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ARTICLE

Medicine and the critique of war: military psychiatry, social classification and the malingering patient in colonial India

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Abstract

The treatment of injured Indian soldiers in Britain during WWI deployed particular ways of recording injuries and using them to make judgments about loyalty to the Imperial Army by assessing the soldier's ability to malinger. This was possible by using personal correspondences between soldiers and their families for ethnographic ends ie. to determine susceptibility to develop mental illness through a soldier's ethnic background and whether he was from the so-called 'martial races' or not. This classificatory knowledge as well as the suspicion towards exaggerated symptoms was also inherited by Indian psychiatry after partition. However, while these psychiatrists reproduced some colonial biases about susceptibility of illness, they were much more receptive to considering the social experience of patients including their kinship relations at home and in the military. By the end of WWII, symptoms came to be regarded as signs of recovery and readjustment to social relations to make a case for the lasting impacts of war on the soldier's mental and physical health.

Keywords: Military medicine; Psychiatry; Malingering; World war; Colonial India; Kinship

Introduction

The origins of psychiatry as an institution in India can be traced back to the treatment of a group of sepoys of the Indian Army who were deemed as 'lunatics' during service in the late eighteenth century.[1] The isolation of 'undesirable' individuals who could pose harm to public safety has been discussed in the context of lunacy and incarceration starting from eighteenth-century Britain and the exportation of asylums to colonies.[2] By 1912, the relationship between colonial power and psychiatry was formalised by instituting the magistrate with the power to incarcerate the so-called lunatic.[3] Existing scholarship has shown how, instead of asylums representing unidirectional control, they could represent sites which demonstrated an 'utter disregard for the colonial government and of western medicine'.[4] Others have suggested that diagnostic practices varied based on class and whether the patient was Indian or European, where asylums provided knowledge about the broader society.[5] Recent historiography has shown that asylum populations were embedded in wider communities such that treatment by staff would

[1]L.P. Varma, 'History of Psychiatry in India and Pakistan', *Indian Journal of Neurology and Psychiatry*, 4, 1&2 (1948), 27–53.

[2]For lunacy in Britain, see J. Andrews, 'In Her Vapours – [or] Indeed in Her Madness?' *History of Psychiatry*, 1 (1990), 125–43; R. Porter, *Mind-Fog'd Manades* (London: Athlone, 1987). For lunacy in the colonial context, see Matthew Heaton, *Black Skin, White Coats: Nigerian Psychiatrists, Decolonization, and the Globalization of Psychiatry* (Athens: Ohio University Press, 2013); Jonathan Hal Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Cambridge: University of California Press, 1999).

[3]Indian Lunacy Act 1912 (Act No. 4 of 1912).

[4]James H. Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857–1900* (Basingstoke: Macmillan, 2000).

[5]Waltraud Ernst, 'Asylum Provision and the East India Company in the Nineteenth Century', *Medical History*, 42, 4 (1998), 476–502.

have implications for their relations with patients' families outside asylums.[6] Historians have also shown how treatment was based on negotiations and moral treatment rather than coercive techniques alone.[7] Others have shown how psychiatric institutions was centralised to increase efficiency, with the place of psychiatry in overall medical sciences in colonial India being rather marginal, which shaped stigmas around the admission of relatives and led to families abandoning the mentally ill.[8] The process of encoding criminal tribes who were susceptible to crime by birth through classificatory knowledge to assess susceptibility to commit crime was an ongoing process.[9] This classificatory knowledge also shaped the assessment of populations in asylums and remained integral in medical evaluations during the Great Wars.[10] Thus, one can ask: to what extent did classificatory knowledge play a role in assessing loyalty and diagnosing soldiers? While initially classificatory knowledge was used for the nonrecognition or denial of mental illness, the same knowledge and its contradictions provided the impetus for the recognition of mental illness among soldiers.

In this article, I contend that Indian soldiers' expression of psychic and physical costs of war to their families was used for medical surveillance but also to gauge the motivation of soldiers. By discussing case reports from WWI and WWII, both in colonial India and Britain, I discuss how overtime the expression of these symptoms came to be considered as opportunities to effect changes in domestic relations which mirrored political realities of weakening colonial rule and growing influence of the indigenous medical elite. While relations with families back home were initially used by the censor to evaluate soldier's psychological experiences during WWI, without any need felt at all to understand how relations with the family could help in articulating or exacerbating distress, by WWII, improvement of mental condition of the soldier-patient was understood by how well soldiers had adjusted to concrete social relations at home and in the military. In the first section, I will consider how personal correspondences of soldiers and families were put to use for ethnographic ends ie. to understand whether the soldier's behaviour was in line with expectations from social groups defined by race and ethnicity. The second part of the article will consider the military psychiatry's attempt to integrate psychoanalysis in its practice of treating soldiers and the way this reproduced colonial biases towards the Indian soldier, yet also created greater space for the relevance of familial relations in treatment. Often psychobiology and psychoanalytical treatments would compete, with the military favouring the former.[11] In the third section, I discuss cases published after the partition of the Subcontinent into India and Pakistan. In Pakistan, the loss of medical personnel due to migration after the partition of the Subcontinent resulted in a renewed interest in psychiatry as a civilian institution. For the development of psychiatry as a civilian institution, paradoxically, Indian psychiatrists now split between Pakistan and India had to revisit medical experiences of WWII in which Indian soldiers fought alongside the Allied Forces. I consider the ambivalent stance of Indian psychiatrists, as they reproduced colonial biases as well as urged a shift to more humane forms of treatment and psychotherapy.

