

The Mad and the Past: Retrospective Diagnosis, Post-Coloniality, Discourse Analysis and the Asylum Archive

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Before attempting to use as a historical source the Lucknow Lunatic Asylum case notes of the British colonial period in India, it is necessary to determine which methodological approach is most viable. The approach of historians, who attempt retrospectively to diagnose the patients of the past from the clinical details of case notes, does not satisfactorily deal with the criticism that data on medical case notes is less a series of objective observations and more a product of the power relations of the period. In contrast, medical and postcolonial historians treat the information on the case notes as a set of discursive constructions rather than a series of objective observations. By tracing the discourses in operation during construction of the Lucknow case notes, this paper identifies the ways in which the notes can be read as a series of colonial and medical discursive representations rather than as a set of clinical data.

THE LUCKNOW PSYCHIATRIC CASE NOTES

Three volumes of psychiatric case notes have survived from the Lucknow Lunatic Asylum established by the British in 1859. The new asylum at Lucknow, a major city and cultural centre on the plains of northern India, was part of a programme in the 1860s and 1870s that developed a coherent colony-wide approach to those the colonial authorities considered to be “insane” (Mills, in press). This programme benefited from new legislation, Act XXXVI of 1858, that determined the policy for both the “civil” and the criminally insane. The programme also saw the rapid expansion of the asylum network in India, as 16 of the 26 asylums that

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Disease	Name	Age	Caste	Occupation	Admission	
Date	Symptoms					Diet

Fig. 1.

operated under the jurisdiction of the Indian Government by 1880 had their origins in the 1860s and 1870s.

The case notes offer a rare glimpse of what was happening inside these asylums during this period of expansion. The three volumes cover the period 1859 to 1872, but the volumes seem to be numbers 1, 2 and 4 of a series, with volume 3, covering the period September 1865 to October 1868, missing. The signatures at the bottom of case notes match the names of the superintendents recorded in the asylum's separate annual reports, suggesting that these British medical officers authored the notes. However, these superintendents were also the civil surgeons for the entire area in and around Lucknow. As such, they had a range of other duties to attend to, with the day-to-day running of the asylum in the hands of mainly Indian subordinates. Each superintendent would have relied on his Indian staff for details when completing the case notes, but it seems likely that he—and these doctors were always male during the 19th century—actually wrote up these documents.

The notes themselves were improvised affairs, and the books in which they appear were originally simply bound volumes of blank paper. Each page was subdivided into various sections for data by means of inked, ruled lines added by hand (see Figure 1). The top right-hand box was always untitled and often unused; when it was used, it included brief details of which particular magistrate had sent the admission to the asylum. The diet column was never used and often written over as an extension of the narrative of the symptoms section.

In the three volumes covering more than a decade, we find diverse details in the narrative section that include date, symptoms, and diet. The case note of Shew Deen (IV, 116, admitted 22.9.69) had an entirely blank narrative section and included details only in the general information categories (disease, name, etc.). In contrast, the record of Jeobodh Kumar's residence in the asylum, which lasted over 30 years, merited more than four sides of notes in the narrative section (IV, 42, 27.2.69).³

Interpreting the details on these case notes is far from a straightforward task. Simple information such as age is difficult to trust. Of the 721 notes, 508 have ages

³The case notes referred to are from the Lucknow Lunatic Asylum for the period 1859 to 1872. The first reference number refers to the volume in which the case note can be found (the original numbers IA, II and IV are retained). The second number is the patient case note number within the volume. The third detail is the date of admission.

that are entered as multiples of 5; in other words, about 70% of the patients were entered as being, for example, 15, 20, 25, or 30 years old upon admission. This suggests a process of estimation for the medical officer filling in the case note. For example, Lobha (IV, 54, 31.8.68) was admitted in August, 1868 and died in November, 1869. Originally judged to be 27 years old, a thick, black line through this figure indicates a change of mind on the part of those filling in the case note, possibly as a result of new information coming to light on the arrival of relatives to collect the body.

While the accuracy of simple dates can be thrown into doubt, the meaning of more complex data such as diagnoses can also be debated. On each case note a one word diagnosis appears (e.g. mania [occasionally with the qualification acute or chronic, rarely with the qualification puerperal], dementia, amentia, melancholia, paralysis of the insane). Evidence from reports elsewhere in the asylum system suggests that the meaning of such simple labels should be approached with caution:

On referring to the reports of former years, I find that Dr. Simpson in 1862 distinguished between 9 varieties of insanity. In the reports for 1863 and 1864, [only] 8 classes are enumerated; mania being subdivided into chronic and recurrent, and dementia into primary and secondary. In the report for 1865 only 5 classes are noted, mania chronic and dementia being made to include the subdivisions of former years. In 1866 the same nomenclature was followed. It has been found impossible to alter the classification of the present report, as the monthly returns and case books have been filled in accordance with it. . . . It would be easy to adopt "a uniform standard of distinction" in all asylums, but the orders on this subject are vague. The circular letter of the Medical Board no. 25, dated 13th July 1854 leaves it to the option of the Superintendents to follow one of two classifications; but it directs that if the minute subdivision is adopted, the varieties must be included under the 5 heads of moral insanity, monomania, [acute and chronic] mania and amentia. The table in the revised rules of 1860 only recognises these divisions. (*Annual Report on the Insane Asylums in Bengal for the Year 1867*, p. 42)

