MADNESS THEN, INSANITY NOW: THE EVOLUTION OF MADNESS AND MEDICINE IN INDIA FROM ANCIENT TO MODERN TIMES

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ABSTRACT

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Title: Madness Then, Insanity Now: The Evolution of Madness and Medicine in India from Ancient to Modern Times

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My thesis will examine how madness and the medical systems that understood it have changed from ancient times to modern times in India. It begins with an examination of medicine in the Vedic era and considers the implications of a magico-religious epistemology that informed the treatment of madness in that time. From there, it moves on to the classical Ayurvedic systems of medicine and discusses the linkages and points of difference from the earlier system. In short, medicine generally becomes more empirically grounded, and madness is seen as having both somatic causes as well as external, "possession" causes.

I then fast forward to the colonial era to focus on the development of the insane asylum under the British over the nineteenth century and the new authority relationships, power structures, and race relations that were implicated in the process. This is an especially crucial point in my thesis, and I spend many pages examining the topic because it is the first time that madness becomes institutionalized in the subcontinent. The next section moves on to the early twentieth century to understand how Ayurveda, dominant mostly in rural areas and long unrecognized by the colonial government, becomes resurrected for a modernized world and plays an important role in the debates around Indian nationalism. Finally, my last section uses anthropological sources to understand the nature of madness and its ties to kinship relations in contemporary India.

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TABLE OF CONTENTS

Introduction	5
Madness in the Vedic Period	11
Madness in the Classical Period	20
The Institutionalization of Mental Health Care	36
The Advent of a Colonial Framework on Medicine	54
Towards a Modern Institution	66
Madness in Contemporary North India	78
Conclusion	91

INTRODUCTION

Mental health has received significant attention recently as new studies suggest it is more normal than anomalous to be afflicted with mental illness.[1] John Copeland, immediate past president of the World Foundation for Mental Health, even calls it the "neglected global health priority."[2] As part of this global movement to increase awareness of the issue and expand treatments to those in need, "India was one of the first developing countries to recognize the need to address mental health with its National Mental Health Programme (NMHP) being launched in 1982,"[3] but the fact remains that "the relationship between the regulation of madness and social responsibility is a complex issue, where the burden of accommodation falls to either the individual or the society at large or both."[4]

Recent legislation in India has shifted the focus of regulating madness from a public security standpoint to an individual, rights-based approach that involves "greater government responsibility in the implementation and regulation of mental health care."[5] I argue that this shift is all but recent and rather finds its roots further back in the history of Indian psychiatry with the transition from the notorious British-era asylums to the modern mental hospitals, and there are several key questions on which we can focus in order to understand the significance of the shift. For example, who has the authority to determine another person to be insane? Does this authority rest with medical practitioners or professionals in society? More basically, is madness a somatic or moral disease? Finally, are madmen's identities intrinsically linked to their insanity or separate from their disease?

The reader should be alerted at the outset that my thesis will not answer such questions in any manner; rather, it will seek to understand how one region, India, has attempted to answer these questions and its implications for contemporary treatment, practice, and legislation. India is a rich

[1] See Young and Copeland
[2] See Copeland
[3] *Ibid.*
[4] See Hyne-Sutherland 203
[5] *Ibid.*, 164

focus for the study of madness thanks to its long and complex history, and the social context in which madness has been treated in India gives insight into the connections between madness and other fields, such as religion, medicine, and imperialism. Indeed, one of the first instances of mental healing in the subcontinent is a charm to cure insanity contained within the hymns of the Atharvaveda. The incantation is at once medical and religious – it is included in the section of the text that explores medical treatments, and it assumes a metaphysics drawn from the prevailing religious ideas of the time. Several thousand years later, madness became tied to the imperial framework imposed by the British with the advent of the insane asylums, the first time madness was formally institutionalized. Though the reach of such asylums was limited, they had important ramifications for colonial ideology and the desire to hide elements of society considered shameful. Since its independence from the British crown, India has devoted much attention to its mental health treatment system, leading to several landmark pieces of legislation that are evidence of an ever evolving and refining attitude towards madness.

My thesis is organized chronologically with the intention of weaving together a story about the development of perceptions and treatments of insanity in India, particularly since the era of British colonialism. However, I include discussions of ancient and classical texts and their approaches to madness for several reasons. For one, when the British first encountered Indian medical texts, such as those of Āyurveda, they believed the texts to be representative of the actual medical practice at the hands of the practitioners. Hence, understanding the evolution of Ayurvedic thought throughout the Common Era was not central to their objectives. While it would be extremely helpful to examine commentaries on Āyurveda and shifts in its medical treatments, I will leave these segments out to limit the scope of my thesis since my study devotes primary attention to the attitudes towards mental illness during the colonial and subsequent periods. Secondly, a cursory glance at ancient and classical systems of thought will help provide context for local remedies prior to the arrival of the British. In addition, Āyurveda becomes a point of major concern of both the colonial government and the Indian

nationalist movements during the era of modernization, so a basic understanding of the Ayurvedic diagnostic and treatment system will aid our study of such interactions later on.

In line with these goals, the first major phase I examine is that of the Vedic age. The medical references in the Atharvaveda are the earliest concrete ones with which we have to work (there is little that we can deduce based on our current knowledge of the Indus Valley Civilization), and one of them specifically mentions treatment of the insane (called *únmaditam* and *únmattam* in Sanskrit). In analyzing the four verses of the charm as representative of treatment of madness in the Vedic period generally, I have run the risk of over-generalizing and basing too much of my argument on limited source material. However, due to the underwhelming selection of primary sources and scholarship, there was hardly a way to bypass the issue, and I find the risk I have run to be preferable to ignoring this important period of history all together.

Around the turn of the Common Era, the classical Ayurvedic system of Indian medicine takes authority over treatments. The primary sources for this phase, especially regarding the treatment of insanity, are much richer and well developed; in addition, the scholarship on this era is far better developed. I have chosen texts, both primary and secondary, to highlight the ways in which "answers" to the broad questions above were refined and/or revised through the transition into the classical period to provide a sense of continuity and to develop focal themes for my thesis. Overall, we can observe greater weight placed on empiricism as madness becomes progressively medicalized in the Ayurvedic tradition. Ayurvedic knowledge and treatments continued expanding through the centuries such that Āyurveda has practically become synonymous with Indian medicine for a modern observer reflecting on medicine in India prior to the arrival of the British.

The next phase addressed in my thesis is the colonial era under British rule. Once again, I justify fast-forwarding through history with the assertion that the classical texts and their theories (not necessarily the lived practices) were of prime importance for the British administrators, at least

until the early 1900s. This period witnessed the emergence of non-indigenous (perhaps better called non-local) medicine in India. The insane asylum became imported into India from Europe, where it had already been implemented, and ushered in the institutionalization of insanity in the subcontinent. I have expanded on this section to great length relative to the thesis length because it is one of the most fascinating eras in Indian medical history and shapes the present developments in the mental illness treatment that seek to move past the legacies of the asylum. The connection between medical power and colonial power raised new challenges to the existing systems of medicine in India (primarily Āyurveda) and to the Indians who used them. I also included a section on the modernization of Āyurveda in order to give more context for the interactions between Western medicine and Indian medicine within which the treatment of madness is situated. For the first time, control over insane members of society became linked to the deeply-engrained notions of cultural superiority and served to legitimate British domination of the subcontinent. A separate question asks whether the institution turned out to be good news for the patients; in many cases, it appears to be the opposite case. The asylums generally treated patients as social ills of which society needed to be relieved rather than deserving treatment to cure them of their illness; this is precisely the attitude that modern legislation is progressively reversing.

From one angle, the history of the asylum comes to an end with the independence of India in 1947; nevertheless, the impacts of the asylum reach far into the following decades, and the modern mental hospital in India uses the framework of the asylum to help define what the modern institution will *not* be. This is correlated with the rise of outpatient care and the focus on therapy rather than exclusion and control. Lastly, by means of anthropological work, we get a glimpse into the variety of mental illness treatment facilities in contemporary north India. Some institutions seem to be the offspring of the British asylums while others strive to integrate care with the family, traditionally the locus of medical treatment. We also develop an appreciation for the difficulty of pinning down a single narrative of mental illness and are often left to grapple with the conflicting accounts of the institution

and various family members to understand the myriad ways in which madness both dissolves and forces a strengthening of familial relations.

One criticism of the approach I've taken in my thesis – covering thousands of years of history in a mere eighty pages – would fairly point out that my treatment of each section would be superficial at best. I have aimed to supply enough history to set the context, and my focus has been addressing the ways in which broad questions and attitudes about madness – such as whether madness is identical with or separate from the patients whom it afflicts – have transformed through the centuries and given context to recent developments.

Finally, I would like to say a few words about my sources. Much of what we know about Vedic healing is contained in the primary sources, the four Vedas; the Atharvaveda contains most of the Vedic passages related to medicine and thus includes the charm to cure insanity. I have used Kenneth Zysk's translation and analysis in *Religious Medicine* for the purposes of my thesis; his work is one of few scholarly treatments of Vedic healing, so the choice of sources was rather limited. I also cross-referenced his analysis of the charm with Fred Smith's analysis of the same incantation as part of a massive study of possession to avoid depending too heavily on one interpretation of the verses. For my examination of Ayurvedic approaches to madness, I have used the translations of Priyavrat Sharma for accessing the primary sources and the analyses of Dominik Wujastyk to understand their context. While there are many Ayurvedic sources that address madness, I have largely limited myself to the Compendium of Caraka (the *Carakasaṃhitā*), one of the two main sources of Ayurvedic knowledge. The Compendium begins by outlining the fundamentals of Āyurveda, including the three humors (*doṣa*s) and the numerous herbs and natural remedies that are prescribed. Interestingly, it is organized not by disease – *e.g.* insanity – but rather presents first a dense section on the diagnosis of hundreds of diseases. It then moves on to the specific features of each and later describes the remedies for each. While the Ayurvedic system does not derive as such from the Vedas, it holds the Vedas in high regard and often attributes its origin to them, most likely to gain social legitimacy. It

largely moves away from the heavy reliance on religious metaphysics found in Vedic healing but still makes room for seemingly incomprehensible diseases that are then attributed to spirits and deities.

The development of treatments for madness in the colonial era is addressed most comprehensively in *Mad Tales from the Raj* by Waltraud Ernst, who examines many documents from the Raj, such as the reports of asylum superintendents. She organizes her study by theme: colonial politics, the institutions themselves, the role of the medical profession in colonial India, the patients held in the asylums, and finally the theories that informed the practice of medicine (primarily by the British). She considers the role of the asylum both in the lives of the patients and for colonial ideology. One of her most recent studies, *Colonialism and Transnational Psychiatry*, tracks the development of the modern Ranchi Indian Mental Hospital, which largely moves away from the asylum system. I have included a discussion of the modernization of the mental health institution in between the asylum era and the contemporary age. Finally, my section on contemporary north India is heavily based on the anthropological study by Sarah Pinto, *Daughters of Parvati*, which examines women in particular to make sense of the connections between mental illness and the struggles and demands of kinship. I engage with her analysis to reexamine the approach I have taken in working with my other materials because the picture of mental illness she paints with her words is complex in a unique way – it addresses at once the limitations of language, the desire to connect with other humans, and the flaws in current frameworks of understanding Indian psychiatry.

The result, then, is a light walk through several thousand years of history, considering the various perceptions of madness: somatic, moral, a form of social deviance that needed quashing, an affliction that needed care, the identity of a patient, or simply one among many facets of a human life. Ultimately, the reader will find the colonial era and the subsequent modern period to be the core focus for which the discussions about ancient and classical healing are designed to provide basic background and context.

MADNESS IN THE VEDIC PERIOD

Our journey of examining madness in India will begin several thousand years ago in the Vedic era, elements of whose principles and worldviews can be found still in much of present-day Indian and Hindu culture. One of the key difficulties in studying medicine and madness in the ancient period, however, is the limited number of primary sources and the limited scholarship to date. One of the most comprehensive studies of healing in the Vedas was undertaken by Kenneth Zysk, whose book, *Religious Medicine: The History and Evolution of Indian Medicine* (1993) will be the primary source material for my discussion here. Since there is limited material with which to work, my focus in this section especially will be on ideas and implications rather than information; it is also important to keep in mind that due to the limitations of evidence available from this time period, many claims will be based on speculation rather than well-founded "facts." Unfortunately, there is not a feasible way around the issue, so we must work with what we have available, which includes Zysk's book.

The scriptures of Vedic medicine, "[u]nlike the ancient Egyptian and Mesopotamian medical traditions which have specific treatises outlining their medical systems," appear together with the religious literature contained in the Vedas (Zysk 4). Of the four Vedas, the Atharvaveda contains most of the hymns concerning medicine and healing though the metaphysics underpinning the treatments is established in the Ṛgveda, which is mostly religious in nature; both of these scriptures were preserved by means of an "extraordinarily accurate" oral tradition until they were written down much later (Zysk 5). Hence, it is evident from the outset that Vedic medicine was intertwined with Vedic religious practices, and we must examine medicine in this period as joined to religion. Nature played a key role in Vedic medicine as well: for instance, the Ṛgveda mentions the male plant divinity Kuṣṭha, and the Atharvaveda refers to the complementary female divinity Arundhatī, a healing plant

goddess.[6] Hence, we will proceed with the understanding that medicine, religion, and nature were inseparably intertwined.

As mentioned above, "magico-religious" sums up the Vedic approach to medicine, and Zysk describes it in the following way:

> Causes of diseases are not attributed to physiological functions, but rather to external beings or forces of a demonic nature who enter the body of their victim and produce sickness. The removal of such malevolent entities usually involved an elaborate ritual, often drawing on aspects of the dominant local religion and nearly always necessitating spiritually potent and efficacious words, actions and devices. (8)

What is most striking about Vedic medicine, then, is that it appears to have understood disease in non-somatic terms (we will elaborate on this later); that is, the body itself became merely a means of carrying and expressing the disease without being fundamentally changed or degraded in the process. The healing process naturally focused on the spirits afflicting the diseased person rather than bodily treatments, and ritual became the primary means of curing the patient. An entire science of demonic possession and subsequent treatment was born from the combination of metaphysics and ritual practices; we can refer to it as *bhūtavidyā*, or the knowledge of spirits. A healing ritual would include religious incantations and charms, such as the ones found in the Atharvaveda. We will examine one that treats insanity later in this section. Such utterances were meant to grab hold of the demonic entity and encourage it to leave the body of the patient. The possessor could then be transferred into the ground, into another person, such as an enemy, or carried away and out of the community by animals and birds.[7] Many of these demons became mythologized and incorporated into the religious lore. They were put in contrast to the deified remedial herbs, which were sometimes worshipped as goddesses.

Several important ideas emerge from this discussion of medicine: words were understood to have power in and of themselves; the mechanism by which they could cure patients was based on a

[6] See Zysk x
[7] *Ibid.*, 9

framework of benevolent and malevolent possessing entities that could be driven away and contained by the power of words. Secondly, even though we may be tempted to see the principles of Vedic medicine as random or based purely on imagination, there was really an empirical, quasi-scientific approach underlying them; Zysk writes that "[t]he empirical medicine evident during this period, on the other hand, involved both observation and experience in order to determine the cause of disease and to effect an appropriate treatment" (8). Charms and utterances were carefully observed for their efficacious properties in order to control the good and bad spirits. The succeeding classical Ayurvedic system was even more recognizably empirical in its approach, continuing and building upon the observation-based methods of Vedic medicine.

I would like to say a few quick words about the notion of words themselves containing power, especially since this thesis seeks to understand perspectives on madness. In twenty-first-century America (and in most places across the world), we may be inclined to laugh or at least giggle at the thought of curing medical issues with words and onomatopoeic sounds, especially since our knowledge of medicine is heavily somatic. However, mental health treatment is still understood at least partially in non-somatic terms. Psychiatrists, of course, can prescribe medications for patients that control the levels of certain hormones inside the body. However, there is a long tradition of talk therapy that believes in the power of words to effect change and potentially cure the patient of mental illness, though some may assert that this form of treatment is declining in popularity.[8] Still, almost all of us can say from experience that the comforting words of a friend, parent, or other trusted person can have a very real, healing effect on our minds, bodies, and spirits. Granted, our society doesn't subscribe to the same metaphysical system as Vedic medicine; we would consider words to affect a person's internal emotions, not external spirits. In any case, an honest evaluation of our own

[8] The Doctor, The Patient, The Society, The Culture, taught by Dr. Stephen Sonnenberg. Personal communication, Spring 2017.

understandings of mental health can help us to see an ancient medical system in a more sympathetic light.

Having established this background about the workings of Vedic medicine, let us examine a charm to cure insanity using Zysk's translation of the Atharvaveda Saṃhitā (Śaunakīya recension) 6.111 (1993:62-63). Since this is the only charm related to madness from Vedic literature, I will reproduce it below for convenience along with some of the key Sanskrit terms included by Fred Smith in his reproduction (477):

6.111

1. O Agni, for me, release this man who, bound [and] well-restrained, utters nonsense. Hence, he shall make an offering to you when he becomes sane [*ánunmaditaḥ*].
2. If your mind is agitated, let Agni quieten [it] down for you. [For] I, being skilled, prepare the medicine, so that you may become sane.
3. I, being skilled, prepare the medicine so that he, insane [*únmaditam*] because of a curse of the gods and demented [*únmattam*] because of the *rákṣas*-demons, may become sane.
4. Let the Apsarases return you; let Indra [and] Bhaga re[turn you; in fact,] let all the gods return you so that you may become sane.

The charm makes clear our previous discussion of disease as the result of some external entity(ies). Interestingly, we can observe both possession by unwanted spirits as well as the abandonment by benevolent entities. Verse 3 asserts that the madman in question is "insane because of a curse of the gods" and "demented because of the *rákṣas*-demons." Zysk takes this to be a form of insanity (*únmatta*) caused by "evil forces invading his body" (62). He contrasts this stronger form of insanity with *únmadita* madness, which is the result not so much of possession by undesirable demons but rather of personal transgression of moral laws, hence incurring the wrath of the gods. Smith is not entirely convinced that this distinction is significant due to the "absence of evidence for systematic usage of these terms in the *AV* [Atharvaveda]," but it could foreshadow "the later āyurvedic distinction between *unmāda* caused by accountable pathological factors and *unmāda* brought on by unaccountable invasive entities" (477). Regardless, it is clear that the treatment is not

overtly somatic since it is grounded in the epistemology of medical diagnosis – that is, the treatment involves bringing back the benevolent spirits and seeking release from the demonic entities.

Two other points about the charm are striking – one, the ritual priests who recite the charm "prepare the medicine, so that you [the insane one] may become sane." We can observe here an intersection between the magico-religious attitude to disease and the use of nature and herbal remedies to aid the treatment. This raises an interesting question about whether the accompanying rituals were themselves believed to perform the healing or whether they were mere accompaniment for the herbal remedies, in which case the natural formulations may have been believed to heal. Based on Zysk's characterization of Vedic medicine, it seems more likely that the rituals, words, and sounds were understood to be truly potent, and the herbal medicines would have been a natural result of a culture that recognized divinities in plants. However, Zysk asserts that the "ritual practice is…purely symbolic, with the emphasis placed on purification and on the expulsion of the demon" (62). He also suggests that the medicines may have been intended "to calm the patient…and to drive away the evil forces invading his body" (62). Perhaps, then, the medicine was understood to be a powerful healing substance itself, but the mechanism by which it worked depended on a magico-religious schema in which the rituals symbolically aided the efficacy of the medicine. In any case, what is important to realize is that though the medicine may have been important, it only appears once in two verses of the incantation; on the other hand, every verse refers to celestial beings and the powers they exert. There is little doubt that the gods and demons were crucial for ritualized medical treatment.