During WWI, British authorities motivated people in India to join the imperial army by promising monetary benefits and respectability that soldiers could bring to their clans by donning the uniform and

[6]Anoushka Bhattarcharya, 'Colonial madness: community and lunacy in the 19th century India', in Winterbottom and Tesfaye (eds), *Histories of Medicine and Healing in the Indian Ocean World* (United States: Palgrave Macmillan, 2016).

[7]Debjani Das, *Histories of Madness: Insanity and Asylums of Bengal in 19th Century India* (Oxford: Oxford University Press, 2015).

[8]Sarah Ann Pinto, 'Unchained Minds: Lunatic Asylums in the Bombay Presidency, 1793–1921' (unpublished PhD thesis: Victoria University of Wellington, 2017); Shruti Kapila, 'The Making of Colonial Psychiatry, Bombay Presidency, 1849–1940' (unpublished PhD thesis: School of Oriental and African Studies, University of London, 2002); Shilpi Rajpal, 'Psychiatrists and Psychiatry in Late Colonial India', *The Indian Economic and Social History Review*, 55, 4 (2018), 515–48.

[9]See Sajay Nigam, 'Disciplining and Policing the "Criminals by Birth," Part 1: The Making of Colonial Stereotype – The Criminal Tribes and Castes of North India', *The Indian Economic and Social History Review*, 27, 2 (1990), 131–64; Choudhary Laxmi Narayan and Deep Shikha, 'Indian Legal System and Mental Health', *Indian Journal of Psychiatry*, 55, 6 (2013), S177–81.

[10]*Op. cit.* (note 4).

[11]See Shruti Kapila, 'Masculinity and Madness: Princely Personhood and Colonial Sciences of the Mind in Western India, 1871–1940', *Past and Present*, 187 (2005), 135.

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by ensuring the well-being of their families through wages, financial rewards and pensions. This can be seen from the posters that were distributed to encourage people to join the army. In these posters, the visual depictions of the Indian soldier were accompanied by messages such as, 'Who will take this money, rifle and uniform? The one who gets recruited (*bharti*) in the military'.[12] Another poster depicting an oversized Indian soldier on the map of India mentioned, 'This soldier is defending Hindustan. He is also defending his home and family members. The best way to help your family is to get recruited in the military'.[13]

Although from the pamphlets it might appear that recruitment helped soldiers safeguard the well-being of their kin groups, deployment only resulted in further isolating the recruits from the wider kin. Once the Indian soldiers were deployed and injured during WWI in European and Middle Eastern fronts, their psychic experiences, in effect, reflected their estrangement from families and thus even a sense of betrayal towards the colonial army which had recruited on the basis of the promise that deployment would only strengthen the soldier's relation with the wider clan or kin group.

Medical surveillance in a British hospital

While engaged on the Western Front during WWI, the Indian Army experienced great number of casualties. Brighton was chosen as the site where medical facilities were set up overnight to provide care to the wounded and sick Indian soldiers. Three buildings were given by authorities for this purpose: the workhouse (renamed as the Kitchener Hospital), the York Palace and the Royal Pavilion. In 1916, the Pavilion opened a hospital for limbless soldiers where almost 6 000 injured soldiers were treated and given prosthetic limbs. A total of 23 000 Indian soldiers were treated in the hospital facilities before they were redeployed to the Middle East. While the hospitals and the treatment of Indian soldiers were meant to project to colonial India, particularly the families of the soldiers, how well they were being taken care of the actual experience of the injured soldiers was entirely different. Medical care to soldiers was still considered integral in projecting to families of soldiers that their family members had been taken care of adequately, and to ensure that injured soldiers were returned to the battlefront in the most efficient manner possible. Therefore, medicine was considered essential to military victory.[14] Personal correspondences in a British hospital where injured Indian soldiers were brought during WWI can be a useful archive to help illuminate the psychic and medical realities of the war which were elicited through communications with family and comrades. These communications in addition to generating knowledge about the soldier's mental well-being also helped in understanding their dedication to serve in the imperial army. A lot of these correspondences were translated into English from Hindi or Urdu.