This passage illustrates that diagnosis and classification were far from uniform or standardised processes. The problem of nonstandard diagnosis and classification was one that dated back at least until the 1850s, with attempts to impose a uniform way of diagnosing and recording diagnosis having failed. More remarkably the example shows how the classificatory systems used in one single asylum varied from doctor to doctor and from year to year. Indeed, similar comments in reports 20 years later show that the issue of standardising diagnosis and recording diagnosis had still not been settled: "The several types of insanity are not clearly defined: they dovetail, overlap and merge into one another, and as the case progresses the type of insanity often changes altogether" (*Annual Report on the Insane Asylums in Bengal for the Year 1885*, p. 3). These comments clearly indicate that the simple diagnostic labels on the case notes did not have clear and distinct correlations to specific sets of symptoms.

While it would be unwise, then, to trust in the reliability of such basic information as age and diagnosis, the case notes do contain fascinating detail in the narrative sections penned by the superintendents. This information will be the focus of this article. But first, how is this information approached by the historian?

PSYCHIATRIC CASE NOTES AS HISTORICAL SOURCE

The obvious way to use historical psychiatric case notes as a source for exploring the past would be as those who wrote them intended. In other words, the historian might accept that these documents are records of the patients' illnesses, and use them to trace who was treated where and for what disease. Historical psychiatric case notes could be, therefore, useful for exploring the mental illness of patients of previous eras and the epidemiologies of the past.

Indeed, throughout the 1990s, a number of writers chose to adopt this approach. Persaud (1993) studied Samuel Coates' memorandum book between 1785 and 1825 and suggests that "schizophrenic symptoms were rare in 1790 and common in 1823" (p. 510). Turner (1992) attempts to assess the "melancholy" and "mopish" behaviours recorded on case records from as far back as the 17th century in order to conclude the opposite of Persaud, that "the historical evidence behind recency disease theories of schizophrenia seem thin" (p. 427). Using the information presented on the case notes as if such data were an accurate record of symptoms, these authors try to establish if schizophrenia is a condition of modernity or a constant in human experience.

Other studies also mention schizophrenia in their conclusions, although they are less interested in the recency debate and more interested in assessing the types of illness as understood in today's psychiatric idiom for which patients were admitted to Victorian asylums. Parker, Dutta, Barnes and Fleet (1993) decided after analysis of case notes from Rainhill that they would "carry out a retrospective analysis of the diagnosis made in 1890 . . . using all the clinical information available in the case notes." They conclude that

according to the retrospective diagnoses, depressive illness and schizophrenia comprised the largest categories, as they do today. Alcohol-related illnesses also account for a large number of diagnoses. Acute confusional states and personality disorders came next in order of diagnostic frequency, and acute confusional states were certainly diagnosed quite frequently. Patients with personality disorder, however, did not seem to be very often admitted to the Asylum. Schizo-affective psychosis and schizophreniform psychosis were not diagnoses included in the above list. This is probably a result of insufficient day-to-day clinical information being available from the notes. (p. 100)

In his two part study of the Royal Edinburgh Asylum at the end of the 19th century, Allan Beveridge (1995) analysed a sample of patient case notes using the 1975 Research Diagnostic Criteria of Spitzer, Endicott and Robins. His findings were that "organic illness featured prominently in the Asylum population, especially amongst West House patients . . . comparatively few patients met the criterion for schizophrenia although the numbers were higher for East House patients" (p. 143).

As Parker and colleagues suggest, the researchers using the retrospective diagnosis method are not unaware of problems with the sources they are using. These authors suggest "insufficient day-to-day clinical information," or what Persaud

(1992, p. 93) calls “confusing past terminology” as potential hazards for those wishing to diagnose from old case notes. Similarly, Turner suggests the possibility that documents from asylums of the past may record “madness” in ways meaningful to physicians of that period and culture but are less intelligible to people from outside of that period and culture. He advises that “care must be taken in the use of modern operational criteria, based on first-rank symptoms and research-based assessments, for diagnosing psychotic illness from historical accounts” (Turner, 1992, p. 428).