The second element deserving attention is the mention of the lunatic being "bound [and] well-restrained" because of "utter[ing] nonsense." Here, the madness seems to be characterized primarily by a disharmony between the lunatic and the community – he speaks in ways incomprehensible to his society, and he may have even been violent and thus requiring restraint for the safety of his neighbors. Hyne-Sutherland asks in her dissertation why societies define madness, and she describes how "[t]he very act of defining madness is a means of effecting control over the uncontrollable" (88).

In addition, based on her research of modern-day understandings of madness in India, "ascriptions of madness identify the relationship between a person and his or her society and not necessarily the internal state or experiences of an individual" (75). Both of these themes are at play in our examination of Vedic-era madness, revealing that certain basic assumptions about madness and the mystery that surrounds it connect our understandings today with those of an ancient culture. For example, the madman uttering nonsense is considered mad because it strains the relationships built on communication between that person and his community members and doesn't necessarily indicate an internal condition or frightful experience. The restraint is evidence of the society's attempt to control what appears to be uncontrollable and threatening behavior.

This is not to suggest that modern society has made little progress with regard to mental health treatment but rather to emphasize that madness as social deviance that cannot be easily accepted by society is a common theme that transcends time and space. Interestingly, the charm asks Agni to "release [the] man," and yet in order to be considered "cured" and acceptable for release into the community, he will have to be released from the bindings that society has placed on him. Viewed in this light, the physical restraint is a symbol for the clutches of Agni and the other deities who have grasped the patient, who is subject both to the authority of the deities as well as the authority of the priest and the community he represents. The healing process is possible only with both the priest, who performs the ritual and prepares the medicine, and the gods, who return to the man upon the priest's request.

Before finishing our discussion on Vedic healing, a word ought to be said about the social class of healers because their social status is correlated with (and possibly a cause of) the transition into the classical Ayurvedic systems. Vedic society was divided into three important classes according to Georg Dumézil's characterization of ancient Indo-European society.[9] The learned

[9] See Zysk x

medical healers formed part of the third, agrarian-oriented order and thus passed their folk knowledge and literature orally. Thus, says Zysk, "the healing hymns of the *Atharvaveda*…reveal one of the earliest forms of folk healing of Indo-European antiquity, and offer an excellent example of ancient folk literature."[10] Many of the Vedic healing hymns brought together knowledge from the first-order sacrificial priests "whose words and actions were thought to bring them in direct contact with the greater cosmic forces" (Zysk xi). Thus, the healers were positioned to engage religious incantations as well as their herbal knowledge, and since they were not constrained by the rules and norms of purity that bound the first-order priests, they could freely serve "the needs of all people regardless of social standing" (Zysk xi).

Originally, or so it is thought, the healers occupied a role that was on a similar level as that of the sacrificial priests. In time, however, the medical healers became considered contaminated from interactions with ritually "impure" segments of society and were subsequently "excluded from the higher, more sacred circles of the sacrificial cults" (Zysk xi). This limitation may have become a form of liberation for the healing priests because they could interact with communities on the margins of mainstream Vedic society without much concern for maintaining ritual purity. Contact with "heterodox ascetics and renunciants who did not censure their philosophies, practices and associations…[contributed to] a vast storehouse of medical knowledge [that] developed among these wandering physicians who…began…to conceive a radically new epistemology with which to codify and systematize this body of efficacious medical data" (Zysk xii). The gradual result: the classical systems of Ayurvedic medicine, to which we will turn next.

Let us first take a moment to review the key themes from the ancient period, which laid the foundation for medical knowledge development in the Indian subcontinent from roughly five

[10] See K. G. Zysk, "Reflections on an Indo-European system of medicine," in *Perspectives on Indo-European Language, Culture and Religion, Studies in Honor of Edgar Polomé*, Vol. 2 (McLean, Virginia: Institute for the Study of Man, 1992), 321-36, quoted in Zysk xi

thousand years ago according to Zysk's speculations. For one, Vedic healing relied primarily on a magico-religious epistemology in which the physician was responsible for gaining control of the benevolent and malevolent deities and spirits that either abandoned or possessed the patient. The healing process involved elaborate rituals to the accompaniment of magical incantations and sounds, and many of the sacred hymns were modeled after and/or borrowed from the literature of the sacrificial priests. In time, the medical segment of society separated itself both from and due to the authority of the religious priests. This allowed the healers to develop their own authority, free from the strictures of purity, leading to the Ayurvedic system.

If we were to ask the question whether Vedic medicine (and mental health treatment) was more somatic or moral, we would probably conclude it was ultimately somatic, though in a radically different way compared to modern-day somatic treatments.[11] The healing ritual did indeed involve some sort of medicinal preparation, and the spirits whom the healer controlled and expelled did possess the body of the patient. We may liken them to diseases like pneumonia that grip the patient's body, and the ancient system of treating those diseases involved medicines and incantations rather than antibiotics. A moral understanding of madness would be apt to emphasize work therapy or other comparable treatment, not an external healing ritual that would dispel the demonic entities.

Finally, we can ask the question of whether madness is something a person has or something a person is.[12] Based on the Atharvaveda charm, it appears that insanity was not identical with the person insofar as the treatment was concerned. The patient and his body functioned as the covering and means of expression for the demonic entities who possessed it. Driving away the spirits and bringing the good spirits back would presumably restore the patient to normalcy. However, insofar as the society was concerned, the madman was probably identified with his madness because all that

[11] We mentioned earlier that Vedic medicine is largely non-somatic; we are using "somatic" in slightly different ways, the difficulty of using the term points to the complexities of defining disease as bodily or non-bodily.
[12] See Hyne-Sutherland 99 for a detailed exploration of this question

mattered was that he posed a threat to the normal functioning of the community, either through senseless speech or through physical aggression, hence the need to bind and restrain him. Both perspectives are at play here, suggesting that they are not mutually exclusive.

MADNESS IN THE CLASSICAL PERIOD

The transition to the classical systems of Indian medicine, commonly known as Āyurveda, brings about important developments in the history of medicine in India as notions of what madness is and how to treat it undergo significant change. Āyurveda as a medical system comprises a huge body of literature whose topics blend medicine with religious medicine, astrology, and yoga.[13] In addition, numerous authors have contributed their findings to the corpus of manuscripts, two of the most famous being Caraka and Suśruta, whose Compendia "are absolutely fundamental to Āyurveda" (Dominik Wujastyk xxvi). As is the case with many historical documents and manuscripts, Caraka and Suśruta likely did not compose in entirety the compendia attributed to each; indeed, the *Carakasaṃhitā* (the Compendium of Caraka, henceforth quoted as CS) suggests in the statements at the end of each chapter that the Compendium is the framework of another author, called Agniveśa, who learned it from his teacher, Ātreya; it was merely redacted by Caraka.[14] In addition, proposing a date for an enigmatic author like Caraka is no simple task, and "current scholarship tentatively places the composition of the earliest version of the *Compendium* in about the third or second centuries [BCE]" (Dominik Wujastyk 4). This dating is based on references in the texts of Chinese monks and the connection between Āyurveda and Buddhism, and the Compendium as we know it today may not have been completed until even 300 or 400 CE. In our discussion, we will say simply that "Caraka says xyz" or "Caraka's text mentions abc"; we should keep in mind the challenges and questions of history, which suggests Caraka did not write all the statements attributed to him, but they will not be crucial for our purposes.

It would be wise to begin with a brief introduction to the basic methods and assumptions of the Ayurvedic medical systems. A large portion of my discussion here will be based on Dominik Wujastyk's detailed study, *The Roots of Āyurveda*. Perhaps the most unique feature of Ayurvedic

[13] See Dominik Wujastyk xxiv
[14] *Ibid.*, 4

medicine is the doctrine of the humors, or *tridoṣa-vidyā*, which bears striking resemblance to the Hippocratic medicine that formed a medical basis in the Western world. Āyurveda relies heavily on the trio of *vāta* (wind), *pitta* (choler), and *kapha* (phlegm); the latter two form the core "duality [that] underlies a great deal of Ayurevdic thinking, a duality of hot and cold, dry and wet…medically in choler and phlegm" (Dominik Wujastyk 74). *Vāta* takes a more significant role over the other two as the *doṣa* that, according to Suśruta, "is the cause of the existence, origination, and disappearance of all beings."[15] The three humors are intimately connected with the seven *dhātu*s, or body tissues, and the body's waste products. As digestion is the central process of the body, "cooking" ingested food to turn it into a bodily tissue, diet is of utmost importance in Ayurvedic treatment. Other remedies include plant- and animal-based medicines, massages, bloodletting, sweating, and surgery.[16] Understanding the specifics of Āyurveda's tenets is extraneous for the present task except for the aspiring Ayurvedic doctor, but a basic understanding will allow us to make better sense of the passages dealing with madness later on.

Another characteristic of Āyurveda's approach that will become crucial to realize later on when Āyurveda will be placed in contrast to the Western medicine brought by the British is that it is principally allopathic – that is, it treats a cause with its opposite. Essentially, "one uses things which are the corresponding contraries to the causes of the diseases, applied in the right dosage and at the right time" (Dominik Wujastyk 19). Dominik Wujastyk notes several instances in the Ayurvedic literature where such an approach is explicitly outlined. For example, in the section on epidemics, Lord Ātreya quotes a saying that "[t]hose who know about herbs use cold to soothe diseases caused by heat…[a]nd the medicine for those diseases which are caused by cold is heat…[he goes on to say that] diseases caused by depletion cannot be soothed by anything other than a supplement…[a]nd similarly, diseases caused by surfeit cannot be soothed by anything but deception" (Dominik

[15] See the Compendium of Suśruta, quoted in Dominik Wujastyk 74
[16] See Dominik Wujastyk xvii for a more elaborate overview of the basic tenets of Ayurveda

Wujastyk 48). This is an important notion because as it modernized, Āyurveda became the "indigenous and native" alternative to "allopathic" Western medicine, the so-called "Indian medicine for Indian bodies." In reality, it was (and is) just as allopathic as the Western medical system with which it was contrasted.

So far, we may be tempted to think that Āyurveda was a fundamentally different medical system from the Vedic healing we encountered previously. Indeed, the somatic doctrine of the three humors, so central to Āyurveda, was effectively absent in the Atharvaveda medical hymns. In addition, we have not yet encountered ritual as a common means of treatment, especially since Āyurveda medicalized in a more familiarly empirical way the diseases that were previously seen to be the work of benevolent and malevolent deities. By the time of the Common Era, many diseases were understood to stem from an imbalance of the humors or blockages of transport tubes in the body that transport fluids, including *manas*, the mind, and nervous impulses.[17] While possession and rituals to combat it continued from the Vedic age through the classical period and into the present day as well,[18] "the medical ideas and practices preserved in the early Vedic literature…do not form an obvious precursor to the system of classical [A]yurveda…such medical material…is remarkable more for its differences…than for its similarities" (Dominik Wujastyk xxix). The question then remains of how to account for the fact that the Ayurvedic Compendia claim to be derived from the Vedas and revere the Vedic corpus. Wujastyk suggests this may have been rather a "bid by medical authors for social acceptance and religious sanction" (2003:xxix). By owing allegiance to the Vedas, which served and still serves as the basic core literature of Hinduism, the medical authors would have positioned themselves as legitimate members of Hindu society as well as legitimate in their methods of treatment. If we accept Zysk's proposition that healers in the Vedic era gradually became pushed out of the higher, ritually purer segments of society, then the Ayurvedic system that developed from

[17] *Ibid.*, xx
[18] See Smith 544 for ethnographical accounts of modern day possession based on fieldwork in Kerala

their literature may have risked losing social legitimacy unless the authors could sustain its reputation by appealing to the foundation of the religious literature as also the foundation of the medical literature. If nothing else, such a theory makes for an engaging story.

A word ought to be said here about Āyurveda as "religious medicine" or Āyurveda as "Hindu medicine." In the late colonial period, Āyurveda became revitalized as a form of medicine appropriate for Indian bodies and merged with ideas of a modernized Hindu society (this was partly since Unani medicine became "Islamic medicine" because Unani practitioners were largely Muslim, so Āyurveda became "Hindu medicine" since vaids were mostly Hindu). Around the turn of the first century CE, there is little doubt that developments in Ayurvedic medicine took place with the background of Hindu concepts, assumptions, and metaphysics. For instance, Ayurvedic physicians grappled with *karma*, fundamental in a discussion of Hinduism, and its applicability to medicine.[19] However, there is evidence that suggests Ayurvedic authors were not concerned with making Āyurveda distinctly "Hindu," and there are several points in the texts where the authors pay little attention to the taboos of the religious authorities. For example, Āyurveda freely prescribes meat and alcohol as part of its treatment regimens, and their use "is presented so completely without apology or explanation" (Dominik Wujastyk xx). One of Caraka's commentators, Cakrapāṇidatta, even says that "[t]he recommendations of medicine are not intended to help achieve virtue (*dharma*). What are they for, then? They are aimed at achieving health."[20] At the same time, we should be careful not to overstate the divide between religion and medicine and their individual goals as both worked in conjunction to provide spiritual and physical health for the population, respectively. For example, Caraka mentions that the "prodromal symptoms of the patient of insanity caused by the wrath of gods [are]

[19] See Meulenbeld 196
[20] See Cakrapāṇidatta on Caraka 1.9.29, quoted in Dominik Wujastyk xxi (translation by Dominik Wujastyk)

inclination to violence on gods, cow, brāhmaṇas and ascetics…" (CS 2.7.11).[21] Clearly, he as a medical author still worked within the framework established by religious conventions and metaphysics.

The Ayurvedic system is the first robust, primarily medical tradition that developed in the Indian subcontinent. However, we should clarify what we mean by "medical" since our contemporary understanding of "medical" may be apt to bring to mind hospitals, surgeries, drugs, and prescriptions to treat illnesses, and so on. Indeed, correcting for the difference in time periods, we can observe such features as herbal drugs and surgeries[22] in Āyurveda. But perhaps unlike or more so than our modern conception of medicine, the Ayurvedic system had a holistic approach built into it that was concerned not only with the disease at play but also the overall constitution of the patient, the environment, and other factors. For example, Wujastyk writes that "environment is important: it is vital to be in tune with the special qualities pertaining to each of the seasons" (2003:xx). It makes sense, then, why Caraka considers Āyurveda to treat a "conjunction of body, sense organs, mind and self" and how the "[m]ind, self and body…make a tripod on which the living word stands" (CS 1.1.46-47). We could expect that the mind and its derangement would be afforded considerable attention in a tradition that considers the mind to be one of the "locations of disorders as well as pleasures" (CS 1.1.55). This leads us naturally into a fascinating discussion of insanity.

Let us first develop a fuller understanding of the mind in the Ayurvedic system before discussing its derangement. Caraka begins his section on the mind by stating that it "is defined as the entity which…is responsible for production or otherwise of knowledge," and its "[a]ction consists of control over the senses, self-restraint, reasoning, and analysis" (CS 4.1.18-21). We can identify two broad themes, then, concerning the mind – there is an element of self-control ("control over the senses" and "self-restraint"), and there is a component of proper knowledge and understanding

[21] I am quoting the text as follows: CS refers to the Carakasaṃhitā, the first number refers to the book number (*sthāna*), the second number to the chapter, and the final number to the verse.
[22] Suśruta's Compendium is particularly famous as a text with a strong focus on surgery.

("reasoning" and "analysis"). Hence, the mind of a person, not an external force or even a proper constitution of the humors and tissues, was primarily responsible for making sure its possessor behaved according to societal expectations and reasoned according to established knowledge and norms. Thus, the mind had control both externally (outward behavior) and internally (thought process). Indeed, Caraka clarifies the latter point by stating that "[t]he sense-object is received by sense organs along with the mind…[t]hen the mind analyzes it in forms of merits or demerits and forwards it to Buddhi (intellect) which produces decisive knowledge by which one proceeds to speak or to do something with full knowledge" (CS 4.1.22-23). From these passages, it is important to note first that the mind as an entity that held authority over the person was recognized in the medical literature and secondly that it was crucial in maintaining the social well-being of a person.

One may suggest that we are reading perhaps too far into "self-restraint" and that the control implied there really refers to "the emphasis...on moderation: whether it be in food, sleep, exercise, sex, or the dosage of medicines…" (Dominik Wujastyk xviii). In this case, the behaviors kept in check by the mind may serve more personal purposes, such as maintaining a healthy body, rather than keeping behaviors in line with socially established decorum. I suggest that there is evidence for both – Wujastyk provides a list of "corruptions…[that cause] defilement of the intelligence, destruction of the pathways along which the mind flows and, finally, insanity" (2003:245). Overlooking what may be reverse causation for the moment (the derangement of the mind being caused by such corruptions rather than causing them itself), the list includes "eating or drinking bad things," "a failure in the performance of appropriate religious rituals," and "one's reason being devastated by mental anguish" (2003:245). We can observe three unique forms of corruption – that in the realm of ethics, that of deviation from social expectations, and that of personal ability to think clearly (this latter point may have manifested itself in either of the first two, either by leading the person to ingest something he shouldn't ingest or fail to fulfill the community's expectations of him); nonetheless, we can see both

restraint for personal benefit as well as self-control to fit with social norms in the functions of the mind.

Despite the mostly somatic understanding of the mind we have thus encountered, it is important to realize that psychiatry in Āyurveda is discussed in the section on *bhūtavidyā*, which "indicates that, originally, this branch was concerned with disorders thought to be caused by possession by non-human spiritual beings" (Meulenbeld 185). It is not rigorously treated as a major component of Āyurveda, but it is there nonetheless. In line with the overall trend moving from Vedic to classical, in which many diseases began to be reinterpreted as having natural causes in a "process of demystification," insanity started to be comprehended as caused by an imbalance of the humors (Meulenbeld 186). Rather than ascribing insanity to demonic possession alone, Caraka says that "[i]nsanity is of five types such as – those caused by vāta, pitta, kapha, sannipāta [combination of all three] and exogenous" (CS 2.7.3). The latter is particularly interesting because it acknowledges possession by deities as a valid form of insanity even when medicine was becoming increasingly empirical and observation-based. Meulenbeld suggests that this may have been because the Ayurvedic practitioners did not wish "to exclude patients suffering from these disorders from their practice… [and perhaps] did not like the idea of leaving these patients to the care of the exorcists" (186). In this case, the inclusion of possession-based types of madness may indicate a desire on the part of the physicians to assert their authority and expand their sphere of influence in the community. Alternatively, it may have been the case that *āgantukonmāda*, or exogenous insanity, helped account for forms of social deviance that were not explicitly negative or painful, described as mad only for being different from the "norm."[23]

Let us examine, then, passages from Caraka's Compendium that describe the symptoms of madness. Several points will become apparent: symptoms vary according to the *doṣa* that is out of

[23] This forms part of a fascinating discussion of possession into which we will not delve for space constraints. See Fred Smith's massive study for further reading.

control, and they represent a wide range of behaviors, including those that are not threatening per se to other members of society but would be annoying nonetheless, those that are directly threatening to other members of society, and those that would attract harm to the lunatic himself. Caraka begins with the assertion that "[i]nsanity is defined as wandering about of mind, intellect, consciousness, knowledge, memory, inclination, manners, activities and conduct" (CS 2.7.5). This list appears to be a little vague and overly broad in scope at first, but we as a modern audience cannot help but wonder if we could do any better. We merely have to think of all the diverse cases in which we may be tempted to call a person "mad" in order to realize that our list is no shorter – we would call a person a lunatic for making strange sounds in public, for adhering to faulty rules of logic, for taking actions that clearly bring about harm to himself, and so forth. Hence, Caraka also seems to be defining insanity broadly as a collection of non-normative and disruptive behaviors much as we would. Very quickly, however, he describes the particular symptoms with far more precision, such as "foaming of mouth…inopportune excitement…liking loneliness…" (CS 2.7.6:1). This list may have been generated *a priori* by considering socially strange and disruptive actions, or it may have been a compilation of issues pertaining to those first deemed "mad" according to another standard – I am inclined to think the latter was more so the case due to the specificity of the symptoms listed. It makes the most sense to suggest that physicians like Caraka empirically examined their patients who had been considered lunatics already to create a list of abnormal characteristics for easier diagnosis and treatment in the future.

