeared to be an indictment of three centuries of psychiatric care by the British as Independence drew near. She pointed out that in the 1950s the newly independent governments of

⁸⁹³ Presidential Address, TNAI Conference, *NJI* (January 1935) vol. xxvi, no. 1, pp. 5-6.

⁸⁹⁴ Information obtained personally from annual and triennial reports of the inspections of mental hospitals in India from 1900 to the 1930s.

⁸⁹⁵ Wilkinson, Alice (1958) *A Brief History of Nursing in India and Pakistan*, Trained Nurses Association of India, Diocesan Press, Madras.

⁸⁹⁶ Healey, Madelaine (2013) *Indian Sisters: A History of Nursing and the State, 1907-2007*, Routledge, New Delhi, p. 77.

⁸⁹⁷ For further details see Mowbray, Patricia (2008) *Florence Nightingale and the Viceroy: A Campaign for the Health of the Indian People*, Haus Books, London.

⁸⁹⁸ See http://www.nhp.gov.in/sites/default/files/pdf/Bhore_Committee_Report_VOL-1.pdf The Bhore Report, *The Report of the Health Survey and Development Committee* Government of India Calcutta, 1946. (Accessed 30th September 2016).

⁸⁹⁹ Wilkinson, *A Brief History*, p. 78.

India and Pakistan had sent nurses to the UK for training in psychiatric nursing and she hoped, in what appears to be genuine naivety, that this would ensure that mental nursing would then be put on a proper basis in both countries.⁹⁰⁰

Perspectives on general nurses and mental nurses

Some insight into the lives of British nurses in India can be found in advertisements in professional journals. Thus in March 1922 the *British Journal of Nursing* announced an unspecified number of vacancies for staff nurses with British troops in India and these were posts which could be filled immediately. Applicants had to be fully trained nurses, possessing midwifery qualifications, and aged between 27 and 35. The posts were temporary and work could be in family hospitals as well as with soldiers. Pay was Rs250 'per monsoon' with no gratuity at the end of the contract but with free passages to and from Britain. In addition to the pay successful postholders were entitled to their own rent-free quarters with fuel, light and the service of *punkah wallahs* also provided.⁹⁰¹ They were also entitled to an outfit allowance of £20 or £25 if they had previously served in the Military Nursing Service.⁹⁰²

The personal testimonies of British nurses working in India give some primary source information into their professional lives and experiences. Thus Angela Bolton, of the Queen Alexandra's Imperial Military Nursing Service (QAIMNS)⁹⁰³, served in India from 1942 to 1945 and wrote a memoir about her life and work there. She worked in several general hospitals across the country and did a two month placement in a psychiatric unit 'where I felt particularly useless and ignorant.'⁹⁰⁴ She suffered much personal ill health, contracting hepatitis, glandular fever and dengue fever, which she regarded as an occupational hazard. She much enjoyed the opportunities for travelling, horse riding and socialising. She relished the camaraderie of the treatment team and told Major-General Thompson, who headed

⁹⁰⁰ Wilkinson, *A Brief History*, p. 79.

⁹⁰¹ See Yule and Burnell *The Concise Hobson-Jobson*, pp. 256 and 463 respectively. A *punkah* was a portable fan, traditionally made from a large, swinging leaf. The *wallah* was the servant paid to agitate it to generate cooler air in the 'hot weather.'

⁹⁰² Advert, *British Journal of Nursing*, 11th March 1922, vol. 68, p. 149.

⁹⁰³ The Indian branch of the service was known as the Queen Alexandra's Military Nursing Service for India until its amalgamation with the QAIMNS in 1926. See <http://www.qaranc.co.uk/queen-alexandras-imperial-military-nursing-service-for-india.php> (Accessed 10th September 2017) for further information.

⁹⁰⁴ Bolton, Angela (1986) *The Maturing Sun: An Army Nurse in India, 1942-45*, Imperial War Museum, London, p. 127.

medical services in Assam, that doctors and nurses worked more closely together in India than in England. Bolton admitted she had little experience of nursing the mentally ill whilst serving in India. In her opinion

*The unquestioning reverent obedience to doctors that had been instilled into us when we were training had changed to an easy comradeship that made life pleasanter and more productive of ideas for the patients' welfare.*⁹⁰⁵

These first hand descriptions of life and views of nursing practice were echoed in a personal interview with another QAIMNS sister, Mrs Anne Empsall, who had served in India during World War Two.⁹⁰⁶ Mrs Empsall recalled and relished the respect and admiration she received from white soldiers in wartime India. She had clear memories of working in Poona, of the many social activities she enjoyed and of the unrelenting heat. She and her fellow nurses were much sought after for social and sporting events. Although it cannot be determined if such experiences were typical of British nurses in India they do give some insight into aspects of their lives. White qualified nurses were implementers of Western medicine and, therefore, as agents of empire were part of the colonial enterprise enjoying privileges because of it.

The first academic history of nursing in India was produced by Madelaine Healey in 2013.⁹⁰⁷ A key finding in Healey's research was her identification in the nursing profession of a 'heavily Christianised discourse of obedience and service'⁹⁰⁸ and one of 'duty, service and self-effacement.'⁹⁰⁹ This led to an inbuilt modesty in the overwhelmingly female occupation of nursing. In her view the subservience of nurses to doctors meant that the former's achievements were often hidden. The situation was further complicated by the distinction between nurses who were British-based or military, Anglo-Indian or Indians themselves. The profession was further weakened when many qualified, experienced nurses left for Europe when the First World War began.

⁹⁰⁵ Bolton, *The Maturing Sun*, p. 193.

⁹⁰⁶ Personal interview with Mrs Anne Empsall (née Gill) on 19th July 2012 then aged 94. Sadly Mrs Empsall died in 2013.

⁹⁰⁷ Healey, *Indian Sisters*.

⁹⁰⁸ Healey, *Indian Sisters*, p. 4.

⁹⁰⁹ Healey, *Indian Sisters*, p. 32.

Healey argued that from the mid nineteenth century nursing had become a respectable profession for British middle class women in India and this respectability was reinforced by their commitment to religion. She believed that from the early twentieth century Western nurses coming to India perceived themselves 'as emissaries of a professionalised version of nursing, with a role to play in the cultural mission of imperialism.'⁹¹⁰ In other words, a nurse had exchanged, in Coventry Patmore's famous phrase, the 'Angel in the House'⁹¹¹ for the role of an angel in the Raj.

The leadership of nursing in India developed strong international links with nurses from the English speaking dominions of Australia and Canada as evidenced in each issue of *NJI*. Such an international ethos, argued Healey, enabled them to be part of the cultural project of imperialism whilst neglecting localised issues of Indian nationalism.⁹¹² With their deep colonial roots she saw them as agents of empire whilst being representatives of a worldwide profession.

The role of nuns and missionaries in the nursing profession was both praised and criticised by Healey. Christian Missionaries, who were mainly Protestant, dominated nurse training in India prior to Independence and have maintained a key role to the present day. However she argued that nuns, because of their vows of poverty, humility, submission and self-sacrifice, and their willingness to work in the poorest of communities, actually reinforced the low status of nurses in India. Healey has written that their impact had emphasised the stigmatisation of nurses and reinforced a tradition of low pay and exploitation.⁹¹³

The growth of general nursing in India has been researched by Rosemary Fitzgerald and she has made a particular study of the role of missionaries in this. At the end of the nineteenth century, she observed, most white nurses in India lacked formal qualifications but possessed the 'natural feminine qualities' associated with caring for the sick.⁹¹⁴ However, as the twentieth century progressed missionaries played an increasingly important role in the training and academic examination of

⁹¹⁰ Healey, *Indian Sisters*, p. 14.

⁹¹¹ Cited in Cooper, Suzanne Fagence (2001), *The Victorian Woman*, V&A Publications, London, p. 10.

⁹¹² Healey, *Indian Sisters*, p. 30.

⁹¹³ Healey, *Indian Sisters*, p. 35.

⁹¹⁴ Fitzgerald, Rosemary (2006) 'Making and Moulding the Nursing of the Indian Empire: Recasting Nurses in Colonial India,' pp. 185-222, in Powell, Avril A. and Lambert-Hurley, Siobahn (Eds) *Rhetoric and Reality: Gender and the Colonial Experience in South Asia*, Oxford University Press, New Delhi,

nurses. As with many other historians of nursing in India she made no references to mental nurses in her study.

Anglo-Indian girls, often educated in missionary or church school, proved to be a significant source of nurses, observed Healey. At Independence in 1947 80% of civilian and military nurses were from that community.⁹¹⁵ Although there were a growing number of nurse training courses in the 1920s and 1930s and a regulated system of exams from 1926, Healey believed that nursing was 'stunningly underdeveloped' in 1947.⁹¹⁶ She expressed articulately the weaknesses of the general nursing profession in India whilst neglecting almost completely the discipline of mental nursing.

This failure of the British Raj to develop nursing was recognised at the highest level in the medical hierarchy. Major-General J. B. Hance (IMS) blamed this on the attitudes of the authorities responsible for maintenance of hospitals. Speaking at a meeting of the TNAI in 1943 Hance commented that

*As long as trained nurses are regarded, paid and housed as menials it is not reasonable to expect that large numbers of Indian ladies will come forward to dedicate themselves to this work.*⁹¹⁷

In addition many Indians attached a moral suspicion towards nurses because they were often single women away from home and performed intimate personal caring tasks towards strangers.

The conditions in which nurses worked in India had been recognised as 'deplorable' in the Bhore Report but that it was in the power of governments to remove the obstacles to progress if there was the political will to do so.⁹¹⁸ In her analysis of Bhore Healey concluded that the official report reflected the underlying truth that the colonial state had reinforced negative stereotypes about the role and value of women in India, both European and Indian.⁹¹⁹ As a result of her study she

⁹¹⁵ Healey, *Indian Sisters*, p. 55.

⁹¹⁶ Healey, *Indian Sisters*, p. 74.

⁹¹⁷ Cited in Healey, *Indian Sisters*, p. 73.

⁹¹⁸ Cited in the Bhore Report in Healey, Madelaine (2010) "'Regarded, paid and housed as menials": nursing in colonial India, 1900-1948,' *South Asian History and Culture*, vol. 2, no. 1, p. 65. DOI:10.1080/19472498.2011.531609 (Accessed 11th August 2017)

⁹¹⁹ Healey, "'Regarded,'" p. 65.

surmised that the problems of nursing in India were due to an unequal relationship between a patriarchal state combined with a weak professional organisation shaped by its colonial roots. In her opinion the professional status of nurses foundered because of their close and subservient relationship to the heavily masculinised profession of doctors within such a patriarchal setting.⁹²⁰ Angels perhaps, but symbolic angels without teeth.

Unfortunately Healey's pioneering study made no direct reference to psychiatric nursing. The overall lack of documentary evidence available to historians concerning the views of mental nurses has been generally recognised. However she has declined to legitimate or even to recognise the work of this unassuming branch of the profession, this hidden dimension in nursing, as if it had not existed.

European women as a whole in India were in a contradictory position, as Ann Stoler has explained. On the one hand, she argued, they faced profound restrictions because of their gender in their domestic, economic and political life especially when this was compared with developments in Europe in the first quarter of the twentieth century.⁹²¹ On the other, though, they were the physical embodiment and often the physical representative of a superior Raj. They played the ambiguous roles of both subordinates in the colonial hierarchy and active agents of imperial culture in their own right.⁹²² As white women they personified these dilemmas for the British in India.

To add to this, as Stoler has pointed out, white women acted as a form of moral compass. She cited the warning observation of Georges Hardy, a French educationalist, who advocated racial vigilance to prevent the risk of racial degeneration. In 1929 he wrote [A] man remains a man as long as he stays under the gaze of a woman of his race.⁹²³ Stoler argued that many men actually contravened Hardy's statement through their liaisons with Indian women and white women only brought their ethical influence to India in large numbers when the country had been made politically, medically and physically safe for them from around the late nineteenth century.⁹²⁴ The triumph of this female moral influence

⁹²⁰ Healey, *Indian Sisters*, p. 40.

⁹²¹ Stoler, Ann L. (November 1989) 'Making Empire Respectable: The Politics of Race and Sexual Morality in Twentieth Century Colonial Cultures,' *American Ethnologist*, vol. 16, no. 4, p. 634.

⁹²² Stoler, 'Making Empire,' p. 634.

⁹²³ Stoler, Ann Laura (2001) *Carnal Knowledge and Imperial Power: Race and the Intimate in Colonial Rule*, University of California Press, Berkeley, USA, p. 1.

⁹²⁴ Stoler, *Carnal Knowledge*, p. 1.

over imperial military men, sometimes as unofficial nurses, was the subject of numerous popular novels by British women during the Raj. Such writers as Diver and Perrin, both of whom were born in India to British families, praised the strength and courage of white women facing the many hostile challenges presented by India whilst lamenting the misunderstanding of their position by the authorities back in Britain.⁹²⁵

British nurses coming to the colonies were part of these imperial contradictions. They went to the Boer War (1899-1902) in South Africa in significant numbers and experienced freedoms unavailable in Britain. Charlotte Dale found in her research that nurses there demonstrated their skills as expert practitioners earning respect from their male medical and military colleagues because of them. They also enjoyed their off duty hours with picnics, dancing and riding alongside male colleagues and not always with chaperones as might be expected at home. Dale recorded that the nursing image of the 'self-sacrificing angel' was being threatened by their behaviour.⁹²⁶ She proposed that this was one factor that led to the formation in 1902 of QAIMNS. The QAIMNS provided an organisational structure through which authority and discipline amongst nurses could be implemented. Its existence recognised that nurses had now become a permanent presence in wars and it led to internal control of nurses by nurses, though subordinate to a male, military authority.⁹²⁷

The issues of nurses as representatives and practical implementers of Western medicine has been researched by Helen Sweet and Sue Hawkins in their studies of colonial and post-colonial nursing. Their book included articles on nursing from four different continents. They considered Western medical practice in colonised countries from a Foucauldian perspective, where the significance of power relationships, involving institutional, racial and political categorisations, was expressed through language and behaviour.⁹²⁸ From this viewpoint doctors and nurses were agents of empire and had both overt and covert impact on colonial

⁹²⁵ See, for example, Diver, *Captain Desmond V.C.* and Perrin, Alice *The Anglo-Indians*.

⁹²⁶ Dale, Charlotte 'The social exploits and behaviour of nurses during the Anglo-Boer war, 1899-1902,' in Sweet, Helen and Hawkins, Sue (Eds) (2015) *Colonial Caring: A history of colonial and post-colonial nursing*, Manchester University Press, Manchester, p. 75.

⁹²⁷ Dale, 'The social exploits,' p. 75.

⁹²⁸ Sweet, Helen and Hawkins, Sue (2015) 'Introduction: contextualising colonial and post-colonial nursing,' in Sweet, Helen and Hawkins, Sue (Eds) *Colonial Caring: A history of colonial and post-colonial nursing*, Manchester University Press, Manchester, p. 1.

peoples. By their presence they played an explicit role in imposing aspects of their religion, their language and their education, by creating a hierarchical power structure and by providing statistical information to assist the government in running the colony. They also played a covert role by imposing one set of cultural standards whilst undermining native and traditional ones.

In the view of Rima Apple European nurses in the empire held an iconic status in their role as actors on the imperial stage.⁹²⁹ They were ambassadors for the imperial project and represented both Western medicine and Western life in the eyes of colonial subjects. Female nurses held positions and responsibilities which had not been available to previous generations of women, Apple wrote, and which were challenging and exciting. Like many of her peers Mrs Empsall had thrived on this reverence and excitement.

In their book in about the work of medical women in India Dr Margaret Balfour and Dr Ruth Young criticised the prejudice against female doctors in India illustrating the disparities in pay and conditions of service.⁹³⁰ They declared that British women doctors had now assumed the 'white man's burden,' in India on unequal terms. They declined to say that the colonial encumbrance was also carried by white nurses. However they were consistent with others of their profession in that their book made no reference to mental illness, mental hospitals or mental nurses, whether female or male.

Doctors' views of mental nurses

As the more powerful figures in India, doctors had their own perspective on the mental nursing profession. From the evidence gathered it was clear that the medical profession's view of its subordinate staff was not always complimentary, one element being the generally low social status of nurses. In 1900 writing his annual report of the asylums in the Bombay Presidency, Dr G Bainbridge, the Surgeon-General for the Government of Bombay, entered into the debate on the use of physical restraint on asylum patients, the majority of whom were Indian. He accepted the comments

⁹²⁹ Apple, Rima (2015) 'Afterword' in Sweet and Hawkins *Colonial Caring*, p. 232.

⁹³⁰ Balfour, Margaret I. and Young, Ruth (1929) *The Work of Medical Women in India*, Humphrey Milford, OUP, Bombay, pp. 11-12.

from asylum superintendents, whom he had met personally and who wished to reduce its use but, referring to nurses, he reported that:

*until a more educated and intelligent class of persons is attracted to asylum service by improved pay, there can be but little advance in the details of managing insanes.*⁹³¹

A reluctant admission was made by Bainbridge that, unfortunately, the confinement of patients within enclosures was essential:

*not only by the want of capacity and attentiveness on the part of the warders, but by their own low intelligence which renders a large proportion of the cases unmanageable and unimprovable.*⁹³²

Significantly, Bainbridge refrained from using the term *nurse* preferring *warder*, an indication that control of his patients was required rather than care. The term *warder* reflected the custodial nature of the hospital, as until 1905 asylums in India were run by the Director-General of Prisons and not by the health department.⁹³³ In addition it might also be a reluctance to accept that mental nursing was itself emerging slowly in the UK as a discipline separate to medicine.

The low wages paid to the non-medical staff did not encourage a professional career. In 1899 Bainbridge recorded the monthly pay of different employees at the Colaba Asylum in Bombay which had both European and Indian patients and staff. Thus the superintendent, who was European, received Rs800 a month, whereas his Assistant Superintendent, who was Indian, received only Rs100. The Head Overseer was paid Rs70 and the Second Overseer Rs60. In the male part of the asylum a Male Warder 1st Class received Rs12 per month and a Male Warder 2nd Class Rs10. The female section of the asylum was nursed by women and a Female Warder 1st

⁹³¹ Bainbridge, G. Surgeon-General, (1900) Government of Bombay *Report of the Lunatic Asylums in the Bombay Presidency for the Year 1899*, Government of Bombay, Bombay, p. 12.

⁹³² Bainbridge, *Report*, p. 12.

⁹³³ Sharma, S. D. (2004) 'Mental Health, The Pre-Independence Scenario,' in Agarwal, S. P. (Ed) *Mental Health: An Indian Perspective, 1946-2003*, Elsevier, New Delhi, p. 27.

Class was paid Rs10. There were no Female Warders 2nd Class in this particular asylum.⁹³⁴

The doctors' opinions of the nursing staff seemed not to have changed by 1910 although by then the pay of Male Warders 2nd Class had been reduced to Rs8 a month.⁹³⁵ Thus Dr Stevenson, a successor to Bainbridge, wrote in his inspection report of the Colaba Asylum for 1910 that Indian men of fair intelligence could easily obtain better paid jobs which were less physically threatening. It is hard to disagree with his conclusion that:

*[I]t must be recognised that the work of an Asylum Warder, which means constant association with, and continual care of insanes, with no holidays, is one which no man who is worth anything will take up unless the pay and other conditions are such as to compensate him for the life he has to lead.*⁹³⁶

Bainbridge and Stevenson clearly did not anticipate a high quality of care in the mental hospitals for which they were responsible. The latter presumably believed that the role was more suited to women, who would not expect as much in income or conditions of service.

Further evidence of the medical viewpoint of the inadequacy of nurses was provided by Major Ewens (IMS), the medical superintendent of the Punjab Asylum in Lahore. In 1908 he indicated in the introduction to his textbook for alienists in India, that there was a lack of well trained and skilled nurses in the country as employment as a nurse was regarded as a dirty, low paid job with low status.⁹³⁷ There were few other references to nurses in his manual perhaps because of his low opinion of their value in the treatment of the insane.

The 1925 text book on mental illness in India by Lt Col Jagoe Shaw⁹³⁸ and his articles for the *IMG* echoed the views of Ewens. Hence in 1932, reflecting on his

⁹³⁴ Bainbridge, *Report*, p. 12.

⁹³⁵ Government of Bombay (1911), Stevenson, H. W. Surgeon-General, (*Report of the Lunatic Asylums under the Government of Bombay for the Year 1910*, Government of Bombay, Bombay, p. 4.

⁹³⁶ Stevenson, *Report*, p. 4.