While most historians would hope “that our notes in 1990 [are] considerably more objective in their nature and considerably less Dickensian in their style” (Parker et al., 1993, p. 105), investigators who use retrospective diagnosis as a historical method often accept that the details on case notes are clinical “facts” from which medical judgments might be made. Such investigators are convinced that the information on case notes is a more or less accurate rendering of the person who was the subject of that case note. Moreover, the retrospective diagnosis used in these articles is dependent on faith in the information found in case notes. This represents an implicit belief that information is objectively observed and recorded clinical data. The language of case notes is, then, a transparent medium through which the subject can be viewed and represented. Any hint that the details on the note are anything less than a clear and untampered account of the subject of the note would discredit the belief that the information contains “symptoms” with possible psychiatric interpretations. To be “symptoms,” the events recorded on the case note have to be acceptable as scientifically observed and recorded, that is, observed and recorded objectively and impartially.

There are, however, sound reasons for doubting that the information on the case notes can be used as accurate representations of the individuals. The most obvious reason for doubting the objectivity of the information is the objection raised by linguistic theorists to the idea that language is a clear medium that simply and accurately relays information about the world. Hayden White (1978) calls this belief “the illusion on which all of the modern human sciences have been founded . . . that words enjoy a privileged status among the order of things as transparent icons, as value-neutral instruments of representation” (p. 232). Instead, “language in texts always . . . functions ideationally in the representation of experience and the world” (Fairclough, 1995, p. 6). That is, language is a creative medium, acting to produce new objects (representations and ideas) when describing the world rather than simply reproducing the subjects about which it is written.

Many historians of both medicine and colonialism have been influenced by these linguistic arguments. Those historians (see, for example, Risse & Warner, 1992; Macleod & Lewis, 1988) consider medical knowledge and medical documents in light of such ideas, argue along with Ludmilla Jordanova that “it is a mistake to separate the knowledge claims of medicine from its practices, institutions and so on. All are socially fashioned, and so it may ultimately be more

helpful to think in terms of mentalities, modes of thought, and medical culture than in terms of 'knowledge,' which implies the exclusion of what is inadmissible" (Jordanova, 1995, p. 362).

Such an emphasis is on the social and cultural nature of medical information rather than its transparency as a medium for accurately depicting the world. Medical knowledge, then, reflects the values and beliefs of researchers, clinicians, and the medical culture of which they are a part rather than the objects of their inquiry. Looking at psychiatric records in particular, historians have made similar assertions. Matthews (1984) argues in her study of female psychiatric patients in 20th century Australia that the records accurately captured "the masculine bias of our language and its organisation of reality" (p. 28). Coleborne (1997) similarly concluded that the case notes available on female patients in 19th century Australia were gendered narratives that tell more about the male doctors' beliefs about women than about the women described in the documents. "The observations made of the scrutinized patients in the asylum," she writes, "reveal a range of social practices and attitudes towards them" (p. 48).

Historians who worked with colonial rather than psychiatric records have reached similar conclusions about information contained in those documents. For example, post-colonial historians and subaltern theorists such as Amin (1987) and Guha (1988) examined documents generated by colonial governments. Amin looked at legal documents from British India and objected that "historians of colonial India have hitherto, by and large, coupled their political opposition to pronouncements made by English judges on the 'native' accused with an uncritical reading of judgments" (p. 167). He shows how the judgment passed on the "riots" at Chauri Chaura satisfactorily explains the criminal acts of the crowd, as their picketing of liquor and meat shops is blamed on the prices charged by the shopkeepers. However, this record slyly turns a Hindu/Muslim declaration of unity (based on the issues of temperance and vegetarianism) charged through with religious and political implications into a simple act of wanton criminality by a typical mob. He argues that the explanation entered in the legal records is formed within a political discourse, where the demonstration of dissent is emptied of political significance by the act of recording the causes as economic. He concludes that "an economistic reading of the evidence did not yield a politics of the accused, but it has of the judgment itself" (p. 198).

Similarly, Guha (1988) demonstrates how official documents relating to the peasantry in colonial India were written in a prose reflecting colonial designs and relations. To simply label actions amongst the peasantry as a "rebellion" is to judge those actions in the context of the interests of the colonial state. In what he calls the prose of counter-insurgency, he shows how the "struggle for a better order" becomes "disturbing the public tranquillity," and how "resistance to oppression" becomes the "daring and wanton atrocities on the Inhabitants" (p. 59). He concludes that for the historian using colonial documents, "texts are not the

record of observations uncontaminated by bias, judgment and opinion. On the contrary, they speak of total complicity . . . these documents make no sense except in terms of a code of pacification which, under the Raj, was a complex of coercive intervention by the State and its protégés, the native elite, with arms and words” (p. 59). The documents are evidence of the way that the colonisers thought and wrote, not of the ways in which Indians at Chauri Chaura thought and acted.

This article, then, rejects the idea that it is possible to use historical psychiatric case notes as if they contain objective and accurate observations of patients. If language functions ideationally, then the information contained in historical documents is the product of the circumstances in which those documents were written rather than a transparent representation of the subject of the text. When this belief guides inquiry, historians approach documents to discover more about the *circumstances* in which they were produced. By analysing the discourses evident in the psychiatric case notes, it is possible to learn more about the values and beliefs, mentalities, and culture of those who composed the psychiatric case notes of Lucknow.