The symptoms depend on the *doṣa* that is responsible for the insanity. For example, *vātika* insanity mostly comprises behaviors that are not dangerous for either the madman or society but could very well be highly disagreeable. Such symptoms include "frequent and inopportune smiling, laughing, dancing, singing, playing musical instruments…longing for non-available eatables while [showing] disregard and strong dislike for the available ones" (CS 2.7.6:1). We may even liken these symptoms to certain behaviors of children that can become frustrating for the adults in charge of

them, such as begging for foods that aren't available and laughing due to insensitivity to the seriousness of the matter at hand. We would not call the children "mad" for we expect such behaviors to disappear with increasing maturity. In this light, *vātika* insanity is characterized by a lack of the maturity we may expect from adult members of the community. The indications of *paittika* insanity, on the other hand, are in fact dangerous for others in society and would have necessitated an imposed restraint for the greater safety. For example, "[i]ntolerance, anger…inflicting injury to own people or others with weapons, brickbats, whips, wooden sticks, and fists…" are clearly deviant actions that pose a threat to the social well-being (CS 2.7.6:2). Finally, *kaphaja* insanity resulted in behavior that wouldn't have been very problematic except to the madman and his close family and friends. The symptoms described in this section give the image of a downtrodden, quiet, and lonely man, such as one who is "[s]tanding in one place, observing silence…frequent[ly] sleeping" (CS 2.7.6:3). There is little reason to believe that these behaviors would have attracted the displeasure of passersby or strangers in the community – after all, such an afflicted man would not have been playing music uncalmly or beating up his neighbors; rather, this madman would have been brought for treatment most likely by a close family member concerned about why the patient was suddenly so reclusive and unwilling to interact with others and help with family chores.

Each of the afflicting humors was understood to cause madness through a somatic, empirically-grounded mechanism, such as "Vāyu [wind] [becoming] aggravated by the intake of rough, deficient and cold foods…"; the "*doṣa*s get vitiated in the person having small proportion of *sattva* (*guṇa*) [pure or good quality] and affect *hṛdaya*, the seat of intellect…" (CS 6.9.5). The three forms of insanity caused by humoral imbalance previously discussed were considered "curable," and an Ayurvedic physician presumably knew the proper prescription of "unction, fomentation, purgation…snuffing, smoking…inhalation of herbal juice…[and] bath" to cure the patient (CS 2.7.8). In case he didn't know from memory the exact dosages and proportions in preparing the mixtures,

Caraka outlines these soon after. The following is an example of a medical preparation to treat insanity among other diseases.

> Undamaged garlic decorticated 200 gm. daśamūla 100 gm. should be boiled in water 5.12 liters remaining to one-fourth. The ghee 640 gm., garlic juice 640 gm. along with the juice of kola (jujube), radish, vṛkṣāmla, mātuluṅga and fresh ginger, pomegranates, surā, curd water and sour gruel each 320 ml. and the paste of triphalā, devadāru, rocksalt, trikaṭu, ajamodā, yavānī, cavya, hiṅgu and amlavetasa each 20 gm. should be cooked. This ghee by intake alleviates colic, gulma, piles, udara, inguinal hernia, anaemia, spleen enlargement, female genital disorders, fever, worms, disorders of vāta and kapha and all types of insanity. (CS 6.9.52-56)

To say the least, Caraka is impressively specific with the proportions of each ingredient, and he assumes a familiarity among other physicians of the technical terms and names of herbs and other ingredients that he uses.

On another note, the notion of words possessing power that we mentioned earlier in the Vedic section in relation to modern talk therapy continues through this period – Caraka suggests that "[a] friend should console him [the lunatic] with religious and purposeful words" (CS 6.9.79). I would suggest that unlike the Vedic incantations, which were intended to dispel malevolent spirits, the mechanism by which words heal in Āyurveda is more grounded in the patient himself without reference to external entities – talk therapy was intended to bring about a moral improvement in the patient's outlook on life and cure him of the mental illness. Among the treatment methods, however, are some that may strike us as rather odd – "frightening, inducing surprise and forgetting, desaturation and blood letting…" (CS 2.7.8). Caraka explains the logic as follows: "[h]e should be terrorised with teeth-less serpent, trained lion or elephant or armed thieves or enemies, or the royal servants should take him out well-tied and terrorise him intimidating to kill by king's orders…[t]he fear of life is above that of the bodily affliction and as such it leads to pacification of the mind deranged wholly" (CS 6.9.84). We can thus assert with confidence that Ayurvedic physicians relied on both somatic as well as moral treatments for their insane patients, suggesting that they recognized a component of each in the causes of madness.

Perhaps a quick aside about physicians' ethical expectations would be helpful after a mention of the violent and threatening treatment methods advised for lunatic patients. Dagmar Wujastyk notes that "Caraka indicates fairly clearly that these threats are just that: the patient is at no time in real danger of losing his life" (2012:138). She follows up with several examples, such that "the snake's fangs should have been removed…[and] it is very unlikely that true criminals were at the physician's disposal…" (2012:138). Hence, she concludes that the threats engaged in lunacy treatment are a form of deception itself, and while Caraka is "demanding honesty of the practicing physician…[he] differentiates between lying and withholding the truth" and speaking truthfully from speaking the full truth (Wujastyk, 2012:133). In this scheme that "reflects a fundamental paradigm of medical paternalism," the physician takes full authority over the lunatic patient and proceeds with a course of treatment in which the ultimate goal, bringing to rest the patient's disturbed mind, justifies a breach of ordinary ethical expectations of the healer. Wujastyk also notes that "the actual mental processes that bring on this change are unfortunately not explained by Caraka," so we must be left to imagine how such treatment would have worked to heal madness (2012:138-9).

Interestingly, deception and the use of threat in treating madness is an instance where Āyurveda deviates from its "explicitly allopathic" approach of treating the cause of the disease with its opposite (Dominik Wujastyk 8). Much like Caraka, Suśruta advises "show[ing] him [the patient] startling things, or tell about the death of one dear to him…[and] intimidate him…with tamed elephants and poisonless snakes."[24] However, "just a few sentences before (Uttaratantra 62.12), Suśruta describes how the fear for one's life, but also the loss of what is dear to one, can be the very causes of madness" (Wujastyk, 2012:139). In this case, Ayurvedic treatment takes a more recognizably homeopathic approach – treating like with like.

[24] Suśrutasaṃhitā Uttaratantra 62.17-21b, quoted in Wujastyk, 2012:139

So far, we have discussed broadly two methods of treatment for insanity in the Ayurvedic tradition – the somatic treatments, such as "garlic juice" and "curd water," and the non-somatic ones, such as "frightening" and "inducing surprise." It appears that these were used in conjunction to treat the insanity caused by the imbalance of *doṣa*s because while insanity was brought into the realm of the "empirico-somatic" (versus the "magico-somatic" in the Vedic period), it was understood to have other, moral dimensions as well. The authority of the physician could overpower the authority of the disease in these cases, hence their classification as "curable" (CS 2.7.9); there were cases, however, in which the insanity asserted its authority even over the physicians. The *sānnipātika* insanity, caused by a "combination of three *doṣa*s," was "said as incurable by the experts," and it appears that some forms of *āgantuka*, or exogenous, insanity were also incurable (CS 2.7.7). Regarding the latter, there was uncertainty as to the true cause of the disease – "[s]ome say the inauspicious action done in previous life [is] its cause…[it] also is caused by intellectual error…" (CS 2.7.10).

It is also evident that such insanity came in three forms according to the "object [of] insaning (*sic*.) by insanity-producing agents – such as violence, pleasure, and worship" (CS 2.7.15). The violent one was incurable on account of incorrigible behavior, such as "enter[ing] into fire…strik[ing] himself with weapon…and tak[ing] other suicidal action" (CS 2.7.15). For the madman committed to taking his own life, there was little that the physicians could do to save him, and Caraka is unclear about exactly which remedial measures were applied. It is possible that the same measures described for the two curable types – "recitation of mantras, wearing of roots and gems, auspicious rites, offerings, gifts, oblations, religious rules, vow, propitiation, fasting, blessings, prostration, visit to religious places, etc." – may have been applied to the violent one (CS 2.7.16). (I say it is unclear because in the section on treatments [CS 6.9.88], Caraka speaks generally about treating "insanity caused by gods, sage, fore-fathers or gandharvas" while in the section on diagnosis [CS 2.7.15], he specifies those remedial measures as applying to the "two…curable ones.")

In any case, this section is most striking for the continuation of the magico-religious elements from the Vedic healing system. In this case, however, they seem to indicate a recognition of the limits of medicine and its physicians working "in this world" and that there were causes of insanity that could not be readily explained in empirico-somatic terms, such as possession by gods, *gandharva*s (celestial musicians), and forefathers. The insanity caused by each *grāha*, or "grabber" (possessor in this case), resulted in behavior pertaining to the characteristics of each, including symptoms that may not appear to indicate anything "wrong" or "undesirable." For example, madness caused by the *gandharva*s manifested itself as "fondness for musical instruments played by mouth, dance, music, food and drink, bath, garland, incense and perfumes, [and] liking for red apparel" among other seemingly benign characteristics (CS 6.9.20). It may be reasonable to believe that such qualities may not have been indicative of madness in and of themselves, but certain people deemed lunatics may have exhibited such characteristics to an unusual degree. Furthermore, if their insanity had not been cured or alleviated by the somatic treatments outlined, these symptoms may have been likened to an external cause, including possessors such as gods and *gandharva*s. Interestingly, each *grāha* was linked to a personality, and a person with such natural tendencies would be more likely to be affected by the respective entity. In the case of the *gandharva*s, for instance, they would "enter into the person who is fond of praising verses, vocal and instrumental music; has liking for other's wife, perfume and garlands…" (CS 6.9.21).

While the majority of the symptoms of madness in classical Āyurveda do carry an obvious negative quality, such as "perverted intellect, psychic agitation…impatience, [and] incoherent speech," we cannot ignore the seemingly positive connotations of certain symptoms of exogenously caused insanity, such as "calm look, serious, unassailable," which were due to insanity caused by gods (CS 6.9.6, 6.9.20). Going back to Meulenbeld's suggestion that exogenous insanity may have been included in the medical texts so as not "to exclude patients suffering from these disorders from their practice," it may have been that the medical practitioners felt compelled to exert authority over a

range of non-normative behaviors, including those that may have felt quite pleasant for the lunatic and were not threatening to other members of society (186). The non-normative in these cases may refer to behaviors that were unusual for that person's established behavioral pattern. Nevertheless, one may point out, for example, *gandharva*-induced insanity results in a fondness for music, dance, and incenses, and the likely victim of such insanity would have been someone who already enjoyed music and perfumes or had that latent tendency. I would suggest that such a person perhaps used to enjoy music and perfumes but still worked as a contributing member of the community. His behavior may have become labeled as insanity when his love for music and incense left him unable to perform the tasks expected of him, at which point his family or close friends would have brought him to an exorcist if they believed he was being possessed. In order to provide treatment to such people, the Ayurvedic physicians may have felt compelled to include a discussion of exogenous insanity in the texts.

With this, let us conclude our section on madness in the classical period with a recapitulation of the most salient themes. First, I would like to clarify that our examination of Āyurveda was limited to the theoretical, text-based system as we did not consider commentaries and accounts of its lived practice. This was partially to fit the scope of this thesis and partially because the texts, not the lived practice, was initially the point of concern for colonial authorities (this thesis takes the colonial era as its primary focus). It is not simply plausible but highly likely that everyday treatments did follow literally from the texts. Physicians likely used a "complex heritage of texts and practices" in their everyday medical roles much like the hybrid that Smith has noticed among Ayurvedic practitioners in contemporary Kerala reportedly "follow[ing] the practices of possession and exorcism outlined in the *IŚP* [*Īśānaśivagurudevapaddhati*, a tantric text]" (544).

Perhaps the most important shift with the advent of Ayurvedic medicine is the medicalization of madness and other diseases into obviously somatic terms. However, we concluded earlier that Vedic healing was, in its own way, somatic. In order to distinguish between these two senses of

"somatic," we used "empirico-somatic" to describe Āyurveda and "magico-somatic" to refer to Vedic medicine. That is, Āyurveda placed the body as central, and most causes of illness were grounded in it, such as imbalances of three humors. Attribution to external possession largely gave way to empirically identifiable causes. In addition, Ayurvedic practitioners adopted an empirical approach to studying the body, the result of which was the complex understanding of channels in the body that transported various substances, including the mind and the humors. This contrasts with Vedic healing, in which the body did not contain within it the causes of illness but rather functioned as a conduit through which external spirits would bring on diseases.

Regardless, possession continued to hold a place in Ayurvedic medicine, possibly because medical practitioners wished to provide treatment to patients whose diseases defeated the established medical knowledge and cures. While affliction by gods, *gandharva*s, and other entities may seem to be a more serious form of madness than one caused by, for instance, an excess of the *pitta doṣa*, this does not necessarily appear to be the case. *Paittika* insanity resulted in behaviors that were obviously threatening to other members of society, but certain symptoms of possession insanity, like a fondness for music and dance, would have done considerably less to harm others and would have probably been pleasant to experience for the patient. Hyne-Sutherland identifies this peculiarity and analyzes it as follows:

> There is a wide range of behaviors indicative of *unmāda* according to this medical text [the Compendium of Caraka], some far more agreeable than others. So much more than "mental illness," *unmāda* can actually be viewed as a condition that, depending on the symptoms, can lie anywhere on a spectrum of well-being, from incredibly impaired to exhibiting super-human traits. Certain stereotypical features occur in more than one definition – incoherent speech and excessive laughter, for example – and some are more specific, such as the *gandharva* type having an affinity for music. The condition *unmāda* was, in some ways, defined as a very positive experience…To an extent, even the *gandharva*-subtype seems to describe a largely positive experience…After all, even the positive symptoms would have impaired a patient's ability to function in a normal way, in accordance with social roles and expectations. (91-92)

The key, then, to understanding *unmāda*, madness, in Āyurveda is examining deviance from established norms, both social and personal, rather than conditions of derangement or painfulness.

Interestingly, this theme underlies even our present-day usages of the word madness – the ever-popular "madly in love" makes the point quite well. For the person who is "madly in love," the experience of the "madness" is probably one of ecstasy and ebullience of joy. Others may call such a person "mad" because his excessive love keeps him from fulfilling his duties and expectations, such as forgetting about important work meetings because of thinking about the next date night.

Finally, it is important to realize how long Āyurveda has endured – the core texts were written in India around two thousand years ago, give or take five hundred years, and Ayurvedic knowledge is being incorporated into medical repositories all over the world.[25] Part of the remainder of this thesis will explore the journey of Āyurveda as it modernized and faced other medical systems, such as that of Western biomedicine brought by the British.

[25] See Fincher viii

THE INSTITUTIONALIZATION OF MENTAL HEALTH CARE

The institutionalization of mental health care at the hands of the British was one of the most important historical markers for mental health treatment in the Indian subcontinent for the complex issues of racism, classism, and colonialism that it raises. One could look at the lunatic asylums established in the late 1700s onward as the zenith of the irony of British colonial rule, or one could see them as a social experiment, a means to enforce the hierarchies of race and class that the Raj brought with it, keeping in mind, however, that it would be simplistic merely to posit the "colonial elite" in opposition to the "exploited natives" (Ernst, 1991:8). Never quite a static phenomenon, the asylum system changed over the nineteenth century as the tensions and contradictions between social protection, personal greed, and colonial authority shifted one way or another. The most comprehensive study on this particular chapter of the Raj was undertaken by Waltraud Ernst. Her book, *Mad Tales from the Raj*, which focuses on the insane in India from 1800-1858, will be the primary source of material for my discussion.

Since the asylums were a product of the British community in India, it would be natural to ask about the composition and role of this group. When the British East India Company took over rule of the subcontinent in 1757, a small but powerful British community resided at major company centers, including Bombay, Madras, and the capital at Calcutta. Strictly speaking, these expatriates were not colonizers in the sense that the word is used to describe European colonies in the Americas. Many of the British in India considered India to be "the land of hopes and dreams" where they could one day make a fortune to take back home to England (Ernst, 1991:10). Especially since India was a temporary residence rather than their future home, the community remained tight-knit and largely distanced from the native Indians ("natives" to use Ernst's term; I opt for "locals"). The asylums reflected these characteristics woven into the fabric of the British – a desire to emphasize European superiority, a need to separate the higher-class members of society from the lower-class counterparts, and the promise of making a quick fortune. At the same time, the institutions exhibited

the compromise between such attitudes and the humanitarian motives that one would expect to underlie the provision of health care.

My discussion of this pivotal chapter in Indian medical history will proceed according to the following general outline: the European medical professionals in India, the theories motivating the lunatic asylums, the institutions themselves along with the patients maintained there, and the politics surrounding the system. As a word of caution, many of the "medical doctors" referred to in this section were British doctors practicing in India, not ethnically Indian doctors.

The first half of the nineteenth century dramatically altered the perceptions, reputation, and role of the medical profession in India. Broadly speaking, it transitioned into a legitimate career from a money-making opportunity fraught with embezzlement and suspicion. The "mad-doctors," so to speak, faced a steeper path to legitimacy than their fellow medical professionals since "[t]hose who dealt with the mad, treating or caring for them, tended to a certain extent to share the stigma that was bestowed upon their charges" and since psychiatry was a marginal specialization within medicine (Ernst, 1991:89). Even medical colleagues would consider the mad-doctors substandard for specializing in an unfounded branch of science.

Doctors in general held a tenuous reputation with the public due to the numerous shady incidents that occurred and the subsequent rumors spread. Graphic imaginative accounts such as butchers receiving a surgeon's certificate are testament to the distrust of medical professionals,[26] and while exaggerated, they do at least suggest systemic inappropriate use of authority. In fact, Ernst writes that appointees for a surgeon position were "frequently not so much fulfilling a position as a medical officer [since they desired] the potentially large fortunes that could be made in the East" (1991:92). In fact, one of the most frowned-upon sources of income was the exploitation of hospital

[26] See W.B. Beatson, 'The Indian Medical Service, Past and Present', review in *British Medical Journal*, 2, 1902, p. 1182, quoted in Ernst, 1991:92fn5

contracts. It was part of the surgeon's duty to care for his patients by providing them sustenance, garments, and other basic needs.[27] However, there was little to stop the surgeons from pocketing a few of the provisions for the sick along the way, which took its toll on the patients.