The ways in which soldiers communicated their wounds and injuries to their comrades and how these wounds and injuries were documented by British military doctors can allow us to interrogate the purpose that might have been served by the personal correspondences for the military doctors and injured soldier, and how these might have, in turn, shaped the medical encounter itself.[15] In the case of the injured Indian soldiers of WWI, one can explore how the letters they sent shift from being mere correspondences between injured patients to being artifacts of medical observation.[16] The Indian Mails Censor Office

[12]Imperial War Museum, Art. IWM PST 12574. URL: https://www.iwm.org.uk/collections/item/object/31123.

[13]*Ibid.*, Art. IWM PST 12580. URL: https://www.iwm.org.uk/collections/item/object/31129.

[14]For the importance of medicine in ensuring military victory during the Great Wars, see Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010); Mark Harrison, *Medicine & Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2004).

[15]See Lauren Kassell, 'Paper technologies, digital technologies: working with early modern medical records', in Anne Whitehead *et al.* (eds), *The Edinburgh Companion to the Critical Medical Humanities* (Edinburgh: Edinburgh University Press, 2016), 122.

[16]See Lauren Kassell, 'Casebooks in Early Modern England: Medicine, Astrology, and Written Records', *Bulletin of the History of Medicine*, 88 (2014), 595–626; Christopher Cullen, 'Yi'an (case statements): the origins of a genre of Chinese medical literature', in Elizabeth Hsu (ed.), *Innovation in Chinese Medicine* (Cambridge: Cambridge University Press, 2001), 297–323.

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established in 1914 in Rouen, and later, Boulogne was headed by Evelyn Berkeley Howell. Howell began to probe the letters for clinical insights and evidence of loyalty and spirit. Howell's superiors saw his work 'as a window into Indian psychology', and in February 1915, the India Office called on Howell's censors to provide 'some work of analysis of the classes and regiments from which the more despondent views [are reported]'.[17]

In one letter to his family, an Indian soldier wrote, 'Do not think that this is war. This is not war. It is the ending of the world. This is just such a war as was related in the *Mahabharata* [the Indian epic] about our forefathers'. This anonymous *sepoy* [from the Persian word *sipahi* meaning soldier] was one among over one million Indians, including over 621 224 combatants and 474 789 noncombatants, sent overseas between August 1914 and December 1919 for the Great War.[18] Santanu Das comments about these mediated forms that they are 'neither the transparent envelope of sepoy experience nor just scribal literary embellishments, these letters are some of the earliest encounters between South Asian plebeian history and textual form: given their heavily mediated nature, they are read as palimpsests where, underneath various accretions, one can still hear the echo of the sepoy heart'.[19] Doing medical history from 'below' enables us to explore how patients understand and treat their medical symptoms, instead of assuming that physicians or medical expert's advice is taken by patients at face value.[20]

Some letters attempted to bypass the restrictions on the reporting of the actual events of war by deploying a coded language. The language through which soldiers communicated the psychic and physical impacts of war also reflected the nature of care they received, and how this was embedded in broader war efforts to return them to the front line in the most efficient manner possible. Soldiers drew upon metaphors to demonstrate their anxieties about having to return for service without fully recovering. In one letter, an Indian soldier wrote, 'The state of affairs is as follows: the black pepper is finished. Now the red pepper is being used, but occasionally black pepper proves useful. The black pepper is very pungent and the red pepper is not so strong'.[21] In this correspondence, black and red pepper are used for Indian and British troops, respectively. However, David Omissi in his collection of letters mentions in the footnote to this letter that the censor had interpreted the statement as, 'the Indian troops fight more fiercely than the British troops'.[22] While for Santanu Das, the use of metaphors indicated how the Indian soldier navigated between different cultural worlds, I read this particularly as a question about how fears about redeployment were voiced, as the soldier occupied a liminal position between being a combatant and a patient. What would it then mean to think about the British hospital as a place where the emergence of Indian soldier's experiences of combat were voiced, but also one where in documentary practices of compiling letters, it was lost?[23] We can now consider how the patient's subjectivity emerges in these mediated and censored correspondences.

An interesting aspect of these letters is that they were compiled by identifying one's ethnic and religious background, such as Pathan, Punjabi, etc., as well as Muslim, Sikh, etc. These identifiers were part of the broader attempt to classify soldier's behaviour according to the sociological group to which he belonged, and the behaviour expected of these groups by the British during the early twentieth century. There is ample evidence of the British effort to differentiate and classify a wider Indian population by

[17]Hilary Buxton, 'Imperial Amnesia: Race, Trauma and Indian Troops in the First World War', *Past & Present*, 241, 1 (2018), 221–58.