Lucknow’s Case Notes: Narratives of Colonial Fantasy and Medical Legitimacy

Consider the following case notes.

Jeeh Singh. . . . Dementia. Hindoo. Cultivator. 28. 13 May/62

Sent from Oonao. Civil Surgeon certifies that he has been insane for 2 months from no apparent cause—at times very violent and disposed to smash everything which comes in his way. Replies very incoherently to questions.

Shortly after admission he became much quieter—was regularly employed in the garden + improved in health + general appearance. I consider him now quite cured and he is discharged Aug. 5 1862. (IV, 194, 13.5.1862)

Dabee Singh. Mania. Brahmin. Beggar. 40. 16 April 1861

1861 April. This man was under observation in the Jail for sometime previous to his admission. There he complained that he was kept out of his just and lawful rights + demanded his release. He will eat nothing but sweetmeats. After a time his case was sent in from Hurdai from which it appears that he has been insane for the last three years. That he is not violent but very abusive of all without distinction. He is very much emaciated + suffers from diarrhoea, the effect of the sweetmeats on which alone he subsists.

June. In the last month has subsisted solely on melons. He eats 12 to 16 per day along with half a pound of chilli. Diarrhoea is less + altho’ still there has laid on flesh.

1864 This man has been in rude health for the last two years—eats + sleeps well. No difficulty of dieting him. Has regularly worked in the garden—very solicitous for his discharge. Says he has a mother alive in the Hurdai district. Discharged cured 5th Oct 1864. (IV, 94, 16.4.1861)

Both seem to read as narratives of complete mental and physical recovery. Yet these case notes can be read as such only because of the kind of information that appears on those documents, information that is the product of certain writing practices.

The information on these documents can be separated into two categories. The first is data on the patient's physical condition: Jeeh Singh is "much improved in health," while Dabee Singh has details of his diet, his emissions and his general physical appearance. The second category is not data on the patient's mental condition (as might be expected) but a record of certain types of behaviour, such as ability to work. How is this to be explained?

The "Physical": Medical Legitimacy and the Indian Body

The importance of information about the physical condition of the insane patient throughout the period for which case notes are available is emphasised by the examples below.

Mostt. Bunnoo. Chronic Mania. 35. Moosulman. Beggar. 12th November 1870
Violent

12th Novr 1870. Sent in by the Cantonment Magistrate of Lucknow for re-admission was discharged from asylum on the 5th Novr 1869.

June 26. 1873. Admitted to hospital for diarrhoea.

Jan 7. 1874. Bunnoo died this day. She has been insane for about 7 years + in hospital nearly 7 months. She had chronic diarrhoea + became anaemic. (IV, 231, 12.11.1870)

Written in 1870, her entry reads like a chart of physical demise rather than as a record of mental aberration. The record stresses that she was deemed violent by the Cantonment Magistrate and states simply that she was insane for the best part of seven years before she died. Yet most of the data concerns her physical condition; the date that her diarrhoea set in, the length of time that she remained afflicted with this bodily condition, and the subsequent developments and complications in her physical state are all accorded sufficient significance to enter the case note. This degree of concentration on the physical health of the internee is evident in notes from earlier volumes as well.

Bholah. m. Mania. 30. Hindoo. Cultr. 24 Jany/63

1863. Sent in by Deputy Commissioner Roy Bareilly was found wandering about cantonment there—on admission is much attenuated + suffering from dysentery, his intellect appears very much affected but there is also much bodily debility.

March. This man gradually sunk since his admission—the dysenteric motions improved but he could not eat + the vital powers gradually exhausted. On 23d March, he died. (II, 6, 24.1.1863)

The only reference to Bholah's mental state on the entire document is a brief mention of the fact that his intellect appears odd, but without manifestations of this mental state. The majority of the record is a series of observations on the man's physical condition and afflictions, mentioning his drawn out condition, his weakness and the progress of the disease thought to have a grip on his body.

A notable feature of the case notes is that death is always recorded when the patient expires in the asylum. Obviously a bureaucratic imperative was in operation

here for purposes of internal accounting. However, what is remarkable about this record of death in a document—ostensibly a record of mental ill health—is that information on the physical causes of a physical demise is rarely omitted. The above examples each contain details of the circumstances of death; often statements on the case notes are far more explicit. Bhola Dass “died in hospital from pneumonia” (II, 172, 27.4.1865) while Goolabdie simply “died of general debility” (II, 147, 5.1.1865). Kunsee “died of debility the result of repeated epileptic fits” (II, 143, 17.12.1864); Gosalee “died of chronic diarrhoea” (II, 1, 8.1.1863), a couple of months later Shewrutton “died of choleric diarrhoea” (II, 12, 23.3.1863), followed by Dhavee, who “died of chronic dysentery” (II, 14, 10.4.1863). The attention to detail in these examples, recording different verdicts on what must after all have been similar ways of dying, is worth noting, as are the following.