Several events in the early nineteenth century remedied this issue by raising the barriers to entry into the medical profession. For example, beginning in 1822, candidates were required to have a diploma from certain surgery schools,[28] and 1855 brought competitive exams that solidified the medical profession as a legitimate career rather than a sneaky and dishonest profit venture. Despite such changes to the medical profession generally, psychiatry, or rather the treatment of lunatics as it was probably better understood at the time, remained marginalized for good reason. For example, the Beardsmore incident, which highlights the tensions between the medical board and the private madhouse owner (who was not, by any means, qualified or knowledgeable in medical practice), "was a challenge to the board's authority…[by] [t]he very fact that a medically unqualified individual with a lower-class background was allowed by the Company's authorities to manage an institution" (Ernst, 1991:95). Hence, members of the medical board worried that doctors of the mad threatened the foundations of their authority and legitimacy, and lunatic asylums were little recognized with few, if any, interest groups to represent their unique interests.[29] Remember that the doctors and professions we have been discussing refer to Europeans, not ethnic Indians. It would be until about 1855 before Indians were accepted into higher ranks of the medical service.[30]

While these general changes were taking place within the British Indian medical community, a more significant shift was occurring with the way madness had been understood. Ernst refers to this as the "medicalization of madness" over the first several decades of the 1800s as mental health treatment gained recognition as its own specialty within medicine (1991:101). It is important to note

[27] See Ernst, 1991:93
[28] *Ibid.*, 96
[29] *Ibid.*, 97
[30] See Ernst, 2014:1

that this is not the first time mental illness is recognized as a unique malady. Rather, this can be seen as the first time (within the British Indian context) that the *treatment* of madness is recognized as deserving its own attention and specialization. Ernst expresses the shift as follows:

> When in 1856 Dr J. Cantor was finally authorized to take over the charge of the Beardsmores' asylum, the seal of medical supremacy in the treatment of the insane in British India's main centres was set. However, only slowly was the care for the mentally ill to become universally acknowledged as an area of medical science requiring specialist skills. Cantor's appointment could nevertheless be seen to mark a movement away from the conviction that the care of the mad was merely a 'difficult' and 'peculiar' task, to the opinion that the mentally ill could only be looked after by specialists with broad medical qualifications. (1991:101)

This process of medicalization was received unevenly with some medical professionals under the impression that "a knowledge of the nature and treatment of Insanity is now expected of every well-educated man"[31] while others expressed two decades later that the average medical professional showed little additional knowledge of the methods of treating the insane than the general public.[32] In any case, a discussion of the medicalization of madness raises the question of the somatic and moral dimensions of madness. I would assert that the process by which madness gained more recognition in the medical world did not fundamentally alter the somatic understanding of madness that already existed. In the classical Ayurvedic context, it is evident from the earlier chapters that madness was understood in largely somatic terms; even with British doctors in India, madness was indeed conceived of as primarily an affliction of the body. Thus, there was the underlying assumption that medical doctors could treat madness. While the somatic conception of madness didn't change over the early 1800s – madness remained fundamentally a disease of the brain[33] – it became recognized as a separate discipline within medicine deserving of its own treatment methods and certification.

[31] See J.C. Bucknill and D.H. Tuke, 1858; J. M. Granville, 1877; cf. Scull, *Museums of Madness*, p. 166, quoted in Ernst, 1991:101fn26
[32] *Ibid*.
[33] See Ernst, 1991:103

Nevertheless, the justification for a specialized, somatic approach to madness found challenges, notably with the Tukes, Quakers in Britain who subscribed to a "doctrine of 'moral therapy'" to treat madness (Ernst, 1991:102). Understanding lunatics to lack self-restraint and control, they advocated for "kindness and moral education" to treat lunacy and gained great prestige for the success of their methods (Ernst, 1991:102). This presented a challenge to both the medical doctors treating the mad as well as the medical boards in general. After all, the medical professionals could not claim to produce the high recovery rates that the Tukes could, challenging the idea that somatic medicine was best suited to treat madness and the underlying assumption that madness affected the brain. This naturally threatened doctors' reputations, theories, and of course, incomes.

We will return to the Tukes again in a discussion of the philosophies that influenced the understanding of lunatics as socially deviant human beings. Before touching on that topic, some words ought to be said about the relationship between the British treatment system and Ayurvedic medicine. An imperialist state brings with it an ideology of superiority over its subjects and nearly every dimension of their identities. Indeed, the "great colonial medical myth…[saw] [t]he medical doctor…[as] a major pillar of European colonial ideology in that his services for the good of humankind were seen to legitimate foreign rule and to serve as proof of the unquestionable superiority of western civilization in general" (Ernst, 1991:111). Though interaction between the two systems was limited, folk medicines, such as temple healing, pandits, and pujaris, needed to be subordinated in order for the British to maintain colonial order. It would be interesting to examine the difficult question of whether, at this time, the medical boards and doctors sought to learn about Āyurveda before condemning it or if their distaste was motivated internally by the idea that the medical system they brought and practiced was superior by virtue of its being a product of western civilization.

In either case, it would suffice to say that British medical boards in India felt a strong conviction that European medicine was superior to that offered by local Indians, even though

European doctors were occasionally confronted with evidence that Indian practitioners prescribed effective remedies.[34] In this capacity, one can sense a feeling of threat underlying the attitudes against Indian medicine, and reports of Āyurveda's effective remedies "tended to fuel the ever-growing hostile response towards them" because they made western medicine appear less formidable than the colonial state would have liked (Ernst, 1991:105). Unsurprisingly, the opinions towards local medicine fell in line with the generally racist understanding of Indians woven into the fabric of the Raj, and Indian practitioners received worse treatment than the mixed Eurasians, who were already considered beneath the Europeans.[35]

One can discuss the guiding philosophies of the asylums in two contexts: the treatment approaches and the political ones. Here, I would like to address the motivations behind the variety of treatment methods. As a word of caution, it should be noted that for much of the earlier part of the nineteenth century, notions of individualism rooted in the philosophical writings of Locke, Hobbes, Pinel, and Esquirol contributed to the imprecise and inconsistent application of terminology, especially concerning the treatment of the mad. From our earlier mention, consolidation of lunacy treatment did not come until the middle of the 1800s. As a result, "[i]t would therefore be an attempt doomed to failure to postulate anything like an 'authoritative definition' of *the* contemporary concept of insanity" (Ernst, 1991:134).

With this in mind, we can analyze treatment methods as an interplay between somatic ideas and moral ideas. It is important to realize that in general, a given doctor's methods did not derive solely from any one philosophy; rather, his approaches blended (rather imperfectly) various theories about the origins of madness. One such guiding principle was a theoretical distinction between the "mad" and the "idiots," which was hardly useful in practice for appropriately categorizing patients. Where idiots were understood to be beyond cure due to bad reasoning, the "mad" were seen to

[34] *Ibid.*, 104
[35] *Ibid.*

reason correctly but from false premises. Evidently, there was an assumption that false premises could be corrected, but improper reasoning was hopeless. Funny enough, one could call the British in India generally "mad" by this definition – reasoning correctly from false premises. The colonial agenda was based on a false premise of racial and cultural superiority but then used proper reasoning to find ways of asserting the dominance of the "superior" Europeans. In any case, the madness was ascribed certain causes, many of which concern an exposure to the new and discomforting situations. For example, the fear of being caught by a tiger, sudden fright, and exposure to a new, tropical climate[36] were cited as reasons for madness. Nevertheless, the ascribed causes rarely changed the course of treatment, but they did engender an attitude of sympathy rather than blame towards the madmen.[37]

In addition to the Lockean distinction between the "mad" and the "idiots," non-medical approaches included the "moral therapy" of the Quaker Tukes as well as the "non-restraint" of Hill and Conolly. The language of these systems "assumed centre-stage in official reports and regulations" over the medical theories primarily advocated by members of the medical boards (Ernst, 1991:134). Hence, a clear tension existed between the Company authorities, who found the success of the non-medical approaches alluring in the larger interest of treating the mentally ill for both their own good and the greater social order, and the medical practitioners, who were forced "to provide medical reasons for unreasonable behavior if they wanted to maintain their public and self-image as knowledgeable experts" (Ernst 147). Whose legitimacy won out is not an easy question as doctors often blended the non-medical theories into their existing medical practice, and the overlap points to the ultimate futility of clinging to such rigid categories as "medical" and "non-medical" though they can be of some use for the present purposes. Dr. W. Cambell of Bombay serves as a prime example. Incorporating Dr. John Brown's theory of most diseases resulting from an excess or deficiency of

[36] See *Pembroke House*, Med Cert, 1818-1892, quoted in Ernst, 1991:146fn30
[37] See Ernst, 1991:41

irritability, he used medical means such as narcotics to bring lunatics into contact with the pleasurable and the good while shielding them from the irritable.[38] In essence, regarding the treatment of the mad in the first half of the nineteenth century in British India, we can observe a balancing act on one level between the authorities of somatic and moral conceptions of madness and on another level between the authority of the Company directors, who found the success of moral treatments promising, and the medical professionals, who desperately tried to give medicine a reputable name in lunacy treatment because their own reputations and incomes hinged on it.

This would also be an appropriate place to point out that the British doctors' treatments combining a moral theory with somatic treatments mirrors in some ways the Ayurvedic system from our earlier chapter, the very system against which the British doctors rallied. Though primarily somatic, Ayurvedic medicine took a strong moral approach at times; our reader will recall the purposeful and spiritually uplifting words prescribed by Caraka (along with the occasional threat in dire situations) to supplement the multitude of herbal remedies described in the texts.

Earlier, we mentioned that it would be misleading to say there was one established and universally accepted approach to treating madness within the British medical community. Indeed, the unevenness applies just as well to the asylums across the subcontinent at any given point in the early 1800s as well as to the conditions of the asylums generally over the course of the 1800s. The story that emerges is one of frequent change within the asylum, caught between various private and public incentives, against the backdrop of an unchanging, hegemonic symbol of the asylum throughout British India. We will discuss three major asylum centers: Bombay, Madras, and Calcutta, with a special focus on the latter. Note that there are few data available to derive an accurate image of the rates of mental illness in the general population and fewer data still for the percentage of those institutionalized in the asylums. Especially when asylums held minor significance compared to jails

[38] See Bm Med B to Govt, 24-5-1853, quoted in Ernst, 1991:135fn6

and hospitals, institutionalization for mental illness affected a very small percentage of the population. An additional challenge comes with the fact that treatment of mental illness was traditionally the charge of family and friends, at least for the Indians, and many families would hide their lunatics from the public for fear of a tainted social image. Finally, street lunatics, at least in Bengal, would frequently be sent to jails or hospitals instead,[39] possibly due to the high cost of the asylums.[40] As such, the asylums are not significant so much due to the number of people affected but rather because of their symbolic importance, an idea we will return to towards the conclusion of this section.

With that being said, the asylums in India can be thought of as part of a social experiment beginning in Britain and evolving to meet the demands of philanthropists and human rights advocates. Hence, it would be a mistake to think of the asylums as a tried and true method of controlling socially deviant behavior since they, like the European hospitals Foucault analyzes, are "a quite new form, virtually unknown in the eighteenth century, of institutional spatialization of disease [madness in the present case]" (20). In his analysis of the European context, the family is "[t]he natural locus of disease [and also] is the natural locus of life" as opposed to the hospital, which is an "artificial locus" (17). The larger idea is that the asylum at this time (early 1800s) was still a relatively new institution that reorganized traditional treatment channels even in England. British asylums in India were more or less modeled on European ones but with "concessions…made to local climactic factors, and, what is more, the quality and comfort of premises [that] varied considerably according to prospective inmates' race and social class" (Ernst, 1991:68). Despite their prohibitively high costs, they were seen to serve two very important goals: "the protection of the Public on the one hand, and the relief of the most unhappy Class of human beings on the other."[41] The result was nothing consistent across India: the Bombay asylum was secluded and constructed in a horseshoe design that

[39] See Ernst, 2006:61
[40] See Ernst, 1991:61
[41] See Bg Jud D, 25-4-1806, quoted in Ernst, 1991:61fn14

made surveillance and maintenance efficient, the Madras asylum was shabby and resembled inferior army barracks, and the Calcutta asylum looked more like a city office that would be used to control the city, not its madmen.[42] However, this would change over the next fifty to sixty years with the general move towards standardizing mental health treatment according to policies made in England.

Most of the asylums in India also began the nineteenth century in the private hands of medical officers. We already mentioned that medicine was seen as a lucrative profit venture at this time, so imagination alone would suffice to suggest the detriment of the patients under the "care" of the madhouse owners. For example, officers would submit high provision bills to the board under the pretense of providing proper food and supplies for the patients, but even the Medical Board was not blind to the small quantities of food actually provided to the patients, concluding that "there was too much reason to believe that, on some occasions at least, the health and life (of the patients) was sacrificed for the avarice of the Surgeon."[43] As a quick note on scope, the Calcutta asylum in 1817 confined only about thirty to forty patients; as discussed previously, the asylum was not particularly significant for the number of people it affected in its dire conditions.[44] Nevertheless, the abuses of the asylum system did not go unnoticed, and one of the most important ways of increasing scrutiny and consistency was to place them into public hands instead.

Madras and then Bombay were the first to de-privatize in 1808 and 1826, respectively, in order "to have a medical officer who had no financial interest in the running of the institution take charge of the asylum's management" (Ernst, 1991:69). Only Calcutta remained in private hands until rather late, and it was owned by the same family from 1821 until 1856.[45] One can sense a desire to care for and prevent abuses to the madmen behind this shift since it was motivated primarily by the injustices of the private madhouse owners against their patients, which aligned with the goals the

[42] See Ernst, 1991:68
[43] See IOR: Bg Mil D, 8.4.1816, 2, 12, quoted in Ernst, 2006:51
[44] See Ernst, 2006:50
[45] See Ernst, 1991:69

Court laid out as mentioned above. However, this presents two issues: for one, "whether an asylum was privately or publicly owned did not by itself determine conditions inside the institution, nor did it guarantee its cost efficiency" (Ernst, 1991:69). In fact, though publicizing the asylums did increase financial and management oversight, it also contributed to deteriorating quality of care, especially for lower-class patients.[46] Once again, we can observe a clash between the legitimacy of the medical board and the ultimate authority of the asylum doctors as the arbiters of mental health care.

It is impossible to miss the obsession with separating asylum patients by race and class, which became pronounced over this same period and whose effects can be felt even into the present day. Given that the British strongly wanted to distance themselves from the Indian subjects they ruled, it would be surprising indeed if the asylum were to be a point of unity between the races and the classes. The cleavages were most evident in the Bengal asylum, to which we will turn now. My main source material for this discussion will be Ernst's paper, "Lunatic Asylums in Bengal."

The Bengal asylum, compared to that in Bombay or that in Madras, was particularly segregated by race; in fact, Indians and Europeans were placed in separate institutions altogether, not simply in different corners of the same building.[47] The logic behind it seems straightforward enough – racial divisions in the asylums, especially in Bengal, mirrored the colonial separations that determined eligibility to participate in the government and other powerful activities. Indeed, Bengal was particularly notorious for separating "persons with 'European habits' from 'Natives'" (Ernst, 2006:74), so the asylum there naturally had relatively stronger racial divisions. Unsurprisingly, the inferior treatment, particularly in the form of meager food rations, went to the Natives.[48]

What is not as apparent immediately is why the British would need to or want to separate based on class. The first reason, certainly the more superficial one, is the question of the Eurasians –

[46] *Ibid.*, 71
[47] See Ernst, 2006:73
[48] *Ibid.*, 65

the "unwanted side-effects of what was perceived as overly close British-Indian relations."[49] Because they belonged neither with the Europeans nor the Indians and could be looked down upon by both groups (especially if they were poor),[50] the factor of class was used to admit them into the asylums. The more profound reason is the attitude of the British toward their own paupers, madmen, and other "low-brow" people and their relationship to the colonial objective.

As with any ruling or dominating group of people, the British needed to maintain a very formidable self-image, and evidence to the contrary would undermine their colonial government's authority. Hence, the ruling elite were particularly concerned about their own lower-class members and felt a strong need to conceal their existence from the Indians. This naturally translated into using class as a factor in asylum admission, and British madmen (especially if they were lower-class) would be repatriated at least once a year[51] in order to keep them away from the Indian public eye. Once again, it should be noted that in terms of absolute numbers, this phenomenon was not particularly significant as the European asylum in Calcutta held around a hundred European inmates around the late 1850s, and Madras and Bombay held a tenth of that number.[52] However, it is important for the larger attitudes of colonial rule that it suggests.

On the issue of race, I would like to take a moment to focus on the European asylum population because within it, a significant divide existed between the experiences of the military personnel and the civilians. For lunatics from the military, who made up the majority of the European asylum population, "[c]onfinement in the madhouse was in many cases merely one step amongst several in a sequence of institutionalization" (Ernst, 1991:120). For example, military asylum

[49] See K. Ballhatchet *Race, Sex and Class. Imperial Attitudes and Policies and their Critics, 1793-1905* (London: Weidenfeld and Nicolson, 1980). Christopher Hawes, *Poor Relations. The Making of a Eurasian Community in British India, 1773*-1833, (Richmond: Curzon, 1996), quoted in Ernst, 2006:75fn122
[50] See D. Arnold, "European Orphans and Vagrants in India in the Nineteenth Century," in *Journal of Imperial and Commonwealth History*, vol. 7, 1979, 106-14, quoted in Ernst, 2006:75fn123
[51] See Ernst 1991:56
[52] See W. Ernst, *Psychiatry and Colonialism: The Treatment of European Lunatics in British India, 1800-1858* (University of London, School of Oriental and African Studies: unpublished PhD thesis, 1986), quoted in Ernst, 1991:56fn1

patients had often been transferred between military duty, the hospital, and the prison, and their repeated institutionalization was frequently a result of rigorous oversight and monitoring. Civilians, on the other hand, often ended up in the asylums because they lacked a strong network of family or friends who could assume responsibility for the patients' deviant behavior.[53] Hence, even within the European asylum population, the asylum held different significances for different groups: in the case of the military members, the asylum was part of a network of institutions committed to controlling and concealing nonconforming behavior that would make the British appear weak of mind or behavior. Conversely, the asylum served as the recourse for mental health care for the European civilians who had no care network otherwise. The tension between institutionalization due to care and support versus the lack thereof will resurface in our discussion of the contemporary Indian context using Sarah Pinto's ethnography. If nothing else, this suggests at least that the asylum cannot be simply reduced to a symbol of colonial oppression and control but rather served several crucial functions with respect to different populations.

We have mentioned several times that the experience of mental health treatment depended not so much on the medical board's guidelines or ideals but rather the approaches of individual doctors, and the Bengal asylum is no exception. By doctors, I should clarify that I mean asylum superintendents, who "determined the extent of comfort and care provided for inmates" (Ernst, 2006:64); Indian sub-assistants were responsible for implementing the decisions of the superintendents. In terms of power structure, the superintendents were European surgeons or assistants responsible for the administration of a wide geographic area; as such, they could not possibly spend most of their time working in the asylums themselves. However, by single-handedly deciding on food and other provisions for the asylum inmates, they were primarily responsible for asserting colonial power structures concerning mental health treatment[54] and could quite literally

[53] See Ernst, 1991:122-123
[54] See Ernst, 2006:64

choose whether patients lived or died since death patterns closely followed dietary adjustments[55] (reduced diets clearly led to more deaths). While many a superintendent's choices did have deleterious effects on the patients, such as in the cases of Surgeon G. Paton[56] or Dr. Payne,[57] there were occasionally doctors who prescribed more salubrious regimes, such as Dr. J. Sutherland.[58] This may be because of the unusual affection he held for his patients, taking care to learn most of their names and personalities.[59] In this capacity, the asylum superintendent was the arbiter of colonial authority, and more often than not, his powers were not used to truly care for the patients.

On the topic of race and class, one quick note ought to be mentioned. The standard narrative suggests a hardening of racial attitudes over the course of the 1800s due in large part to the Sepoy Mutiny of 1857 and the subsequent takeover of the government by the English Crown in 1858. Ernst, however, suggests the opposite pattern may have been at play. She cites the example of the Begum of Mysore,[60] who was a "native" admitted into a European asylum based on high social standing. This would suggest that the Raj was more concerned with social image than racial purity, which is not senseless based on the previous discussion of British attitudes towards the European poor and mad. Most likely, the Begum displayed behavior that was in line with British ideas of "proper," hence her admission into a superior asylum. Underlying this may be the notion that even Indians could outgrow their supposed inferiority to an extent with British manners and customs.