[18]See Santanu Das, 'The Indian Sepoy in the First World War', *The British Library* (2014). URL: https://www.bl.uk/world-war-one/articles/colonial-troops.

[19]*Ibid.*

[20]See Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98; Nicholas Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870', *Sociology*, 10 (1976), 225–44; *op. cit.* (note 15), 121–35.

[21]*Op. cit.* (note 18).

[22]David Omissi, *Indian Voices of the Great War: Soldier's Letters, 1914–1918* (Palgrave Macmillan, 1999), 49.

[23]For a discussion on patient–doctor relations in the context of early modern medicine where a similar question is asked, see Mary Fissell, 'Making meaning from the margins: the new cultural history of medicine', in Huisman *et al.* (eds), *Locating Medical History: The Stories and Their Meanings* (Baltimore: Johns Hopkins Press, 2004).

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groups and behaviours which shaped recruitment policies. The censor 'diligently categorised letters by martial race'.[24] In fact, the identification of soldiers by ethnic groups often led to contradictory ethnic traits and, for the first time, to the detection of non-white war trauma.[25] The most notable of recruitment handbooks of the time included Sir George MacMunn's *Martial Races of India* (1933) and P.D. Banerjee's *Fighting Races of India* (1899).[26] What we observe in these texts is the use of 'colonial ethnography' which classified populations based on their traits, in which comparisons were made between European and Indian races.[27] After 1857, there was shift in recruitment from Bengal to Punjab and North-Western India; however, as David Omissi reminds, the classification of populations through the 'martial-race theory' was fragile, which led to the emergence of 'martial classes' from races which can be interpreted as representing the fragility of race as a biological category alone.[28]

These letters were reworked overtime within the hospital administration as well as by the censor. In this sense, we can treat the letters as a form of accretion, both because they were part of a larger bundle, and also because they had to be worked upon in successive stages of translation, management and compilation.[29] The psychological impacts of war on soldiers are evident in the descriptions of war shared by soldiers to their family members and friends. Soldiers also expressed their conflicting relations to colony on the one hand and kinship on the other hand, which became even more prominent among symptoms of mental illness, as the colony moved to Partition, as I will show later. In a letter written to Zemindar Dhani Ram in Punjab from a cavalry brigade in France, Nawal Singh protested, 'You say to me "do not write to me in a disturbed manner". No, the fact is that you asked me of having troubled in the mind. No, the fact is that you asked me to say truly how things were here, and so I wrote plainly and told you'.[30] It appears as if the soldier's protest is a form of despondency in relation to the war as much as towards the family. The soldier's depiction of the interiorisation of the effects of war and its impacts on psyche were often also described through supernatural causes. Nizam-ud-din, serving with 129th Baluchis, requested a replacement amulet for his comrade Bagh Ali, who was considered to have become 'possessed' and subjected to 'seizures' according to his comrade.[31] In a letter written from the soldier, Abdul Raheem (admitted to the Brighton Hospital) to Fatah Muhammad, the former voiced Islamic eschatological themes where the soldier's body appears as an object of divine wrath, when he writes, 'Nowadays as the world is under dangerous calamities which are in the specimen of God's wrath, and the world is directing its charges against the world in its drawn dagger, as spoken by the tongue of the promised *masiha* (messiah)'.[32] In a letter written from the Indian General Hospital in Brighton, another injured soldier writes in complete abjection, 'I am telling you the trouble. What can I say of the war? It is a manifestation of divine wrath. There is no counting the number of lives lost. We have to deal with a terrible and powerful enemy, who is completely equipped with every sort of contrivance. Out of the 64th Regiment which arrived in full strength, only about ten men are left. In my regiment the 57th absolutely none are left, with the exception of the *jamadar* now appointed *subedar*, and only one newly joined Lieutenant'.[33] Thus, one cannot assume that all Muslim soldiers attributed pressures on psyche to supernatural causes and were mindful of the psychological impacts of war.

[24]*Op. cit.* (note 17), 229.

[25]Joanna Bourke, 'Shell-Shock, Psychiatry and the Irish Soldier During World War', 158, cited in *op. cit.* (note 17), 231.

[26]George Macmunn, *The Martial Races of India* (London: Low, Marston & Co., 1933); P.D. Banerjee, *A Handbook of the Fighting Races of India* (Calcutta: Thacker Spink, 1899).