Kem Kurun. 50. Hindu. Labourer. 8 July 1869

Certified by the Magistrate violent

8th July 1869. Sent in by the Depy. Commr. of Oonao in a very weak state.

20th July. Died of chronic diarrhoea. (IV, 858.7.1869)

The patient’s physical condition is the medical officer’s only opinion, with the cause of death being the only medical detail he recorded. Significantly, the column at the top left of the page where the diagnosed mental condition is usually found is empty, and the only information about the man’s behaviour that might be linked to his mental state is supplied by a civil rather than a medical officer. While one might argue that this patient was alive for less than a fortnight in the custody of the asylum, which would have been too little time for the medical officer to form an opinion on his mental state, no such explanation can be offered for the following example below.

Gokul. Dementia. m. 18. Brahm. Cultivator. 17 Nov/64

17th Novr 1864. Sent in by Deputy Commr of Oonao.

29th Sept 1865. Died of chronic dysentery. (II, 139, 17.12.1864)

Here, where a diagnosis does exist, there is no information about the *basis* for that verdict. The only medical detail in this document of a man who has been incarcerated for almost a year because of his supposed *mental* state is the cause of his *physical* demise. Quite simply, then, these case notes are dominated by information on the patient’s body rather than on his/her mental state. One obvious explanation for all this information on the patient’s physical state is that the asylum superintendent was no specialist in mental illness during this period in British India. The author of the Bengal asylum report of 1877 stated readily that “few medical officers have had the opportunity of studying insanity” (*Annual Report on the Insane Asylums in Bengal for the Year 1877*, p. 33). In other words, the Civil Surgeon who found himself charged with the superintendence of the local asylum was trained as a physician and a surgeon, not as a psychiatrist. His field of expertise was the body and its workings and his day-to-day business in running

the dispensaries would require him to routinely observe, record and treat features of the body. This goes some way in explaining why the asylum case notes are often simply records of physical symptoms: all the superintendent was trained to do was to observe the body. When confronted with a group of patients in a medical institution, he would naturally fall back on what he knew best and most about, and get on with the job of observing and recording the bodies of those patients (Foucault, 1973; Major-Poetzl, 1983; Armstrong, 1994).

But to simply dismiss the emphasis on physical data as the result of bureaucratic practice or professional habit is to ignore the politics of the period when psychiatry was establishing itself as a discipline. Another way of explaining the emphasis on physical data has been offered by Andrew Scull (1991), who looked at British asylum documents for the 19th century and attempted to relate this knowledge to the power relations of the period. He points to the fact that the medical profession's insistence that mental illness was a matter of physiological disruption served its purposes as an interest group. He identifies three tasks among members of the medical profession in the first half of the 19th century: "persuading those with power in the political arena of the horrors of the traditional and still flourishing madhouse system and thus of the urgency of reform; establishing asylums run on the new system of moral treatment as the solution to the problem of providing care and treatment for the insane; and reasserting and establishing on a more secure foundation medicine's threatened jurisdiction over madness" (p. xxiv).

Central to the last part of this project was the development of an intellectual rationale for the claim that madness ought to be the exclusive preserve of those who were medically trained rather than, for example, those with religious training. Scull (1991) directly links the assertion that "the brain, as a material organ was liable to irritation and inflammation and it was this which produced insanity" (p. xxx) to this last part of the project. In other words, the physicalist discourses on mental illness were a product in many cases of the discursive construction of the body as the site of mental illness, which was related to the professional ambitions of many medical professionals in the 19th century.

The nature of the information included on the case notes from the Lucknow lunatic asylum can be linked to a number of medical discourses, from medical legitimacy to the anatomo-clinical gaze. Yet a look at the more detailed information about the physical state of the patients suggests that the case notes are not solely linked to these medical discourses. The general observations noted about the cranium of patients in the early 1860s—Chumula, for example, "has a low forehead and narrow head" (IV, 15, 13.5.1860)—were replaced by more accurate data by the end of the decade. In the first entry on Kudhlay's record in 1868 is the detail "circumf of head 20 inches" (IV, 20, 14.12.1868). Hulwar's entry, determined by the British officer as "cir of head $20\frac{5}{8}$ in" (IV, 22, 30.12.1868), is scribbled on his case note. The doctor who compiled the document for Dulloo was evidently taking

an interest in this part of his job as he did not simply record the measurement but passed the comment that “his head measures *only* 20 inches” [author’s emphasis] (IV, 36, 20.2.1869).