At this point, we have developed in detail an understanding of the system of asylums that the British introduced in colonial India. I would like to reiterate and contextualize several key themes throughout the history of the asylums over the course of the 1800s. To begin with, the superficial purpose of the asylum was to treat those displaying madness, where "madness…is behavior that

[55] *Ibid.*, 64
[56] *Ibid.*, 65
[57] *Ibid.*, 70
[58] *Ibid.*, 71
[59] See *Annual Report of the Insane Asylums in Bengal for the Year 1863*, (Calcutta: Bengal Secretariat Office, 1864), quoted in Ernst, 2006:71fn107
[60] See IOR: India Pol D, 19.8.1857, 54, quoted in Ernst, 2006:76

deviates from some posited norm…behaviors and experiences that [are] perceive[d] as abnormal" (Hyne-Sutherland 10). In other words, the asylums served to control socially deviant behaviors. However, the asylum in its incipient stages was motivated more profoundly by two factors: a widespread understanding among the British of their own cultural "superiority," and the promise of making quick money as a surgeon or asylum doctor in British India. The notion that India needed civilizing and westernization to outgrow its "pre-European…despotic rule and barbarism" served as a basic British assumption (Ernst, 1991:17). However, lunacy policy naturally came to reflect the diversity of personal ideological positions among the officers in India. For example, Lord Falkland supported ample investment in asylums and mental health provisions due to his "humanitarian"[61] attitude while others found his proposals spending money on less necessary systems. In addition, the Utilitarianism of James and John Stuart Mill found expression in the building of a large-scale asylum in Bombay in place of several patchy ones in 1820.[62] Even the treatment that patients received varied principally on the attitudes of the superintendents in charge, who set food and provision quantities. The larger idea is that the first half of the nineteenth century saw a great diversity of thought and approaches to the asylums.

When we assert that the asylums served to control socially deviant behaviors, we can identify two senses in which they may play this role, according to Hyne-Sutherland:

> [W]e can distinguish two different frameworks on opposite ends of a spectrum for describing what madness is. Most definitions will not engage solely with one framework or the other, but rather lie somewhere in the middle…When one chooses to define madness through the assumption that the condition is synonymous with the person who has it, as in the case of "mentally ill person" and *unmatta*, it is frequently the case that the purpose of the definition is to establish the relationship of the person to society in general…The alternative is to choose to define madness as a separate entity, one that someone can have or show signs of, but not something that fundamentally defines who they are *vis-à-vis* their family or society…[T]he choice of framework depends on the function of the definition: if the definition serves to protect the social body and maintain the status quo, it is frequently the case that an identification of a person with madness is sufficient…On the other hand, if the definition

[61] See Ernst, 1991:19
[62] *Ibid.*, 21

> serves to protect individuals to whom madness is ascribed – to legislate rights for them or to cure them from illness – then there is a separation of the person from the problem. (99-101)

This distinction is important because it helps us assess the congruency between the intentions of the British in establishing the asylums versus the actual treatment provided there. We mentioned previously that both public protection and patient protection were goals of the British asylum system,[63] so it may appear as though their framework fell in the middle of the spectrum described above. However, I would argue that at the core, the British tended to see lunatics as identical with their madness such that in order to control the insanity, they needed to control the lunatics. The absence of formal legislation protecting the rights of the mad and the absence of standardized, salubrious treatment approaches combined with the fact that treatments rarely depended on the cause assigned to the madness suggests that the illness was not distinguished from the person whom it afflicted. Put another way, curing patients may have been the ideal for higher level officers and the medical boards, certainly in part because the reputation of the boards depended on curing patients (with the understanding that what it meant to "cure" a mental patient had no consistent meaning).

However, the image of the asylum that we have based on Ernst's research points to the opposite reality – asylum superintendents were notorious for pushing their patients to the limits of what their bodies could handle, often resulting in patient deaths. Joined with the basic assumption of madness afflicting the brain, the central organ controlling behavior, it seems unlikely that a significant number of doctors would have considered the madness separately from the patient. Furthermore, the passing around of European military lunatics from one institution to another gives no reason to believe that their madness was singled out for treatment in a mental health facility; rather, the fact of their socially problematic behavior was the key, so it made little difference in a sense whether such patients were confined in a prison or asylum. Such evidence leads to the

[63] See Bg Jud D, 25-4-1806, quoted in Ernst, 1991:61fn14

conclusion that the British asylum agenda was primarily about protection of the society and the status quo and not about alleviating affliction for the patients or their families. Viewed in this way, the authority of society generally to impose its dominant order superseded the authority of those in charge who may have truly wished to provide for the patients' benefit.

The mid-1850s nevertheless represent an important shift with the de-privatization of the major asylums and close supervision of conditions in accordance with the Indian Lunatic Asylum Act. Even though the Act "aimed at preventing one of the threats most dreaded by the Victorians: wrongful confinement," it did not substantially alter the relationships established between the patients, mental illness, and society (Ernst, 1991:45). Even through the 1987 passage of the Mental Health Act, the fundamental public security approach to madness still would not be altered.[64]

Perhaps the greatest significance of the asylums, however, is their function as a medium of colonial power. While Ernst would caution us from the "generalizing assertion that 'medical power' and 'colonial power' worked hand in hand," I would declare that these two forces did indeed work together, though perhaps not in all cases (2006:73). On one level, the asylums, which were themselves a sort of work-in-progress through the 1800s, can be counted along with other institutions like schools and jails as symbols of British superiority over "native" Indians. The mere existence of such "brick-and-mortar manifestations of British patriotic pride and self-satisfaction [that were] intended to be awe-inspiring to the indigenous population…was one of *the* proofs of moral and social progress and of the superb character of western civilization and rationality" (Ernst, 1991:64). Even though the asylums did not affect very many people in terms of absolute numbers, the symbolic power they had over the Indians was enormous, and their existence reinforced a positive feedback look of British ethnocentrist attitudes. For example, however controversial the asylums and medical doctors were internally, the colonial elite could still marvel at their

[64] See Hyne-Sutherland 162

constructions as examples of the humanitarian work being done by British hands (I say "internally" to mean within the British community since several groups, like the Tukes, found the medical approaches to madness useless in favor of moral therapy methods). This contributed to a further strengthening of the British self-image, which further justified such costly ventures.

Finally, the asylums represented the British colonial response to the pathologizing of socially errant behaviors – by considering the mental illness as practically synonymous with the patients, the answer became a type of "out of sight, out of mind." Especially in the case of the European lunatics, the colonial rulers had a vested interest in hiding the lunatics from the general public so as to preserve the image of the British as a formidable government. The structure of the asylums mirrored this desire because many of the asylums would be located outside of main city centers and out of the public eye. The haphazard approach on average to treating mental illness, certainly prior to the 1850s, suggests that curing the disease itself was not the primary concern but rather the suppression of unwanted behaviors in whatever form necessary.

THE ADVENT OF A COLONIAL FRAMEWORK ON MEDICINE

I would like to suggest now a temporary departure from the treatment of mental illness and the asylum system as we move into the early 1900s to revisit Āyurveda and analyze how it was affected by colonial rule since a significant portion of our earlier discussion of mental illness and its treatment was under the umbrella of Āyurveda. Understanding the ways it was shaped by colonialism will help provide context for present-day medicine and treatment of mental illness in India. What we will find is that British disregard for Ayurvedic medicine did not erase the tradition but rather contributed to its revival decades later in certain ways. The majority of my discussion in this section will be based on Rachel Berger's book titled *Āyurveda Made Modern*.

Several noteworthy trends surface as we examine the pressures Āyurveda and its practitioners faced with the advent of Western biomedicine. First, the question of theory versus practice is raised since Ayurvedic knowledge was traditionally maintained in Sanskrit,[65] yet the day-to-day administration of Ayurvedic treatments involved little interaction with the Sanskrit texts themselves (by this time, we have evidence that the practice of Āyurveda was not correlated exactly with the texts, and quotidian treatment would have used vernacular languages). Second, a vital question of authority emerges as several groups attempted to lay claim to Āyurveda and its fate. Finally, the politicization of Āyurveda takes on new forms as great efforts are undertaken to understand the proper role it should play in the medical scheme of the colonial government. My approach through this, consistent with the rest of my thesis, will be primarily analytical. Hence, I do not venture to construct a detailed historical account of the developments in Ayurvedic medicine. As a result, the facts presented may appear patchy and disjointed. The purpose is to engage them in a discussion of power structures and pressures on the existing medical framework.

[65] See Berger, 2013:31

That said, I would like to first clarify some terminology used above, namely "biomedical" and "biomoral." Throughout the colonial period, Western medicine is cast as "biomedical" while Āyurveda is seen as "biomoral" (at least according to Berger's study and sources). These terms, though they appear rather innocuous on the surface, convey a fair bit about the imperial conception of Indian medicine. In general, as we have seen already, the British colonial mindset was one in which they located themselves at the center of progress. Hence, the "moral" undertones of Āyurveda, especially among British medical doctors, implied that the medical tradition had strong connections to local spiritual traditions and could be tainted by fields and phenomena other than pure medicine or science. The notion that Āyurveda was ultimately not based on the same principles of logic and reason on which Western medicine was grounded "mov[ed it] firmly out of the scope of rational medicine" (Berger, 2013:24). It was thus assumed to be "inappropriate and unreliable in the context of medical modernity" (Berger, 2013:24). For example, in 1916, the government asked the chief medical commissioner in each province about the condition of local medicine in order to determine if the practitioners and institutions should receive government aid. The chief commissioners responded by urging the government to withhold funding since "Āyurveda…fundamentally lacked awareness of surgery and of the circulatory system [and] practitioners lacked training and…practice could not be standardized" (Berger, 2013:71). What the commissioners seem to have been wanting was a medical system that was conceived in the same terms as the system with which they were familiar. Upon finding Āyurveda to be radically different (Āyurveda did not speak of the circulatory system as such but nonetheless had been treating Indians for centuries) and relatively regionalized, their immediate reaction was one of dismissal.

This underscores an interesting point about the way the British imperialists recognized Āyurveda. Among their ranks, individuals like Sir William Jones "lauded [Ayurevda]…as a key area of

Hindu philosophy and history,"[66] going on to explain how the medical knowledge was delivered to humans by Brahmā and other deities with the "practical methods of curing diseases."[67] This unmistakably positive description appears to be at odds with the understanding that Āyurveda was "backwards" in its approaches and not founded on "true" science. Indeed, it may be that Jones was in a minority group given his particular designation as an Orientalist. Nevertheless, it is at least consistent with British exoticization of foreign cultures, which manifested itself in several forms, including the picturesque movement concerning visual art, sculpture, and music.[68] Such descriptions, though positive, often turned a blind eye to the particular cultural contexts of the artifacts and concepts examined. With the present case, Āyurveda may have seemed fascinating to the Orientalist crowd. However, it was largely regarded by the Indian Medical Service[69] as foreign and "defy[ing] categorization with no serious bearing on health care" towards the beginning of the twentieth century, roughly until the 1920s (Berger, 2013:74). Whatever categories were employed oversimplified the picture. For instance, in the context of collecting demographic information about the Indian population governed by the colonial power for uses beyond just medicine, the Raj "impos[ed] rigid colonial categories of personal and group identification [that ran] contrary to the complex processes of claiming identity and negated the possibility of intersectional identities in favour of a primary designation such as 'Brahmin' or 'Tribal'" (Berger, 2013:52).

[66] *Ibid*., 42-43
[67] See Jones, 'On the Literature of the Hindus, from Sanscrit, communicated by Goverdhan Caul, with a short commentary', 340, quoted in Berger, 2013:43fn77
[68] See Mavis Batey's article, "The Picturesque: An Overview" for further discussion of the picturesque movement in England.
[69] D. G. Crawford, a Lieutenant-Colonel in the Indian Medical Service, described the IMS in 1907 as follows: "The Indian Medical Service, as now constituted, consists of Medical Officers who have been appointed, after open competition in England, for service under the Government of India. In organization and in rank, it is essentially a military service, though a large proportion of its members are always in civil employment. The military members are attached to one or other of the Commands and Divisions, between which the Indian Army is now distributed. The civil members are similarly attached to one or other of the several administrative provinces. But all form one corps, and are liable to be transferred, according to the exigencies of the service, to different spheres of duty…Officers of the Indian Medical Service serve with the native troops, and still preserve the regimental system" (152).

Another related key feature of British understanding of Āyurveda around the beginning of the twentieth century was a sharp divide between the theory of Āyurveda, mostly conceptualized in Sanskrit, and the day-to-day practice, which involved little Sanskrit but a much greater emphasis on local languages and contexts. The Sanskrit texts, such as the *Carakasaṃhitā* and the *Suśrutasaṃhitā*, were in the guardianship of the pandits and priests who could explain the full theory of Āyurveda. The practice and medical treatments themselves, however, were the territory of the vaids, who operated locally and whose medical training concentrated on treatment. The Orientalists, due to their focus on textuality and codified knowledge, interacted with the world of the pandits and learned about an Āyurveda that was not lived out; the medical commissioners operated more locally but still understood little of the actual practice of Āyurveda and probably did not care too much at the time, either.

This raises an important question about the authority of the texts versus the authority of practice. In the British library and colonial government, the texts wholly spoke for what sort of a medical tradition Āyurveda was, and this pattern was not limited to Āyurveda. A similar phenomenon occurred with colonial understandings of the Law Code of Manu, which similarly came to stand in for the whole legal framework of Hinduism. Outside of the confines of the libraries and offices, however, the quotidian practice of Āyurveda dominated, and this dichotomy contributed to misunderstandings of Indian medicine. As a result, Āyurveda tended to be marginalized in politics and was not legally permitted to play a meaningful role. It is interesting to note, however, that especially in rural areas, the "legal" did not often dominate the local traditions that had been built up over the centuries as "Vaids…along with regional and local variations on the figure of the health practitioner, were predominantly responsible for doling out the implements of healing" (Berger, 2013:46).

Around this time, the early 1920s, a fundamental shift occurred in the way the colonial medical agenda recognized Āyurveda. Once it came to the attention of the British in charge that Āyurveda was largely responsible for the treatment of people in rural areas, it became incorporated

into the larger colonial mission of disseminating medical treatment to the Indian population. Rather than try to fight the tradition as incomprehensible and altogether unscientific, the Raj found ways to creatively harness its pragmatic role in society and engage it as a conduit for the colonial government's own medical agenda. Put another way, Āyurveda for the first time came under the serious radar of the colonial government, which strove to use it for its own purposes. In terms of the divide between textuality and practice, the lived practice was suddenly afforded a new importance but not in its own right – as will become evident, it was crucial for the fulfilment of the purposes of the British medical agenda. With a focus on the actual practice, naturally, the practitioner himself became the center of the debate on Indian medicine, essentially "[giving] the colonial government access to the current state of the indigenous medical systems, where the Pandit had only been able to provide insight into its theoretical meaning in a broader civilizational context" (Berger, 2013:75). Textual authority gave way to the authority of practice, yet ironically, this did not mean that the vaids were suddenly responsible for managing the health of the population though it could be said they "finally entered the age of modern medical bureaucracy" in 1923 (Berger, 2013:73). Rather, they were engaged as cogs in the larger machine of the colonial government.

Naturally, this shift involved a dismantling of deeply rooted ideas about an Āyurveda that was "inescapably ancient" (Berger, 2013:55). The Society for the Resuscitation of Indian Literature's book in 1899 titled *Āyurveda; or the Hindu System of Medical Science*[70] is one perfect example as it presented Āyurveda as "timeless…[and] divorced from contemporary medical experience."[71] Yet, as we have seen, this was not the case because Āyurveda had indeed evolved dramatically to meet the medical needs of the Indian population. Nevertheless, as early as 1895, there were genuine efforts on the colonial government's part to investigate the uses of native drugs. For instance, the Indigenous Drugs Committee, through its concern for public health outside of the context of any specific practice

[70] See Manmathnatha Datta, *Ayurveda; or the Hindu System of Medical Science* (Calcutta: H.C. Dass, 1899) in Berger, 2013:55fn9
[71] See Berger, 2013:55

of medicine, "resulted in a survey of medical knowledge and those who held it" (Berger, 2013:51-51). The committee put forth several recommendations that led to the development of an industry for indigenous drugs in India. Its proposal included the suggestion that "definite pharmacological preparations of certain indigenous drugs…be made at the Medical Store Depots for distribution to the various hospitals and dispensaries for trial and report."[72] Nevertheless, racially influenced imperial attitudes persisted, and a greater weight on indigenous drugs did not translate into a genuine respect for those who possessed them. Indeed, the committee prized the drugs but slandered the informants, framing the "traditional practitioner as a figure who had merely stumbled upon a great find, but who was unequipped to make valuable use of it" (Berger, 2013:59). Put differently, this instinct to view indigenous practitioners as quacks resulted in the colonial system "[holding] up the value of Indian botanical material while denigrating the systems that had traditionally organized this knowledge" (Berger, 2008:102-103).

The recognition of how Ayurvedic medicine was really administered to the population finds itself under the overall trend on the part of the colonial government of shifting medical authority to the provinces, essentially turning medical provision into a national objective that would be implemented locally. The shift is perhaps best represented in the Montagu-Chelmsford reforms of 1919-1921 and the effects of WWI, and it brought with it "a softening in the official attitude toward indigenous medicine" (Berger, 2008: 104). The Montagu-Chelmsford Report was the product of conversations between Montagu (the Secretary of State for India) and Chelmsford (Viceroy of India), and the principal recommendation was that some aspects of provincial governance should be shifted over to Indian ministers.[73] In short, it is part of the trend of "Indianization" of health care and put more emphasis on the provinces. It likely was not the case that the Raj dramatically revised its ideology and mission; rather, one compelling but perhaps incomplete explanation holds that the war

[72] See NAI Home (Medical) December 1895, nos. 15-18, 795, quoted in Berger, 2013:55
[73] See "Montagu-Chelmsford Report," Lotha.

placed a significant financial strain on medical services and resources, so it became much more fiscally sensible to engage with the existing structures of medical treatment rather than rebuild the networks from scratch. These existing structures included principally the local practitioners and, to some extent, indigenous medicine. The move towards provincialization provided more responsibility of basic health care to regional officials, who were less well-qualified and knowledgeable, but it also outlined more lucidly the expectations of accountability to the local population that was much more difficult to treat under the national sweep of the Indian Medical Service. In essence, as Berger describes the shift, "pragmatism had to outweigh colonial ideology, and systems already in place could not be ignored" (Berger, 2008:104).

The early twentieth century was, without a doubt, one of the most transformative time periods for Āyurveda. The turn of the decade around 1930 brought several shifts in the role Āyurveda played. One of the broadest changes is that the practitioner, previously disregarded and suppressed, became the center of debate regarding Āyurveda, and along with this came a standardization of Ayurvedic medical practice, so to speak. It is also around this time that nationalist sentiments prominently asserted themselves in the discourse of medicine.

One of the most fundamental changes to Āyurveda was in the legitimization of Āyurveda practitioners – how vaids were trained and how they gained credibility with the population. The local governments' need for a standardized, professional system of local medicine led in time to the creation of institutions to prepare Ayurvedic professionals, such as a department for Ayurvedic medicine at the Benares Hindu University.[74] The courses taught mirrored the style of Western medicine courses – "examinations, a dictated notion of progression from subject to subject, and little hands-on experience [that was] counter to the traditional process of learning" (Berger, 2008:106). While local practitioners themselves may have also felt that the degree course provided additional

[74] See Berger, 2008:105

credibility, this shift challenged the core of Āyurveda's transmission of medical knowledge. Traditionally, students would learn as apprentices under their teacher, gaining a vast range of hands-on experiences in their local contexts. The shift to institutions (modeled after Western structures) as the purveyors of authority could be seen also as part of a move to make Āyurveda more universal and less geographically specific.