[27]Heather Streets, *Martial Races: The Military, Race, and Masculinity in British Imperial Culture, 1857–1914* (Palgrave Macmillan, 2004); Gavin Rand and Kim Wagner, 'Recruiting the "Martial Races": Identities and Military Service in Colonial India', *Patterns of Prejudice*, 46, 3–4 (2012), 232–54; Gavin Rand, '"Martial Race" and "Imperial Subjects": Violence and Governance in Colonial India, 1857–1914', *European Review of History*, 13, 1 (2006), 1–20.

[28]David Omissi, *The Sepoy and the Raj: The Indian Army 1860–1940* (The Macmillan Press Ltd., 1998).

[29]Warwick Anderson, 'The Case of the Archive', *Critical Inquiry*, 39, 3 (2013), 532–47.

[30]Nawal Singh to Dhani Ram, 29 December (1915) BL, IOR, L/MIL/5/826/1, cited in *op. cit.* (note 17).

[31]Nizam-ud-Din to a friend, 26 April (1915) BL, IOR, L/MIL/5/825/3, cited in *op. cit.* (note 17).

[32]From Abdul Rahim Clerk, Post Office, To Fatah Muhammad Syal, Vaughan Avenue, Stamford Brook, London, June (1915). URL: https://www.bl.uk/collection-items/excerpt-letter-from-abdul-rahim-to-fatah-muhammad-syal.

[33]From Muhammad Asim Subeydar, 57th Rifles, Indian General Hospital Brighton, to Subeydar Major Firoz Khan, 56th Rifle, F Force Egypt, 28 May 1915 (1915).

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In a letter by Ram Singh written from the Kitchener Hospital to his father, Subedar Madhun Singh (7 Co. 2/39 Garhwal Rifles Lansdowne), one can notice how writing to a family member from the hospital was possible when both the father and the son were serving in different units during the war. The son wrote to his father from his hospital bed, 'we are not allowed to write about war x x x what is put in the papers is all lies, we have only captured four-hundred yards of trenches. The war is very hard'.[34] Thus, an important fact is that one cannot think about the family as detached from the war by physical distance, as it was possible for various members to be involved in war efforts on different fronts. It is therefore difficult to dissociate kinship from war, particularly given the tradition of British recruiters to recruit several men from the kinship networks with the help of village elders who were given the rank of a noncommissioned officer.[35]

The soldier's experience of physical injury often also appeared as indistinguishable from psychological experiences of war in which recovery meant a return to the battlefield.[36] Another soldier wrote, 'I got two bullets in my right hand and wound from a shrapnel in my right side. The wound in my hand has healed. The bullet has not yet been extracted. It is 5½ inches deep. I was taken to the X-Ray room (*bijli ghar*). I am hoping the bullet will be extracted very soon'.[37] Later in his letter he asks the addressee if the latter had heard that only a few regiments survived. While describing his experiences of war, he writes allegorically, 'It is now the month of *Cheyt* (harvest month for the winter barley crop in Northern Punjab). There is a full crop of ripe barley. Crowds are gathering round the woman who parches the grain. She parches the whole lot at once. Her stove is very hot. I hope you will read very carefully what I have written so badly'.[38] It is also important to mention that the document's translation was maintained with revisions along with explanatory notes about the content of the letters. For instance, after the end of the letter, the translator wrote, 'By the woman who parches the grain he (the soldier) means the enemy'. The experience of physical injury therefore became indistinguishable from experiences of anxiety about redeployment. Injury and the psychological experience of having to return to battlefront were voiced by one soldier, when he wrote, 'I have been wounded twice, and now this is the third time that I am being sent to the trenches. The English say it is all right. How can it be alright! As long as one is unhurt, so long they will not let one off. If Parmeshwar allows, I will escape, but the butcher does not let the goat escape'.[39] What is particularly interesting is how even, with the censor in place, the soldiers continue to communicate poetically to avoid restrictions and to express grievances about the war from the hospital

[34]Letter From Ram Singh to his Father Subedar Madhun Singh, May (1915) BL IOR/MIL/5/825/4 f.428. URL: https://www.bl.uk/collection-items/excerpt-letter-from-ram-sing-to-father-subadar-madhun-sing.

[35]Seema Alavi, *The Sepoys and the Company: Tradition and Transition in Northern India, 1770–1830* (Delhi: Oxford University Press, 1995).