These measurements were, of course, linked to the phrenological project to record head size in an attempt to discern correlations between cranial capacity and mental capabilities. This project was part of the general move towards anthropometry in Western culture, which had begun in the 18th century and which was receiving official endorsement in India by the 1860s with the publication of George Campbell’s *The Ethnology of India* in 1865 (cited in Bates, 1995) and the subsequent Ethnological Committee in the Central Provinces of 1866/7 (Bates, 1995, pp. 219–239). This measuring of bodies grew from what has been called “the peculiarly recurring idea that is deeply rooted in Western scientific and popular thought . . . the idea that moral character is rooted in the body” (Urla & Terry, 1995, p. 1), which led to a host of medical and scientific surveys of populations around the world. These surveys were constructed with the belief that governments would be able to map out areas where bodies considered deviant were believed to concentrate. In India these surveys were collected in the form of the census, which Rachel Tolen (1995) argues “were undertaken with the goal of amassing a body of knowledge about the various peoples of India, their customs, and their manners, in order to aid in their efficient administration” (p. 81). The information about Indian heads on the Lucknow case notes throughout the 1860s is comprehensible, then, in terms of the very political project of mapping populations thought to pose a threat to settled rule by searching for physical correlations to moral or behavioural patterns considered problematic.

Yet when remarks on skin colour—“is of slight build and very dark in complexion, with very bright, restless eyes” (IV, 6, 11.2.1860), or personal hygiene—“not violent but filthy in his habits” (IV, 50, 4.2.1869), are included on the case notes, it is possible to see how the collection of physical data goes beyond the simple compilation of information for governmental purposes. As David Arnold (1993) suggests, “Over the long period of British rule in India, the accumulation of medical knowledge about the body contributed to the political evolution and ideological articulation of the colonial system” (p. 8). In other words, knowledge of Indian bodies was not just comprehensible in terms of the evolution of systems of effective government. The body was a site for the construction of difference, and difference lay at the heart of the power relations of the 19th century controversies about who was fit to enjoy the privileges of economic, legal and political enfranchisement (Urla & Terry, 1995). People demonstrably different from those who held the power to exclude from the economic and cultural benefits of modernity were considered unfit to be included. As such, “the ideal human body [was] cast implicitly in the image of the robust, European, heterosexual gentleman,” resulting in “the idea that individuals who deviate from that ideal are morally and socially inferior and that their social or moral disruptiveness is always somehow embodied”

(Urla & Terry, 1995, p. 4). The information on Lucknow's case notes on skin colour or the degradation of the patient's approach to their own body is not comprehensible in terms of contemporary theories on mental illness. It is comprehensible, however, in terms of what David Arnold (1993) calls the "ideological articulation of the colonial system." In other words, these entries on the case notes are not clinical observations understood as uncontaminated scientific data, but are located in the project of defining the "otherness" of those to be excluded from power. In this case it is the colonized Indian who is being demarcated as different from the "European heterosexual gentleman."

It would seem, then, that much of the information on the case notes, data on patients' bodies that in many cases dominate the documents, is the product of discourses linked to the power relations of modernity and colonialism. It would be extremely difficult for the historian to use this data as "scientific" information that meets criteria sufficient to qualify for use in diagnosis. The historian, however, can use it to explore the ways in which bodies were constructed and represented in the 19th century within a variety of political agendas.

Mental Illness and Recovery: The Colonial Fantasy of Reforming the Indian

Despite the amount of physical information included on the case notes, there are some references to the behavioural state of the patient and the responses of the patient to the therapeutic regimes available in the asylum. For example:

Heengun Khan. Mania. Mussulman. Cultivator. 26. 30th April 1860

Sept. 60. An inhabitant of Moosalbagh. Is said to have been subject to fits of insanity for 12 or 14 years. During intervals has been able to work. Is of a very restless disposition + much taken up with his personal appearance, decorating himself with whatever in the shape of supposed finery falls in his way, not despising as a necklace an old leather Doomchee. Is occasionally violent + continually begs for release. General health and appetite good.

Oct. 24. For the last month has been generally quiet + well conducted, working hard in the garden + greatly pleased at receiving commendation or trifling rewards. Today became unaccountably violent, had to be confined—blister applied.

March 1861. For the last three months, there has been a steady improvement in this patient. He takes his meals well + has done bheestie's work very steadily. For the last month his demeanour has so much improved that on his relatives coming to enquire after him I discharged him on the 24th March, cured. (IA, 13, 30.4.1860)

The case note for Heengun Khan reads as a heartening story of improvement as he recovers sufficiently from being fitful and violent to being healthy enough for release. Yet look again at the type of information recorded to indicate illness and recovery. Illness is violence and self-absorption. Recovery is obsequious obedience and the desire or ability to work steadily. Pick out the adverbs of illness and recovery: "unaccountably" as opposed to "steadily." The issue to be considered here is whether the privileging of the ability to work and to be governable (because

obedient and steady) over the need to be expressive of fluctuating inner desires and feelings (which are unpredictable and sometimes violent) is necessarily a natural correspondence to the state of mentally healthy over mentally ill.