One may be tempted to think that this would bolster the legitimacy of Indian medicine by granting it the same reach that the Western system held, but there are important subtleties to consider. One result of the move to institutions, usually located in urban centers, was "the further marginalization of rural-based, untrained medical practitioners who did not conform to the system" (Berger, 2008:106). If rural traditional practitioners were frowned upon in the past as quacks, then their situation grew much worse because they didn't even have a degree in this "quack" medicine (I should clarify, however, that such a harsh stance towards Āyurveda had softened by this point, and I use such jarring language to emphasize the point rather than convey a fact). An added challenge to these rural practitioners was a financial divide between them and the degree-certified vaids. The courses necessary to become qualified in the eyes of the colonial government (and arguably other [urban] vaids as well) involved a great financial investment, which led itself to a positive feedback loop. Those with money could train to become degree-certified vaids; their degrees would ensure that their income would be significantly higher and that they would have the rights to issue death and medical certificates, a "trade that provided a more lucrative option than merely treating illness or vending medicines" (Berger, 2008:106).

Earlier, we saw that there existed an important divide between the pandit as the guardian of the formalized Ayurvedic writings in Sanskrit and the vaid practicing Āyurveda locally in the vernaculars. In relation to the colonial state, this resulted in an inconsistency between what Āyurveda was "supposed to be" according to the Indians (specifically, the pandits) themselves (the British mostly regarded it as tenuous anyway) and how it was actually practiced. As the vaid became the

center of discourse, the two sides came closer together because the "practitioner as the arbiter of tradition [was] resonant socially through his reliance on modern Hindi…and culturally resonant through his reliance on textuality" (Berger, 2013:82). He had both the authority to speak for Āyurveda as a medical system, and he could interact with ordinary Indians without "reliance on the 'religious' infrastructure…[and the] formality involved in these encounters [with pandits]" (Berger, 2013:82). The vaid also became the vehicle through which the colonial state was able to access the current state of Āyurveda, and his new role as center spokesperson is perhaps best represented in the emergence of medical pamphlets that combined a medical discourse with a nationalist one.

For some background, this time period saw the development of a Hindi-speaking middle class in North India.[75] In order to be able to gain more control in the public sphere, however, this new middle class needed to be able to read and write in the context of the publishing industry that had become established by the early 1920s, and medical discourse constituted a considerable portion of the pamphlet material generated. In this scheme, authority naturally rested with the authors of these pamphlets, many of whom were vaids, since the criteria for legally writing literature that would be circulated in the public sphere were not as stringent as the requirements to be a recognized practitioner in the eyes of the colonial government. As Berger writes, "scientific information coupled with ideological learning could construct authority" (Berger, 2008:108).

What purpose did these pamphlets play, and why did they become a commonplace source of basic medical advice? At the base, this medium was easily accessible in Hindi requiring no mediation of doctor or priest. Secondly, it was also a medium through which relatively "unqualified" individuals could also express their opinions. Most importantly, however, is the sense of nationalism that underlay these writings, so much so that the "new authors were Indians first, in body and in politic, and vaids or authors or entrepreneurs second" (Berger, 2013:105). The larger goal was to lay the

[75] *Ibid.*, 107-108

foundations for an authentically Indian state – one that would be stripped of its colonial and generally foreign aspects. Insofar as medicine was concerned in this framework, indigenous Indian medicine was considered the ideal for treating Indians. This was not to suggest that Western biomedicine was bad or dangerous; rather, it was meant for Westerners, not Indians. The racialization of medicine, potentially to be understood as part of the colonial state's agenda, becomes clear in the 1925 Āyurveda guide of Shyamsundar Sharma, who appeals to differences in climate to emphasize the need to treat Indian bodies with Indian medicine.[76] Ironically, though, these guides to Āyurveda contained very little of Ayurvedic principles as found in the texts, such as assessing the body holistically through the lens of the humors, focusing more on treatment of a specific illness, which could be considered the typical biomedical approach. In a sense, they were not meant to illuminate the medical theories of Āyurveda; rather, they are a testament to the interwoven quality of medicine and nationalism at a time when many Indians felt like their own homeland was not under their own control and needed a return to a glorious, perhaps imagined, past. In trying to assert the connections between Indian medicine, Āyurveda, Indian spirituality, Hinduism, and the Indian body, these authors attempted to paint the image of a modern India as a country of healthy, middle-class citizens, usually imagined as Hindus, living in satisfaction according to modernized Vedic principles.[77]

This above section attempts to gain clarity on the larger trends of politicization of medicine in the subcontinent in the first four decades of the twentieth century. I would like to briefly summarize some of the authority relationships implied in the politicization of Āyurveda. One of the first questions that arose when the British came into contact with the Ayurvedic medical tradition and that persists into the modern age is that of legitimate medicine – who gets to determine what is "objective" medical science? It appears that the colonial state had a very rigid understanding of what it meant to have proper knowledge about the human body, including a conception of the circulatory

[76] See S. Sharma, *Ayurved-Mahantva* (Lucknow: 1925), 13, quoted in Berger, 2008:109fn22
[77] See Berger, 2008:112

system and surgery. By their standards, Āyurveda did not constitute true biomedicine and was thus termed biomorality instead. This was ignoring the fact that Ayurvedic practitioners had indeed gathered a lot of valuable information about local herbs and remedies over the centuries and had developed fairly cogent treatment networks. When Āyurveda became institutionalized and moved away from the local sphere into a standardized urban environment, it gained some legitimacy within the colonial system as a rigorous medical system that has the capacity to train individuals to become qualified to ensure the health of the population. Yet ironically, in order for it to attain a higher reputation, it had to shed the traditional system of apprenticeship in favor of the allopathic-style degree course.

As Āyurveda moved away from the traditional local focus, one can see the question raised of what kind of authority a medical system has. For centuries, Āyurveda seemed to have answered that medicine ought to be locally focused. This was the natural result of the high costs of transmitting information across large stretches of land. However, by the middle of the twentieth century, local medical authority was deliberately cast as part of the Indian nationalist ideal – Indian medicine for Indian bodies. Claiming Āyurveda as ideal for Indians revealed a desire of middle-class Indians to gain more authority over their own bodies and asked the question of what it meant to understand the body in indigenous terms. For decades, colonial surveys and surveillance of the Indian population "had a hegemonic effect on the conceptualization of the Indian body" (Berger, 2013:52). If Āyurveda could be engaged more prominently in mainstream discussions of the body, then it would become a way for Indians to understand their bodies in Indian terms once again.

Finally, one can ask the question of who gets to use Āyurveda. It had mostly been the case that the vaid held authority over the actual practice while the pandits preserved the Sanskrit texts of the tradition. The British initially maintained this system, though they mostly ignored the domain of the vaid. When they began gaining a deeper understanding of indigenous medicine, it was as though they claimed authority over the medical knowledge that Ayurvedic healers had developed over the

centuries. It became necessary for the colonial state to legitimize Ayurvedic medicine, whose herbal remedies it framed as a discovery of its own. Nevertheless, the cultural value that Āyurveda held with the average Indian legitimized it as a tradition at a time it was being marginalized by the British, and the trust placed in the vaid by local populations ensured that Āyurveda would survive well into the modern age though it would take on new meanings.

TOWARDS A MODERN INSTITUTION

Previously, we delved into great detail describing the colonial asylum structure, the British response during the nineteenth century to the need to control nonconforming behaviors and to enforce the myth of colonial superiority, followed by a lengthy discussion of Āyurveda's transition into the modern era and the ways it interacted with colonial rule generally speaking. We left off around the 1930s, when Āyurveda came under greater scrutiny by the colonial government, especially in order to use it for the Raj's medical administration purposes. This section will attempt to bring these two themes together, perhaps somewhat artificially, in the discussion of the transition from the asylum structure to the modern mental hospital. The Ranchi Indian Mental Hospital, "the largest public psychiatric facility in colonial India in the 1920s and 1930s," will be used as a case study to draw broader conclusions about the nature of insanity treatment in India and the integration of indigenous treatments into the Western medical structure (Ernst, 2014:xvii). This discussion will also lay the foundation for the final section analyzing the treatment of madness in contemporary India.

Rather than go into great depth about the intricacies of the transition to the modern hospital, I prefer to focus on themes and bring in finer details as necessary. That said, I will focus on several major ideas: the process of Indianization, nationalism, racial inequities, treatments, and symbolism.

The asylums, we mentioned, were significant principally because they were a symbol of colonial authority, both over the patients confined within as well as the land and its culture that was under British control. The hospital in some ways retained the colonial mindset but transferred more authority to Indians in a process known as "Indianization," which coincided roughly with the decentralization that came with the Montagu-Chelmsford reforms. Naturally, due to the fundamental change in the way the Raj controlled and administered medical care for Indians, many questions arose regarding the power that ethnic Indians would possess. Ernst describes it as follows:

> Foremost among these [issues and questions] is whether members of the gradually emerging group of Indians in senior positions should be most appropriately pigeonholed as mere collaborators with the colonial project, who fulfilled Macaulay's earlier nineteenth-century vision of the British colonial state and its educational institutions of raising an Indian middle class that could interpret 'between us and the millions whom we govern – a class of persons Indian in colour and blood, but English in tastes, in opinions, in morals, and in intellect.'[78] (2014:2)

Such questions are closely related to the issues surrounding Āyurveda as a medical tradition in this time period. Essentially, Indians were curious to understand what it meant to be truly "Indian" after being ruled for close to two centuries by the British, and the British wondered how to meet Indian demands for self-authority but still remain in the top rungs of the power and authority pyramid. After so many years of cross-cultural interaction, it was practically impossible for Indians to return to the ideal laid out in much of the "lay" medical literature: Indians governing Indian bodies using traditionally Indian cultural artifacts, such as Ayurvedically-based treatment in the context of a modernized Vedic culture. In addition, it was understandably difficult for the British to relinquish control over so powerful a structure such as medical administration in India to people who were generally deemed inferior. Finally, the question of whether Indians could be "elevated" into British habits and values is evident in Macaulay's statement and operates alongside the other issues raised above.

Indianization here refers to the transferring of power and higher rank positions in the medical administration to Indians, such as Jal Edulji Dhunjibhoy, the superintendent of the Ranchi Mental Hospital. This shift can be seen as a product of Indian nationalism and self-governance because it became a way for Indians to take on greater authority roles within the medical system that was charged with their treatment. One could say that a significant transfer of power had occurred when Dhunjibhoy was appointed to the "coveted" position as the superintendent of such a new, expansive modern treatment facility (Ernst, 2014:3). His extensive Western education at the Bombay

[78] See Macaulay 1935, in E. Stokes, *The English Utilitarians and India* (Delhi: Oxford University Press, [1959] 1982), 46, quoted in Ernst, 2014:2fn7

Medical College was complemented by the utmost support of the Raj for his further training, and he had received numerous complements among medical professionals both in colonial India as well as in Britain.[79] On the surface at least, there was evidence to suggest that the "official requirement for equity between European and Indian senior officers" had come to fruition and that Indian demands for self-governance and self-administration were being heeded.

However, as with any racialized system, dismantling prejudice was going to take much longer. There are two arguments to be made here: for one, though Dhunjibhoy may have achieved a remarkably high position in the medical administration, he did battle against significant racism along the way through to the end of his career. Secondly, someone concerned with the issue of "authentically Indian" would point out that Dhunjibhoy was the medical equivalent of Macaulay's vision for Indians – a man of "Indian…colour" but Western trained and working with primarily Western treatment methods in a Western-conceived institution.

Prejudice against Indians took numerous forms, but I will examine only some of the more significant ones here.[80] On one level, some Europeans worried that after such intimate contact for some centuries between the colonial power and its subjects, the subjects may be inescapably dependent on and inadequate without the colonial power. Later historians specializing in colonialism gave this idea significant weight,[81] some scholars referring to it as the "comprador bourgeoisie."[82] One can detect in this perhaps a willingness to afford the colonial subjects full human dignity and equality but also a consideration for the practical psychological effects of their situation under colonialism. Others downright pathologized entire communities of people. For example, Lt. Col. W. S. J. Shaw, who had been a superintendent of a hospital near Poona, considered the Parsi community, which had been held in special respect with the British compared to Hindus and Muslims, infected

[79] See Ernst, 2014:3-4
[80] *Ibid.*, 4-17
[81] *Ibid.*, 4
[82] See P. A. Baran, *The Political Economy of Growth* (New York: Monthly Review Press, 1957), quoted in Ernst, 2014:3fn8

with dementia praecox;[83] Dhunjibhoy, being Parsi himself, was unsurprisingly out of favor with Shaw. It is important to note that in general, racial theories still held considerable weight, and one could even argue for separating the "racial hygiene" theories of individuals like Shaw and the "mental hygiene" theories of those like Dhunjibhoy (Ernst, 2014:14). This is to say that the proper division of and distance between races, embodied in the ideas of Shaw, occupied almost an equally legitimate space as the treatment of mental illness, which appears to be the primary concern of doctors like Dhunjibhoy. Embedded in "racial hygiene," unlike in the "comprador bourgeoisie," was a notion that Indians were inescapably subordinate to the British rulers, no matter "their formal positions and achievements within the imperial order" (Ernst, 2014:14).

At this point, we have identified three important, related but different ideas of the racial divisions between the Indians and the British – it is key to focus on their understandings of racial equality and the implications for rising Indian doctors like Dhunjibhoy. Macaulay, on one hand, seemed to believe that Indians could become equal to the British by adopting British customs and tastes; in twenty-first-century America, this would be called colloquially a "coconut"[84] – "brown" on the outside ("Indian in colour and blood") but "white" on the inside ("English in tastes, in opinions, in morals, and in intellect"). However, Indians would not be considered inherently equal in this framework since they would need to be "brought into"[85] the British idiom. The "comprador bourgeoisie"[86] idea suggested a true equality of the races underlying an imposed imperial order that had made one race dependent on the other – in practice, this meant that it would be unwise to grant Indians full equality and control over the Indian medical administration. Finally, Shaw's

[83] See Ernst, 2014:11
[84] See Chow
[85] This is a phrase used by British music collectors in India to describe the process by which Indian music could become acceptable for a British audience; see Woodfield, 2000:169.
[86] It should be noted that this is anachronistic in some sense – this term became applied retrospectively in the 1970s and 1980s, not during the time of the British rule itself; see Ernst, 2014:3.

understanding of "racial hygiene" maintains an inequality between Indians and British regardless of how "Westernized" and well-regarded by Westerners the Indian doctors may have been.

It is clear that despite the diversity of opinion on racial differences, hardly a prominent thinker advocated on behalf of the Indian doctors; indeed, Arthur Brock, active in the field of sociology, "put his finger on Shaw's underlying agenda and was discredited for it by reference to his lack of Indian experience" (Ernst, 2014:13). This meant Dhunjibhoy and others like him had an especially steep slope to work against, and it would be no surprise that "Indians practising indigenous medicine [would be] relegated to the bottom rungs" (Ernst, 2014:6). As a side note, one can wonder whether the racism was entirely internally produced or whether economic success played a partial role – certainly European doctors vying for career opportunities were in competition not only with other Europeans but also with European-trained Indians and, to a much lesser extent, Indians practicing indigenous medicine. Most likely, however, given the prevalence of racial discrimination throughout the Raj over the centuries, professional competition added merely another layer of resistance to Indianization.

Allow me to digress briefly – I would like to say a quick word about the relevance of the questions raised in the process of Indianization – I made specific reference to "coconut" above in a relatively recent news article from 2014 because the fundamental issue has all but disappeared. Indians (as with Mexicans and Afro-Caribbeans in their respective communities) are still answering the question of what it means to be truly "Indian" and just how deep ethnic identities run. We can observe a spectrum of "Indianness" threading together the various positions we have encountered – on one end, "Indian" meant having the brown skin and ancestry described by Macaulay, appearing to be from the Indian subcontinent outwardly, while adopting the customs of the British. On the opposite end lay the beliefs of the Ayurvedic pamphlet authors and the rising Hindi-speaking middle class under the slogan of "Indian medicine for Indian bodies." Indian nationalism insisted that in order to be truly "Indian," one ought to have adopted traditionally Indian cultural practices, such as

the use of Āyurveda in place of the biomedicine brought by the imperial government. In this schema, driving out colonial rule involved also driving out the cultural products, including medicine, that came with it.

In any case, such persistent racial attitudes on the part of the British translated into numerous structural inequities under the guise of equality; a couple of examples of Dhunjibhoy's hospital at Ranchi and its relationship to the European Mental Hospital of Englishman Berkeley-Hill situated nearby will suffice. For one, due to the actions of European advocacy groups, the European Medical Hospital received funding from the central government, saving it from the "underfunding and deterioration of services" that afflicted Dhunjibhoy's institution (Ernst, 2014:10). In addition, the British were generally held to a different standard of acceptable speech – Berkeley-Hill as a European could get away with his mockery of his seniors, and his "cantankerous [reputation]…does not appear to have done him much harm in terms of his professional career" (Ernst, 2014:11). On the other hand, the Indian doctors could easily come under suspicion of disloyalty if they criticized the "systemic prejudice and parochial narrow-mindedness" they were so often subject to (Ernst, 2014:11).

Moving away now from the divide between theoretical equality and practical inequity, I would like to discuss the treatments administered at Ranchi and their connections to the earlier methods in the asylums and to Ayurvedic treatments that claimed authority over much of rural India. It is important to keep in mind that Ranchi Indian Mental Hospital was a unique urban institution that was a direct product of colonial developments in India and is thus a natural extension of or progression from the notorious asylums. However, it also partially bridges the divide between Ayurvedic and biomedical treatments that occupied a significant space in the discourses of Āyurveda in the early twentieth century.

A discussion of the treatments in the modern Indian hospital raises many questions about the integrity of indigenous medicine, which was now much more prominent compared to the early

twentieth century thanks to both the passionate nationalist discourses with which it was intertwined as well as the gradual recognition by British medical officers of the potential value of Ayurvedic treatments. Dhunjibhoy could be described on the whole as eclectic in his approach to treatment, which "was flexibly cosmopolitan and transnational and cannot adequately be captured by reference to any single approach, let alone be restricted to 'colonial psychiatry'" (Ernst, 2014:206). He himself said that "[w]e introduce all the latest approved Western methods of treatment with due regard to Eastern conditions."[87] While this included what we may call the horrific treatments of shock therapy and extended sedation, recent developments in the Occident, he also experimented with indigenous Indian herbs and remedies, such as sweet basil and Indian snakeroot.[88] Such herbs were fairly common among Ayurvedic practitioners, and they provided often cheaper alternatives to European remedies. Here, we see resurfacing a theme we mentioned earlier: Āyurveda became more acceptable to the European-trained medical professionals when it became evident that its remedies would be a more cost-effective alternative.

