British colonialists established lunatic asylums in India for the treatment of insane Europeans and Indians modeled on English institutions. They were initially constructed as they were in other parts of the British empire and the world to segregate those who were dangerous or troublesome to their neighbors by reason of mental illness. Such asylums were in fact detention centers. Based on the annual returns, however, one might conclude that treatment was also a priority, sometimes more so than others, but it was not until 1922 that the term "lunatic asylum" was changed to "mental hospital" (Shaw, 1932). The first mention of a lunatic asylum in India can be found in the records of the Bombay Presidency, Consultations of 14 March 1745/46, "ordering a place near the back of the hospital to be fitted up for lunatics, at a cost of Rs. 125" (Crawford 1914: II-395). It was not until 1806, 60 years later, that the asylum at Colaba was established, which was the principal asylum serving Bombay throughout most of the 19th century (N. B. 1812 map of Bombay versus Crawford 1914: II-400).

The first lunatic asylum in Calcutta was founded by George M. Kendardine, who had the dubious distinction of becoming "the youngest surgeon of the Indian Medical Service not to rise," having been dismissed for neglect of duty in 1767 and reinstated after demanding a public inquiry. Kendardine died on 19 May 1787, and two days later the Medical Board recommended "the foundation of a regular asylum" with Assistant Surgeon William Dick in charge, who built it at his own expense and rented it to the East India Company at Rs. 400 per month (Crawford 1914: II-428-9). A private asylum for Europeans opened in 1817 in Bhowanipore replacing the poor facilities of the government institution, and the Dullunda Lunatic Asylum for Indian patients opened in 1847. It was only several hundred yards distant from the European institution and managed by the same superintendent. The first lunatic asylum in Madras was approved in 1793 and built the following year by Assistant Surgeon Valentine Conolly, who was also Secretary to the Medical Board from 1791-1793.

European and Indian patients were segregated either in separate asylums (e.g., Dullunda for Indians and Bhowanipore nearby for Europeans) or in separate wards of a single asylum (e.g., Colaba Asylum serving Bombay). The policy of returning European servants of the East India Company who were certified insane while in India was adopted by the Company in 1818, based on the premise that "an early removal from a hot climate affords the patients the best chance of recovery." (Public letters to Bengal 28 June 1820, 91-98 quoted by Farrington 1976:127). Upon returning, many of the patients were treated at the Pembroke House in Hackney until 1870 and then at the Ealing Institute from 1870 to 1892. Detailed case books of the Pembroke House and Ealing asylums are now on file in the records of the India Office. The Lunatics Removal Act of 1851 provided

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for any person of unsound mind in custody to be removed to England at the expense of the East India Company, a debt for which the individual was responsible to the Company. By 1866 after the Crown had taken over from the Company, the Secretary of State for India, Sir Charles Wood, objected to the practice of sending Anglo-Indians to England if the potential benefit did not seem commensurate with the cost. This policy was reclarified repeatedly to prevent persons being inappropriately shipped at government expense.

The following is representative case indicating the approach to management Company patients returned from India in 1825 (Case book 1846 Indian Office Records: K/2/351):

Patient John Bolton
Gunner, First Battn Artillary
Admitted 3 February 1825
This patient was sent from his Corps to the Asylum, he has undergone very active treatment with very little benefit, he labored under phrenetic mania, on his admission active treatment was continued, repeated applications of leeches and cold applications to the head, active purging and a severe antiphlogistic regimen, the use of Digitails, and confinement to a darkened cell removed the inflammatory affections of the membranes of the brain. He has since been tranquil, morose, taciturn and melancholic, perfectly incoherent on all subjects—He may occasionally require restraint, should be kept quiet, should have a plain diet, and no wine or spirits, will require constant observation, his bodily health is now good.

R. Atkinson, Surgeon
Lunatic Asylum
23 April 1825

In treating insane patients in the Indian lunatic asylums the value of simple interventions and kind treatment was recognized in the earliest records. The reports for Bhowanipore and Dullunda in 1856 and 1857 emphasize the importance of a good diet and the soothing effects of tobacco smoking. Chronic patients were found to benefit from opportunities to converse with "sensible" people (Bengal 1858:8, 11; Bengal 1863). Recreational activities and amusements for the patients that were sometimes made available are specified. According to the report for 1862, at the Dacca Asylum Indian musical instruments and games were provided after the evening meal. Those who could manage it were allowed to go to the bazaar or to attend local festivals with the Keepers (Bengal 1863:33, 23).

Accommodations were minimal for most patients in these institutions. The provision of wooden platforms so that the patients would not have to sleep on the floor or ground was a notable improvement in the Dacca Asylum in 1872, helping to diminish the rates of medical illness, morbidity and mortality (Bengal 1873:29, 12). Later reports in the Punjab expressed some concern that patients be provided with separate sleeping accommodations to prevent the physical and sexual abuse of patients by one another.

The officers in charge of the asylums in India during the latter half of the 19th century, whether British as most were or from other European nations, were strongly influenced by the sentiment against mechanical restraints and social value emphasizing the humane and therapeutic treatment of mental patients that were prominent in English psychiatry during the 1850s and 1860s (see John Conolly 1973 [rpt. of 1856 ed.] and Samuel Tuke 1964 [rpt. of 1813 ed.]). Consequently, considerable attention was focused on the use or non-use of restraints in the
annual returns. In one instance, for example, the superintendent of Golaba Asylum was criticized for using leg-irons on a criminal European patient. The Surgeon general wrote:

In my opinion this is a mistake, as likely to irritate rather than soothe, and to render the patient more than ever desirous of effecting his escape; besides, I do not consider the reason given by the Superintendent a sufficient one, particularly as the man is stated to be generally quiet and orderly in his conduct. To my mind, this case illustrates Dr. Niven's remark of 'a poor lunatic receiving too much treatment, and too little care' (Bombay 1874:21).