[36]For critiques on the pathologisation of disability through the use of medical model aimed at 'fixing' it, see Beth Linker, 'On the Borderland of Medical and Disability History', *Bulletin of the History of Medicine*, 87, 4 (2013), 499–535; Richard K. Scotch, 'Medical model of disability', in Susan Burch (ed.), *Encyclopedia of American Disability History* (New York: Facts on File, 2009), 602–603; Catherine J. Kudlick, 'Disability History: Why We Need Another "Other"', *The American Historical Review*, 108, 3 (2003), 763–93; Harlan Lane, *The Mask of Benevolence: Disabling the Deaf Community* (Knopf, 1992). The need to understand the impacts of disability on kinship through first-person perspectives and those of caregivers describing how people live with disability has been widely discussed by historians and anthropologists; see Susan Wendell, 'Unhealthy Disabled: Treating Chronic Illness as Disabilities', *Hypatia*, 16, 4 (2001), 17–33; Julie Livingston, *Debility and the Moral Imagination in Botswana* (Indiana University Press, 2005); Rayna Rapp and Faye Ginsburg, 'Enabling Disability: Rewriting Kinship, Reimagining Citizenship', *Public Culture*, 13, 3 (2001), 533–56; Daniel J. Wilson, *Living with Polio: The Epidemics and Its Survivors* (University of Chicago Press, 2005); Emily Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850–1940* (Cambridge: Harvard University Press, 2000). Recent work on disability and the pressure on conjugal relations among American veterans includes Zoe Wool, *After War: The Weight of Life at Walter Reed* (Durham: Duke University Press, 2015).

[37]Letter from Pay Havildar Shadma Khan, 40th Pathans, Kitchener Indian Hospital Brighton, to Gunner Hafiz Nawat Khan, Hong Kong, 28th May (1915) BL IOR/MIL/5/825/4 f.412. URL: https://www.bl.uk/collection-items/excerpt-letter-from-pay-havildar-shadma-khan.

[38]*Ibid.*

[39]'Letter from Ragbir Singh to Gajander Singh, 8 April 1915', in Omissi (ed.), *Indian Voices*, 53, cited in Aparna Nair, '"These Curly-Bearded, Olive-Skinned Warriors": Medicine, Prosthetics, Rehabilitation and the Disabled Sepoy in the First World War, 1914–1920', *Social History of Medicine*, 33, 3 (2020), 798–818.

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in the anticipation that the recipient, a loved one, would understand what they have written. The site where the unjustness of war was voiced was, paradoxically, the same place that was meant to project the benevolence of the empire to colonial India.

Psychological distress was not only related to returning to the battlefield but feeling worthless returning home with a loss of a limb ie. the loss of being economically independent and productive as a male and therefore one's position and respect in extended kin. Lance Naik Phina Ram voiced his anxiety about his family not accepting him as an injured soldier, 'They (his family) will even turn me out at home… I do not know whether to tell people at home what was happening to me or not. I am very anxious. If they do not welcome me at home, I am thinking of going on a pilgrimage and living by myself on what government may give me'.[40]

The malingering soldier

During WWI, British Medical Officers also conducted scientific studies on injuries experienced by Indian soldiers. British officers believed that their Indian subordinates deliberately harmed themselves to be invalidated for military service or to receive compensation. The statistical nature was intended to unsettle or undo these suspicions, but the attempt also resulted in flattening the soldiers' experiences by using quantitative data as an argument.[41] During WWI, while British Medical Officers were engaged on the Western Front, the need to maintain medical records arose to stimulate an interest in medical cases in conditions of routine military work and the deficiency of scientific equipment in clearing stations close to combat areas.[42] To solve the problem of the lack of interest, consultants who were eminent surgeons were asked to serve as liaison officers. They stimulated interest among medical officers in medical cases by organising conferences, giving lectures and promoting the establishment of medical societies, even for medical officers at the front, thus enabling the training of doctors in military medicine to provide expedient treatment for combat-related injuries.[43] Through statistical analysis, the medical staff deliberated the best way of treating wounds on the hand experienced in high numbers by the Indian soldiers.

In a study conducted by Col Sir Seton in 1915 at the Kitchener Indian Hospital, he explored how the medical staff documented injuries and their causes in the context of the hospital, to which many hundreds of injured Indian soldiers were being brought.[44] The study's title page mentioned 'Secret Not for Publication', indicating the confidentiality of its finding at the time of its publication. During WWI, Seton was appointed as the commanding officer at the Kitchener Hospital. A close look at his study can help us explore how medical knowledge was deployed to determine whether injuries were self-inflicted or not. Seton writes that although the wounded soldier remembers the date on which he was wounded, 'he generally does not know the direction from which the projectile came, and is liable therefore to be doubtful as to which of two wounds (bullet or shell fragment) is the wound of entry; and this, when capable of determination at all, can only be decided by rules governing the action of projectile on human tissues'.[45] Here, to ascertain the 'direction factor', which the patient is rarely capable of doing, Seton suggests that the doctor's imagination plays an important role to ascertain the relative position of

[40]Phina Ram to Lachman Brahman, 28 (December 1915–January 1916) BL, IOR/L/MIL/5/826/1, RIC, cited in *ibid.*

[41]Nick Hopwood *et al.*, 'Seriality and Scientific Objects in the Nineteenth Century', *History of Science*, xlviii (2010), 251–85; Volker Hess and J. Andrew Mendelsohn, 'Cases and Series: Medical Knowledge and Paper Technology, 1600–1900', *History of Science*, xlviii (2010), 287–314.