However, Ernst asks us to be careful in suggesting that Dhunjibhoy was very open-minded to Ayurvedic treatments – while it is difficult to establish a case either way, it is possible that he considered indigenous herbal remedies acceptable for rural areas but overall outmoded and unscientific for a such a modern hospital as his.[89] What we can conclude, however, is that the earlier disconnect between Indian medicine and British biomedicine had given way to a more robust interaction between the two systems. Nevertheless, British doctors' perceptions of Āyurveda still exhibited the range of opinions as before, though perhaps the distribution may have shifted a little in favor of Āyurveda based on the evidence from Ranchi. Some professionals, for example, "support[ed] legislation aimed at institutionalising traditional medical systems…along Western lines by making them subject to scientific scrutiny [while] [o]thers objected to any recognition being given to what

[87] See Report 1930-32, 14, quoted in Ernst, 2014:205fn1
[88] See Ernst, 2014:173-174
[89] *Ibid.*, 174-175

they saw as un-improvable, outmoded and unscientific practices" (Ernst, 2014:175). The criticism of Āyurveda as unscientific persisted in general, but some doctors felt it would be worthwhile to adopt into a European framework certain effective remedies developed in the indigenous tradition.

We have thus far limited our discussion of treatments to the somatic realm, but the Ranchi hospital also engaged various "moral" (or at least non-somatic) treatments, though it is difficult to say whether these were linked to the ideas of the Tukes in the earlier asylum period or whether these were the natural result of global advances in psychiatry. For example, about half of the patients found treatment by occupational therapy in forms of gardening, carpentry, meal preparation, and so on. Such therapy provided an alternate to the "haze induced by medication," allowing patients to experience more "normal" life, and it also accomplished work for the institution and ultimately, the state (Ernst, 2014:196). Work therapy in the way Dhunjibhoy instituted it also helped patients overcome their sensitivities to caste and other categories. Some other forms of non-somatic treatment were quite creative for the time[90] and helped locate the Ranchi hospital within the larger nationalist discourse. For example, Dhunjibhoy, who was himself detached from nationalist politics[91] due to his identity as a Parsi, found dance therapy an appealing treatment after attending a demonstration of the Bratachari Movement in Calcutta, founded by G. S. Dutt.[92] For Dutt, the dance movement served as a way of "breaking down social barriers of caste, religion, sex and age," bringing Indians together in a shared sentiment of national identity (Ernst, 2014:191).

On the other hand, other forms of therapy were tailored to patients' individual identities, such as religious therapy involving religious discourses and feasts on holy days. Both of these forms of therapy juxtaposed point to the growing importance of treating mental illness both on an individual level with special attention to important dimensions of patients' identities like religion as well as on

[90] For a history of occupational therapy, see A. A. Wilcock, ed., *Occupation for Health*, vol. II (London: British Association and College of Occupational Therapists, quoted in Ernst, 2014:191.
[91] See Ernst, 2014:192
[92] *Ibid.*, 191

a communal level in order to allow patients to experience life within a society of many individuals without being isolated on the basis of their mental illness. Overall, to use Hyne-Sutherland's framework once again, we can observe a shift towards locating mental illness in patients but not identical with their identities. The greater recognition for the patients' well-being in areas such as religious fulfilment and occupational satisfaction afforded them an identity separate from their illness, unlike the case with the lunatic asylums from a hundred years earlier.

In terms of authority questions, we have an interesting situation: the insanity of the patients, which we would ordinarily expect to exert control over the structuring of patients' lives, was liberating in that it freed them from the roles they would have been expected to play under the authority of the dominant social order. In addition, work therapy freed the patients from the clutches of constant medication, which was the expression of the authority of the doctors wielding it. Nevertheless, one could ask whether the work therapy was a release or subjugation to the economic needs of the institution since "[i]ssues of exploitation and power can arise whenever vulnerable people are not fully recompensed for the value of their labour" (Ernst, 2014:193). In any case, within the authority exerted by the mental health institution generally, the modern hospital of Ranchi could be seen as granting the individual patients greater dignity over their own humanity, allowing them to experience more of the ordinary daily life they may have without their insanity but in the absence of social expectations based on class or caste.

Finally, another point must not be forgotten – our entire discussion about the Ranchi hospital thus far has been based ultimately on the accounts of Dhunjibhoy's life from the writings of his daughter, the personal accounts of the other British medical officers, and others involved in administering treatment at the hospital. Nowhere have we encountered a patient's testimony – in a very real sense, "the account of the patient is silenced" (Ernst, 2014:93). Hence, even in the process of writing this thesis, we are affirming the authority of the institution and those involved in its functioning over the patients, but we have no alternative. The best we can do is imagine the patients'

perspectives based on the institutional evidence that is available. Hence, it could be inevitably overbearing for us to conclude that patients found the modern hospital "friendly and homely"[93] due to the innovative therapy methods and entertainment like croquet, tennis, and music.[94] Evidence does suggest, though, that patients did appreciate such an atmosphere compared to the conditions they may have faced at home.

Before bringing the themes from this section together, I would like to add one note about the importance of family. In pre-colonial times, family and friends were understood as the primary caretakers of the insane, the "natural locus" of disease due to the "gentle, spontaneous care, expressive of love" that is given primarily by close family members (Foucault 17). In the case of the asylum, we saw that depending on the type of lunatic, a supportive or an unsupportive family could be the reason for being brought to the asylum. Indeed, the relationship between the institution and the family is extremely complex; even in the case of Ranchi, it is likely there were some patients whose families institutionalized them out of hope of better care in the hospital while others were brought to the hospital in order to get rid of an undesirable family member.[95] This theme will continue to thread its way through the section on modern Indian mental health treatment and will become even more visible.

Michel Foucault analyzes the hospital as "an artificial locus in which the transplanted disease runs the risk of losing its essential identity" (17). This is to say that within the confines of the hospital, the disease would be treated and cease to exist or at least disappear. For a moment, I will gloss "hospital" as "asylum." Examining the British lunatic asylums through this lens yields a surprising result – in theory, the asylums were intended to treat mental illness (though one could argue that the deeper intention was to hide socially deviant behavior in order to allow the colonial elite to better

[93] See Report 1937, 12, quoted in Ernst, 2014:99fn131
[94] See Ernst, 2014:199
[95] *Ibid.*, 99

exert their power), but the asylums became much more a symbol for the illness itself. Rather than lunacy "losing its essential identity" within the asylum walls, one could say it transferred its identity to the very institution that was erected to treat it. Even if the disease within did die or lose its "essential identity" (recall that it was very difficult to say whether a patient was truly "cured"[96]), it would live on through the symbol of the asylum; indeed, the symbolism persists to the present day. With the development of the modern mental hospital, however, Foucault's analysis becomes more applicable. The hospital at Ranchi primarily did serve to treat mental illness and provide for the welfare of its patients, and this idea is one well worth keeping in mind as we move into modernity.

At this point, I would like to review some of the salient themes from the process of Indianization of the colonial medical systems, which found "full success" in the Ranchi Indian Mental Hospital (Ernst, 2014:25). At a broad level, Indianization is in large part a product of the nationalist discourse that shaped the indigenous Ayurvedic medical system and the fundamental notion of what it meant to be "truly Indian" and to free oneself from colonial power structures. Many Indians believed that in the medical social sphere, India had to return to an Ayurvedically-based administration to overthrow the colonial government. In this light, Dhunjibhoy, the superintendent of the Indian Mental Hospital at Ranchi and our focus for this section, did not break free from the colonial medical structure but rather worked from within it to combat systemic racism and prejudice. While he was Western-trained and administered a Western-conceived hospital, he was open to experimenting with alternative treatment methods, some of which were derived from Ayurvedic medicine, to create a pleasant environment for the patients institutionalized there.

In terms of symbolism, the modern hospital is a significant break from the earlier asylums, which were an important symbol of British superiority and authority. The modern hospital was primarily intended to treat the mental illness of its patients with an appreciation of the holistic

[96] See Ernst, 1991:85

makeup of the patient aside from the illness itself, not act as a fist of the dominating colonial government that sought to quash evidence of the British "weak." This may be seen clearly in the terminology used to describe the patients in the asylums, who were often referred to as "inmates."[97] This contrasts with the Ranchi hospital's term, simply "patients," even though many of those at Ranchi were technically criminal lunatics.[98] We also ought to be careful about drawing a sharp biomedical/indigenous divide because, as Dhunjibhoy's therapy styles reveal, there was greater interaction between the two systems despite the lingering attitudes of many British elite concerning the "unscientific" nature of indigenous treatments. The important takeaway from this section, in any case, is that the modern hospital begins to separate the identity of the patient from the identity of the disease so that the story of the patient can interweave with the story of the disease, not become limited to it. This will be a prominent theme in Sarah Pinto's analysis of the relationship between mental illness and kinship in contemporary India, and we find in this transition a foreshadowing of developments in the legal language that seek to emphasize patient-centric care that is intended to alleviate the patient's ills primarily and protect society secondarily.

[97] See Ernst, 1991
[98] *Ibid.*, 36

Since we have devoted many pages for the discussion of the asylums, which occupied a pivotal phase of psychiatry in India, it would make sense on one hand to organize our discussions of contemporary developments in the context of themes pertaining to the asylum, such as enforcement of authority by those considered "superior" and the desire to rid society of its madmen. When we turn to the contemporary psychiatric scene as depicted in Sarah Pinto's ethnography, *Daughters of Parvati*, there is indeed little doubt that the ideas of the asylum and what it stood for continue to shape psychiatry and discussions around it. Since Pinto specifically examines women in her anthropological study, she notes the phenomenon of "'dumped women' – a social and medical crisis iconic of the asylum era…[and how] the *idea* of dumped women is part of how people have come to understand contemporary Indian psychiatry and address its current crises and darker past" (13). Other themes, such as the "enact[ment] of power systems on and through patients," continue from the asylum era though in different forms; for instance, the imposition of power structures for which the asylum was once responsible now tends to be expressed through pharmaceuticals because "drugs…[help] regulat[e] and enforc[e] ways of being" (19).

However, attempting to analyze contemporary notions of madness through the lens of the asylum era's legacies and discontinuities would be ultimately a superficial endeavor, suggests Pinto, since psychiatry in India is "a complex map of personhood, bodies, and brains; ideas about what it means to be a person, a citizen, a man, a woman, and what it means to love, to desire, or to care for" (26). Once we "look beyond the asylum as a ground for critique, beyond the question of its persistence as a system of discipline…an (*sic*.) symbol of the regulating of norms," we may begin to appreciate the dimensions in which "the history of the asylum in India and things particular to contemporary psychiatric practice in a pluralistic setting tell us something about madness other than that psychiatry is, first and foremost, a way of enforcing what society views to be 'normal'" (22). Rather than try to seek continuities or even discontinuities in themes established in the asylum era,

Pinto encourages us to adopt a fresh stance altogether, one that is much more attuned to the blend of "instabilities of love, medicine, and narrative" that play an integral role in the expression of insanity (22). In fact, she describes her own book, at "second glance," as one about "love, marriage, and family…especially about the violence and undoing that are part of their makeup, the way bonds are unpurled and knitted into new designs much like the sweaters [she] once watched village women unravel and remake to fit the shapes of growing children" (7). Rather than organizing her ethnography around ideas of authority, control, and normalcy in a medical setting, rather than seeing madness as fundamentally a form of social deviance, she finds it much more enriching to understand madness as woven into a larger story of delicate, meaningful, and beautiful but potentially deleterious human relationships – their dissolving and their reconstruction.

We can thus consider Pinto's book as an invitation to critically examine the approach we have used thus far in our consideration of madness, its perceptions, and its treatments. We have tended to focus on themes of authority and social deviance; in this section, we will relegate these foci in favor of understanding madness as a dimension of the human experience manifest through interpersonal relationships. We will engage with the stories of several women (but only one in particular) depicted in the pages of Pinto's ethnography as an introduction to the complexities of constructing a just picture of insanity. Our reader may be tempted to entertain the thought that this entire paper up until this point has been based on a faulty, somehow incomplete analysis since we are now highlighting the merits of an alternative approach. The latter, perhaps more holistic approach is naturally better suited for an analysis that draws on anthropological sources than historical sources. An ethnographer can hear, record, and respond to the subject's voice; by contrast, "[a]s is always the case when dealing with one-sided institutional evidence, the account of the patient is silenced" (Ernst, 2014:92-93). The difficulty of adopting a patient-centric approach, then, is built into the nature of the sources for the earlier sections. Nevertheless, we can focus on one theme characteristic of the asylums because it continues to underlie the relationships detailed in Pinto's book – abandonment. However, where

abandonment in the asylums implied a desire to rid society of its unworthy or inferior members, it manifested in the settings studied by Pinto as "a blurry field of everyday acts of loving, caring, treating, and being" (29).

There are two more important points to mention before exploring madness in contemporary (north) India. One, there will be little to no mention of Āyurveda in this chapter, which may seem odd given the detailed treatment of Āyurveda earlier. Present-day Indian psychiatry shows evidence of various influences, so unless we were to visit an Ayurvedic practitioner specifically, we are unlikely to see Ayurvedic treatments that follow largely from the texts. Pinto's book will take us through several mental illness treatment spaces, including an old asylum, a private ward, and a public government hospital, neither of which is a dedicated Ayurvedic center; these spaces themselves, we shall see, are wound up into the sticky, often ill-defined web of love and family relationships. This is not surprising as traditional relationships in India are often based on notions of "giving" and "indebtedness" (*e.g.*, the duties a young man has in caring for his elderly parents)[99]; madness, then, could be a powerful agent in the undoing and twisting of such relationships, especially in the context of abandonment. Secondly, treatment of insanity involves a close engagement with the legal system and its comprehension of insanity. Thus, an aside about major developments in the legal language of madness leading up to the present day would be helpful.

Hyne-Sutherland examines three key pieces of legislation spanning a century: the Indian Lunacy Act of 1912, enacted during the latter period of the asylums, the Mental Health Act of 1987, and the Mental Health Care Bill of 2013. She pays close attention to the ways in which the legal language surrounding madness has changed over time, concluding that perspectives shifted "from what to do *about* a person with madness to identifying and understanding the actual condition of the person" (70-71). Where the 1912 Act refers to a "'lunatic' [as] an idiot or a person of unsound mind"

[99] See Sarah Lamb's ethnography of a rural Bengali village, *White Saris and Sweet Mangoes: Aging, Gender, and Body in North India*, for a detailed treatment.

and the 1987 Act designates a "'mentally ill prisoner' [as] a mentally ill person for whose detention in…[a] place of safe custody…an order…has been made," the most recent bill suggests a "'prisoner with mental illness' means a person with mental illness" (69). Legally, at least, madness is considered in a crucial way separate from the person whom it afflicts; it thus affords the patient an identity greater than the mental illness itself. Interestingly, we can begin identifying this shift in perspective with the development of the modern hospital under Dhunjibhoy in the 1920s and 1930s thanks to the language used to refer to the mentally ill ("patients" as opposed to "inmates") and his emphasis on work therapy. However, it was not until almost eighty years after this time that the legal system adopted a comparable attitude. Pinto's research, published in 2014, then, is situated in a time period when the legal language for the mentally ill was in a crucial, transformational phase.

Nevertheless, the Supreme Court had already taken several steps that encouraged treatment rather than the institutionalization of the mentally ill. For instance, the Agra Mental Hospital that we will encounter shortly was directed by the Court in the 1990s "to refashion itself as a research and teaching institution…Agra became part of a health system emphasizing outpatient medicine and focusing on rehabilitation instead of residency…, plac[ing] emphasis on treatment rather than institutionalization" (Pinto 54-55). The context for Pinto's work, then, is a social and legal approach to medicalized madness that is in the process of shifting from one aiming to pin down the patient – socially, legally, and medically – to one addressing the illness in the context of the patient's holistic situation. One could well remark that the treatment of insanity is hence becoming more "Āyurveda-like" due to the emphasis on careful, holistic evaluation (recall that Ayurvedic texts would advise physicians to prescribe medicines after having considered the humoral and substantive composition of the patient because "one size did not fit all").

It is against this background that we first encounter Ammi, an aged woman with schizophrenia in whose story we can begin to appreciate the complex relationships between mental illness and family relationships. Pinto learns about Ammi, whose name is really Neelam, in large part

through her daughter-in-law, Tulsi. She and her husband, Nishchal, were primarily responsible for bringing Ammi back from the Agra Mental Hospital, where she was institutionalized for several decades of her life. Many in the family blamed her ex-husband, Keshav, for her confinement at Agra, the mere name of which is a euphemism for the institutionalization of family members deemed mad thanks to its infamous connection with the asylum.[100]

It would be easy, and tempting indeed, to see Keshav as responsible for "dumping" Ammi at the hospital since he fell in love with a woman he met overseas and decided to divorce Ammi. Such a reading would resonate with a "prominent critique" that in India, psychiatry serves to remove burdensome women for "protecting families from the contagion of women's mental illness…and removing faulty or shameful elements from kinship networks" (Pinto 23). However, in her introduction, Pinto asserts that her book shows the limits of such arguments, which oversimplify the complexities of love and uncertainties in kinship. We could certainly identify "dumping" in the case of Ammi, if we were to use such a loaded term, since Tulsi describes her mother-in-law as a "worm…when she was in that place" (Pinto 44); it would be crucial to realize, however, that this "reduc[tion] to 'nothing'" was not primarily the fault of the family – rather, it was the *institution* that robbed Ammi of her humanity (Pinto 45). Bringing her home allowed her to regain her humanity; Tulsi describes how "[s]he is a whole person now" (Pinto 44). The argument presented at the beginning of the paragraph helps us begin to identify themes of abandonment, but we must be careful not to generalize and misconstrue the delicate kinships that are navigated in the sea of mental illness. It would be a misrepresentation to suggest that Ammi's illness caused her to be a stain on the family's reputation; Pinto noticed in studying Ammi that "schizophrenia was something very human and full of thwarted efforts to 'connect'" (45).

[100] See Pinto 54

Nevertheless, it would be a mistake also to see Ammi's family united in the view presented just above. An important dimension of understanding mental illness in India is the ways in which it reorders the family and results in relationships that are both "patterned, following the rules of north Indian kinship" and "improvisatory" (Pinto 75). Part of Nishchal's and Tulsi's responsibilities according to traditional family values was to look after Ammi and invest their energies in her. The same could be said about Nishchal's younger brother, Dhananjay. However, Ammi would only occasionally recognize and hardly ever connect with her younger son, so there loomed a chasm between them that was all but traversable. Keshav recognizes this failure to connect on Ammi's part and cites it as an important reason for the tensions within the family[101]; he also blames Nishchal for failing to connect with his brother. Nishchal takes a different view – he is convinced that Keshav did not make an effort to connect with Ammi; Ammi indeed "has compassion…you [Keshav] must have compassion" (Pinto 66). To this, Keshav replies that compassion was easy for Nishchal to talk about because he does not live with Ammi long-term and does not have to go through the daily struggle that Keshav does. It becomes evident that kinship is important to understand in order to analyze the ways in which mental illness is handled, yet there is a sense in which such an entanglement of family relationships is universal; perhaps, as Nishchal says, "Here [in India] the whole treatment is integrated with the family…not like in the West where they [patients with mental illness] are treated individually, as a case, away from their family," yet the difficulties of love in family kinships is hardly a local phenomenon (Pinto 66). Nevertheless, Pinto analyzes the difficulties of assigning blame and the cause of Ammi's schizophrenia quite nicely:

> For Keshav, Ammi's inability to 'connect' was vitally important, a sign of incompatibility with family life and relations, of the inability to be incorporated into reciprocal bonds. His younger son's hurt was understandable, and in Ammi's inability to recognize others was an offense similar to Nishchal's broken bonds with him. For the family to remain coherent, Ammi must come second. Connection was a state of being, a precursor to relationships.
>
> For Nishchal, recognition and connection were not given qualities but efforts. They had to be offered to be received. Though Ammi's inabilities to recognize others caused pain, connection

[101] *Ibid.*, 66

> was a goal, not a quality, and reaching out in spite of absence was necessary for rehabilitation, a form of intimacy Ammi had been denied. For Nishchal, connection was not a condition but an action, one that could reinstate the humanity lost in institutional life. It was the work of being human, of making human again. (67)

Within the family, the mental illness of one family member disrupts freedom for the others and the hierarchies that bind each one to another. Nishchal and Tulsi made the right choice in bringing Ammi home according to their understanding of their filial obligation. In a very real sense, Ammi was freed from the clutches of the institution, where she was not treated as a person capable of connection in their view, but this spelled the limitation of Tulsi's freedom. Pinto says, "[k]inship involved the same thing: loss of freedom was part of the securities of marriage" (51). Mental illness, closely connected with vulnerabilities of kinship, could be seen in transactional terms as well – who must sacrifice what for whom in order to maintain connections or, more likely, constantly rework and strengthen disconnections. In addition, it could be understood as forcing a reordering of the hierarchies that normally connect family members to one another. For example, according to the prevailing norms of kinship, a son and his wife are obligated to care for his mother; in this case, it would be expected of Nishchal and Tulsi to tend to Ammi. However, due to habits developed inside of the "ashram," as Ammi ironically referred to Agra,[102] Ammi would offer to massage Tulsi's legs instead.[103]

In many ways, the unknowability of what really happened inside the hospital mirrors the difficulty of piecing together a truth about Ammi's life from her own fragmented speech and the discontinuous nature of Nishchal and Tulsi's visits to the hospital. On one hand, the hospital harmed far more than it healed, effectively robbing Ammi of her humanity. Yet it was also the recourse which Keshav and his son took when Ammi's illness was becoming unmanageable. Arguably, there was an element of love and care in even that decision. Finally, there is the account of the head of the hospital, K. C. Dube, whose "portrayal of Agra…could not differ more" from Tulsi and Nishchal's (Pinto 53).