The work of several feminist scholars is important here, as they argue that asylum regimes in Europe were not concerned with restoring a natural state of mental health when it came to female patients. Ripa (1990) insists that “the asylum sought to force women back into the mould from which they had just tried to escape” (p. 160), and that in 19th century France “to be cured meant to be passive and submissive. The image of healthy womanhood put forward by the special doctors, those products and exponents of bourgeois society, was of silent women who showed moderation in everything, and who sublimated all their own desires in their role as mothers” (p. 161).

Showalter (1987) finds this to be similar to the experience in England during the same period as “the ladylike values of silence, decorum, taste, service, piety and gratitude . . . were made an integral part of the program of moral management of women in Victorian asylums” (p. 79). It was not just in the lunatic asylum that “recovery” was linked to imposed norms. Monk (1996) examines the Magdalen asylum in Australia, which was opened and operated for the reform of “fallen women” in the 1880s. Here she finds a regime centred around the performance of laundry duty, specially chosen as an essentially female task. Thus, the correct performance of this task was supposed to signify “reform,” or rather a return to the desired norm of domesticated femininity. Reform or recovery in women was very much judged in these institutions not by reference to some natural standard of health and illness but by reference to a standard of behaviour derived from the social and cultural discourses of patriarchy.

With the idea that recovery from mental illness could, in certain circumstances, be a judgment on an individual’s compliance with certain prescribed ways of behaving, the case note of Heengun Khan included above appears to be rather more than a simple record of the patient’s behaviour. Neither was the following case note atypical:

Ramcharum. Acute mania. 25. Hindoo. Beggar. 11th May 1870
Certified by the Magistrate violent

11th May. Sent in by the Depy. Commr. of Oonao. It appears to be a case of mania from excessive bhung smoking.

April 4th 1874. For several months Ramchuram has seemed to be in his right mind. He has been useful in helping to cook for the other patients. To be brought before the Committee.

7th April 1874. Cured, made over to his friends by order of his friends. (IV, 192, 11.5.1870)

This case note records the direct relationship between the ability to work and the assessment of recovery. The only information included to justify the patient being in his right mind is that he is now able to labour and is useful. Indeed, the doctor who composed the following example acknowledges that when he had to

determine whether somebody was mentally “well,” he was actually looking for certain characteristics.

Wazeeran. f. Mania. 28. Mussul. Beggar. 15 Jany/63

1863. Sent in by City Magistrate found knocking about the City, is very violent and wild in manner and expression.

1868 May 5. This woman has been five years in the asylum. She seems to be well, at least she works + does what she is told + gives intelligent answers to questions + is quiet, eats and drinks + sleeps properly.

She says she is a prostitute + will return to the exercise of her profession if released.

May 11. Discharged. (IA, 13, 30.4.1860)

In qualifying his assessment that she is “well,” he seems to imply that the criteria for being judged “well” were not an esoteric series of standards regarding proper perceptual relations between the inner life and the outer world but merely the requirements he lists, that is, she appears to be socially functional. The criteria for being socially functional were productivity, obedience, intelligibility and self-regulation.

Nikolas Rose (1985) gives an account of *political economy* as an understanding of the universe that developed throughout the 19th century in Europe. It was thought that the natural, self-regulating mechanisms of the economy operated in a benign way to produce a wealthy and well-organised society, and that each individual was expected to earn an independent living by participating in a responsible manner in the labour market. As such, those who chose not to engage in the economic system, typically those who refused to sell their labour, were condemned as flouting the natural and beneficent mechanisms. Such people became the focus of asylums and workhouses. A belief in the essential morality of humans encouraged the idea that such people were in need of reform, for within them existed the essence of a moral (industrious, compliant, deferential, modest) person who simply needed encouragement (Rose, 1985, p. 26).

The characteristics connected with the virtues of work and the ethics of political economy were certainly valued by the British in India by the 1860s. According to MacMillan (1982), “the qualities that were most prized were efficiency, practicality, conformity” (p. 73), as they sought to create, “a socio-economic environment that rewarded hard work, thriftiness, and a desire to get ahead” (Zastoupil, 1994, pp. 135–6). This enthusiasm for political economy and the virtues connected with work explains why a patient’s ability to labour featured so heavily in the case notes compiled by British officers. The culture of political economy dictated that industry was good, indeed natural, so the evidence of a previously disruptive individual now working would have been interpreted as a “recovery” of the natural state. Quite simply, the case note constructed the 19th century European conviction that the desire to labour was natural and normal.

Indeed, it was within this language of the virtues of work and the ethics of political economy that a discourse of difference was constructed in 19th century Europe. Nancy Fraser (1989) demonstrates how work in the West was one of

the key areas in which gender difference was constructed: "Take the role of the worker. In male dominated, classical, capitalist societies, this role is a masculine role . . . there is a very deep sense in which masculine identity in these societies is bound up with the breadwinner role" (p. 14). Women's work was constructed as reproduction rather than production, and where women were expected to perform productive tasks these tasks were carefully fenced off as different and inferior.