⁹³⁷ Ewens, G. F. W. Major (IMS) (1908) *Insanity in India. Its symptoms and Diagnosis. With reference to the relation of crime and insanity*, Thacker, Spink, Calcutta, p. 3.

⁹³⁸ Jagoe Shaw, *A Clinical Handbook*.

career after six years in retirement, Shaw wrote of the great difficulty in attracting suitable nurses because of the lack of interest amongst Hindus and Muslims in the role unless they were looking after relatives. He said he had expended much energy in recruiting one 'attendant' per six patients in his last hospital at Yeravda, near Poona, and had ensured that the nursing of Europeans was by Europeans and Anglo-Indians, most of whom were ex-soldiers.⁹³⁹ He was resigned to there not being a skilled and reliable body of nurses to meet situations like this or to nurse Europeans in geographically remote settings. These deficiencies, as Jagoe Shaw acknowledged, meant an extra burden of responsibility had fallen on his fellow medical professionals.

It has not been determined to what extent nurses might have been critical of the medics and the articles in the *NJI* were always respectful towards their professional colleagues. However one intervention indicated that some were prepared to voice their opposition. In 1913 twelve nurses took the serious step of writing to Lord Willingdon, the Governor of Bombay, to protest at the high handedness of the doctors with whom they worked.⁹⁴⁰ The Governor's response was not known but the findings below suggested that the working environment did not change much until the exigencies of the Second World War.

With these shortcomings in mind a number of proposals from doctors were implemented which were intended to improve the stock of nurses and those they nursed. It became a tradition that the vicereine would sponsor a charity connected with health, especially that of females. Thus in 1885 the National Association for Supplying Female Medical Aid to the Women of India was established by the Countess of Dufferin to raise funds to build hospitals and dispensaries across India.⁹⁴¹ Her initiative, popularly known as the Dufferin Fund, led to the construction of health facilities across India and to the training of Indian women in medicine and nursing. The fund was successful at raising donations amongst colonial

⁹³⁹ Jagoe Shaw, 'The Alienist Department,' *IMG*, vol. 78, p. 341.

⁹⁴⁰ Harrison, Mark (2009) 'Introduction,' in Harrison, Mark, Jones, Margaret and Sweet, Helen (Eds) *From Western Medicine to Global Medicine: The Hospital Beyond the West*, Orient Blackswan, New Delhi, p. 28.

⁹⁴¹ Mowbray, Patricia (2008) *Florence Nightingale and the Viceroy: A Campaign for the Health of the Indian People*, Haus Publishing, London, p. 138.

administrators and in Britain and led to greater opportunities for Indian women to become qualified as doctors or nurses in their home country.⁹⁴²

A need had been identified to care for sick Europeans in their own homes. Thus a later vicereine, Lady Minto, established her Lady Minto's Indian Nursing Service (INS) in 1906 to supply qualified nurses for domestic nursing across much of India and Burma.⁹⁴³ Priority was given to the care of Europeans who lived in areas too remote to have a hospital. Previously the only organised agency to meet these needs was the *Up Country Nursing Association* which had existed in only two provinces: the Punjab and the United Provinces.⁹⁴⁴ The Minto initiative provided a form of nursing care in the European community where transfer to a general or a mental hospital was not feasible. Neither of these vicereinal innovations did much to promote mental nursing.

Writing in the *Nursing Journal of India (NJI)* in 1923 a Dr F. Butcher of the IMS gave his views on nurses in an article about their role in the private practice of caring for Europeans in their own homes in India.⁹⁴⁵ Some white families preferred this option rather than endure the stigma of their relatives being admitted to a mental hospital. Ideally, he wrote, the patient should be in hospital but if this option was not available the nurse must have certain attributes. She should be tall and strong because:

*maniacs, until they know the nurse, have an uncanny way of trying to take advantage of a short person. She should be cheerful and patient; a nervous woman is quite useless.*⁹⁴⁶

Dr Butcher advocated that nurses made use of warm baths in their practice and he also recommended their use of cold water because of its deterrent effect but warned

⁹⁴² Sehrawat, Samiksha (May-June 2013) 'Feminising empire: The Association of Medical Women in India and the Campaign to Found a Women's Medical Service,' *Social Scientist*, vol. 41, no. 5/6, pp. 65-81. At <http://www.jstor.org/stable/23611119> (Accessed 29th November 2017)

⁹⁴³ Information about recruitment to the Indian Nursing Service can be found at the Royal College of Nursing Archive at <http://rcnarchive.rcn.org.uk> (Accessed 22nd October 2016). See for example *Nursing Record*, November 19th 1910, pp. 414-415.

⁹⁴⁴ See, for example, the entry in the *British Journal of Nursing*, July 28th 1906 vol. 37, p. 69.

⁹⁴⁵ Butcher, 'Mental Nursing' *NJI* vol. XIV, no. 4, pp. 89-92.

⁹⁴⁶ Butcher, 'Mental Nursing,' p. 89.

that the shock of it could be dangerous to the distressed patient.⁹⁴⁷ Butcher's article made it clear that he saw mental nurses primarily as disciplinary figures.

He alerted the nurse to the importance of watching 'melancholics' with much care 'especially if educated and capable of concealing their own mental suffering' because of the risk of suicide.⁹⁴⁸ Butcher's 1923 reference to suicide was one of the first of its kind to be included in the *NJI*. It has been identified in the memoirs of Butterworth, Cameron, Wakefield and others that actual or attempted suicide did occur amongst the British in India and knowledge of its occurrence was widespread. The *NJI* was founded in 1910 and its lack of coverage of self harm and suicide may reflect the delicacy of the topic for its editor. However it would require further research to determine if this was indeed the reason or if there was another.

Other IMS doctors had views of what they wanted from a mental nurse. One of the most forceful medical advocates of what a nurse should be was Lt Col Berkeley-Hill, of the EMH. In 1924 he declared he had identified what he called 'the nursing problem of the hospital.'⁹⁴⁹ He regarded their pay and conditions of service as 'decidedly good,' but was aware that mental hospitals were

*still regarded as God-forsaken places of confinement and many people still feel that it is a disgrace to be connected with them in any capacity.*⁹⁵⁰

Writing in the *NJI* in June 1930⁹⁵¹ and in his autobiography⁹⁵² Berkeley-Hill prescribed precisely the qualities which he believed a good mental nurse must possess. In the first instance the nurse had to be a woman. Berkeley-Hill declared that, because of the skills of the doctors, the drugs they used and the abilities of the female nurses if they met his requirements, there was no longer a need for male nurses to manage difficult or aggressive patients. When he visited the Bloomingdale Hospital in New York State in 1929 he declared to his hosts that the European

⁹⁴⁷ Butcher, 'Mental Nursing,' p. 90.

⁹⁴⁸ Butcher, 'Mental Nursing,' p. 91.

⁹⁴⁹ Berkeley-Hill (January 1924) 'The Ranchi European,' *JMS*, vol. 70, no. 288, pp. 67-68.

⁹⁵⁰ Editorial (24th November 1924) *Times Of India*, 'Ranchi Mental Hospital,' p. 10. Retrieved from ProQuest Historical Newspapers Historical Newspapers at <https://search-proquest-com.libaccess.hud.ac.uk/?accountid=11526>

⁹⁵¹ Berkeley-Hill, Owen (June 1930) 'Some principles of mental nursing,' *NJI*, vol. XXI, no. 6, pp. 127-129. This article was reprinted in the British Journal of Nursing in July 1930.

⁹⁵² Berkeley-Hill, *All Too Human*.

Mental Hospital at Ranchi was superior for several reasons, one being that his hospital did not employ male nurses.⁹⁵³ Berkeley-Hill only used the term *nurses* to indicate those who had undergone a professional training course. He referred to unqualified nurses as *attendants*.

In his view the mental nurse had to have all the attributes essential for a good surgical or medical nurse i.e. 'sympathy, loyalty, diligence and devotion to duty' together with a:

*God-given gift of saying and doing, without hesitation or apparent effort, exactly the right thing in the right way and at the right time.*⁹⁵⁴

The nurse did not always have to be 'the cleverest or the best educated woman ... but no woman without it [i.e. God's gift] is suited to the care of the insane.'⁹⁵⁵ Without this divine quality the female applicant might not have been employed at the EMH.

In Berkeley-Hill's opinion the nurse had to possess 'limitless patience, gentleness and tact.' She must be 'thick skinned' to cope with the many irritable, abusive and insolent patients found in hospitals. To manage 'insane patients' effectively she 'must cultivate, assiduously, gentleness and tact and listen to all patients' without showing any favouritism. She must be able to cope with all the noise, restlessness, destructiveness and lack of cleanliness amongst the patients on the hospital ward.⁹⁵⁶ Berkeley-Hill determined that she 'must not coax or lie' to a patient in the hope of short term goals. She must never promise a patient who will not go to bed that they were merely being asked to go to their rooms to dress for a concert or a dance. If she did this she would inevitably lose respect through her deceit. Additionally her dishonesty would have a lasting, detrimental effect on the institution as 'the patient will have lost confidence in the hospital as a whole' with repercussions for future treatment.⁹⁵⁷ The nurse was required to have respect to and loyalty for her workplace. Indeed, the nurse's exemplary behaviour had to be displayed beyond her workplace. When away from the hospital she 'must maintain strict confidentiality or absolute reticence' at all times. For, warned Berkeley-Hill, the

⁹⁵³ Berkeley-Hill, Owen *All Too Human*, p. 292.

⁹⁵⁴ Berkeley-Hill, (June 1930) 'Some principles of mental nursing,' *NJI*, vol. XXI, no. 6, p. 128.

⁹⁵⁵ Berkeley-Hill, (July 1930) 'Some principles of mental nursing,' *BJN*, p. 171. This was a reprint of the article in the previous month's *NJI*.

⁹⁵⁶ Berkeley-Hill, *All Too Human*, p. 292.

⁹⁵⁷ Berkeley-Hill, 'Some principles,' *NJI*, p. 129.

fact that someone had been under care in a mental hospital may do him or her irreparable harm when restored to the outer world.⁹⁵⁸

If she could have met all these exacting requirements the mental nurse would be welcomed by the all male medical hierarchy of the European Mental Hospital. Whether she would be permitted to practice these not inconsiderable personal skills, as a respected and independent professional in her own right in the 1930s seemed unlikely. It was very rare in the *IMG* to find any references to mental nurses which did not refer to them as *de facto* servants to doctors.

An explanation for this subservient position has been provided by Nolan. He argued that there was a connection between the supremacy of the medical model and the relegation of nursing to a lower status occupation. In his opinion 'cure' had become the supreme goal in psychiatry, the mechanism by which to prove the advanced skills and knowledge of the discipline.⁹⁵⁹ In this scenario 'caring' did not achieve a successfully completed course of treatment. Caring was a mere adjunct to the doctoring activity and something which could be managed by untrained relatives.

Evidence from Indian professional journals showed that the term *warder* was no longer being used in the 1920s. An unqualified nurse was referred to as an *attendant* and regarded as having a menial status. Recent studies of attendants in colonial Australia by Monk has shown that 'attending' became an occupation in its own right with its own culture rather than a precursor to a later profession in nursing.⁹⁶⁰ Once again there has been so far a paucity of research on this topic in British India which has prevented straightforward comparisons.

In 1924 the EMH had a nursing complement of 7 European male attendants, 5 European female nurses including a matron and these staff were supported on the wards by 25 male and 35 female attendants.⁹⁶¹ Whilst these basic statistics were available, research into the original surviving medical records at the European Mental Hospital in Ranchi revealed only limited evidence to fill the gaps in our knowledge of the work of psychiatric nurses.

⁹⁵⁸ Berkeley-Hill, 'Some principles,' p. 129.

⁹⁵⁹ Nolan, *A History*, p. 46.

⁹⁶⁰ Monk, *Attending Madness*, pp. 16-17.

⁹⁶¹ Berkeley-Hill, 'The Ranchi European' p. 69.

Treatments and the role of the mental nurse

With limited knowledge about mental nursing profession, it is helpful to look to the treatments and the role of the mental nurse in India. In the 1930s a number of new treatment techniques were developed in Europe such as insulin coma therapy and electroconvulsive therapy. The growth in these physical therapies was dependent on skilled general nursing for their implementation and success and Niall McCrae has observed that an air of prestige was bestowed on the mental nurses working on these innovative procedures.⁹⁶² Borsay and Dale have argued that mental nurses had to acquire the kinds of skills necessary for intensive or acute physical care. Most mental nurses had had some experience of caring for people with epilepsy and this familiarity facilitated their work in these new challenges. It was this relative ease of transition that gained them greater respect and understanding amongst general nurses.⁹⁶³

In order to understand some of the tasks of the mental nurse it was beneficial to consider their involvement in hydrotherapy, one of the key methods of treatment at the EMH in the 1920s and 1930s. The medical regime there required that on admission to the hospital all patients were to be kept in bed for at least a week to give them an opportunity for extended rest. Those patients who were suffering acute excitement, and who were not prepared to stay in bed, were usually treated by means of hydrotherapy or prolonged immersion in water at an agreeable temperature in a bath of a special design. It had a canvas cover with a hole for the head which when necessary would be placed over the bath to prevent the patient getting out. The temperature of the bath was maintained at 94F to 96F (34C - 35.5 C) and meals were taken in it. Bathing took place in the patient's own room. Attendants ensured that the temperature remained constant. They were not allowed to speak to the bather, apart from the basic civilities, as the patient had to have the quietest environment to facilitate his or her recovery.⁹⁶⁴

The existing case records of patients at the hospital in the 1920s and 1930s illustrated the widespread use of hydrotherapy and gave evidence for the

⁹⁶² McCrae, Niall (2014) 'Resilience of institutional culture: mental nursing in a decade of radical change,' *History of Psychiatry*, vol. 25, no. 1, p.71. DOI: 10.1177/0957154X13512575.

⁹⁶³ Borsay and Dale 'Mental Health Nursing,' in *Mental Health Nursing*, pp. 11-12.

⁹⁶⁴ Berkeley-Hill, *All Too Human*, p. 71.

understanding of its significance as a form of treatment. The medical notes concerning Mrs W E, an Anglo-Indian woman, will be used as to illustrate treatment practice.⁹⁶⁵ She spent most of her life between 1928 and 1958 in the EMH where she eventually died. She had been diagnosed with paranoia and delusions of grandeur. Her records indicated that for 31 consecutive days from 14th January 1936 she was placed in the bath from 8am to 6pm without being allowed out. Nurses made brief entries on the file every two or three hours recording her moods and what time she had her meals and when she drank tea. Some days she remained quiet and on others she was quite agitated and talkative. The nurses carried out their instructions by, for example, on one morning ordering her to return inside for her bath when she had deliberately left her room before the commencement of the day's treatment. After each session they followed the standard practice of always drying and vaselining her. There was no indication on the case notes that the course of treatment had made any difference to her mental health.

No records have been identified which have given the views of the nurses at this hospital. In the case of hydrotherapy they appeared to have been given clear directions by the doctor in charge, and to have complied with them, as part of the patient treatment programme. The use of the cover in the bath to maintain a patient there for up to 10 hours at a time indicated a form of mechanical restraint but one which was legal under contemporary Indian lunacy legislation for certified patients.

Hydrotherapy was a technique employed internationally and not just in India. Research in Sweden gave insight into the procedure and its impact on patients and nurses underlying its delivery there in the 1930s during the same time period at Ranchi. The work of Gunnel Svedberg, a Swedish psychiatric nurse, demonstrated the practicalities of the work.⁹⁶⁶ He found that originally its use had been based on a German model of practice which had been intended as a move away from restraint and control. He interviewed retired nurses and his research found that in 1934 they regarded the treatment as acceptable then and it was not viewed by them as a form of punishment. His respondents told him that some patients were calmed by it but this was often because they were exhausted by the physical exertions inherent in

⁹⁶⁵ See medical case records on Mrs W E at CIP Archives DVD 017, ANC Roll 24, A-699-O-F.

⁹⁶⁶ Svedberg, Gunnel 'Narratives on prolonged baths from psychiatric care in Sweden during the first half of the twentieth century,' *International History of Nursing Journal* (Spring 2000) vol. 5, no. 2, pp. 28-34.

their mental condition. Monitoring the bather was a tiresome and an unpopular task and was often delegated to the least experienced and youngest member of staff. Patients were susceptible to skin complaints as they spent many hours sitting in water contaminated by their own urine and faeces. Hydrotherapy was later replaced by occupational therapy. Svedborg concluded that:

[L]ike many other psychiatric treatment methods, prolonged baths first brought hopes for the alleviation of patient suffering and the providing of dignified care, only to become associated after a time with dashed hopes and coercion.⁹⁶⁷

The case notes extant at the EMH showed that some of the bathers occasionally objected physically or verbally to the nurses supervising them. Their protestations were recorded meticulously, though briefly, on their notes for the duration of their course of treatment. In practice the doctor was devolving tasks in order to implement the prescribed programme. As the notes studied revealed that hydrotherapy was used there for at least 20 years the implication was that the medics trusted mental nurses to carry out assigned duties.

In a later article Svedborg stressed that patients understood clearly the position of power which nurses had over them when the latter were in charge of bathing. He cited a former psychiatric patient who said that nurses could be rough and unhelpful and acted as 'executioners' when they carried out the doctors' instructions.⁹⁶⁸ His findings were reminiscent of Mrs W. E.'s objections.

Occupational therapy was another therapeutic nursing tool used at the EMH. Berkeley-Hill claimed to have introduced it to India in 1923 acknowledging his debt to its practitioners in American mental hospitals.⁹⁶⁹ He observed that it had been in existence in America since the eighteenth century with much success in patient recovery. It was being rediscovered in Britain following the horrors of the First World War. He divided the type of therapy to be undertaken into two classes. The first was aimed at those patients in the 'recoverable group' where effort was concentrated

⁹⁶⁷ Svedborg, 'Narrative,' p. 34.

⁹⁶⁸ Svedborg, Gunnell (Winter 2002) 'The use of prolonged baths in psychiatric care: understanding through fiction,' *International History of Nursing Journal*, vol. 7. no.1, p. 31.

⁹⁶⁹ Berkeley-Hill, Lt Col O. A. R. (March 1930) 'Occupational Therapy,' *IMG*, pp. 157-160.

upon a programme that would prevent deterioration and that would 'more quickly replace, by substitution, false ideas and beliefs by contact or interest in normal activities.'⁹⁷⁰ For them the aim was to conserve their mental capacity and so prevent deterioration. The intention was to provide or re-provide if lost through illness, the necessary practical and social skills for a return to the British or Anglo-Indian community on discharge. The second class were in a group for whom recovery was not expected. Their energies were to be utilised and their productive abilities were to be maintained as, for them, they were likely to become permanent hospital residents.

He devised and introduced what he called a *Habit Formation Chart* for use by nurses in the Occupational Therapy department at the hospital.⁹⁷¹ The doctor would identify one or more objectionable traits in his patient and devise an appropriate action for the nurses to take. The chart had four columns headed: *Habit, Methods adopted to correct, Result and Remarks*.

The practical use of the chart, which was to be compiled weekly, was illustrated by an example taken from the medical records at the European Hospital.⁹⁷² Mrs B G was a 45 year old British woman, who had twice been married, and had been admitted to the hospital in March 1927. Two unacceptable habits were identified in Mrs B G's behaviour: her use of obscene language; and her wandering around the OT department. Berkeley-Hill prescribed three methods for nurses to correct these problems: 'stop her cigarettes, splash her with cold water, and give her a new dress'. The chart entries for 6th March 1931 indicated that the care plan had been successful as she had been very quiet and well behaved. The *Remarks* column observed that she 'has not been very abusive this week' and that 'she has been doing a little work this week' and had been 'restricted from wandering whilst in OT class.' The case notes did not indicate whether following this attempt at behaviour modification she had received her new dress.

Thus nurses' actions were intended to ensure that Ms B G changed her behaviour in such a way to meet the doctors' prescribed treatment. From a Foucauldian viewpoint this was imposing a regime of moral responsibility which served to create anxiety and guilt in the mind of the patient. An interpretation of this

⁹⁷⁰ Berkeley-Hill, Owen "Occupational Therapy," p. 159.

⁹⁷¹ Berkeley-Hill, *All Too Human*, p. 254.

⁹⁷² See medical case records on Miss B G at CIP Archives DVD 020, ANC Roll 36, A-988-0-M.

practice was that Mrs B G was being compelled by a form of blackmail to act as a stranger to herself in order to meet the official approval of those in charge of her at the hospital.⁹⁷³ Mental nurses were obliged by alienists to implement a regime to change what she preferred to do and her file showed they carried out their instructions correctly.