[102] *Ibid.*, 49
[103] *Ibid.*, 56

History would know Dube as a progressive leader who criticized physical restraint in psychiatry and advocated healthy relationships to promote an environment of well-being within the hospital. What then, is to bring these accounts together? Perhaps the answer is that the hospital was not "one thing" as we may want to describe it – rather, it was a complex institution that must be understood through the various stories we may hear about it. The truth of the asylum, then, is one such truth destabilized by mental illness. The insane asylum was born as a symbol of British colonialism and as the implementation of the desire to make the shameful or deviant members of society disappear. There is little evidence in the case of Agra that either of those purposes continued. By this point, the hospital had become "a place for experiments in freedom, for challenging received wisdom about the nature of the mental patient and the environment in which she must abide" based on historical records, yet the testimony of those who know closely one such patient severely undermines such a positive conclusion (Pinto 53). This mirrors the difficulty of assessing Ammi's personality within the home – at once, she was someone who did not connect with her son and someone fully humanized, desiring to recreate those connections if given the chance.

Earlier, we discussed the development of the Ranchi hospital in the context of the shift away from asylums under the powerful leadership of Dhunjibhoy. The image that resulted contrasted heavily with that of the asylum from earlier times – rather than hide the weak in society, the modern mental hospital respected the patients' human dignity and provided options like work therapy to give them at least a partial experience of being a productive member of the community. The historical record would describe Dube's leadership from 1950 to 1975 in a similar light, pointing to the "unlock[ing] of the wards…[and the] occupational therapies to supplement and in some cases to replace restrictive practices" (Pinto 54). Yet we know from Pinto's fieldwork that such a view would be heavily one-sided. We could wonder whether Dhunjibhoy's hospital was similarly subject to criticism from the families of those confined. The reality is that the historical record that placed the hospital at the center is largely silent to the accounts of the patients and their families.

We mentioned that historical accounts tend to silence the voice of the patient while anthropological accounts, in allowing engagement with the patient directly, can provide a more holistic image; interestingly, Pinto's book hardly provides text for Ammi's words. She addresses this as a question of ethics – "[b]ecause [Ammi's] language and self-knowledge were conditioned by psychosis – a state considered, legally and in formulas for research ethics, to be of compromised rationality – it was not possible to locate an expression of consent in conventional terms" (47). She continues to write:

> My interests, then, fell on the way other people's lives, other people's histories were formed by way of Ammi's. The movements of Ammi's confinement and rehabilitation were also theirs…Ammi's life was woven into family life in the way kinship was, more than a collection of histories or perspectives on the past…Her illness and movements brought people together, pushed them apart, and made them reevaluate the nature of family, care, and love for decades, though for most of that time Ammi was physically absent, a void at the center of a vortex. (48)

One of Pinto's central themes in writing her book is that it is richer to understand the effects that one's insanity can have on that person's relationships with others as well as its effects on interpersonal relationships between people who know that person affected by mental illness. The disagreements over the cause of Ammi's institutionalization, her release, and her capacities to form and maintain connections with other humans shifted accountability from father to son to daughter-in-law. At once, storytelling is a way of preserving history and meaningful experiences, yet the stories surrounding a family member with mental illness, much like psychotic speech itself, falter and jump around from pole to pole, defying efforts to extract a single truth or even one truth.

Due to space limitations, I chose to limit my discussion in this section to only a few chapters of Pinto's ethnography. The further chapters focus on two distinct spaces of mental illness treatment – the private clinic and the government hospital. The stories contained therein explore the ways in which mental illness reworks marital relationships since many of the women depicted are on the

"margins of marriage."[104] The private ward, nicknamed Moksha[105] by Pinto, "capitalized on horizons of uncertainty, including hope; it made use of inherent instabilities in intimate life, kinship, and narration; and it destabilized truths, making facts more fungible in the supposed interest of making things more certain. The effect of this was long-term involuntary commitment for women who had mental illnesses but may have fared well enough in the world, looking after themselves and using clinical care as outpatients" (Pinto 114). In the private ward, the family was hardly to be seen but not because the patients' families didn't care for them. Though this setting may appear much like the old asylum, forcing a separation between the patients and society outside, "[n]o one [including family members]…considered these women subhuman, animal-like, or incapable of social life" (Pinto 84). Pinto thought it better to consider Moksha as a "setting for acute care…a living space for people who need no restriction but who benefit from a bit of care…a halfway house…for starting [the patients'] lives anew…with the halves in the wrong places" (144-145). Due to "the way intimacy itself destabilizes language and involves risk…[m]adness, here, was on a spectrum of recognizable responses to love" (Pinto 113).

She contrasts this setting with that at the Nehru Government Hospital, where open doors encouraged the family to play an active role in treating the patients (part of the reason for this was also shortages of staff). Nehru, like many government hospitals, represented the move towards deinstitutionalization and focused primarily on outpatient care. Because many of Nehru's patients were from poor backgrounds, the hospital was often a space in which the patients wanted to rest because there were "fans, lights, [and] running water" [106]; it was not a place from which patients wanted to escape as was the case with Moksha. It is also at Nehru that that we also observe an instance of possession that would remind us of our previous discussion from the Vedic and classical

[104] See Harlan, Lindsey and Paul Courtwright, eds. *From the Margins of Hindu Marriage: Essays on Gender, Religion, and Culture*. Oxford: Oxford University Press, 1995, quoted in Pinto 84.
[105] In Sanskrit, *mokṣa* means "liberation" or "freedom," which sharply contrasts with the reality of the private ward.
[106] See Dr. C.'s quote in Pinto 163.

periods – "…when asked if a god or spirit had been coming to her, the answer was yes. A goddess had been 'grabbing' Kavita and demanding food…" (Pinto 165). We will not delve into her case, but it suffices to say that possession by deities is very much alive as a mode of mental illness in India today, though it would not be treated with incantations and religious rites as it would have been a couple thousand years ago, at least not in the hospital.

On the surface level, *Daughters of Parvati* shows that there is not one mainstream perception of mental illness and its subsequent treatment in contemporary India – the three different spaces through which Pinto leads us involve vastly different methods of treatment along with the questions and issues that go along with each, though Āyurveda, another focus of this paper, does not play strongly in either case. In some ways, institutions like Moksha are remnants of a darker colonial past in which the asylums sought to separate the sane from the insane, the worthy from the unworthy, the dignified from the shameful. On the other hand, modern hospitals like Nehru seem to have kept up with and perhaps led the legal developments in which madness became more of an affliction rather than the definition of a patient's identity. On a deeper level, though, Pinto reveals the "windstorm of narratives" that attempt to make sense of mental illness as well as its connection to love, family, and marriage (242). We specifically examined ways in which Ammi's madness had to be understood not only as an object of treatment in the Agra Mental Hospital but also as wound up in the tensions in the family members' relationships to one another. The stories of the women at Moksha and Nehru, into which we did not delve for space constraints, speak to the connection between madness and the vulnerabilities of marital love and sexual relations.

In the legal sphere, we mentioned that legislation has progressively afforded patients with mental illness an identity separate from their insanity. The scope of the law doesn't stop there, however, and it also addresses the relationship between madness and marriage. For example, the question raised in contested marriages is whether the allegedly insane partner could have "chosen a union in full capacity of mind"; in addition, "[d]ivorce, custody, and nullification cases depend less on

a person's rationality in entering a union than on the way mental illness prohibits the ability to fulfill marital duties" (Pinto 244). Hence, madness is understood legally to obstruct the completion of obligations accepted in marriage, whether by choice of love or by arrangement. Yet, there is a sense in which the legal language presumes a definition of marital bonds as the standard. The stories of the patients like Ammi, to an extent, challenge the idea that there is a defined ideal in family relationships that must be maintained or at least toward which the parties involved must work. Kinship involves "an effort to undo, to allow dissolution, as well as to re-form and bring together. Bonds must be unmade as well as made" (Pinto 74). Where legally, a dissolution in kin relations may be seen to shade into madness that inhibits the fulfillment of the duties assumed in those relationships, such breaking apart and rebuilding is part of the natural flux of relationships, and madness does not have to be that which breaks them apart; the story of Ammi's illness is tied both to the reordering of kinship within the family and to the efforts therein to reconstruct.

Daughters of Parvati tells a story that is at once local and universal. It forces us to reexamine the fragilities of our own relationships through the ways in which Ammi's illness reorganized her family "unit" and the connections therein. It makes the point that mental illness must be understood in the context of kinship, broken relationships, and reconstructed humanity and that sometimes, we may come to grapple with the delicate nature of human relationships only when something like mental illness forces a disruption and reevaluation. Love can both cause madness and also be a signal for an underlying madness (especially in the case of "wrong" or inappropriate love).[107] The family, easily considered a symbol of stability and locus of care and affection that may begin breaking down now or then, may rather be "always in a state of breakdown" in which family members attempt to maintain their connections in the face of every little change and adversity (Pinto 73). Connections with other people, family or otherwise, may not be given but are rather the object of deliberate

[107] See Pinto 244 for four rough categories of madness connected with love and intimacy based on the women encountered in the book

effort.[108] Finally, the ethnography is a testimony to the power and simultaneous futility of words and narratives. Where history presents an account that opposes those of witnesses, we may be left to appreciate the validity of all those stories at once, much like with psychotic speech in which the lines between truth and falsity, reality and imagined history, blur and effectively disappear. If nothing else, we learn from this book that madness is difficult to pin down as any one thing, that it is not simply the degeneration of relationships but that it is wound into the thread that rebuilds them, and that its study imparts insights that are at once specialized and broadly applicable.

[108] See Pinto 67 for the contrasting opinions of Nishchal and Keshav regarding Ammi's ability to "connect" – Pinto implicitly encourages us to adopt a perspective aligned with that of Nishchal

CONCLUSION

This thesis has led the reader through about five thousand years of history to answer the question of how medicine and madness, particularly the perceptions of and attitudes towards madness, have transformed through the millennia in what is now India (technically, the geographic focus for most of this paper is South Asia and not just India; only the final section on contemporary treatments of madness focuses on India post-independence) to shape modern developments in the treatment of mental illness. We began in the ancient period from which time we have concrete evidence of treatments for madness according to the Vedic texts thanks to an incantation in the Atharvaveda, which contains most of the religious and medical healing literature from that period. At the risk of overanalyzing the charm, we can conclude that madness was understood to be a mode of possession, usually by malevolent entities, but also involved the departure of benevolent spirits that ordinarily should exert influence over a good man. The human body was seen primarily as a means of expression for the demonic spirits without becoming fundamentally altered in the process. Yet there was a distinctly "medical" approach to treatment to supplement the rituals and chanting of the charm – the medical priest describes that he prepares medicines to help dispel the afflicting spirits. It is unclear based on the charm alone that the medicine was understood to be potent without the charm; hence, we used the term "magico-somatic" to describe treatment of madness in the Vedas. At once, madness depended on "magical" incantations and spirits, yet the disease was ultimately located in the body. We also noted that while the madman was understood separately from his disease, the fact of his lunacy would have necessitated restraint and control for the protection of the greater society.

As we transitioned into the classical Ayurvedic system of medicine, developed roughly around the turn of the Common Era, we observed the shift from "magico-somatic" to "empirico-somatic." According to Zysk's speculations, Ayurvedic priests incorporated the framework of the religious priests with the knowledge of botany and pharmacopoeia gained from the fringe members

of mainstream society. Unhindered by restrictions of ritual purity, or so the story goes, these medical healers came into contact with a wide variety of community members and compiled the knowledge developed into the Ayurvedic texts, notably the *Carakasaṃhitā* and the *Suśrutasaṃhitā*. This ushered in the first rigorous medical tradition in the subcontinent, and the body, along with the diseases afflicting it, began to be conceived in recognizably somatic terms. One of the most unique features of Āyurveda is the doctrine of the three humors – *vāta, pitta,* and *kapha* – whose imbalance can result in disease. We found that madness took a different form when one rather than another *doṣa* was primarily responsible, and in some cases, the deviant actions posed a threat to society. At other times, madness was characterized more by lugubrious behavior. There was also the category of "external" madness, which could have been a recognition of the limits of Ayurvedic diagnosis. Alternatively, it could have been a way for Ayurvedic priests to gain greater authority such that they could still provide treatment in cases where patients may be taken to an exorcist instead. Due to inclusion of seemingly "positive" qualities in the symptoms of madness due to possession, such as an affinity for music, we concluded using Hyne-Sutherland's analysis that the defining feature was not dangerous or painful behavior but rather deviance from an established norm. Stretching this idea perhaps too much and pointing to the rather jarring threats prescribed in certain cases, we could say that treating madness was not primarily for the benefit of the patient but rather for ensuring the smooth functioning of the community; this would be largely conjecture, however.

The next major phase we examined was the age of British colonialism, in particular the 1800s with a special emphasis on the first half of the century. In many ways, this is one of the most complex periods of medical history in India, and there is a wide variety of primary sources, such as the papers of medical superintendents, that have been analyzed by scholars like Waltraud Ernst. What we learn is that the asylums established in the major British centers like Bombay, Madras, and Calcutta were packages of irony – the word "asylum" is usually used with a positive connotation in English to mean "shelter" or "protection," yet the insane asylums of the Raj were quite the opposite for the patients.

Many asylum superintendents profited off the inmates' provisions, leading to many deaths behind the dark walls of the institutions. One could make a fair argument that the asylums were really meant for the protection of society, for the removal of the shameful segments of the population. The latter idea helps connect the asylums with colonial ideology since the British officers needed to maintain their self-image as formidable rulers. Part of the messiness of mental illness treatment came from the connection between medical careers and promises of quick but shady fortunes. While legislation helped clean up the medical profession generally, treatment for mental illness was often embroiled in disagreement, sometimes even over the potential for Western somatic medicine to treat mentally ill patients.

The early- to mid-1900s could be described as a period of modernization and the transition away from the medical systems established by imperial rule. We examined two roughly simultaneous developments: the greater official recognition of a (modernizing) Āyurveda on the Indian medical scene and the development of the modern mental hospital that sought to escape its asylum past. Āyurveda was not taken seriously by the colonial administration until it was recognized as a cost-effective means of administering medical treatments, especially in rural areas. Despite heavy skepticism of its methods, the British gradually afforded it greater authority; combined with the passionate nationalist discourses of the time, which incorporated Āyurveda into their visions of an independent, authentic India, Āyurveda underwent several changes that would ensure its survival well into the future. For example, the traditional system of apprenticeship that emphasized attention to the local context was replaced by a degree-course -style education that attempted to legitimize and expand the reach of Āyurveda.

Concurrently, through the process of Indianization, authority over medical hospitals was gradually transferred to Indian doctors, such as Dhunjibhoy. Despite persistent racism, he was able to create a successful mental illness treatment facility that emphasized care and rehabilitation rather than exclusion and confinement. He incorporated new methods, such as work therapy and herbal

remedies that Āyurveda had long known, to develop a modern hospital that would allow patients to feel cared for and useful to society. Where the asylums had understood their patients as largely identical with their illness, Dhunjibhoy's hospital at Ranchi allowed its patients to maintain an identity separate from the illness, such as religious identities around which certain therapies would be oriented. We could see this as anticipating developments in the legal language, which slowly moved towards referring to patients as being afflicted by mental illness rather than defined by it; this is perhaps best seen in the Mental Health Care Bill of 2013. Indeed, we could say that such recent legal developments are grounded in the history of the asylum, the history of Western medicine's interactions with traditional Indian medicine, and the efforts of leaders of modern mental hospitals to move away from the ideology of the asylum and bring the focus of mental health care to the patient first and foremost.

The 2013 Bill coincides roughly with Sarah Pinto's anthropological research of mentally ill women in north India. She asks us to adopt a new frame of reference that moves away from the questions we had been asking in our historical study thus far – rather than analyze madness and its treatment in terms of authority relationships, contrasts between exclusion and care, or contrasts between somatic and moral views, it is richer to understand mental illness through kinship. That is, many of the patients she studied were caught in a web of vulnerable relationships, either with their children, their spouses, or their lovers, and she found it nearly impossible to generate one account of any of their stories. The reworking of those relationships and the duties and expectations that went along with each was as much part of the mental illness as was the institution or the family that was supposed to provide treatment. Madness, she writes, was almost more about navigating the ordinary bumps and dissolutions in kinship than about deviance from normalcy. *Daughters of Parvati* presents a picture of madness that is radically different from that in any other source examined in this thesis. Part of the reason is that this is the only ethnographic source we have employed significantly, and by its very nature, it is able to engage with the speech of the patient, family members, and hospital staff.

Along the way, Pinto infuses her own stories of managing strained relationships and finds several striking points of similarity between the vulnerabilities she experienced and those she witnessed in her research. Ultimately, the conclusion she draws is that families indeed care deeply for their mentally ill relatives, and some institutions incorporate family into hospital treatment while others tend to isolate their patients from the outside world. Mental illness is wound up in the often ill-defined network of relationships that involve love and commitment, and it cannot be examined merely as an object of attention in the institution.

On a final note, we could ask why it is important to study mental illness. If Sarah Pinto's book holds any weight, then psychological vulnerabilities are part of the natural dissolutions of and subsequent efforts to rebuild relationships with other human beings. Understanding mental illness and the ways in which our society handles it speaks volumes about our capacities to face strained connections and communicate the needs and sensitivities of individuals in the community. In addition, studying a society's response to its mentally ill patients reflects on its culture. Psychologist Nev Jones asserts that "culture profoundly influences every aspect about how madness develops and expresses itself, from its onset to its full-blown state, from how the afflicted experience it to how others respond to it, whether it destroys you or leaves you whole" (Dobbs). We saw that patients with mental illness largely suffered as subjects of the asylum system, which largely stripped them of their humanity. With the advent of the modern mental hospital and the accompanying emphasis on rehabilitation rather than suppression, patients' whole identities were given greater attention. Finally, modern legislation, reflecting several of the important transitions of attitude in the post-asylum era, is helping India create a culture in which those with mental illness are treated as valued, "whole"[109] members of society.

[109] See Dobbs

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