[42]Ian R. Whitehead, *Doctors in the Great War* (Pen & Sword, 1999).

[43]Ian R. Whitehead, 'The British medical officer on the western front: the training of doctors for war', in Cooter *et al.* (eds), *Medicine and Modern Warfare* (Editions Rodopi, 1999), 176–8.

[44]Col. Sir Bruce Seton, Bt., I.M.S., Commander Kitchener Indian Hospital, 'An Analysis of 1 000 Wounds and Injuries Received in Action, with Special Reference to the Theory of the Prevalence of Self-Infliction (*Secret Not for Publication*), *1915 Brighton*' (1915) BL IOR/L/MIL/17/5/2402. URL: https://www.bl.uk/collection-items/analysis-of-1000-wounds-injuries-received-in-action.

[45]*Ibid.*, 3.

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the patient and the enemy when the former was injured. The patient's own opinion is dismissed as unreliable, and the doctor thinks on his behalf.

Seton then describes injuries in different areas of the body and raises doubts as to whether the soldier was likely to injure himself in those parts, unless he intended to commit suicide. Based on this rationale, he subtracts the number of injuries from the total number of cases (the assumption being that the Indian soldier was not likely to commit suicide). Of the remaining few cases, he suggests that they are too few to cast doubts on the Indian soldier to be causing self-inflicted injury. Seton had a particular idea of what constituted self-inflicted wounds. These did not include cases of internal or nervous disfiguration, because they latter defied any kind of deliberation and intentionality.[46] By drawing on statistics of a regiment in which a great proportion of soldiers received wounds on their hands, Seton concluded that 'it would be fairer to the Indian Army to seek some other explanation, before suggesting, as is very commonly done, that there is a strong suspicion attaching to any individual with a wound in his hand, especially in a left hand'.[47] Dispelling suspicion towards the soldier was contradicted by dismissing the soldier's own claims about injury. Seton's study also helped to debunk the notion of an unfit soldier, demonstrating how actively physicians were involved in facilitating the Indian soldiers' return to the battlefield. Here, one would have to place the debunking of suspicion about self-mutilation as not necessarily based on altruistic reasons, but to rehabilitate the injured soldier's body for redeployment, which was a concern shared by psychiatry and military medicine more broadly.[48]

World War II, Indian psychiatry and experiments with psychoanalysis

The scepticism towards the Indian soldier as malingering was retained even during WWII. In 1944, Norman Pacheco wrote about the incidence of battle deafness among Indian soldiers. He argued that it was uncommon to see a British soldier completely deaf as a result of wounding or exposure to blast or battle experiences, compared with Indian soldiers, whose deafness he attributed to psychological causes.[49] Most Indian soldiers had been injured on the Italian front and had to be treated by Royal Army Medical Corps psychiatrists who 'owing to the language barrier had no knowledge of the psychology of the Indian sepoy and no criteria with which to discriminate between the malingerer and the psychoneurotic'.[50] While admitting that both Indian and British soldiers were equally inexperienced, deafness was attributed to malingering and thus was treated a form of 'contagion' and seemed to increase, with soldiers slightly deaf becoming completely deaf overtime.[51] Pathans were considered to be especially susceptible. Most Indian soldiers were portrayed as not expressing any fear of returning to the battlefront, compared with British soldiers who threatened to commit suicide. While Pathans who had belonged to the martial race were well known for their bravery, the martial race theory was invoked in a different manner in WWII than WWI ie. to refer to Pathans as religious fanatics, who had remained in a state of tribal conflict and thus continuous psychic tension. The onset of hysteria among Pathan soldiers was attributed to the loss of amulets. Their loss of hearing was interpreted through the cultural importance of ears for Muslims when they placed their thumbs on the lobes of the ears during their prayers.[52] The Pathan practice of leaving a tuft of hair at the side of the external ear because of the

[46]*Ibid.*, 6.
[47]*Ibid.*
[48]See Heather R. Perry, *Recycling the Disabled: Army, Medicine and Modernity in WWI Germany* (Manchester: Manchester University Press, 2014); Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011).
[49]J. Norman Pacheco, 'Battle Deafness in Indians', *Indian Journal of Neurology and Psychiatry* 1, 1 (1948), 18–25.
[50]*Ibid.*, 19.
[51]*Ibid.*, 24.
[52]*Op. cit.* (note 49).