Recorded personal experiences of nurses in colonial India were limited which has meant a reliance on secondary sources such as psychiatrists who held a different agenda. A study of Berkeley-Hill's published works reveal that he could be eccentric, cantankerous and opinionated. Nevertheless he demonstrated a pride in his hospital and a strong desire for improving the treatment of patients there. He recognised that nurses had a significant part to play in the care of residents, although a subordinate one to the doctors.

Less patronising and more appreciative views of nurses by doctors can be recognised in the mid 1930s. Thus Dr C J Lodge Patch, the medical superintendent of the Punjab Mental Hospital in Lahore, in his 1934 text book on mental diseases noted that the experienced nurse can distract the acute maniac 'into a state of cheerfulness or elation by knowing his foibles and using them for his good.'⁹⁷⁴ Both the wise physician and the wise mental nurse, he wrote, will recognise a patient's remissions and relapses. They will also make themselves aware of the person's environment and life in order to discover the reasons behind these improvements and deteriorations.⁹⁷⁵ He concluded that section of his book with practical advice on how nurses should administer force feeding to resisting patients when the latter were too poorly to be influenced by the personal skills of the nurse. Lodge Patch's writings showed he valued the skilled contributions of mental nurses in his hospital and was willing to accept their views as professional members of his treatment team.

Conclusion

Nursing in India originated with British middle class women inspired by Florence Nightingale and seeking to establish a new profession in a colonial context. One theme throughout this chapter has been the neglect of the mental nurse by the

⁹⁷³ This argument is adapted from the discussion of Foucault in Digby, *Madness*, p. 75.

⁹⁷⁴ Lodge Patch, *A Manual* p. 302. His son and grandson were born in India and both became practising psychiatrists.

⁹⁷⁵ Lodge Patch, *A Manual* p. 317.

nursing establishment in India. The leadership praised the general nurse as a dedicated heroine risking her health in the cause of duty, an imperial angel in the hospital or cantonment. Meanwhile her sisters and brothers in the mental hospitals nursed distressed *Imperial Minds* anonymously, their skills often unrecognised by alienists and historians alike. The TNAI made it difficult for mental nurses to become members and its journal published few articles about them until the 1930s by which time the importance of psychology to general nursing had been recognised. Meanwhile doctors, because it was in their own best interests, had clearly and frequently stated opinions of what mental nurses should be doing. Research for this thesis on mental nursing has been much dependent on the writings of alienists, and treated cautiously because of the bias.

Little evidence has been found on how mental nurses viewed their duties and how they saw their own professionalism. They were a truly 'hidden dimension' in the mental health care system and shared some of the stresses identified for Europeans in India. Dale, Sweet and Hawkins, Apple, Healey and other academics have produced excellent studies of imperial nursing but have ignored the contribution of mental nurses across the empire including India. A need for a comprehensive history of psychiatric nursing in the Indian sub-continent has been identified, one which might unveil their importance and, as Nolan indicated, legitimate the services they provided.

So far the thesis has demonstrated how Western psychiatry in India developed, how British residents there faced the challenges of mental stress and how alienists and mental nurses perceived their professional roles. The next chapter will consider how treatment was delivered to those distressed *Imperial Minds* who entered the European Mental Hospital.

CHAPTER 7

A case study of the European Mental Hospital at Ranchi, 1918 to 1947.

Lt Col Owen Berkeley-Hill – ‘Is there any thought that is constantly in your mind?’

Mrs WE – ‘I came here to marry the Prince of Wales’

*Mrs WE, patient at European Mental Hospital (1928)*⁹⁷⁶

Introduction

With the use of original medical records Chapter 7 will consider the lives of distressed *Imperial Minds*, the EMH patients as they journeyed through the hospital. In keeping with the themes of the thesis it will indicate that the records researched illustrated that some European and Anglo-Indian patients were isolated from their communities and how they had had great difficulty in coping with the stressors they faced as stewards of empire. The chapter will examine the autonomy of individual psychiatrists in promoting Western psychiatry in India. In particular it will look at treatment regimes devised and implemented by them in the EMH between 1918 and Independence. By using case histories of individual patients it will identify innovation in the treatment of Europeans and Anglo-Indians. The limitations of these tasks will be recognised as the analysis was based on a relatively small number of surviving records. The issue of whether the EMH with its high boundary walls was a prison-like institution or whether it was more open, or *permeable*, to contacts from outside will be considered. New information critical to our understanding of the lives of patients of the EMH will be revealed from archival records. It takes the form of ‘medical history from below,’ a concept promoted by Porter to challenge the often unchallenged history from above written by professional psychiatrists.⁹⁷⁷

⁹⁷⁶ See case records on Mrs WE at CIP Archives DVD 017 ANC Roll 24, A-699-O-F. The Prince of Wales, the future Edward VIII, toured India in 1921-22 amidst huge publicity and for many years was considered one of the world’s most eligible bachelors.

⁹⁷⁷ Porter, Roy (March 1985) ‘The Patient’s View: Doing History from below,’ *Theory and Society*, vol. 14. No. 2, p. 193. Porter extended his elevation of the patient’s voice in his 1987 study *Mind-Forg’d Manacles*, see especially Chapter 5 ‘The Voice of the Mad.’

Informed consent was not possible in this study and so the patients were only referred to by their initials. The first reference to each patient will be in bold to acknowledge that they were actual historical if neglected actors in the imperial diaspora.

A mental hospital for Europeans in India

In the final quarter of the nineteenth century there was general acceptance amongst British doctors of the need for a new hospital solely for mentally ill whites and Anglo-Indians in India. The racial segregation was justified by Jagoe Shaw, who had been a medical superintendent at three mental hospitals in India until his retirement in 1926 and, in effect, the senior British alienist in India. He declared that:

*[E]uropeans, and persons of European habits, should not as a rule be treated in the same hospitals as Indians, not on any grounds of sentiment, but because the accommodation and amenities necessary for the one are unsuited to the other.*⁹⁷⁸

Until the First World War doctors working in India had had little training in mental diseases. As part of the IMS or the Army Medical Service⁹⁷⁹ they were military officers and required to have a working knowledge of the ubiquitous and often fatal diseases such as cholera, dysentery and malaria which had the effect of reducing the ability of soldiers to fight effectively.⁹⁸⁰ The 1914-18 war generated greater recognition of psychological medicine following the mental shock experienced by thousands from relentless exposure to warfare on such a massive scale.⁹⁸¹

⁹⁷⁸ Jagoe Shaw 'The Alienist' p. 333.

⁹⁷⁹ The Army Medical Service provided medical services to soldiers of the British Army only. The Indian Army was serviced by the IMS.

⁹⁸⁰ Ernst, Waltraud "Doctor-patient interaction in colonial India: a case of intellectual insanity," p. 214 in *History of Psychiatry* vol. 1. 1990, pp. 207-222

⁹⁸¹ For further detail see Macpherson Sir W.G. (1921) *History of the Great War based on official documents by direction of the Historical Section of the Committee of Imperial Defence. Medical Services: General History Vol.1*, Macmillan, London and Downing, Taylor (2016) *Breakdown: The Crisis of Shell Shock on the Somme*, 1916, Little, Brown, London.

The delay in building the hospital had much to do with the cost, as the official annual reports of the asylums for Europeans in India reported.⁹⁸² However the matter came to a head with the pressure on resources in response to the First World War. The European mentally ill could not be repatriated because of the hostilities and many Anglo-Indians had no direct connections left with Britain. Mental health services were challenged by the numbers of soldiers returning in a distressed state from the Western Front and Mesopotamia. Thus, for example, between 1st and 28th January 1918 95 Indian soldiers arrived in Bombay, the first port of call in India, destined for mental hospitals.⁹⁸³ Gajendra Singh observed that the Indian Army lobbied the government after the war ended and he credited them with providing the impetus for change and improvement in psychiatric services. Consequently at the beginning of the Second World War 1,000 beds were reserved in hospitals for Indians suffering war neuroses.⁹⁸⁴ In addition the Government of India encouraged older psychiatrists, both European and Indian, in December 1942 to come out of retirement and join or rejoin the IMS.⁹⁸⁵

The European Mental Asylum was finally opened in 1918 at Ranchi in northern India for people suffering from a mental illness who were regarded as of European or Anglo-Indian origin. Following the implementation of the Indian Lunacy Act it was renamed in 1921 the European Mental Hospital. During the Second World War its huge catchment area was expanded to include Burma (present day Myanmar). It appears that the hospital was never used for serving British soldiers as the latter were treated in military hospitals and were likely to be returned to the UK, in the first instance to the Royal Victorian Military Hospital at Netley on Southampton Water.⁹⁸⁶ However records show that wives of some senior military officers and wives of members of the Indian Civil Service did receive treatment at the EMH. The hospital was constructed on virgin land in a clearing in the jungle in a remote and

⁹⁸² See, for example, Government of the United Provinces of Agra and Oudh (1913) *Report and Returns of the Lunatic Asylums in the United Provinces of Agra and Oudh for the Year 1912*, Government of India Press, Allahabad, p. 2.

⁹⁸³ Singh, Gajendra (2014) *The Testimony of Indian Soldiers and the Two World Wars: Between Self and Sepoy*, Bloomsbury, London, p. 51.

⁹⁸⁴ Singh, *The Testimony*, pp. 52-53.

⁹⁸⁵ See National Archives of India. New Delhi, Office of the Director-General of the IMS (1943), Recruitment Section (Branch – 2), File No. 16-3-1/43-R-2.

⁹⁸⁶ Hoare, Philip (2001) *Spike Island: The Memory of a Military Hospital*, Fourth Estate, London, p. 158.

relatively unpopulated part of northern India. With its two storey whitewashed buildings with verandahs and its spacious grounds it had, and still retains, the appearance of a holiday resort. The numerous rose gardens would have been familiar to its resident patients. The EMH contrasted markedly with the forbidding facade of the asylums to which Europeans in India might have been admitted.⁹⁸⁷

Annual reports from the EMH have not survived from the early 1920s unlike those from other psychiatric hospitals across India and so the exact ratio of male to female patients was uncertain. However, the Triennial Report for the Hospital from 1923-1926 was summarised in *The Times of India* and showed that the numbers of men and women were roughly equal.⁹⁸⁸ In addition the Census of India figures for 1921 indicated that the ratio of European males to European females was 2.5 to 1.⁹⁸⁹ Evidence confirmed, therefore, that the extant records were not representative of the gender balance of Europeans in the post First World War period.

In 1919 Owen Berkeley-Hill became the medical superintendent of the European Mental Asylum, a post he held until his retirement in 1934. His career illustrated Ernst's contention that psychiatry had grown into a global scientific profession. He attended international conferences, visited hospitals in the USA and had been in correspondence with Freud and Kraepelin. In addition he encouraged Indian psychiatrists to improve their knowledge and skills by spending prolonged periods of study in the UK, Germany and the USA.⁹⁹⁰ This evidence illustrated his openness to international influences in his desire to enhance the professional status of his medical discipline.

His autobiography, and some of his journal articles, revealed the eccentricity of his personality but also his genuine passion for promoting the care for the mentally ill. He adopted a motto for the EMH: '[T]he care of the human mind is the noblest

⁹⁸⁷ I did visit a nineteenth century asylum in Vadodara (formerly Baroda) in Gujarat which was built on the traditional Victorian style of the UK. It still functions as a psychiatric hospital.

⁹⁸⁸ See *The Times of India* (4th April 1928), 'Ranchi Mental Hospital: Three Years' Results.' p. 13.

⁹⁸⁹ See the Census of India 1921 at <https://ia800205.us.archive.org/18/items/cu31924014522746/cu31924014522746.pdf> (Accessed 6th June 2017). The returns indicated that there were 124,991 males and 50,746 women of 'European and Allied Races' living in India in 1921. These figures may have been inflated by Anglo-Indians claiming to be "fully" European.

⁹⁹⁰ See Ernst, *Colonialism and Transnational*, pp. 196-197.

branch of medicine' which was displayed at the entrance to the hospital.⁹⁹¹ How this 'nobility' of practice was delivered will be revealed in this chapter.

The archives of the European Mental Hospital

What was created as the European Mental Hospital in Ranchi is today a functioning psychiatric teaching hospital re-designated as the Central Institute of Psychiatry (CIP) on the same site, though the district is now part of the state of Jharkhand. The information compiled in this chapter came predominantly from the original medical case notes which had been recorded onto DVDs around 2008. Many of the original paper patient case files were damaged by rain or termites⁹⁹². These records were studied at the CIP in 2013 and 2016. In total the records of 51 patients (6 male and 45 female) of European or Anglo-Indian origin admitted between 1918 and 1947 were identified.

The surviving files for the years between 1918 and 1990 were transferred onto 60 DVDs and included material on patients in both the EMH and its successor. The vast majority of admissions after Independence in 1947 to the present day have been of patients of Indian origin. The findings will be analysed in greater detail in the relevant parts of this chapter.

As the scope of this thesis was the mental health of the British in colonial India records relating to Indians were not directly relevant to its subject matter. Consequently the focus has been on identifying extant files relating to Europeans or Anglo-Indians. Records were researched in detail of those people with British- or European-sounding surnames who were admitted to Ranchi for the first or only time prior to 1947. This seemingly arbitrary assumption was made in the belief that Britons or Europeans resident in India would not have chosen to use Indian surnames. Some were people who had not returned to the UK and others were Anglo-Indians or Domiciled Europeans⁹⁹³ for whom repatriation might not have been an option. Because of the scope of the study further refinement was needed to

⁹⁹¹ Berkeley-Hill *All Too Human*, p. 259. The words were taken from the seventeenth century Dutch jurist, Hugo de Groot.

⁹⁹² The chewed edges of some of the papers can still be seen on film.

⁹⁹³ People of European origin with no Indian blood connections who had chosen to settle in India. They were often relatively poor and had lost family connections with Britain or Europe.

separate pre-Independence patients from those whose first admission came afterwards.

Some of the files preserved on the discs appeared to be complete, with admission reports giving basic personal information, medical, occupational therapy and nursing notes, legal documents relating to compulsory hospital admissions, correspondence between doctors and relatives on a variety of topics, receipts for payments and parcels sent by relatives and so on. Such files, particularly where they related to patients who spent many years at the hospital, were sometimes 500 pages in length though others often only contained ten. In some files key documents were missing implying that part of the paper content had been lost. Some files did not contain admission sheets and in those cases it was difficult to establish precisely when or how often the patient was admitted, or for how long they were resident.

The backgrounds of the patients for whom records survived varied considerably. They ranged from one who was in the original tranche of admissions in 1918, to those who were admitted during and after the Second World War. Some were from a relatively poor and low status background and one was the wife of a general. Some were railway workers and others part of the senior ruling establishment. Some had had psychiatric treatment in Britain before coming to India and eventual admission to the EMH. During the Second World War a number were transferred from Burma to escape the advancing Japanese. After consultation with the Director of the Central Institute of Psychiatry and the Institute's Chief Librarian it was established that there were no other surviving case notes of people from European or Anglo-Indian origin who had been resident there before 1947.

The material studied gave valuable insight into the lives of some of those British and Anglo-Indian patients admitted to the EMH during the last 30 years of the British Raj. The unfortunate gender imbalance in surviving case notes was inexplicable. The higher incidence of female records cannot be taken as evidence of any deliberate policy of the admission of women as a form of psychiatric social control in the manner proposed by Elaine Showalter.⁹⁹⁴ This was also a position

⁹⁹⁴ Showalter, Elaine (1987) *The Female Malady: Women, Madness and English Culture, 1830-1980*, Virago, London.

taken by Ernst as a result of her research⁹⁹⁵ and the new evidence obtained from the records at the EMH seemed to confirm it.

The case record forms

Case record forms in the EMH medical files have added to our knowledge and understanding of the mental health of the British by providing information on methods of treatment, on the attitudes of psychiatrists and on the social history of some of the patients. Again caution was exercised when conclusions were being drawn about the validity of the evidence. The psychiatrists were exclusively male reflecting the male domain of power in the international profession at that time and place.⁹⁹⁶ The British doctors were from similar race, class and educational backgrounds. The limited information about Indian doctors at the EMH suggested they too came from a privileged background. As the surviving records were overwhelmingly on female patients the attitudes and actions recorded by the doctors cannot elicit a credible comparison with male patients. There were some brief entries by nurses concerning, for example, their observations at prescribed intervals of patients undergoing hydrotherapy but despite providing useful knowledge their authors remained anonymous.

Basic details about the EMH residents were obtained from the admission sheets at the front of each case file and these were present in a majority of the records.⁹⁹⁷ The earlier forms were four pages in length with spaces for additional personal information though these were often blank or just contained single words or short phrases. By 1928 the forms were 14 pages long and contained sections on *Memory, Ideation, Obsessions, Attention, and Dreams and Sexuality*.

In order to establish the capacity of patients' memories the doctor asked them a variety of questions. They were required to repeat a series of numbers such as 2783 and 820937. The doctor would read them a short story and ask them to repeat it in their own words. People were asked where they went to school, where they

⁹⁹⁵ See for example, Ernst, (1998) 'Asylum Provision and the East India Company in the Nineteenth Century,' *Medical History*, vol. 42, p. 493.

⁹⁹⁶ The first female psychiatrist in India was Dr Ajita Chakraborty who qualified in the UK and began practising psychiatry in India in 1960. See her obituary in [BJPsych Bull.](#) 2016 Apr; 40(2): 109. DOI10.1192/pb.bp.115.051995

⁹⁹⁷ The bulk of the information in this section was taken from the records of Mrs W E , CIP Archives DVD 017 ANC Roll 24 A-699-O-F.

were a month ago and at Christmas. The final question in the section asked in what year the Great War broke out.⁹⁹⁸

There was a long section on ideation and the purpose appeared to be aimed at establishing the extent of the person's moral principles. This was achieved by asking such questions as:

What happens when a man is lazy and refuses to work?

If anyone hurts you without intention what would you do?

Why should we judge people rather by their deed than by their words?

Why is better to finish something we have begun rather than to leave it and turn to something else?

There were no surviving records containing detailed answers. Some of the questions were leading and closed, almost as if specific answers were preferred by the psychiatrist. It seemed reasonable to speculate that some of the judgemental comments from psychiatrists on the case files were instigated by what they regarded as unhelpful responses from their patients.

The questions on sexuality suggested the influence of Freud and most likely reflected Berkeley-Hill's deep commitment to psychoanalysis. The patients were asked firstly if they were more at ease in men's or women's society and secondly '*Are you fond of children: (a) boys (b) girls?*' There then followed a list of seven categories of sexual behaviour which the psychiatrist would ask to identify if they were present in the patient. In order to gain an indication of the detail on the thinking given by the doctors towards the influence of sexual conduct it is worth listing them in full:

Inversion

Perversion

Sadism

Masochism

Fetischism

⁹⁹⁸ The test has some similarities with, and can be seen as a forerunner to, the Montreal Cognitive Assessment test (MoCA) devised in 1996 to identify mild cognitive impairment and which is still in common usage amongst psychiatrists.

*Koprophilia*⁹⁹⁹

Exhibitionism

Once again there was no evidence of the responses to such a comprehensive list of conditions.

Taking histories of new patients had become standard practice by the late 1920s in Indian mental hospitals.¹⁰⁰⁰ The records showed that as part of this process the medical superintendent would often write to parents or spouses for further details of their relatives' lives and illnesses.¹⁰⁰¹ By 1945 a 'Personal History of Patients Form' had been created which was sent to relatives to obtain information which 'will help the doctor form an opinion about his treatment and the duration of his illness.'¹⁰⁰² Such records will be explored in the following section.

European Mental Hospital records, 1918-1947

The findings from the EMH archives gave valuable insight into numerous individuals who resided there and provided a foundation that helped understand their experiences. The numbers of patients admitted, their social background, and what they were diagnosed with, will now be considered.

Admissions to the EMH

Some of the patients had come to the EMH with a history of treatment for mental illness in other psychiatric hospitals in India, such as the asylum in Lahore, or in the UK such as Whitchurch Hospital in Cardiff and Horton Asylum in Epsom. The EMH developed a reputation for expertise in the colony and the case notes indicated that doctors from all over the north of India sought admissions for their more mentally disturbed patients.

⁹⁹⁹ Koprophilia, or coprophilia in its current spelling, involves sexual arousal and pleasure through faeces.

¹⁰⁰⁰ See Overbeck-Wright, *Lunacy in India* and Jagoe-Shaw, *A Clinical Handbook*, and Jagoe Shaw, 'The Alienist,' pp. 331-341.