In the colonies difference was similarly constructed between the Europeans and the locals in terms of their productive capabilities. Racial discourses on the "lazy native" (Alatas, 1977) created images of Africans and Asians in the colonisers' minds as unwilling and inefficient labourers. In India this supposed inability of Indians to work effectively was itself construed by the colonisers as a reflection on Indian society and the Indian psyche. Ronald Inden (1990) points out how the Indian mentality was constructed as the opposite of the Western one on the basis of work and productivity: "That mind is . . . governed by passions rather than will, pulled this way and that by its desire for glory, opulence, and erotic pleasures or total renunciation rather than prompted to build a prosperous economy and orderly state. The Indian mind is, in other words, devoid of 'higher,' that is, scientific rationality" (p. 264).

This construction encouraged the British belief that their role in India was necessary: "It is the supposed absence of these assumed attributes of Western culture—such as advanced rationality, individual discipline, and social habits of obedience—that mark the Indians as childlike creatures in need of paternal oversight" (Zastoupil, 1994, p. 175). Moreover, the British role was often conceived as more than simply "oversight." According to Majeed (1992), the growing influence of Utilitarian ideas in the British administration of India by the 1860s meant that many colonisers believed that "it was more important to civilize than subdue," and that many intended for "the whole of Indian society [to] undergo a vast transformation, setting it on a rapid advance up the scale of civilization" (Stokes, 1959, pp. 43–56). In other words, the British fantasised that they would transform India from "uncivilized"—irrational and unproductive, to "civilized"—ordered, industrious and regular. Mukhsoodally Khan undergoes such a transformation, according to his case note:

Mukhsoodally Khan. m. amentia. mussul. service. 25. 8 June/61

1861 June. This man was formerly a sowar in the 1st Regt. of Hodson's Horse at Fyzabad. Was admitted into Regl. Hospital on 14th May on account of mania-cause not apparent—He was noisy, violent + abusive, bit himself on legs + arms + required the constant supervision of attendance to prevent his escaping or injuring himself. Subsequently he had an attack of fever. On admission he was very excitable and talked very unnaturally and abusively.

1862 Feb. In several months past this man has improved in health, has been quiet + well conducted and assisted in the garden. He is stout + strong. All bodily functions properly performed + he does not appear to be labouring under any delusion. His relatives are anxious to remove him + I therefore, as he has been well for months, discharge him cured. (IA, 114, 8.6.1861)

Violent, irrational (“talked very unnaturally”) and unpredictable (“cause not apparent”), he is represented as becoming regulated (“all bodily functions properly performed”), respectful and a good worker. His case note reads as a fantasy of the colonial project, where the Indian Other of the rational and productive European is civilized, made rational and productive, through contact with the benign British institution. A glance at Heengun Khan’s case note at the beginning of this section suggests that Muksoodally Khan’s case note is not unique in this regard. Heengun Khan is constructed as narcissistic and violent at the outset of the case note, but by the end is represented as self-disciplined and productive after a spell under British control.

The information included on the document is not the result of impassive and objective surveillance of the individual in question. That information is instead the product of the imaginings and expectations of a British medical officer during the period of “high colonialism.” The information on work and self-discipline acts to construct in the case note a world where work is natural and normal, where Indians are unproductive and irrational, and where contact with the British regime is so beneficial and effective that Indians become “civilized.” Quite simply, the case notes are sites where the colonisers constructed India and Indians as the Other of the colonisers, and where they represented colonialism as an effective system of rendering useful those they considered unproductive and irrational.

CONCLUSIONS

Discourse analysis is the methodology of analysing texts to reveal the way in which discourses operate to construct representations of the world that are implicated in power relations. Application of this methodology has shown that the case notes from the Lucknow asylum can be read less as a series of objective observations of naturally occurring conditions and more as a collection of statements that construct ideals of social and moral fitness, reflect culturally specific modes of seeing, and legitimise colonial rule.

These discourses of the Other’s body, of the Indian mentality, and of the medical gaze, are all linked to power relations in the period, to the desires and projects of the European bourgeois male, to the colonial order, and to the rise of the medical profession. By tracing them it is possible to identify a number of the ways that the British saw themselves and Indians in the context of late 19th century colonial India.

Thus, historians may legitimately use sources like the asylum records of British India to trace the relationship between power and knowledge, but they must be wary of looking at the records in the hope of using them to explore the epidemiology of the past. The records of the lunatic asylum provide compelling evidence of power relations in colonial India when the details of supposedly “scientific” documents—the case notes—turn out to be a series of representations and

judgments of the Indian. They fail to provide much evidence of the mental states of the Indians of which they are supposed to be a record. Their value as a historical source lies in what they can tell us about the ways that the colonial imagination viewed and constructed Indians. The irony of these case notes is that they offer little insight into Indian mental states but a great deal about the British psyche of that period.

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