The reports for Bhowanipur and Dullunda Asylums in 1856 and 1857 state that the "non-restraint system, in the ordinary acceptation of the term, has been established as the rule of the asylum" (Bengal 1858:3). Later in the report, however, Theodore Cantor, the Superintendent, who was Danish, notes that mechanical restraints were not entirely dispensed with in 1856, but that coercion chains and manacles were reserved for extreme violence. The report suggests that were it not for "cowardly native attendants" they might have had less use, explaining that it was preferable to subdue European patients with an impersonal mechanical appliance than to make them suffer the humiliation and degradation of restraint by native attendants (Bengal 1858:12).

It was widely believed that there was less of a need to use mechanical restraints for Indian patients, since "native Insanes are generally much more manageable than European patients" (Bengal 1858:55). Restraints were employed in Dullunda through the 1870s when ligatures and woolen bags were specified as the means to subdue patients. In 1871 three causes were recorded as warranting their use—excitement, surgical disease and in one case, "eating mud when left free" (Bengal 1873:46).

The use of labor as a therapeutic modality was widely advocated throughout the subcontinent, and its beneficial results led many to tout it as a near panacea in the management of mental patients. It was believed that because the Indian patients generally came from laboring classes, it was much easier to enlist their cooperation than it was with the European patients who scorned labor. Europeans at Bhowanipore reportedly spent most of their time doing nothing (Bengal 1873). It was the stated policy that work be therapeutic and not compulsory; the tasks should not be too taxing and the goal of restoring health was to be kept over that of profit. The benefits of labor were especially emphasized at the Dullunda Asylum, where Dr. Payne reported the recovery of several chronic patients after labor was introduced. Dr. Niven, the superintendent of the Golaba Asylum in Bombay reported in 1873:

It has several times been brought to my notice how well all the noisy patients sleep when they are employed for three or four hours in the afternoon, carrying sand or mud for garden or reclamation purposes from the foreshore when there is ebb tide. My firm conviction is that if the asylum had 20 or 30 acres of cultivable land attached to it the cures would be doubled (Bombay 1874:6).

Other aspects of treatment varied throughout the country. Dr. Smith in Lahore believed digitalis was useful, while Dr. Penny in Delhi mentioned no drugs (Lodge Patch 1931:38). At Ahmedabad Asylum hydrate of chloral is mentioned
as occasionally useful for treating excitement or insomnia, along with a mustard poultice applied to the stomach. Bromide of potassium was mentioned as a treatment for epilepsy. The Superintendent at Ahmedabad reported, "Such remedies (have been) rarely used since a comfortable meal is the best sedative (and) exercise and labour is the best hypnotic" (Bombay 1874:32, 19). Silver nitrate and asafetida were used to treat epilepsy in the Moydapore Asylum. At Dullunda in 1872 drugs were found not to be especially useful, except for the occasional "stimulant in the form of commissariat rum...a very effectual and innocuous remedy" (Bengal 1874:25, 54).

"Current electricity" was mentioned as coming into use in Europe, and it had been tried in Dullunda with "some rather surprising results." Unfortunately, no further details about the clinical response were provided. Technical problems were cited to explain why this technique was not employed in 1873: "the machinery at present available in the Medical Store Department here is primitive and imperfect" (Bengal 1874:25, 14).

The Berhampore Asylum report for 1862 mentioned the effectiveness of blisters to the head or nape of the neck and a cold shower. Here also, however, the emphasis was placed on good feeding, gentleness and kindness in the management of the patients (Bengal 1863:69). One attempt at innovative therapy—originally considered, perhaps, to deal with the intense crowding at the Dacca Asylum in the late 1860s and early 1870s—was an experiment introducing "the Gheel system" of boarding out patients. For those for whom it was felt safe and who had no friend to maintain them, arrangements were made to have them live in the home of a reputable person, where medical officials could periodically check their status. After many unsuccessful attempts, Surgeon-Major J. Wise, the Superintendent at Dacca in 1872, arranged to board six non-criminal insane with two residents. Three others were boarded with the Headmaster of the Normal School, and each boarder was subsidized at Rs. 5 per month. Since it cost Rs. 7-10 to keep them in the asylum the arrangement was considered a financial success. Others followed. The main problem was the considerable fear on the part of those who took in the patients that they were accountable should the patients in their care escape (Bengal 1874:42-43).

Competition between the Western and more popular indigenous medical practices was intense, and toward the end of the 19th century, the British asylum superintendents tended to look with increasing condescension and outright disdain at indigenous practices, such as restraint, phlebotomy, blistering and exorcism, which they took for proof of the relative sophistication of their Western medical tradition. In so doing they forgot or merely ignored the fact that many of these same practices which they so vehemently decreed in the indigenous traditions had recently played a major role in their own therapies as well. This attitude of haughty, yet unsubstantiated superiority followed from the dominance of the Anglicist policy of the colonial government, clearly articulated in Macaulay's Minute on Education in 1835, which sanctioned the predominance of Western values in education and English over Indian languages and culture (Kopf, 1975).

In retrospect, the emphasis placed on the "moral treatment" of the insane through much of the 19th century in the Indian lunatic asylum reports of the British Indian Medical Service reflects humanistic values, regardless of the degree to which these values were actually realized. The extent, however, to which treatment in these lunatic asylums dur-
ing the 18th and 19th centuries was able to ignore the indigenous concepts of mental disorder that were so widely held among Indian patients is no less remarkable. Both phenomena can best be understood as a consistent outgrowth of prevailing policies sanctioned by the British government, advocating reforms in the care of the insane at home and abroad and Anglicist dominance in India.

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