¹⁰⁰¹ See, for example, case records on Mrs AT in CIP Archives DVD 018 ANC Roll 29 A-835-O-F. Mrs AT became involved in Divorce Court proceedings in India and her file indicated her husband's counsel alleged in the hearing that she should not be discharged because of her chronic mental illness.

¹⁰⁰² See records on Mrs VV CIP Archives DVD 017 ANC Roll 24 A-696-O-F.

Table 7.1: Number of admissions to the EMH per patient

Number of admissions	Patients in the hospital
1	38
2	10
3	2
4	0
5	1
Total	51

The average stay for those for whom records were still available was over 10 years and as indicated in Table 7.1 the majority of those admitted had only one admission to the hospital. An analysis of the EMH records suggested that this might have been the consequence of a number of factors: for example that the patients may have needed much greater and longer lasting care than might have been available in smaller and more localised mental hospitals; or that there was no other longer term resource available throughout a half of the Indian land mass; or that it was not practical or relevant for patients with such a degree of mental illness to be repatriated quickly or easily to the UK. The records suggested that the EMH became something of a long stay hospital for white people with conditions that could not easily be managed by Raj society outside its walls. This reinforced the view obtained from research that there were few resources for distressed *Imperial Minds* in India outside the EMH.¹⁰⁰³

Arnold identified that anti-social presentations by Europeans as vagrants, destitute or lunatics were regarded by the authorities as bringing the ruling race into contempt in Indian eyes. Consequently the official reaction had been to make these highly embarrassing traits 'invisible' by institutionalisation or deportation.¹⁰⁰⁴ However in the surviving records there were no recorded instances of doctors requesting that their patients be admitted to the EMH so that they could be kept away from Indians. The EMH was built in a remote area of jungle which guaranteed,

¹⁰⁰³ See Bradfield, *An Indian Medical Review*, pp. 28-30.

¹⁰⁰⁴ Arnold, 'European Orphans and Vagrants,' p. 124.

in itself, a measure of invisibility, reinforced by the boundary walls. The nearest example of such an enforced invisibility related to a young woman who appeared to have had a learning difficulty with an accompanying lack of social inhibition. She was viewed, in the late 1920s amongst some people in her local community, as a nuisance and as at potential risk of sexual exploitation because of her habit of approaching strangers.¹⁰⁰⁵

In recognition of the fact that mental illness and intellectual challenge crossed class boundaries, the authorities did not punish these groups in the way they did those poor whites who were vagrants or petty criminals.¹⁰⁰⁶ It had become accepted that treatment in hospital was appropriate rather than incarceration in a prison or workhouse. There were several examples of medical superintendents at the EMH making considerable efforts to discharge patients to their families or to nursing homes though failing because of the lack of suitable resources. No evidence was gathered that doctors actively wished their patients to remain there indefinitely.

In the British context of a similar time period Jan Walmsley has written how women classed as mentally deficient were institutionalised, and effectively deprived of their citizenship, because of their sexual behaviour which those in authority considered inappropriate.¹⁰⁰⁷ Similar attitudes in India might explain the admission of some female patients to the EMH.¹⁰⁰⁸ Thus **Mrs ER** had had a history of sexual activity which identified her as very vulnerable to exploitation. Her husband was advised not to take her back into their home as she refused to return there willingly.

The contradictory role played by poor families in Britain in maintaining their distressed relatives because of the overall lack of resources, whilst at the same time being official objects of suspicion and surveillance, was emphasised by Walmsley.¹⁰⁰⁹ Evidence indicated that the doctors at the EMH developed greater

¹⁰⁰⁵ See records of Mrs W E, CIP Archives DVD 017 ANC Roll 24 A-699-O-F.

¹⁰⁰⁶ Ernst 'Out of Sight,' p. 252.

¹⁰⁰⁷ Walmsley, Jan (2000) 'Women and the Mental Deficiency Act of 1913: citizenship, sexuality and regulation,' *British Journal of Learning Disabilities*, no. 28, p. 69.

¹⁰⁰⁸ See, for example, records of Mrs ER CIP Archives DVD 020 ANC Roll 36 A-1070-O-F. Interestingly, a letter to her husband in 1926 was typed on notepaper headed 'H. M. European Lunatic Asylum' even though the name had changed to the EMH five years earlier. The words 'Lunatic Asylum' were crossed out and replaced by 'Mental Hospital' written in pen, a practical way to prevent the waste of paper.

¹⁰⁰⁹ Walmsley, Jan 'Community care and mental deficiency 1913 to 1945,' p. 202 in Bartlett, Peter and Wright, David *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000*, Athlone Press, London, 1999.

contacts with the families of those patients who had them from the mid 1920s onwards. Between 1939 and 1947 there was often considerable correspondence between doctors and families. Records showed that visits to patients by parents and spouses did take place but also that doctors often wrote to husbands advising them not to visit their wives, as this might interfere with the latter's recovery plan of complete rest without the interference of a close relative.¹⁰¹⁰ The frequency of such letters suggested that this was a standard action in the treatment programme.

Demographics of patients

Box 7.1 Demographics at the EMH – summary of key findings

- Of the 51 records studied, 6 were male and 45 were female.
- The average age on admission (for over 18s) was 39.27 years, with the eldest person being 73 and the others between 21 and 61.
- The average length of stay was 10.2 years and the shortest stay was one month.
- The number who died in hospital was 16.

Looking in more depth at overall admission to the EMH it was evident that there was usually a slightly higher incidence of male patients than females. The official figures for 1924-26 indicated that the maximum numbers of male and females on any night were respectively 81 and 80 in 1924, 94 and 88 in 1925, and 103 and 94 in 1926.¹⁰¹¹

From the key findings it was clear that there was a great variety in the length of stay of patients, the average being 10.2 years. The shortest stay for which records were available was one month. Three patients were resident for 30 or more years. One of the latter lived at the hospital for 39 years until her death there in 1957. She was one of the first cohort admitted to EMH in 1918. Previously she had spent 8 years in the Bhowanipore Asylum in Calcutta.¹⁰¹² The longest recorded stay at the European Mental Hospital for which evidence was found was 40 years. Five patients

¹⁰¹⁰ See for example, records for Mrs P. CIP Archives DVD 017 ANC Roll 25, A-733-O-F.

¹⁰¹¹ Thus, for example, see *The Times of India*, 'Ranchi Mental Hospital: Three Years' Results.' 4th April 1928, p. 13.

¹⁰¹² See records on Mrs Miss X R CIP Archives DVD 023 ANC Roll 46, A-1253-O-F.

stayed at the hospital for between 20 to 29 years and a further six from 10 to 19 years. Seven patients stayed between 7 and 9 years. Anecdotal information provided by a current doctor at the Central Institute of Psychiatry suggested that there was one female resident, **Mrs W**, who was admitted to the hospital in the 1930s and died there fifty years later.¹⁰¹³

Most of those people who died in the EMH were in old age and had been resident in the hospital for many years. They had chronic conditions, which included epilepsy, or were classed as mentally deficient. An exception was one woman who died in hospital apparently of cancer in her early twenties. She had been admitted compulsorily to the EMH because of her consistent aggression to others and the implication was that other hospitals could not manage this challenging behaviour.¹⁰¹⁴

Occupations of patients

The occupation or status of 39 of the 51 patients was recorded giving an indication of the diversity of the patient population. The categories taken from the official hospital admission entry sheets on the medical notes can be found in Tables 7.2 and 7.3.

Table 7.2: Occupations of male patients at the EMH

Occupation	Number of patients
None – Child	2
Unemployed	1
Seaman	1
Engine Driver	1

Table 7.3: Occupation of female patients at the EMH

¹⁰¹³ Personal interview with Dr Roshan Khanande on 6th April 2016. One of Dr Khanande's poems is included in Appendix 6.

¹⁰¹⁴ See records for Miss NP CIP Archives DVD 017 ANC Roll 27, A-769-O-F.

Occupation	Number of patients
Housewife, widowed, divorced	9
Cohabiting	2
Single	6
Teacher	1
Missionary	3
Ex-governess	2
Ex-gymnastics teacher	1
Prostitute	2
Assistant college principal	1
Army civilian	1
Soldier's wife	2
Soldier's daughter	1
Red Cross worker	1
Wife of planter	1
Wife of Indian Civil Service official	1

A key finding from Table 7.3 was the range of the employment and status of the women for whom records remained. At one level the list included spouses of a senior army officer and of a member of the ICS, men in the highest echelons of Raj society. At the other extreme were women whose EMH records classify them as prostitutes, one of the lowest and most despised ranks of whites in India. In between were women with professions in their own right such as teachers and a governess. The assistant college principal with her husband owned and ran a commercial college in Rangoon. The female status in British India was often linked to or determined by that of the male, whether the latter was husband or father. Procida has identified that British women completing their national census forms often put their own occupation

as that of their husband, an indication of their commitment to the business of the Indian Empire.¹⁰¹⁵

Although their notes gave little evidence about male lives, two of the men came from a relatively low-status background. One, an Anglo-Indian, was an engine driver and lived in a railway colony to where he returned to his job after treatment. The other, a Briton, was a seaman who worked on numerous ships in between hospital admissions. The unemployed man was eventually repatriated to the UK. The two male children were both Anglo-Indian and appeared to have had learning disabilities.

Whilst there was great diversity in the jobs that the women and men were doing, it also appeared that there was some diversity in their ethnic origin, which will now be discussed.

Ethnic origin of patients at the EMH

For all 51 cases studied their ethnic origin was recorded (see Table 7.4) and the facts uncovered reveal the variety in the background of the patients. Most European patients were British or Irish or of Anglo-Indian origin. The only common theme amongst all these patients was their whiteness which was reflected in the racially determined admissions policy of the EMH.

Table 7.4: Ethnic origin of patients at the EMH

Ethnic origin	Number of patients
British/European	20
Irish	2
French	1
Austrian	1
Swiss	1
Jewish (Polish)	2
Anglo Indian	24

¹⁰¹⁵ Procida, *Married to the Empire*, p. 45.

One of the first categories after the person's name on the admission records sheets used between 1918 and 1947 was *Race*, the other key ones being *Gender*, *Religion*, *Age*, *Date of Birth* and *Date of Admission*. The official definition of Anglo-Indian i.e. of having at least one male European antecedent, was used in the compilation of the hospital records.

The substantial proportion of Anglo-Indian patients whose records remain raised questions of their status in society. The concept of an intra-class unity amongst Europeans, although an uncomfortable one, was proposed by Hutchins.¹⁰¹⁶ The common link was their *whiteness* which became problematic when Anglo-Indians were being considered. These difficulties were explained by Stoler in her arguments that the focus of the British in India was not only on the Otherness of the colonised but also on the Otherness of some colonials, those of mixed heritage, the Anglo-Indians, or those 'poor whites' who had lost their connections with Britain, the Domiciled Europeans.¹⁰¹⁷ Thus the position of the two latter groups was inherently contradictory to the British: at times they were seen in solidarity with the British but at others they were viewed with suspicion and distaste.

The Japanese historian Satoshi Mizutani has also maintained that it was class rather than race which determined British attitudes towards Anglo-Indians.¹⁰¹⁸ He argued that the boundaries were disciplined and policed by sociocultural and institutional practices.¹⁰¹⁹ Most Anglo-Indians were the offspring of 'poor whites,' working class men, often soldiers who had had relationships with and even married Indian women.¹⁰²⁰ The Anglo-Indian community existed beyond these boundaries and were generally dismissed as degenerate by Britons. Occasionally, as De Courcy has identified, some Anglo-Indians were able to present themselves successfully as white Britons.¹⁰²¹ In summary, Anglo-Indians as a whole can be viewed as at one end of a class-race spectrum of whites in British India with little likelihood of changing their marginal position.

¹⁰¹⁶ For example see Hutchins, *The Illusion* p.111 and *passim*.

¹⁰¹⁷ Stoler, *Carnal Knowledge*, pp. 66-67.

¹⁰¹⁸ Mizutani, Satoshi (2011) *The Meaning of White: Race, Class and the 'Domiciled Community' in British India, 1858 – 1930*, Oxford University Press, Oxford, p. 46.

¹⁰¹⁹ Mizutani, p. 219.

¹⁰²⁰ Mizutani, p. 221.

¹⁰²¹ See De Courcy, *The Fishing Fleet*. Ms De Courcy gave a number of examples of Anglo-Indian women who married 'pure blood' Britons and were accepted in society. There always remained the fear that the birth of a dark skinned baby might reveal an ancestral secret.

There were no people referred to as *Domiciled European* in the files and *Anglo-Indian* may have been used to cover this category. The records also used the term *European* to define someone of white, British origin. Obviously other patients such as the French and Swiss were European in the geographical sense but their difference was that they were not natural speakers of the English language. The category of origin *Irish* seemed to be shorthand for being lower class and Roman Catholic.

The increasing controversy surrounding the term *European* as the twentieth century progressed has been analysed by Buettner.¹⁰²² The 1931 Census of India estimated, for example, that 30,000 Anglo-Indians deliberately sought ways to present themselves as Europeans in an attempt to hide 'the uncertainty of racial divides.'¹⁰²³ One stratagem they used was to claim Portuguese or Dutch heritage.¹⁰²⁴

Having identified the residents of the EMH and their background, the different conditions they were diagnosed with will now be considered.

Diagnoses of patients

When researching the EMH case notes the diagnoses record the professional term used at the time in India and show how fashions or scientific knowledge changed. Where a precise date was not given it was sometimes possible to give a reasonably accurate estimation. Table 7.5 illustrates some of the diagnoses identified. Some patients, particularly those who stayed for a number of years, received a variety of psychiatric classifications.

¹⁰²² Buettner, *Empire Families*, *passim*.

¹⁰²³ Buettner, *Empire Families*, p. 75.

¹⁰²⁴ Buettner, Elizabeth (2000) 'Problematic spaces, problematic races: defining 'Europeans' in late colonial India,' *Women's History Review*, vol. 9, no. 2, 2000, pp. 277-298, <http://dx.doi.org/10.1080/0961202000200242> (Accessed 4th February 2016)

Table 7.5: Diagnoses recorded on patients' case notes

Categories of conditions	Name of condition	Year mentioned in case notes
Dementia praecox to schizophrenia	Dementia paranoides	1926
	Dementia praecox	1929, 1930, 1936
	Acute confusional insanity/ later dementia praecox	Late 1920s
	Paraphrenia with dementia	1933
	Paraphrenic	Mid 1930s
	Katatonic stupor (schizophrenia)	1937
	Schizophrenia/dementia paranoides	1938/39
	Schizophrenia (paranoid)	1945
	Toxic insanity (schizophrenia)	1940s
Forms of mania	Acute manic	1936
	Mania	1942
	Manic depressive psychosis	1944
	Manic depressive psychosis – mild depression	1946
	Manic depressive psychosis/early GPI	1940s
	Manic depressive (melancholia)	1940s
	Chronic involuntional melancholia	1943
	Involuntional melancholia	1947
	Imbecile	1926

'Mental Deficiency'	Mentally defective and epileptic	1937
	Mental deficiency, flight of ideation	1938
	High grade feeble minded	1945
	Mental deficiency with epilepsy	1947
Other diagnoses	Paranoia, alcoholism, homosexuality	1934
	Tabo-paresis ¹⁰²⁵	1944
	Advanced Paralysis Agitans (Parkinson's Disease)	1944

In addition to the above there were diagnoses, with unspecified dates, of a small number of patients given as 'hysteria,' 'depression,' 'senile dementia' and 'alcoholic.' The diagnoses recorded between the 1920s and the mid 1930s are terms rarely used medically today. Those from the late 1930s represent more modern psychiatric definitions.

The changes in diagnoses confirmed the second stage of psychiatric development in India, a period of more rapid innovation and growing professional confidence, as proposed in Chapter 3. The growth of knowledge in the course of mental diseases and its consequent interpretation is illustrated in Table 7.5. Research findings at the EMH have shown that psychiatrists there had become, for example, more confident in their recognition and explanation of manic depression and its various sub-categories.

An indication of the modernisation in diagnosing mental illness can be seen in the adoption of the term *schizophrenia*. In Overbeck-Wright's first textbook in 1912 there was only brief reference to its precursor *dementia praecox*.¹⁰²⁶ He preferred to ignore this term and use *delusional insanity* instead and this was repeated in his

¹⁰²⁵ Tabo-paresis is a late effect of untreated syphilis on the nervous system in which the sufferer shows signs of General Paralysis of the Insane (GPI).

¹⁰²⁶ Overbeck-Wright, *Mental Derangements*.

1921 textbook.¹⁰²⁷ The word *schizophrenia* occurred in neither book suggesting that he was unaware of or uncertain about research in the German-speaking world. This placed him in the first stage of psychiatric development in twentieth century India, a phase of slow modernisation. Schizophrenia as a diagnosis was first noticed in the EMH records in 1937 replacing dementia praecox which was last used by doctors there in 1936. This last recorded use of the term dementia praecox amongst the 51 patients was in 1938 by a doctor external to the EMH as the latter's diagnosis on the admission of his daughter.¹⁰²⁸

One surprise finding was that in all the 51 finds there was only one reference to neurasthenia. This concerned a patient who in 1928 attributed her illness to her 'neurasthenic husband' who had driven her out of the home presumably because of her behaviour.¹⁰²⁹ The reasons for this cannot be determined from the limited archives available. Whether it was because alienists chose not to use the term or if the files on neurasthenic patients have all disappeared together may never be known.

After looking at how diagnoses at the hospital changed over the years attention will now be given to some of the treatments provided there.

Forms of treatment

The use of hydrotherapy was discussed in detail in Chapter 6. Evidence from the EMH files showed that it was a standard treatment on admission for many patients throughout the existence of the EMH.

During the 1920s and 1930s there had been much speculation amongst central European medical scientists on the relationship between schizophrenia and epilepsy. Research by Niall McCrae of the Institute of Psychiatry in London, showed how experimentation was carried out using intramuscular injections of various chemicals with the intention of inducing fits described by one doctor in Britain in 1940 as resembling 'a violent thunderstorm.'¹⁰³⁰

¹⁰²⁷ Overbeck-Wright, *Lunacy in India*.

¹⁰²⁸ See records for Miss NP CIP Archives DVD 017, ANC Roll 27 A-769. O-F.

¹⁰²⁹ See case records on Mrs WE at CIP Archives DVD 017 ANC Roll 24, A-699-O-F.

¹⁰³⁰ McCrae, Niall (2006) "A violent thunderstorm,": Cardiazol treatment in British mental hospitals,' *History of Psychiatry*, vol. 17 no. 1, p. 81. DOI:10.1177/0957154X06061723. Disturbing film clips of

Whilst these violent thunderstorms may seem horrifying to modern observers Jack Pressman has warned against making judgements on what may now seem clinically appropriate as these are not transhistorical truths. In his research into the history of psychosurgery Pressman found that lobotomy became popular amongst some scientists and clinicians in the 1940s as it seemed to ‘work.’ Just as some injected substances appeared to bring a measure of success by producing a period of calm in the patient so, seemingly, did lobotomy operations. He learnt that the short term successes of the latter changed its use from having a ‘sufficient promise’ to having a ‘certain benefit.’¹⁰³¹ Pressman identified that many patients and their families began to comment favourably on its apparent achievements and potential for cure or relief within the context of the time. His model can be considered as analogous to the uncertainties faced by the mentally ill portrayed in Figure 7.1. New, invasive treatments appeared to offer hope to those who regarded the individual’s situation as desperate or hopeless.

One possible form of treatment in the journey through hospital was the injection of insulin which produced both seizures and a coma. The process required daily treatment followed by five hours of medical and nursing attendance after each administration. It was considered a risky procedure and was initially banned by Edward Mapother at the Maudsley Hospital because of this.¹⁰³² McCrae found that the insulin coma therapy was first used in British hospitals in 1935-6.¹⁰³³ It was implemented soon afterwards at the EMH. Thus the case notes of **Miss NP**¹⁰³⁴ revealed that her course of insulin shock therapy ceased in March 1937 as her condition had shown no improvement through its use. The procedure for **Mrs M**¹⁰³⁵ was ended because of the shortage of staff, a factor noted by McCrae in British hospitals.¹⁰³⁶

insulin shock therapy and the nature of the convulsions it induced can be seen at Hartman, R. C. (25th July 2013), (Video file) <https://www.youtube.com/watch?v=ck82OvdloDE> (Accessed 10th December 2017).

¹⁰³¹ See Collins, Alan (March 2001) Book Review: Pressman, Jack (1998) *Last Resort: Psychosurgery and the Limits of Medicine* in *British Journal for the History of Science*, vol. 34, no. 1, pp. 121-122.

¹⁰³² McCrae, “A violent thunderstorm,” p. 71.

¹⁰³³ McCrae, “A violent thunderstorm,” p. 70.

¹⁰³⁴ See records for Miss NP CIP Archives DVD 017, ANC Roll 27 A-769. O-F.

¹⁰³⁵ See records for Miss MSL CIP Archives DVD 022, ANC Roll 42, A-1158-O-F. Mrs M’s notes are merged with those of Miss MSL and have not been given a separate reference number.

¹⁰³⁶ McCrae, “A violent thunderstorm,” p. 71.

A more frequently used substance for the induction of fits was cardiazol, a preparation easily soluble in water and so suitable for intravenous injection. Its first use was in Budapest in 1935 and in British hospitals in 1937.¹⁰³⁷ Cardiazol convulsive therapy became more popular than the use of insulin as its administration took doctors only a few minutes three times a week and the resulting fits needed much less direct supervision.¹⁰³⁸ As with insulin coma therapy the cardiazol procedure quickly became a regular treatment at the EMH. Thus the case notes of Miss NP recorded in May 1939 that she had had a full course of cardiazol injections but these had been stopped as they had no appreciable effect on her condition. In June 1938 Berkeley-Hill published in the *IMG* his findings analysing the treatment of 42 patients who had been injected with cardiazol. He described the results as encouraging and that in selected cases its use 'appears to be perfectly safe.'¹⁰³⁹

A third method of inducing fits was by electroconvulsive therapy (ECT), where a weak electric current was passed into the brain. It was first tried in Italy in 1938¹⁰⁴⁰ and was in regular use at the EMH by April 1943. Thus **Mrs PP** had 18 shocks in that month.¹⁰⁴¹ The incomplete extant records from the EMH make it impossible to decide on the frequency of ECT treatments, though a typical course lasted a month and consisted of up to 20 shocks.

Observations from the files must necessarily be speculative but certain themes can be identified. It was evident that some newly invented treatments from Europe were implemented at the EMH soon after their invention and sometimes before being widely used in British hospitals. On this basis the EMH can be regarded as at the forefront of the delivery of Western psychiatric practice from the mid 1930s.

In addition it seemed that the longer time a patient remained in hospital the more likely they were to receive a variety of the new treatments. A number of long stay patients were identified who had received hydrotherapy, cardiazol and ECT treatments over a number of years. This enthusiasm for the various forms of shock therapy adopted by psychiatrists in India from the late 1930s was addressed by Ernst. She argued that these new treatment methods presented psychiatrists with an

¹⁰³⁷ McCrae, "A violent thunderstorm," p. 71.

¹⁰³⁸ McCrae, "A violent thunderstorm," pp. 71-72.

¹⁰³⁹ Berkeley-Hill, Owen (June 1938) 'Treatment of schizophrenia by inducing epileptiform shocks by the drug cardiazol,' *IMG*, vol. LXX111, no. 6.

¹⁰⁴⁰ Burns, *Psychiatry*, p. 48.

¹⁰⁴¹ See records on Mrs PP CIP Archives DVD 016, ANC Roll 23, A-671-O-F.

exciting opportunity to tackle the bleakness of schizophrenia.¹⁰⁴² For the first time they had a scientific method bolstered by research which seemed to alleviate the illness. It was experimentation and it was known to be risky but it offered hope to distressed *Imperial Minds* where there had been little before.

Exploring the social background, ethnic origin and diagnoses of those admitted enabled a representation of those people who received treatment at the EMH to be constructed. This chapter will now expand on this understanding by looking at individual case histories.

Individuals and their treatments

The medical records of individual patients from the 1920s gave the alienists' personal assessment of the illnesses of their patients. Many of these were signed by Berkeley-Hill or his colleagues with their handwritten annotations in the margins. The following selection from EMH patient records give an indication of the wide range of their social backgrounds and psychiatric presentations.

Miss XR¹⁰⁴³ was unique amongst the patients for whom records have survived as she was in the first intake of patients admitted to the European Mental Asylum when it opened in 1918 and lived there throughout and beyond the colonial period until her death as an inpatient in 1957. She was born in 1884 and said to be from Assam. In March 1911 she was certified by a civil surgeon Dr B. C. Oldham under Indian lunacy legislation then in existence, Act No. XXXVI of 1858. Oldham wrote on the certification form that the cause of her insanity was 'religious madness'. He described her as 'quite irrational' with 'hallucinations of sight and hearing. Frequently sees people as Holy..... [*illegible*] from the other world and imagines they are speaking to her.' Oldham had observed that she was frightened to mix with the gaol prisoners as they were 'old devils' because they had not been baptised. The asylum shared the same site as the prison at Bhowanipore. The requisite second medical opinion came from an Indian, a sub assistant surgeon whose name was illegible, who described how she talked incessantly on religious matters.

Entries on her case notes from Bhowanipore were sporadic and often on one line only per day. Thus on 22nd March 1911 the hand written entry stated "Has

¹⁰⁴² Ernst, Colonialism and Transnational, pp. 182-187.

¹⁰⁴³ See records on Miss XP in CIP Archives DVD 023, ANC Roll 46 A-1253-O-F.

hallucinations of sight, sees God in her room.’ On 7th January 1913 a doctor wrote ‘Still very quarrelsome. Beats anyone indiscriminately. Has been locked up for several days during the month. Weight 77lbs.’ Between February and October 1913 there was one foolscap page of notes containing only 20 entries, each of observations on a single line. In October 1917 she was transferred to the Berhampore Asylum prior to her admission to the European Mental Asylum eleven months later.

In the EMH medical notes she was classified as a ‘Female NON CRIMINAL LUNATIC’ [capitals used in the original]. In time her behaviour improved and apparently she ceased to be a management problem. This was perhaps confirmed in there being only two pages of entries in the medical case notes between 28 December 1925 and 30th August 1930. On the 1st September 1930 she moved to a home in Calcutta but returned three days later when the staff there decided they could not cope with her. Following her readmission she was referred to as polite and punctual and generally conforming to the hospital rules, perhaps an indication of institutionalisation. She continued to be preoccupied with religion, was later diagnosed with schizophrenia and she remained at the EMH and its successor until her death.

Overbeck-Wright recognised that religious instincts could be diminished or perverted according to the type of insanity, but he did not use ‘religious mania’ as a diagnostic tool. He observed that, in what he termed ‘old standing cases,’ individuals could form delusions which became the most prominent features of their illness.¹⁰⁴⁴ As the twentieth century progressed such religious delusions tended to be diagnosed as schizophrenia as illustrated in Miss XR’s notes. The impact on individuals of religious mania in nineteenth century Britain and its legacy into the twentieth Britain has been explored by Sarah Wise.¹⁰⁴⁵ She demonstrated that obsessions with religion could be confused with eccentricity, learning difficulty or delusional behaviour. With an upbringing in the Victorian age and with her initial treatment by doctors from the same era Miss XR’s experiences paralleled some of her late nineteenth century’s British contemporaries identified by Wise.

¹⁰⁴⁴ Overbeck-Wright *Mental Derangements*, p. 52.

¹⁰⁴⁵ Wise, Sarah (2012) *Inconvenient People: Lunacy, Liberty and the Mad-Doctors in Victorian England*, The Bodley Head, London.

In contrast to Miss XR's apparently friendless, institutionalised existence, **Mrs P**¹⁰⁴⁶ had much greater and more influential family support. The only reference to her first name in 123 pages of notes comes on the penultimate one but unfortunately it is illegible. Mrs P was admitted to the EMH as a voluntary boarder in 1943 aged 49. She was educated at Roedean public school in Sussex, came in 1922 to India where she married a member of the ICS two years later and had two sons. In an earlier admission in 1936 she had been described as suffering from auditory hallucinations, very depressed and weeping frequently.

The notes indicated Mrs P had a strong sense of duty and dignity. She had a fear of talking in front of servants or strangers. She also had a fear of walking about the house following incidents of sleepwalking during childhood. On one occasion she tied her own feet together on the ward at EMH so she would not walk away, she told her doctors. In 1943 Major Taylor, the medical superintendent, wrote to her husband for information on her personal history and he responded with thirteen pages of observations on her behaviour. He asked Taylor if he should send him his wife's diary to aid her recovery. He had sealed it when her illness had begun and so did not know its contents. In February 1944 Taylor wrote again to her husband, by now a senior member of the ICS in Calcutta:

I am hoping she will be able to call on my wife, and have tea and a chat with her some day next week. My wife helps me very much with these patients who lack confidence and she is always willing to help when the proper time comes.

The invitation to tea was reminiscent of aspects of moral treatment therapy instigated at The Retreat in York at the end of eighteenth century.¹⁰⁴⁷ It was likely that Mrs P came from a similar class background to her hostess and would no doubt be familiar with the latter's social etiquette. A visit away from the atmosphere of the ward for afternoon tea in genteel surroundings might have helped facilitate her return to conventional middle class life.

¹⁰⁴⁶ See records for Mrs P CIP Archives DVD 017, ANC Roll 25 A-718-O-F.

¹⁰⁴⁷ See Digby, *Madness, Morality and Medicine*.

Mrs P was seen in March 1944 by Berkeley-Hill, now retired from the hospital but still available for consultations. Both he and Taylor advised her husband that he must not visit her at Ranchi as this would hinder her recovery. Following discussions by letter with her husband Taylor agreed that he would not give Mrs P any more shock therapy. The notes indicated her treatment had included injections, at different times, of cardiazol, paraldehyde and turpentine.

At the opposite end of the social spectrum **Mrs VW**, a 35 year old Anglo-Indian was admitted to the EMH in March 1934. She had previously been resident at the Punjabi Mental Hospital in Lahore and the file indicated that her transfer came in a Government of India instruction that year to remove all European patients from that hospital to the EMH. Mrs VW was ready for discharge in 1934 after 2 months in the EMH and had clear views about her own future. On 25th May 1934 Berkeley-Hill wrote to her uncle who was prepared to take her into his home in the Punjab but he did not agree to this request. A copy of the letter on the file stated that:

She is definitely opposed to returning to you in which case it would be a pity to press her to do. I think too that were she to return to you she would (as she herself says) 'do something desperate.' In such cases it were better for you agree to let her live where she likes.¹⁰⁴⁸

There were numerous entries on her case file from Berkeley-Hill who diagnosed her with 'Paranoia, Alcoholism, Homosexuality' Mrs VW told him that she had been in love with a woman who had had an affair with her husband.

Mrs VW's case notes also provided a breakdown of the costs of care and treatment at EMH. In 1934 Lt Col C J Lodge Patch, the medical superintendent of the Punjab Mental Hospital in Lahore, wrote to Berkeley-Hill about her transfer. In his response Berkeley-Hill indicated the annual costs of the three different kinds of placement at his hospital. Wealthier patients could pay for better accommodation with more servants. Thus a 1st Class patient was charged Rs300 which was inclusive of the wages of three private servants. A 2nd Class patient was charged Rs200 which entitled them to two private servants. The 3rd Class patient did not have private

¹⁰⁴⁸ See records on Mrs VW CIP Archives DVD 021 ANC Roll 40, A-1114-O-F. Mrs VW was readmitted to Ranchi in 1945 and died there three years later aged 49.

servants and was charged just Rs46 annually. A file on another patient, **Mrs MM**, revealed in February 1938 that the third class status had been sub divided into two sections¹⁰⁴⁹ with an upper 3rd Class category entitling the patient to one private servant for a charge of Rs62/8/-.¹⁰⁵⁰ The 1st and 2nd classes remained unchanged but the lower 3rd class did not justify any servants.

In addition Mrs VW contributed to medical training as the subject of a presentation by Berkeley-Hill to his fellow doctors which was typed in detail in the notes. He spoke of the futility of treating her alcoholism 'because its *raison d'être* was the homosexuality' itself and to remove the alcoholism one would have to remove the homosexuality. This was a waste of time he declared, as 'most of them' preferred to remain the way they were. When the discussion turned to transvestitism Dr Pacheco, an Indian psychiatrist, asked without any apparent humour or irony if wearing a kilt was a 'temperamental defect'. Berkeley-Hill said that it was not as it was a tradition connected with a national costume. He then informed his colleagues that his own great grandfather, whom he described as 'a particularly sane individual,' used to dress up as a woman to amuse his grandchildren, an action which Berkeley-Hill described as 'repressed homosexuality' in one patient. There was no discussion on whether such familial cross-dressing had had any impact on Berkeley-Hill's development as his knowledge of psychoanalysis might have predicted.

Mrs VW's notes contained the only instance of an organised discussion amongst medical professionals of a patient's mental illness in the 51 files studied. I participated in a similar seminar at the CIP, for part of which the patient under consideration was present. Such deliberations had been an accepted constituent of medical training since the nineteenth century.¹⁰⁵¹ On the basis of these two examples it seems a reasonable inference that such exercises were held regularly at the EMH.

In April 1934 Berkeley-Hill wrote in the notes that he had spoken to Mrs VW about her 'defects' which he listed as '1. Alcoholism, 2. Homosexuality, 3. Transvestism' Despite these he asked the Head of the Occupational Therapy to make arrangements for her to visit Mrs Mason, a senior nurse, in her rooms dressed

¹⁰⁴⁹ See records on Mrs MM CIP Archives DVD 01E7 ANC Roll 27, A-775-O-F.

¹⁰⁵⁰ Rs 62, 8 annas, 0 pice in the currency of the day. There were 16 annas to the rupee. The currency was decimalised in 1957.

¹⁰⁵¹ See Berrios and Freeman, *150 Years, passim*, e.g. pp. 68-70.

as a boy. Thus in spite of his judgemental attitude he showed quite a modern, tolerant and caring approach to her sexuality. There were no psychoanalytical references in Mrs VW's file where these had been plentiful in the notes of other patients. It may be because Berkeley-Hill was less certain about female than male homosexuality.

Examples of psychoanalysis as a therapeutic tool employed to interpret behaviour were seen in a number of cases. The notes on **Mrs BG**¹⁰⁵² served to illustrate the general tenor of Berkeley-Hill's views as a disciple of Freud. Mrs BG was born in Britain in 1886, married first in 1905 and again in 1915. She was admitted to the European Mental Hospital in 1927 from the Bhowanipore Mental Hospital where she had developed severe laryngitis from constantly shouting loudly. Berkeley-Hill noted on 6th April 1927 that she was wearing dark glasses and she asked to be sent to the Blind Asylum, a suggestion she said had been made to her when she had travelled to India on the ship from England. There was no indication on the file that she had defective vision. Berkeley-Hill wrote in the margin '? Castration' suggesting a psychoanalytical reference to a symbolic castration anxiety referring to the fear of being degraded, dominated or made insignificant.¹⁰⁵³ She had been to Queen's Square Hospital in London,¹⁰⁵⁴ where she claimed to have been 'thrashed with hypnotism' just like Russian people in gaol. The implication in the notes was that she was delusional to which Berkeley-Hill, concentrating on her use of the word 'thrashed,' ascribed 'sexual symbolism – masochism.' On 26th March 1927 his entry stated that she was 'extremely garrulous – Delivered a speech to me which for complete absence of meaning could only be paralleled in a legislative assembly,' an indication of his dislike of politicians. On 5th January 1928 she told him she wanted to avoid 'the Female Section [of the EMH] and the sight of all females,' to which he commented that this was an example of 'Homosexual Panic.'¹⁰⁵⁵

¹⁰⁵² See case records on Mrs BG at CIP Archives DVD 020 ANC Roll 36, A-988-O-M.

¹⁰⁵³ For an explanation see, for example, Zakin, Emily (summer 2011) 'Psychoanalytic Feminism,' in *The Stanford Encyclopedia of Philosophy*, Zalta, Edward N. (Ed) <http://plato.stanford.edu/archives/sum2011/entries/feminism-psychoanalysis/> (Accessed 7th April 2015).

¹⁰⁵⁴ Founded in 1859 and later known as the National Hospital for Nervous Diseases. It exists today as the National Hospital for Neurology and Neurosurgery.

¹⁰⁵⁵ Defined as "panic due to the pressure of uncontrollable perverse sexual cravings" by Kempf, Edward J in 'The psychopathology of the acute homosexual panic. Acute pernicious dissociation neuroses.'

Berkeley-Hill's psychoanalysis of a male was illustrated in the case of **Mr AB**, a 30 year old European admitted to Ranchi in September 1920.¹⁰⁵⁶ Until May 1921 'the case ran a chronic pernicious course' but a change was observed when psychoanalysis began that month. Berkeley-Hill recorded that Mr AB's parents had split up following an unhappy marriage. He had come to India in 1913 where he became obsessed with astrology. Following analysis Berkeley-Hill pointed out that he regarded Mr AB's relationship with a Miss E, aged 42, as the provision of a substitution figure for his mother and elder sister at home in England. Mr AB wrote long letters to Miss E which Berkeley-Hill described as a form of self-analysis. One letter, Berkeley-Hill asserted, contained 'an ever increasing number of the operations of repressed homosexual tendencies' and that 'delusions of persecution' began to appear in Mr AB's writings. The latter during analysis admitted that as a boy he had enjoyed dressing in his sister's clothes and playing a female role in their games and Berkeley-Hill as analyst regarded this as further clear evidence of repressed homosexuality. When Mr AB sent Miss E the gift of a sunshade Berkeley-Hill wrote that this was 'a notorious phallic symbol,' a blatant sexual advance. He observed that Mr AB's health improved as indicated by the content of the patient's letters. Miss E was not amused and later threatened her admirer with court action for his unwanted attention.

His confidence in the value of psychological techniques enabled Berkeley-Hill to present a paper at the All-India Science Congress in January 1930 and this was later reproduced in the *IMG*. He criticised doctors for consistently failing to implement that part of the Hippocratic injunction which required them to pay strict regard to the social as well as the physical aspects of disease when diagnosis and treatment were being considered. He castigated practitioners for what he observed was the increasing tendency for them 'to treat the phantom man and to ignore the real man'¹⁰⁵⁷ thus ignoring the fact that a human is a living organism composed of both mind and body. He repeated these sentiments in an article in 1933 where he said that just as doctors would not allow their medical students to fail to recognise the

http://www.researchgate.net/publication/232552081_The_psychopathology_of_the_acute_homosexual_panic_Acute_pernicious_dissociation_neuroses (Accessed 7th April 2015)

¹⁰⁵⁶ The psychoanalysis of Mr AB is described in detail in Berkeley-Hill, Owen (January 1922) 'A Case of Paranoid Dissociation,' *The Psychoanalytical Review*. vol. 9, number 1, pp 1-27. (Reprint held at Central Institute of Psychiatry, Ranchi.) Mr AB's case notes do not appear to have survived.

¹⁰⁵⁷ Berkeley Hill, *IMG*, May 1930 p. 281.

signs of tuberculosis so they should not allow them to ignore the early signs of dementia praecox.¹⁰⁵⁸

It was clear from an examination of his written medical case notes that Berkeley-Hill believed that psychoanalysis had proved to be a valuable asset in the psychiatrist's repertoire of treatments. He acknowledged that his audience might doubt the credibility or even mock his embracing of psychoanalysis in treating those with mental disorders but he held out a challenge to sceptics: 'Don't laugh at me. Just try for yourself and see what happens.'¹⁰⁵⁹ He might be patronising in his attitudes but he was determined to try new ways of improving the health of his patients.

There are extant medical records on three missionaries. The first, **Miss EI**,¹⁰⁶⁰ worked for the Church of England Zenana Missionary Society¹⁰⁶¹ in Calcutta. She was admitted in November 1944 aged 39 and discharged three months later. She was diagnosed with 'manic depressive psychosis'. She told the now Colonel Taylor that she saw 'the devil in the shape of Gandhi'. The notes recorded that she had been in charge of a nursery in East Bengal, but experienced great difficulties in running it because of wartime shortages and this caused her great stress. She had been in India since 1938 and had not returned home to the UK for a break since then. Taylor recommended a period of leave followed by permanent residence in Britain. He did not recommend her return to India as for highly stressed individuals '[R]elapse in this condition is the rule.' Whether she accepted this advice was not recorded. The second missionary, **Sister ML**, was classed as a 'French lunatic from a convent in Nagpur.' She came to India in 1925 and became the headmistress of several schools. She was committed to the EMH in 1942 aged 58. The following year a diagnosis was given of 'typical mania' but where the 'only unusual feature is an

¹⁰⁵⁸ Berkeley-Hill, Owen (January 1933) 'Psychiatry and General Medicine, Part iii,' *Patna Journal of Medicine*, vol. viii, no. 1. without pagination. (Taken from reprint issued to Berkeley-Hill and held at the Library of the Central Institute of Psychiatry.)

¹⁰⁵⁹ Berkeley-Hill, (May 1930) 'The position of psychology in the teaching of medicine,' *IMG*, vol. LXV (5), p. 282.

¹⁰⁶⁰ See records for Mrs EI in CIP Archives DVD 016 ANC Roll- 23, A-673-O-F.

¹⁰⁶¹ Zenana missions were established in the mid-nineteenth century to send female missionaries into Indian women's houses (zenanas) to convert them to Christianity. Their role later expanded to the provision of health care and education to women and children. The Church of England Zenana Missionary Society was founded in 1880.

absence of volubility.¹⁰⁶² Details of the third missionary are given in the section entitled *Repatriation of patients*.

Records were identified of two children staying at the EMH. Mr **LI** who was from a railway family was admitted in 1926 aged 16 from a boarding school in Agra. The notes indicated he had been certified by Overbeck-Wright the previous year in Agra¹⁰⁶³ under the Indian Lunacy Act of 1912. Berkeley Hill diagnosed him as an imbecile. He wrote a stern letter to the boy's mother stressing that the hospital had no proper facilities for dealing with children like him and he could not be provided with the home life he needed. Berkeley-Hill identified the detrimental impact of Mr LI's father in the letter:

*[I]f your husband would refrain from belabouring the lad and treat the boy decently, it is not unlikely that the disagreeable traits in L's character would disappear in no time.*¹⁰⁶⁴

It seemed that no alternative placement could be found for Mr LI as EMH records showed that he was still living there in 1964.

The second child was **Mr BC**, an Anglo-Indian who came to the EMH in 1935 aged 13.¹⁰⁶⁵ His case history indicated that he had fallen off a spiral staircase at the age of 3 receiving injuries which left him with epilepsy and paralysis on the right side. He was prone to violence and attacking people. Taylor wrote in the medical notes that Mr BC was not a 'proper case' for the hospital and his presence there, with other mentally defective or senile patients, prevented the admission of acute cases who required active treatment, clearly to him an indication of the pressure on resources. Whilst Mr BF was discharged to his parents in 1936 he was eventually readmitted but did not return to the UK with the rest of the family. Little remained of his notes after 1947. He received periodic postal orders from his father in London and then a letter sent by his brother in 1964 to say that their father had died. The postal orders and family contact ceased with his father's demise and the implication from the incomplete records was that Mr BC eventually died in hospital.

¹⁰⁶² See records on Sister ML CIP Archives DVD 021 ANC Roll – 41, A-1118-O-F

¹⁰⁶³ Overbeck-Wright was at this time the medical superintendent of the Agra Mental Hospital.

¹⁰⁶⁴ See records for Mr LI in CIP Archives DVD 018, ANC Roll-28, A-784-O-M.

¹⁰⁶⁵ See records for Mr BC in CIP Archives DVD 015, ANC Roll-21 A-620-O-M.

Published papers on treatment of EMH patients

Berkeley-Hill gave examples of his treatment of patients in academic medical journals such as the *IMG* or the *Patna Medical Journal*. In one article he described the outcome of the treatment of twelve Whites and Anglo-Indians after inducing malaria in them by injecting them with the blood of people who had already suffered from the disease. The blood injected into two patients came from an Indian ward-boy whose blood 'was fairly full of parasites.'¹⁰⁶⁶ The impact of this experimentation on three of his patients is given below.

One Englishman **Mr JAB**, aged 37, had been receiving hydrotherapy between July and September 1924 with little success. He was injected with 2.5 c.c. of infected blood and was then treated with cinchonae¹⁰⁶⁷ for 30 days to tackle the malaria. He became boisterous and highly delusional but his temperature remained normal. In January 1925 it was reported that '*he suddenly regained his mental health.... the change was melodramatic*' [emphasis in original]. He was discharged three weeks later and remained perfectly healthy afterwards according to the six monthly reports supplied by his wife.

A 37 year old Anglo-Indian man, **Mr AWF**, suffering from Korsakov's syndrome was injected with 1 c.c. of malarial blood intramuscularly. He developed malaria which was treated successfully. There was no change in his mental condition and he was discharged home to his wife after a year in hospital.

Mrs H was a 33 year old Russian Jew, a '[T]ypical case of dementia praecox (katatonic).' She was in good physical health but '[W]ould not speak; had to be fed and made to do everything.' She was given ½ c.c. of malarial blood, her temperature rose significantly and after 30 days her condition was said to be critical: she had cold and clammy sweats, was restless and vomiting and her pulse was very feeble. Gradually both her physical and mental state improved and it was reported she became a good worker, began to say a few words and became clean in her habits.

Berkeley-Hill gave no overall analysis of the twelve patients in this study. Of them four showed an improvement in their mental condition but eight did not, two of

¹⁰⁶⁶ Berkeley-Hill, Owen (May 1927) 'A short report on some therapeutic investigations carried out at the Ranchi European Mental Hospital, *IMG*, vol. LXII, no. 5, pp. 243-247.

¹⁰⁶⁷ Cinchonae is the dried bark of a plant which is used to make quinine and used in the treatment of malaria and to prevent haemorrhaging and diarrhoea. See *Oxford Concise Medical Dictionary* p. 149.

them actually dying. There were some common themes: all the patients had a rise in body temperature after their injection and for one person this was as much as 6 degrees Fahrenheit (3.4C); and all showed a decrease in weight during the course of their treatment. There was no indication from Berkeley-Hill whether he thought that overall treatments were worthwhile or that the poor recovery rates and two deaths were sufficient to end the trial. However his experimentation clearly reflected his personal independence, innovation and decision making. Berkeley-Hill demonstrated that the medical superintendent, the colonel of the regiment as it were, was firmly in charge. What was also clear, however, from his written articles and case notes was that he was consistent in seeking new ways to improve the quality of life and the mental health of his patients.

Research from the records of the EMH revealed only one written piece of evidence that a patient was given treatment as a form of punishment.¹⁰⁶⁸ In 1938 Miss NP was forcefully placed in the hydrotherapy tub as she 'was so dirty and aggressive.' Her father was a major who had retired from the IMS and so her social status did not protect her from such actions. Perhaps it would be unlikely that a doctor or nurse would admit in writing to committing definite acts of force which might be interpreted by outsiders as cruelty. However, the written records showed that patients were prescribed specific courses of treatment which the doctors believed were appropriate for the improvement of their mental health irrespective of their background. It seemed likely that the delivery of treatment met some opposition from patients.

An important point to be made was that there appeared to be very few comments on the files from the patients themselves. The extract from the interview with Mrs WE included in the epigraph at the head of this chapter was the only verbatim one extant between a doctor and patient. Whilst the patient voice occasionally resounded with loud expressions of individuality within their case records which were written by the doctors and nurses, their actual voices were silent. This leads to the question of doctor bias, as will now be discussed.

¹⁰⁶⁸ See records on Miss NP CIP Archives DVD 017 ANC Roll 27, A-769-O-F.

The patient's voice or the doctor's bias?

It is important to question the bias which might be inferred within the case notes in order to determine how accurate representation of the patient's lives might be. In his study of medical case notes Andrews warned of the dangers inherent in seeking unbiased evidence from them as they often conveyed more about the preoccupations of the hospital's medical regime than they did about individual patients and their personal histories.¹⁰⁶⁹ He demonstrated that accounts of patients' experiences using case notes were biased in favour of the wealthy, educated, and articulate or extrovert patient. One research finding was that in the EMH case notes contained considerably more written comments on educated patients of higher class status¹⁰⁷⁰ or, for example, on patients whose close relatives were doctors and could supply detailed information in a format familiar to the psychiatrist.¹⁰⁷¹

Andrews illustrated how entries could be prejudiced or how information might be missed out through human error, what he termed:

*numerous deficiencies in the comprehensiveness and integrity of the case records, including inter-textual inconsistencies and sins of omission, and areas of bias and censorship.*¹⁰⁷²

One example from the EMH records illustrated such failings clearly. **Mrs PR**,¹⁰⁷³ who was born in 1906, was interned for 3 years with her family in a Japanese prisoner of war camp during the Second World War. After the war she went to Canada and underwent a course of insulin coma therapy and electric shock treatment which she did not complete. She then returned to India and her transfer to the EMH was arranged from the European psychiatric ward at Bhowanipore Mental Hospital, Calcutta.¹⁰⁷⁴ A captain in the Royal Army Medical Corps (RAMC), who was himself a

¹⁰⁶⁹ Andrews, 'Case Notes,' p. 265.

¹⁰⁷⁰ See records for Mrs AF CIP Archives DVD 019, ANC Roll 35, A-987-O-F. She was the wife of a lieutenant-colonel in the Indian Medical Service who later became its Deputy Director General.

¹⁰⁷¹ See records for Mrs NP CIP Archives DVD-O-F 017, ANC Roll 27, A-769. Her father was a doctor and sent detailed medical notes to the EMH about her physical and mental health.

¹⁰⁷² Andrews, 'Case Notes,' p. 280.

¹⁰⁷³ See records on Mrs PR in CIP archives DVD 020, ANC Roll 38, A-10453-O-M.

¹⁰⁷⁴ Bhowanipore Hospital, which served the Calcutta area, had a Mental Observation Ward for the short term treatment and observation of European patients. A significant number of the patients in this

psychiatrist, sent a report of her circumstances to the EMH. He recorded her recent suicide attempt and reported that she had spent time in a Japanese camp and 'had undergone considerable hardship.' However he did not mention that she had been imprisoned with her parents and her three children, or even that she had any children, and that her parents had both died there. This information, crucial to an understanding of her mental distress, was gathered by doctors at the EMH on her arrival there.¹⁰⁷⁵

In order to establish historical accuracy Marwick emphasised that researchers must determine the authenticity of the sources from which they quote.¹⁰⁷⁶ EMH doctors could often be identified personally as some of the case files contained entries which were signed or initialled by them confirming their authorship. Furthermore the identities of some doctors can be verified from the signatures on copies of letters enclosed in the files or other written records therein. The signatures enabled some comments to be accurately attributable to individual doctors. The records revealed a range of attributes indicating that a psychiatrist could be moralistic, frustrated by his patients' actions, sympathetic or otherwise, whilst sometimes contradicting himself within the same file.

Once authenticity had been proved Marwick believed that historians studying records must consider the extent to which authors of sources were really in a good position to provide first hand information.¹⁰⁷⁷ Psychiatrists at the EMH, like their counterparts in the British mental hospitals, were in a powerful position to do this because of both their inherent authority and their written justification in implementing or withholding treatment for their patients. Many of the latter were certified patients with few legal rights of objection but others were classed as Voluntary Boarders who, possibly in conjunction with their relatives, had to be persuaded by the doctor that a particular course of treatment could be beneficial for their condition. Thus, for example, **Mr FWB**, who was not a certified patient, was persuaded that electric shock treatment would help his situation.¹⁰⁷⁸

study were transferred from there to the European Mental Hospital because of their serious mental health difficulties.

¹⁰⁷⁵ See records on Mrs PR in CIP archives DVD 020, ANC Roll 38, A-10453-O-M. Mrs PR later attempted suicide unsuccessfully at the EMF by drinking phenyl.

¹⁰⁷⁶ Marwick (1989), *The Nature of History*, p. 221.

¹⁰⁷⁷ Marwick (1989), *The Nature of History*, p. 224.

¹⁰⁷⁸ See records on Mr FWB in CIP Archives DVD 019, ANC Roll 34 A-961-O-F.

As Andrews found from his research the medical regime in a mental hospital was in a powerful position to innovate or dictate forms of treatment. The use by Berkeley-Hill, for example, of psychoanalysis was discussed in some detail earlier in this thesis. A distinct difference to the British mental hospitals, however, was the fact that the doctors were serving soldiers as members of the IMS. The military authority of the medical superintendent at the EMH was imposed, if needed, through his role as a lieutenant-colonel and the latter was ultimately responsible for the hospital as if it were an army regiment. Berkeley-Hill instigated seminar discussions about patients amongst his medical team and some files recorded contributions from other doctors but it was clear from the notes that his views as the medical superintendent prevailed.¹⁰⁷⁹ A rare professional disagreement in the notes was recorded after Berkeley-Hill's retirement. He remained in India and lived in a house near to the hospital in which he established his own nursing home and patient records indicated he retained some influence with the hospital authorities. In 1943 Taylor, the medical superintendent, commented that Berkeley-Hill had considered a woman to be a lunatic and had been prepared to certify her. Taylor disagreed and offered to admit her as a Voluntary Boarder which she accepted. She was re-diagnosed on admission as suffering from 'Senile dementia (Paranoid Trend).'¹⁰⁸⁰

There was clear evidence that psychiatrists could be judgemental and hold forthright views which they were prepared to share with and impose on patients' relatives. Thus Berkeley-Hill wrote to the uncle of a patient ready for discharge that although the woman, incidentally aged 35, was 'nothing but a spoiled child, very selfish and self-indulgent and as such unfit to be either a wife or mother.' Nevertheless he had enough respect for his patient to actively agree with her wishes not to return to her uncle and to live where she herself chose.¹⁰⁸¹ In 1937 Taylor described one 31 year old woman, **Mrs OLT**, as 'one of the worst patients I have had to deal with in 20 years,' because of her challenging behaviour.¹⁰⁸² During her 16 years in hospital she was given a wide range of treatments prescribed by different doctors and the notes showed that professionals could not agree on the most appropriate management of her care.

¹⁰⁷⁹ See, for example, records on Miss M SL in CIP Archives DVD 022, ANC Roll 42, A-1158-0-F.

¹⁰⁸⁰ See records on Mrs AMcK in CIP Archives DVD 019 ANC Roll 35 A985-O-F.

¹⁰⁸¹ See records on Mrs VW in CIP Archives DVD 021, ANC Roll 40, A-114-0-F.

¹⁰⁸² See records on Miss OLT in CIP Archives DVD 017 ANC Roll 27 A-771-O-F.

The patient journey and the EMH

Having built up a picture of the patients at the EMH and the treatments given by doctors it is useful to consider the patient journey through the EMH in order to develop a sense of their experiences there. Figure 7.1 was devised for this purpose.

The vertical or diachronic plane represents the changes occurring through the process of time such as new legislation or newly invented treatment methods being introduced. The horizontal or synchronic plane represents the personal changes experienced by the patients as they entered the EMH and progress through therapy with improvements to their mental health with the goal of eventual discharge. Some patients, designated as mentally deficient or long stay, e.g. Miss XR might never be discharged because of the lack of suitable alternative accommodation available or of there being no possibility of repatriation. The archives at the EMH showed that the longer the stay in hospital the more likely the patient was to become institutionalised and so less likely to be discharged.¹⁰⁸³

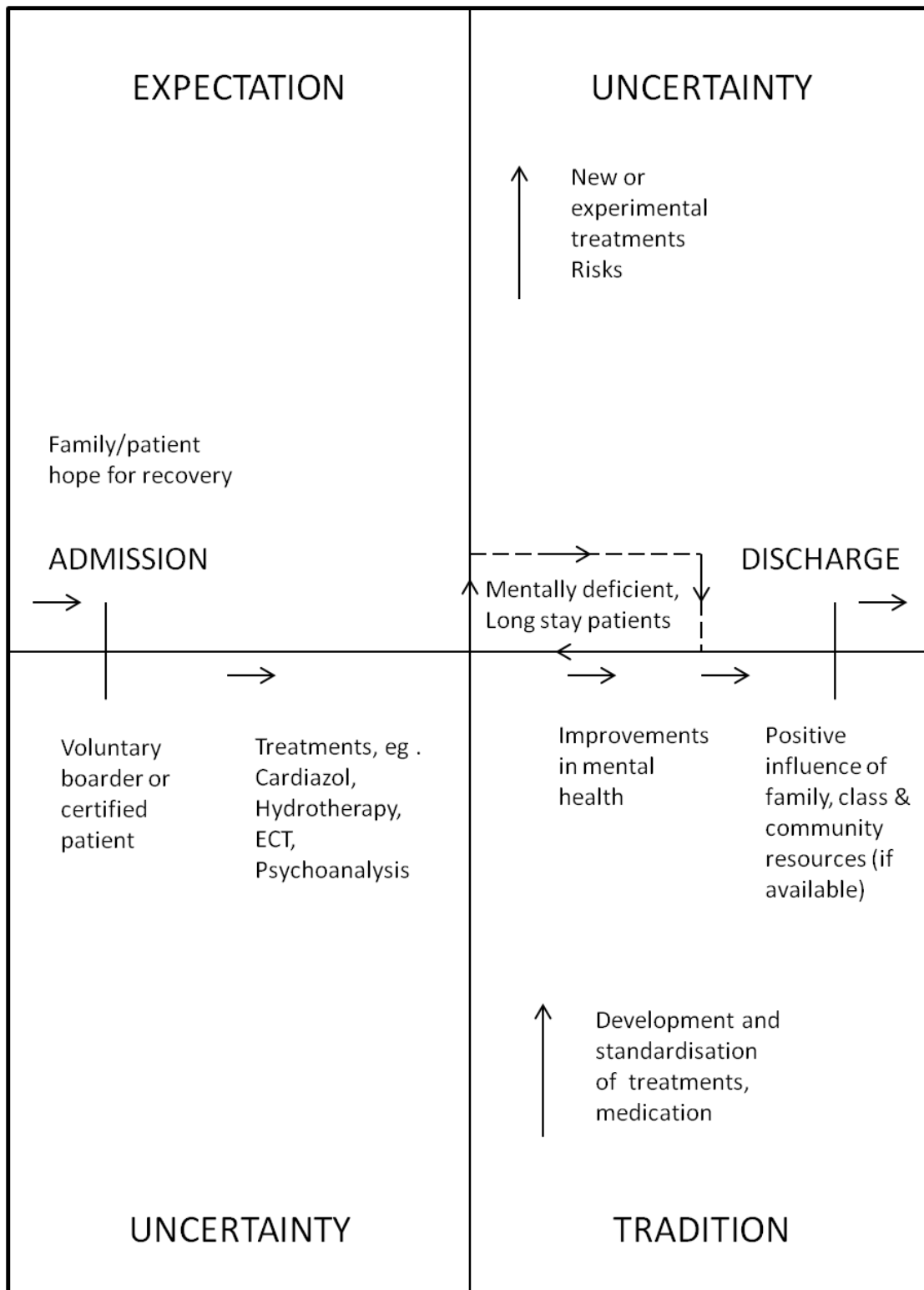
The titles of the four quadrants in the graphic represent the views of the patients and their families and friends. There is the Expectation of a hope of recovery through treatment and hospital admission but it was accompanied by anxiety and Uncertainty about what the individual's future might hold. Thus in the case of Miss El Berkeley-Hill had the expectation that she would recover provided that she had a long holiday and never returned to missionary duties in India. There was the Uncertainty around whether she would comply with his prescription.

The quadrant entitled Tradition relates to the impact of what treatments and procedures had been available and the perception or misperception by the patients and their families of what these were. They may have come to terms with the traditional culture of mental hospitals – 'the way things are done around here' – but as the records illustrated life at the EMH changed significantly over its 30 years of existence. Each time new treatments were introduced more Uncertainty could result

¹⁰⁸³ For a discussion on this topic see Scull, *The Most Solitary* pp. 339-340. Scull wrote how admission to the Victorian asylum in Britain often prolonged the lives of its residents who became both institutionalised and physically quite healthy. Some of the long stay residents at the EMH appeared physically quite healthy, a consequence of a good diet and permanent medical or nursing attention when required. This was evident in my work resettling residents of long stay psychiatric hospitals in the 1970s and 1980s. Staff in residential care homes usually welcomed them as they were generally in excellent physical health as well as being already institutionalised and ready to carry out physical tasks in the home!

for the patients and their families as fresh medical challenges, which some might have regarded as experimentation, faced distressed *Imperial Minds*. The Uncertainty might have been a source of anxiety itself as treatments were often innovatory ventures with risks both known and unknown.

Figure 7.1: The Patient Journey into, through and out of the European Mental Hospital



The lack of alternative accommodation

One significant finding that has recurred from the evidence of the medical notes was that a major reason for the extended stays of some patients was the lack of alternative accommodation to which they could move. There are several examples of the medical superintendent writing to the Salvation Army and other residential housing charities in Calcutta enquiring if they might accept patients who no longer needed treatment at the hospital.¹⁰⁸⁴ In terms of the patient journey graphic, Figure 7.1, those classified as mentally deficient, e.g. **Mr BC**, would today be regarded as having learning disabilities, sometimes did not move on at all. Some of the reasons for this are outlined below.

One female patient **Mrs SMN** was admitted in September 1944 as an 'advanced case of *paralysis agitans*,' which is today known as Parkinson's Disease.¹⁰⁸⁵ The medical superintendent, Major Davis, complained that she had been, in his words, 'dumped' at the hospital as the magistrate had incorrectly certified her. Major Davis later wrote to her daughter to say that in his professional view she was not certifiable and should be admitted to a female hospital and this took place four months after her admission to the EMH. In another case, that of **Mrs AE**¹⁰⁸⁶ a former governess for a titled Indian woman, Davis tried unsuccessfully to locate her husband. He did find her son who replied that he could not afford to pay for alternative accommodation for her. Her son offered advice about her discharge from the EMH to which Davis replied tartly that his hospital was 'not a home for unwanted relatives' and she would leave when the Board of Visitors determined.

The files indicated that there were pressures on the numbers of places in the hospital just before and during the Second World War. As an example of this Captain Laughland wrote in March 1936 that there was:

*a tendency of date to lump mental defectives and senile patients in this hospital, and there is a likelihood of a scarcity of accommodation for acute cases requiring active treatment.*¹⁰⁸⁷

¹⁰⁸⁴ See, for example, records for Miss XR CIP Archives DVD 023 ANC Roll 46, A-1253-O-F.

¹⁰⁸⁵ See records on Mrs SMN CIP Archives DVD 020, ANC Roll 36, A-1009-O-F.

¹⁰⁸⁶ See records on Mrs AE CIP Archives DVD 020 ANC Roll 37, A-1025-O-F.

¹⁰⁸⁷ See records for Mr BC CIP Archives: DVD 015 ANC Roll 21 A-620-O-M. Laughland was an IMS doctor at the EMH.

In May 1936 Laughland reinforced his concerns when he wrote that there were 239 patients in the hospital when the maximum was supposed to be 218.¹⁰⁸⁸

By the twentieth century the long stay mental hospitals in Britain had become repositories for people with a whole range of mental and physical disabilities. Their common position was that there were often no readily available suitable alternative resources. Scull believed that these asylums had become 'largely receptacles for the confinement of the impossible, the inconvenient, and the inept'¹⁰⁸⁹ as identified in Laughland's notes. The moral and political issues underpinning this in the UK have been explored in depth by Mathew Thomson.¹⁰⁹⁰ Parallels to Thomson's research can be drawn with the situation at the EMH between the two world wars as its residents varied considerably in terms of mental capacity and behaviour.

Perhaps Berkeley-Hill would have agreed with Scull's comments on mental hospitals being *museums of madness*, the warehousing of people unable or unwilling to conform to prevailing norms in society. The former constantly criticised the generally negative view of the mentally ill and he was angered when visitors to his hospital summarised its residents as 'amusing' or 'dangerous.'¹⁰⁹¹ He lamented that mental illness was:

*still looked upon by large sections of civilised people as an obscure visitation, often with implicit moral or social obloquy, to be ignored, laughed at, shunned or euphemised.*¹⁰⁹²

However one great advantage of the EMH when compared with the larger mental hospitals in the UK was that it was, like The Retreat in York, on a much smaller scale and they served relatively smaller communities. As a consequence neither ever approached the inhumane restrictions on life in the 'total institution' described by

¹⁰⁸⁸ See records for Mr B C CIP Archives DVD 015, ANC Roll 21, A-620-O-M.

¹⁰⁸⁹ Scull, *The Most Solitary*, p. 370.

¹⁰⁹⁰ Thomson, Mathew (1998) *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain c. 1870-1959*, Oxford University Press, Oxford.

¹⁰⁹¹ Berkeley-Hill *All Too Human*, p. 253.

¹⁰⁹² Berkeley-Hill *All Too Human*, p. 253.

Goffman.¹⁰⁹³ Both hospitals encouraged outings by its residents and the introduction of the EMH charabanc is discussed below.

Throughout the history of the EMH there were comments on the files from doctors about the lack of resources to where patients ready to leave the hospital might be moved. The records of several patients contained letters by the medical superintendents seeking places in a nursing home or missionary establishment. Repatriation became an option for some long stay patients, particularly after 1945 as the British withdrawal from India became inevitable.

One file gave insight into pressures on beds at the EMH during wartime. **Miss DL** had spent 3 months in the hospital in 1942.¹⁰⁹⁴ In the following year a doctor at the mental observation ward at Bhowanipore Hospital in Calcutta requested that she be readmitted to the EMH as a voluntary patient. The medical superintendent wrote that he could not accept her currently because he was only admitting acute cases at the time. The latter would have been admitted compulsorily as certified patients with the authority of a magistrate and two doctors. There are few entries on this file although a letter from Bhowanipore Hospital stated that she had recently been attacking children and often became lost in Calcutta and could not find her way home. She was not actually admitted until 1951. This was the only indication in the 51 case records seen that a patient had been refused admission to the EMH on the grounds of lack of beds irrespective of their behaviour or diagnosis. It seemed reasonable to speculate that this was due to the weight of wartime demands. Patients had begun to be admitted for the first time from the Rangoon Mental Hospital in Burma because of the Japanese advances which added to the pressure on bed availability.

Whilst the lack of accommodation was a problem, there were some who were repatriated, and this part of the patient journey will now be discussed.

Repatriation of patients

In total the records identified that 10 patients were repatriated: five to the UK, one to Switzerland and four to Burma. Of the five patients who were repatriated to the UK all went to psychiatric hospitals there and these included Storthes Hall near

¹⁰⁹³ Goffman, *Asylums*, especially pp. 113-115.

¹⁰⁹⁴ See records for Miss DL, later Mrs DN, CIP Archives DVD 021, and ANC Roll 40 A-1100-O-F.

Huddersfield¹⁰⁹⁵ and Whitchurch in South Wales.¹⁰⁹⁶ **Mrs GWS** had first been admitted to Whitchurch in 1912 following the birth of her first child. She lived in Allahabad with her husband who was a water engineer. She was admitted to the EMH in 1933 and returned to the UK in 1948. A Swiss missionary, **Miss MS**, was returned to live with her aunts in Switzerland. The file contained much correspondence between the medical superintendent at the EMH and the Swiss Consul in Calcutta concerning the arrangement of the transfer.¹⁰⁹⁷ During the Second World War an unspecified number of European residents of the mental hospital in Rangoon, Burma were moved to Ranchi to prevent them being captured by the advancing Japanese. In 1946 the then medical superintendent, Major R B Davis, wrote in the medical notes of one patient who had fled Burma that there were eight patients ready to return to the country.¹⁰⁹⁸ Medical case notes have survived on four of those people.

Repatriation to Europe was considered as an option for chronically ill patients, particularly as Independence approached. Some case files contained considerable detail of the complex mechanics of the processes involved. The legislation covering mentally ill soldiers was detailed in the two text books produced by Alexander Overbeck-Wright, the medical superintendent of the Agra Asylum.¹⁰⁹⁹ The British *Indian Insanes*¹¹⁰⁰ in the military who were domiciled in Britain were seen by a Medical Board and could then be transferred to a psychiatric hospital in Britain by a hospital ship. If such a ship was not available immediately then they would be detained either in the military hospital to which their regiment was linked or at the Yeravda Asylum which had easy access to the port of Bombay.¹¹⁰¹ This legislation extended to Government servants and their dependents who, like their military counterparts, would be repatriated at the state's expense.

¹⁰⁹⁵ See records for Mr RB, who went to Storthes Hall, CIP Archives DVD 022 ANC Roll 43 A-1189-O-M. Despite research at the West Yorkshire Archives, who hold the records for Storthes Hall Hospital, it has not been possible to locate Mr R-B's medical records following his repatriation. I worked at Storthes Hall in the 1980s and 1990s I but cannot remember Mr RB being a patient there at that time.

¹⁰⁹⁶ See records for Mrs GWS, who went to Whitchurch, CIP Archives DVD 016 ANC Roll A-664-O-F.

¹⁰⁹⁷ See records for Miss MS CIP Archives DVD 021 ANC Roll 40, A-1117-O-F.

¹⁰⁹⁸ See records for Miss EMH CIP Archives DVD 020 ANC Roll 36, A-1006-O-M.

¹⁰⁹⁹ Overbeck-Wright (1912) *Mental Derangements in India*, and Overbeck-Wright (1921) *Lunacy in India*.

¹¹⁰⁰ This was the term used to describe chronically mentally ill Europeans in mental hospitals from the mid eighteenth century.

¹¹⁰¹ Section 12, Act IV, Indian Lunacy Act, 1912 described in Overbeck-Wright, *Lunacy in India*, p. 383.

The transfer of 'civil lunatics' to the UK was a more complex and time-consuming process. As Overbeck-Wright noted, many of the larger steamship companies 'absolutely refuse'¹¹⁰² to take mentally ill civilians on board. Instead the medical superintendent had to write to some of the smaller shipping companies to see if they might take the patient, with the support of a nurse or other suitable companion, in the 'off season'.¹¹⁰³ Overbeck-Wright commented that such ships were unlikely to carry a doctor on board and so the individual patient's escort might need to be provided with drugs to administer in case of an emergency. Indian lunacy legislation had no jurisdiction in Britain. Thus on arrival in the UK the patient would need to be seen promptly by two registered medical practitioners and a formal reception order obtained from a magistrate when, as would be likely, compulsory admission was required to a hospital there.¹¹⁰⁴

There are several detailed examples in the files of repatriation of patients to the UK and to Switzerland. The process could take up to a year as it entailed factors beyond the control of the hospital authorities. In addition to the dependence on the availability of ships and the willingness of the captain to transport the patients, there was the availability of funding and agreement of suitable nurses to accompany them and, ultimately, a suitable placement in a psychiatric hospital in Europe or with relatives on arrival.¹¹⁰⁵

The case notes of **Mrs ES** gave details of her repatriation to the UK.¹¹⁰⁶ She was born in 1888 in Penarth in South Wales and her first attack of insanity was in 1912 after the birth of her first child when she was admitted to the Whitchurch Mental Asylum in Cardiff. She later joined her husband in Lucknow where he worked as a water engineer. On admission to the European Mental Hospital in 1933 she admitted hearing voices from God telling her that she was Mary Magdalene and the 'King of the New British Empire.' She was listed as a 2nd Class paying patient. Her husband died and her sister and brother in the UK requested that she return there. Arrangements were made for her to be readmitted to Whitchurch in 1948. The costs of the repatriation are given in Table 7.6 below. Arrangements for the travel to the

¹¹⁰² Overbeck-Wright *Mental Derangements*, p. 15.

¹¹⁰³ A Government of India order of 1899 directed that civil lunatics should be 'despatched to England in June each year. See Overbeck-Wright, *Lunacy in India*, p. 27.

¹¹⁰⁴ Overbeck-Wright *Mental Derangements*, pp. 14-16.

¹¹⁰⁵ See Overbeck-Wright, *Lunacy in India*, pp. 27-28.

¹¹⁰⁶ See records on Mrs ES CIP Archives DVD 016 ANC Roll 22 A664-O-F

UK were made by the agents Martins and Company of 12 Mission Row, Calcutta. Mrs ES sailed from Bombay with the nursing sister on 6th November 1948. The exercise had involved numerous letters from the medical superintendent to his peers in the UK, to family members and to the health department in India. The decision to repatriate was a clinical one and rested with the medical superintendent though he had to negotiate the costs with health bureaucrats

Table 7.6 Cost of repatriation of Mrs E S to the UK in 1948

Costs of repatriation	Rupees
Passage for Mrs E S from Bombay to Southampton	1,000
Half passage for a nursing sister	500
Nurse wage and agency fees	940-15-0
Passports, bank charges, other admin fees	715-7-0
Total cost to the EMH	3,256-6-0

(This converts to GB£244.24 when the exchange rate in 1948 was Rs13.333 to 1GBP¹¹⁰⁷)

Permeable walls or an impenetrable prison?

The actual buildings of the EMH revealed much about attitudes to mental illness at the time. The EMH was surrounded by a 12 to 16 foot high wall which is still intact today. It has been proposed by Ernst that this barrier acted as a screen to prevent Indians observing the behaviour of mentally distressed Britons and so undermining the myth of white racial superiority.¹¹⁰⁸ In the case of the EMH, though, an alternative explanation of this physical protection from Indians might be considered.

The hospital was built in 1918 at a time of political strife and violence when many Indian nationalists felt that their substantial contribution to the First World War

¹¹⁰⁷ Figures supplied by the University of British Columbia at <http://fx.sauder.ubc.ca/etc/GBPPages.pdf> (Accessed 9th May 2016)

¹¹⁰⁸ Ernst, 'Colonial Psychiatry,' p. 159.

had not been rewarded by the British in terms of greater freedoms such as Home Rule.¹¹⁰⁹ The situation was intensified following the Amritsar Massacre in 1919¹¹¹⁰ and many public buildings were put on alert with an armed guard. Berkeley-Hill recounted in his autobiography how the new hospital was sent a machine gun for protection. The general sent to inspect the hospital's defences was shocked to learn that Berkeley-Hill had put the weapon in the charge of an ex-soldier who had had a mental breakdown and killed one of his comrades. He delighted in telling the general that the man was a murderer and a lunatic and asked who else would be a better person to have the weapon. The gun was subsequently withdrawn and the incident reinforced the view of Berkeley-Hill as eccentric and single-minded and augmented his negative reputation with the military establishment. Despite the tense political atmosphere the machine gun had not been supplied with any bullets. There is no record of the hospital ever being threatened physically by demonstrators.¹¹¹¹

The doctors at the EMH were both European and Indian, the latter increasing in number after World War One. The nurses at the EMH were either European or Anglo-Indian. The majority of the employees of the EMH however were Indians and generally filled roles as servants or ward orderlies. The case notes indicated that Indians observed daily the behaviour of the white patients and sometimes actively prevented attempted suicides. The official forms certifying a European or an Anglo-Indian as a lunatic were often signed by an Indian magistrate and the second medical recommendation on the form was often that of an Indian physician. Whereas a patient might have travelled to Ranchi by rail the station is about 15 miles from the hospital and a certified patient would have been brought to the EMH from there in a distinctive vehicle often accompanied by an Indian constable. It seemed inconceivable that they would not have understood the significance of the distinctive vehicles periodically crossing the countryside to the EMH delivering certified patients. It was equally unlikely that the Indian staff did not talk to their families and friends about the distressed *Imperial Minds* with whom they worked each day.

¹¹⁰⁹ For a description of the political situation at this time see Wilson, *India Conquered*, pp. 392-429.

¹¹¹⁰ Lloyd, Nick (2011) *The Amritsar Massacre: The Untold Story of One Fateful Day*, I. B. Tauris, London. On April 13th 1919 General Dyer ordered troops to open fire on a non-violent political meeting in Amritsar. The official figures stated that 379 Indians were killed and over 1,400 wounded. The Indian National Congress stated that there had been 1,000 fatalities.

¹¹¹¹ Berkeley-Hill, *All Too Human*, pp. 260-262.

When he took over the running of the EMH Berkeley-Hill prided himself on the scale and number of improvements he was able to make. One of the acquisitions was a charabanc or 'motor omnibus' which was used to take 14 patients on trips around the countryside four times a week.¹¹¹² At a time when motor vehicles were relatively rare it can be imagined that Indians soon became aware of its connection with the EMH. The case notes indicated that visits beyond the walls were permitted regularly for persons with stable mental health. In a previous post at the Punjab Asylum in Lahore he had allowed a European patient, who had a breakdown after shooting dead his wife and her son when he witnessed them having sexual intercourse, to visit the city 'to take tiffin' at a restaurant.¹¹¹³ He did stop the visits when the man's mental distress became a nuisance to Indians there.

The concept of psychiatric hospitals in Britain having *permeable walls*, that is that they were not completely closed and isolated institutions but had regular visitors from a wide range of social backgrounds, has been promoted by Leonard Smith and other historians. They argued that there was an ongoing dialogue between patients, relatives and doctors facilitating the exchange of information to promote recovery, discharge and resettlement outside the walls of the hospital.¹¹¹⁴ As mentioned in case notes above EMH doctors believed professionally that the presence of too frequent visits by close relatives might impede their patients' recovery. The hospital sought instead to take the patients out into the surrounding countryside and to discharge them promptly when they had recovered. Nevertheless the regular correspondence with families and the doctors' attempts to find suitable accommodation in the community gave a measure of support to the *permeable walls* theory as it related to the context of European mental patients in India.

Berkeley-Hill wrote numerous letters to *The Times of India* on a wide variety of topics relating to mental health and the tone of his correspondence varied from instructional to crusading and hectoring.¹¹¹⁵ The strong influence which newspapers

¹¹¹² Berkeley-Hill 'The Rancho European Mental Hospital,' p. 73. The EMH also had a brass band formed of 22 Indian male attendants who would have observed the behaviour of patients at leisure as well as in treatment.

¹¹¹³ Berkeley-Hill, *All Too Human*, pp. 138-139.

¹¹¹⁴ Smith, Leonard (2008) "'Your Very Thankful Inmate:'" Discovering the Patients of an Early County Lunatic Asylum,' *Social History of Medicine*, vol. 21, no. 2, p. 237.

¹¹¹⁵ See, for example, Berkeley-Hill (1930, November 18) 'The Rebel Child, *Times of India*, p.11.

produced in India had on the British there has been identified by Chandrika Kaul.¹¹¹⁶ It seems likely that a significant proportion of the British in India read his regular letters or articles championing mental health. His fame was significant enough for *The Times of India* to celebrate his medical achievements with a light-hearted poem,¹¹¹⁷ to review his autobiography¹¹¹⁸ and at the end of his life to publish two obituaries.¹¹¹⁹ There are strong grounds for believing that this paper's willingness to publish his articles on topics related to mental illness was responsible for increasing its readership's general knowledge and awareness of psychiatry.

Whenever the history of a psychiatric institution is being considered the issue of social control needs to be addressed. The EMH case notes studied do not suggest that it was a 'total institution' nor that it was closed to visitors. The decision to restrict the too frequent visits by close relatives was a professional one based on the firm belief that these might hinder a person's recovery. In his study of Indian psychiatric patients Mills proposed that the system's function was to 'produce bodies that could prove useful in a colonial system.'¹¹²⁰ In many ways this was also the purpose of the EMH, to return the servants of the Raj to their role in the colony at whatever level that might be. Mills stressed the ill treatment of Indians in mental hospitals in the nineteenth and twentieth centuries but generally this did not appear to be the experience of most residents of the EMH.

The case records suggested a greater medical awareness of self harm issues from the late 1930s than in the earlier days of the hospital. There are references to a number of suicide attempts with the swallowing of phenyl and the eating of glass being amongst the methods used.¹¹²¹ Whether this related to a greater awareness of suicidal ideation or the circumstances surrounding patient experience, particularly during the Second World War, cannot be determined from the limited records available. There are regular references to suicides in the memoirs of retired civil servants and soldiers and these were often written with some sensitivity and

¹¹¹⁶ Kaul, Chandrika (2003) *Reporting the Raj, c. 1880-1922*, Manchester University Press, Manchester. See Chapter 4 especially.

¹¹¹⁷ 'Ranchi Mental Hospital.' *The Times of India*, March 22nd 1926, p. 8.

¹¹¹⁸ 'Recollections of an I.M.S. Man,' *The Times of India*, December 4th 1939, p. 5.

¹¹¹⁹ See *The Times of India*, August 19th 1944, p. 6 and August 25th 1944, p. 2.

¹¹²⁰ Mills, J.H. (2000) *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900*, Macmillan, Basingstoke, p. 112.

¹¹²¹ See, for example, case records of Mr RB CIP Archives, DVD 022, ANC Roll 43 A-1189-O-M.

understanding of the causes which drove people to take their own lives.¹¹²² The regularity of incidents implied that the British in India, a relatively small population, were aware of them. The stresses which impacted on the British in colonial India have been identified throughout this thesis but further research is required to establish the causes and frequency of suicides amongst the representatives of the Raj.

The tenor of the coverage in the *Times of India* suggested that the EMH was a respected institution of the Raj. The hospital did however receive much criticism, though unpublished, from Edward Mapother, a key figure in world psychiatry as will be outlined in the next section.

The 'So-called European Mental Hospital at Ranchi'

Mapother visited the EMH during the Christmas holidays of 1938 as part of an unofficial tour of mental hospitals on the Indian sub-continent. He agreed to the Government of India's request not to publicise his findings and his 50 page document has never been published. Only two pages concerned the EMH and these came in the section entitled the 'So-called European Mental House at Ranchi,' an indication of his strong disapproval of the facility.¹¹²³

The few positive comments he made were tempered with criticism. Thus the grounds were 'very pleasant' but their upkeep was costly as patients would not maintain them because they came from a class who would find such work a 'social indignity.' The medical treatment was 'kindly' but could not be much more as patients were generally in an advanced stage of their illness on admission.

He was aware that some Britons could afford to return to Europe for treatment. He described those inpatients he met as 'so-called Europeans' and they were Anglo-Indians 'whose resemblance to Europeans would not be noticed.' Many of these residents, he wrote, were 'wasters' and 85% received relatively expensive treatment free.¹¹²⁴ The implication from his writings was that he regarded Anglo-Indians as impostors who should pay for their care.

¹¹²² See, for example, Allen (1985) *Plain Tales*, p. 166 and Baden-Powell, Robert (1915) *Indian Memories: Reflections of Soldiering, Sport etc.* Herbert Jenkins, London, p. 90.

¹¹²³ Bethlem Royal Hospital Archives, Bethlem Museum of the Mind EM-01 Series, Box Number C12/4, Series EM, papers of Edward Mapother, p. 26.

¹¹²⁴ Papers of Edward Mapother, p. 27.

Mapother described the EMH as like a cheaper version of an English private mental hospital but one which was unnecessarily funded by the state. It was an 'expensive blunder' created and sustained by officials who had been misled by psychiatrists. What he termed the 'waste' of the EMH could easily be rectified, he said, by its conversion to a private hospital whose admissions were not determined by race.¹¹²⁵

His comments on Berkeley-Hill were also mixed. He called him 'the ablest man that there has been in Indian psychiatry' and one who had developed the EMH up to standards comparable with the West. Yet, Mapother wrote, psychiatry had suffered because of 'the domination of the Freudian School' which he, Berkeley-Hill, had championed.¹¹²⁶

The depth to which Mapother had studied the EMH has to be questioned. There was no indication that he had read case files. He admitted that he had asked that the Occupational Therapy Department be opened for him to see as it was closed for Christmas. There was no suggestion that patients had gone home for the holiday period to their families but this seemed likely to have been an option for those who were prosperous and less poorly. This would have left the acutely ill in hospital along with long stay residents who might not have had a family home they could visit. If this were the case the composition of the hospital residents may well have been different to other times of the year. The case records researched indicated that there had been many Europeans and not just Anglo-Indian residents at the EMH throughout its existence.

Conclusion

What then can be learnt from the surviving medical records? The judgemental and patronising attitudes of the psychiatrists were clearly and frequently illustrated. There was a lack of resources for patients to move to when they no longer needed hospital treatment, though doctors were seen to have made considerable efforts to find suitable aftercare accommodation. There was a clear class bias in place at the EMH as the wealthier were able to have more servants to meet their needs. However the

¹¹²⁵ Papers of Edward Mapother, p. 27.

¹¹²⁶ Papers of Edward Mapother, p. 42.

evidence from the studies suggested that, whatever the backgrounds of the patients, they received the same medical treatment.

The incomplete records of the EMH make it impossible to decide on the frequency of specific treatments. Observations from the files must necessarily be speculative. However, certain themes can be identified. It was evident that newly invented treatments in Europe were quickly implemented at the EMH. It seemed clear also that the longer time a patient had been at the hospital the more likely they were to receive a variety of the new treatments. The low number of cases for whom case notes survive do not allow researchers to draw safe conclusions about the lives of patients at the EMH. However they do enable insights into lifestyles of the different Raj representatives in colonial India and the patients at the EMH must not be viewed as merely distressed and passive historical actors. Their medical notes, however limited, generated valuable knowledge of the European communities in British India. They gave new information on the attitudes of their families and of the professionals who treated them, the introduction of the new treatments and some information on their own distressed *Imperial Minds*.

The EMH was small enough to prevent the impersonal excesses of the larger mental institutions in both India and the UK. Evidence identified indicated that at least one of its medical superintendents objected to the notion of mental patients being ridiculed by the general public and actively encouraged debate on the professional and public understanding of this 'noblest branch of medicine.' Its high walls were frequently 'breached' by its patients on their leisure trips to the surrounding countryside. The EMH cannot be regarded in derogatory terms as one of the *Museums of Madness*. Its residents could, however, in an extension of the research of McCarthy and Colborne, be considered as a minority ethnic group at risk of mental distress, perhaps seeing themselves as 'aliens under one sky.'¹¹²⁷

¹¹²⁷ Diver, *The Englishwoman*, p. 33. This phrase was copied or paraphrased by a number of Britons writing about their community and who lived in India, including Berkeley-Hill and Charles Allen.

CHAPTER 8

Conclusion

The principal aims of this thesis were twofold. One was to test the theory that there were many factors inherent in the lives of the British in colonial India which predisposed them to mental ill health. The other was to seek an understanding of distressed *Imperial Minds* who had suffered mentally in their service to the Raj.

As shown in Chapter 2 the very existence of mental illness has been challenged by some academics, a number of whom regarded mental illness as an invented concept created to justify political oppression and social control of deviants. At times their statements read like political manifestos whose premises would not expect or tolerate challenge. However, it was always the contention of this thesis that mental illness did exist and the biological and social elements which constituted it were present in the British in India.

The thesis has identified that there has been little research into the mental health of the British in colonial India in the twentieth century. The contribution by Ernst and Mills, mostly of the nineteenth century, proved a valuable base on which to build my research. The novels of Kipling, Diver, Perrin and others were shown to identify the impact of the climate, of social and physical isolation, and of the culture of the British in India on the mental wellbeing of the community, the main themes of this thesis.

This thesis proposed in Chapter 3 that the history of psychiatry in colonial India between 1900 and 1947 could be divided into three time periods to facilitate understanding of its development there. Thus it progressed slowly until 1918 when alienists began to respond to the need for treatment in response to the psychological conditions generated by war. The 1920s and 1930s were a period of innovation with the introduction of new treatments by enthusiastic doctors who felt that these gave exciting opportunities to address chronic or previously untreatable problems. The final period embraced the emergency of the Second World War and the rush to Independence. The Bore Report in 1946 was critical of inadequate psychiatric and general health provision generally as the Raj approached its end.

Boundaries, whether cultural, racial or environmental, have played an important part of the research carried out for this thesis. As shown in Chapter 4

Europeans, Anglo-Indians and Indians normally lived separately in racially determined spaces. The divisions imposed on racially defined groups prevented Europeans and Indians being treated for their mental illnesses on the same wards. As often was the case the legally and racially defined Anglo-Indians proved a profound embarrassment to the imperial establishment, particularly if they were dark-skinned.

The study then identified various elements which could be determinants of stress amongst the British. These included a climate which could be hostile, the risk of boredom and a topography which might lead to physical and social isolation, though these were frequently self-imposed constraints. These factors were all potential stressors which might initiate mental illness. In addition, a commonly recurring theme in the research was the underlying fear of another bloody insurrection on the scale of 1857-58 and this was found to be a permanent source of anxiety as recorded in diaries and novels.

The thesis offered a challenge to those who have identified mental illness as an orientalisng practice of imperialism. Whereas Western psychiatry was heavily dependent on the research in Europe it developed an outlook relating to its Indian base. Whilst implementing Western methods of treatment it began to develop a professional internationalism which, although based on racial superiority, transcended the colonial context.

An original contribution to knowledge has been the identification of the rapidity with which new treatments recently devised in Europe were introduced at the EMH. Thus medical records revealed that the administration of cardiazol injections and insulin coma therapy were both regularly practised there within two to three years of their invention. There was no bias in the selection of patients for these innovations and whether rich or poor, European or Anglo-Indian, they were treated on the basis of the clinical judgement of psychiatrists and not on the ability to pay. The thesis found that these methods of treatment reflected the enthusiasm of psychiatrists in implementing new ways of tackling chronic and previously unresponsive conditions. An alternative explanation would be that these treatments represented a tendency to crude experimentation with a small and inconclusive evidence base on which to justify their use. Both arguments can exist together but whichever was preferred it became clear from the original records, and from Indian medical journals, that the treatments were delivered with the purpose of bringing hope of recovery to patients

and their families. The findings placed the EMH at the forefront of international psychiatric practice in the 1920s and 1930s.

The nature of British society in India was considered in Chapters 4 and 5 and interpreted using the *cultural web*, an explanatory technique adapted from academic studies of organisational change. The web reinforced the view in recent scholarship that the British sought to present a united front, even if a superficial one, to preserve the prestige they believed vital for their continued rule in India. British society there was class based but the common theme was its whiteness which indicated an uncomfortable relationship towards Anglo-Indians, whose mixed heritage might be exhibited as less than 'pure' white. The web illustrated that white society in India was that of an artificial and archaic ethnic minority reinforced by its own stories, rituals and routines. It was shown to possess a rigidity, and an inability to change, which acted as a stressor, whether or not Independence was viewed as inevitable in the foreseeable future.

Another subject for further study would be the compilation of a history of psychiatric nurses and psychiatric nursing in India. Chapter 6 showed how mental nurses were generally ignored by the nursing establishment and disparaged by psychiatrists because of their gender and often regarded them as servants. Few primary sources on the history of psychiatric nursing have been identified and research for this thesis did not have enough time to locate more. Such future research would have Nolan's objective of confirming 'the legitimacy of the service' as a profession in its own right and one not subordinate to medicine.

Research into the medical case notes highlighted in Chapter 7 heeded the warnings from academics that such records were inherently biased to represent the psychiatrists' viewpoint at the times of their authorship. As someone who helped compile such notes over a 40 year career as a statutory mental health practitioner I was doubly cautious. The thesis has added to scholarship in its analysis of previously unseen material on individuals from the EMH. The extant records were limited in number which prevented in depth study but gave insight into the lives of distressed *Imperial Minds*.

The thesis supported the recent view of some historians that the British in India were not a monodimensional community. Research at the EMH showed that admission was racially determined but once there patients were effectively divided

into four class groupings dependent on their ability to pay for servants to support them.

Other topics for future research have been identified. One would be a study of the mental health of the Anglo-Indian community whose originally protected existence was threatened by Indianisation. They, like the British, were an ethnic minority but normally did not have the option of eventual retirement to the UK. Anglo-Indians were generally despised by the British because of their racial 'impurity,' and by Indians, who regarded them as being given preferential treatment by the colonial authorities. They were gradually forced out of some of their reserved occupations through Indianisation, so creating an ongoing insecurity. It seems there has been little research into the mental wellbeing of such a challenged ethnic minority, many of whom were nurses.

The thesis has identified the suicides and self harm of the British in India as a third topic for future academic research. Almost every memoir or diary studied gave evidence of actual or attempted suicide by a colonial Briton. Despite the rhetoric generated by some public school headmasters in Britain and those doctors linked to the higher echelons of the British Raj praising the personal qualities of the colonial servant, the writings revealed a high level of sympathy for and understanding of the persons driven to take their own lives. Further research is needed, for example, to confirm that sudden deaths were accidents and not euphemisms for suicide and to obtain some indication of the extent of self harm amongst the white population.

A final topic would be the use of tropical neurasthenia as a diagnosis by psychiatrists. The portability of psychiatric ideas in India was identified in the lively debates in Indian medical and nursing journals and in the discussions at conferences. Evidence was identified of the professional interest in India about the causes, treatment and cure of neurasthenia and its tropical variant and their impact on the imperial project. However, there was only one reference to neurasthenia in the EMH case records, a curious and unexpected finding for which there was no obvious explanation. It might be that in general the patients' journeys had taken them deeper into mental illness or that, simply, the limited records were not representative. Further research might establish a reason.

It was never intended to assess whether the English, or the British, were the 'maddest of all mankind,' an impossible and futile task as such a subjective statement was, by definition, prejudiced and open to interpretations of all societies in

all ages and in all locations and could never be proven either way. However the thesis has shown that stresses were inherent in the business of the Raj, whether from climate, boredom, isolation or culture, and meant that many of the British in India were at risk of becoming distressed *Imperial Minds*.

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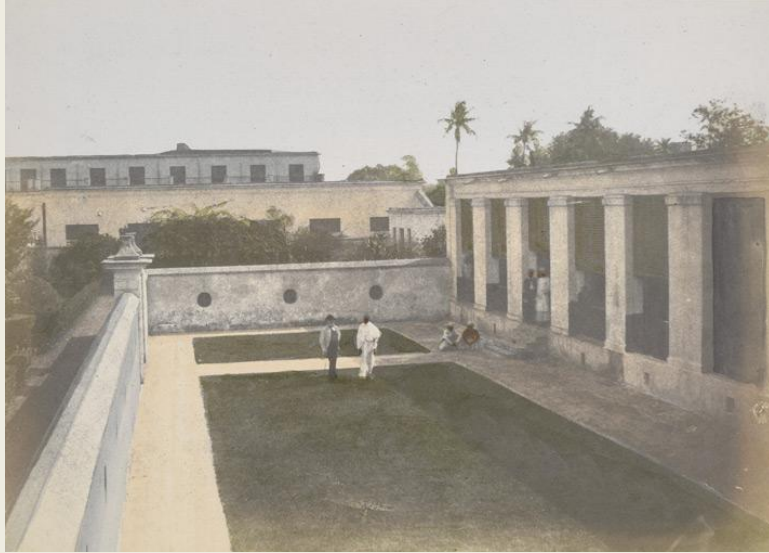
Appendix 1 – Warrant of precedence¹¹²⁸

<p>1 The Governor General & Viceroy</p> <p>4 Commander in Chief</p> <p>8 Members of the Governor Generals Executive Council</p> <p>11 President of the Legislative Assembly</p> <p>14 Chief Commissioner of Railways General Officers Commanding Officers of the rank of General</p> <p>20 Chief Judges</p> <p>21 Lieutenant Generals Chief Commissioner of Delhi</p> <p>23 Air Officer Commanding RAF of India Members of the Railway Board Secretaries to the Government of India Vice Chairmen, Imperial Council of Agricultural</p> <p>24 Additional Secretaries of the Government of India Members of the Central Board of Revenue</p> <p>26 Consulting Engineer to the Government Director General, India Medical Services Director-General, Posts and Telegraphs Major-Generals</p> <p>27 Vice-Chancellors of Indian Universities</p> <p>29 Members of the Indian Civil Service of 30 Standing whose position but for this article would not be lower than Article 34</p> <p>33 Accountants General Class I Brigadiers Chief Controller of Stores Director-General of Archaeology Chief Commissioner of Delhi</p> <p>35 Private Secretary to the Viceroy Secretaries, additional Secretaries, and Joint Secretaries to Local Government</p>	<p>36 Chief Engineers Financial Advisors, Posts and Telegraphs Members of the Indian Civil Service and Indian Political Service of 23 years standing</p> <p>42 Deputy Secretaries to the Government of India Director-General of Commercial Intelligence Director-General of Public Information</p> <p>44 Civilian Superintendent of Clothing Factories Deputy-Director-General, Indian Medical Services Colonels Superintending Engineers</p> <p>46 Controller of Printing, Stamps and Stationery</p> <p>48 Deputy-Director, Railway Board</p> <p>53 Senior Chaplins, other than those already Specified</p> <p>56 Principals of Major Government Colleges Divisional Engineers and Assistant Divisional Engineers of 20 years standing</p> <p>57 Under-Secretaries to the Government of India Librarian, Imperial Library</p> <p>59 Majors Superintendants and Deputy Commissioners of Police of more than 15, but less than 20 years standing</p> <p>61 Assistant Chief Controller of Stores Curator of the Board of Education Examiner of Questioned Documents Lady Assistants to the Inspector General, Civil Hospitals Superintendents of Central Jails</p>
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¹¹²⁸ King *Colonial Urban Development*, p. 242.

Appendix 2

Lunatic Asylum, Calcutta, 1851



Frederick Fiebig
Copyright of the British Library

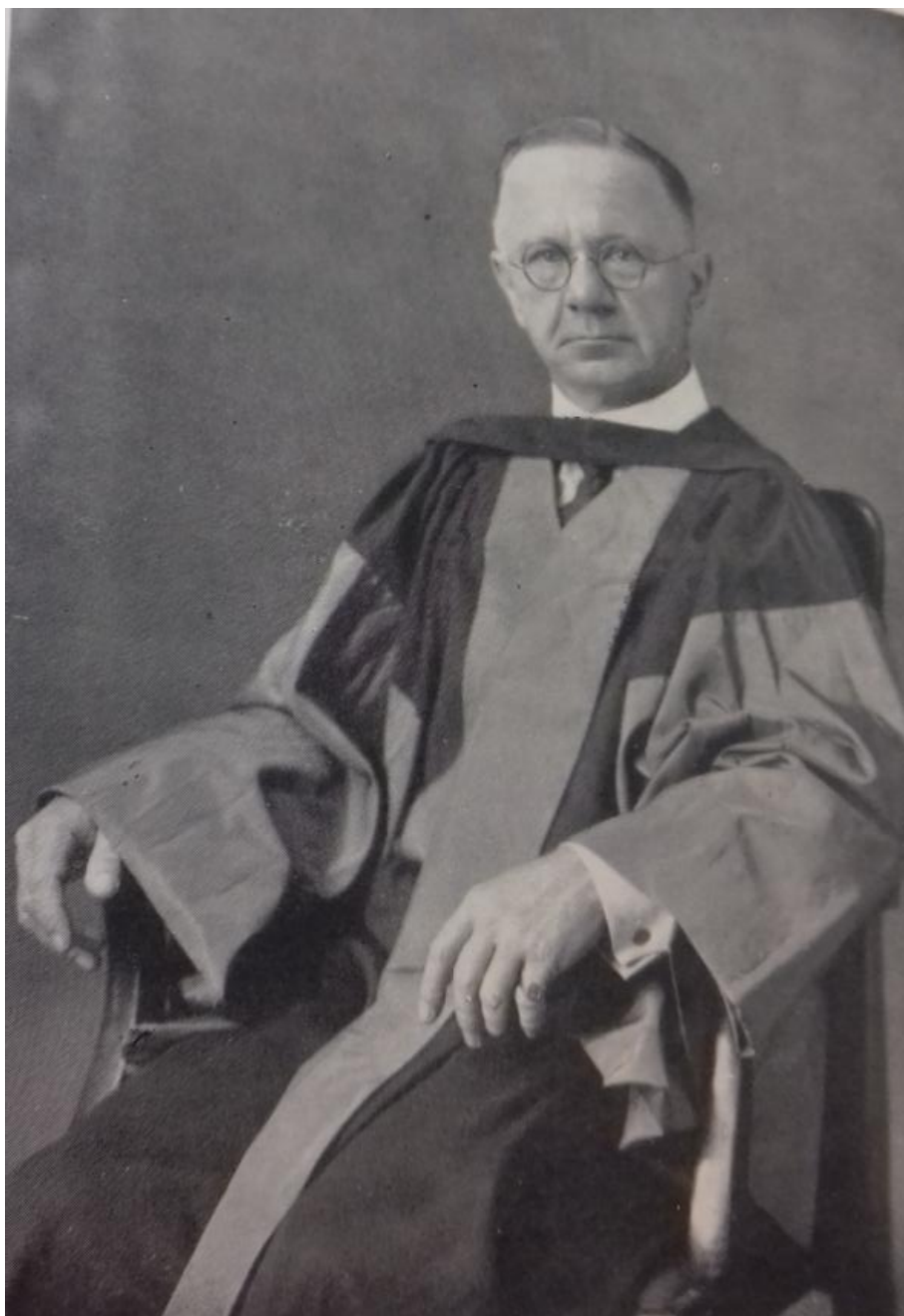
Appendix 3

Lunatic Asylum, Calcutta, 1851



Frederick Fiebig
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Appendix 4 – Portrait of Owen Berkeley-Hill (1879-1944)¹¹²⁹



'By far the ablest man that there has yet been in Indian psychiatry.'¹¹³⁰

¹¹²⁹ Taken from Frontispiece of Berkeley-Hill, *All Too Human*.

¹¹³⁰ Mapother, *Report*, p. 42.

Appendix 5 - The Central Institute of Psychiatry, Ranchi, India, formerly the European Mental Hospital

Ranchi



Appendix 6

Awakening

Buried by someone, someday, in a godforsaken land;
Beneath this free sky my spirit strands.
Forgotten by time, forbidden by my own;
Remembered only by the letters on my tombstone.
Days crawled by, years have gone;
None laid a wreath on my overgrown lawn.
Tell them my story, call out my name;
Tell them I lived, I need no fame... I need no fame.....

Roshan Khanande (2016)

Dr Khanande is a psychiatrist at the Central Institute of Psychiatry in Ranchi, India. He wrote this poem after a visit to the graveyard of patients of the former European Mental Hospital. The site, once immaculate, is now overgrown and derelict. A few damaged gravestones remain but most have been stolen and the contents of the graves removed. The poem recalls the long dead, long forgotten distressed *Imperial Minds* who served an Empire from another era.