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belief that once dead, the person would be lifted from hair in front of the ear demonstrated the 'strong affinity in the unconscious between an explosive noise and the fear of impending death'.[53]

In the symposium on the earliest indications of mental diseases held in 1949 in Allahabad, Davis from Ranchi described patients of schizophrenia. One person was found fanning himself in order to shun thoughts about having sexual relations with a close relative.[54] Another man had made pushing movements against the air with his hands, imagining the breasts of a woman in his fantasy, which would also turn into a phantasy towards his own mother.[55] Patterns of hallucination and delusions were considered to be invariably shaped by religious beliefs and perceptions about authority. One sepoy used to see God Narasingha frequently appear before him. When he shared this with his comrades, they did not believe him. He continued his duty, depressed about his friends' faith in him. He began to keep a sharp knife under his pillow to protect him from the god.[56] He began to see the god even during the day. One night he shouted and was found having stabbed himself. After regaining consciousness, he said he had successfully killed the god.[57] The experience of self-harm was viewed through a Freudian interpretation about phobia as a compensation against repressed sexual wishes, which led to a lurking tendency towards self-punishment.[58] Other cases involved patient's fear of homoeroticism upon stumbling across pointed objects.[59] In the context of an increase in anti-colonial agitation, extreme devotion towards Hindu gods and nationalism was seen as pathological. One patient felt guilt at the death of Mahatma Gandhi whose symptoms were interpreted as initial signs of schizophrenia.[60] In other cases, mental illness represented anxieties in conjugal relations as partition approached, which especially included fears among women about being sexually violated. While these concerns were legitimate, they were dismissed as hallucinations.[61] Another man had a dream about having sex with the wife of a Muslim political leader. The next day he took a Christian name and started to dress like the European and converse in English, with mental illness resembling a confusion between local and western culture.[62] This patient later had a dream in which he had sex with Virgin Mary, after which he broke down. In this context, Rorschach Inhaler Psychodiagnostic Test, also designed to detect malingering, was promoted in which audiences were shown images and asked to describe the mental associations evoked by the images. The technique was considered to help separate cases of schizophrenia from anxiety disorders, because psychoanalysis could wrongly be used for schizophrenia and thus do more harm.[63] Whereas schizophrenics plunged into poorly conceived responses which were hasty, depressed individuals took much longer in responding.[64] Yet the test was considered to have limited value for uneducated people and when Edwin Harper from Allahabad asked Davis about whether the tests had to be tailored to the Indian culture, David replied, 'No, this is the task for Indian psychologists'.[65] Brocklesby Davis considered that even in the Burma corridor, fighting spirit permeated Indians, which was bound up with the superego which enabled the respect for authority with the wish to go home being repressed.[66] This unconscious

[53]*Ibid.*

[54]R.B. David, 'Earliest Indications in Psychotic Cases', Symposium on the earliest indications of mental illness, Allahabad (1949).

[55]S. Banerjee, 'Manneristic Movements in Schizophrenia', Symposium on the earliest indications of mental illness, Allahabad (1949).

[56]A.N. Mukherjee, 'Studies of Hallucinations in Two Patients', Read at the Third Annual Meeting of the Indian Psychiatric Society at Poona, January (1950).

[57]*Ibid.*

[58]*Ibid.*, 31.

[59]*Op. cit.* (note 55), 133.

[60]*Op. cit.* (note 54), 135.

[61]*Ibid.*

[62]*Op. cit.* (note 54), 136.

[63]*Ibid.*

[64]*Ibid.*

[65]*Ibid.*

[66]R.B. Davis, 'Demonstration of Rorschach Testing', Symposium on the earliest indications of mental illness, Allahabad (1949).

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respect for authority and willingness to fight was disproportionately attributed to Indian morale compared with that of the British soldiers. This logic was used to justify prolonged service without the soldiers having to return home. Forward areas experienced high levels of schizophrenia. Acute psychosis was largely interpreted as 'lata' or 'amok' among Eastern soldiers and dismissed as temporary by British psychiatrists.

The interwar period led to increased Indianisation of psychiatry. Indianisation of psychiatric services was an ambivalent process, because it retained some of the colonial biases such as soldiers of martial races being less likely to develop mental illnesses, and conversely soldiers from Southern India being more susceptible to psychoneurosis.[67] Indian psychiatrists suggested that the solution to the problem of the lack of psychiatric beds was the hospitalisation of all those experiencing psychosis. However, denial of mental illness even took place at the hands of Indian psychiatrists. The superintendent of the Ranchi Mental Asylum, an Indian psychiatrist, once even denied likelihood of Indian soldiers to develop traumatic neurosis.[68]

In 1925, an Indian superintendent of the asylum in Bangalore, Noronha, commented on cases of dementia praecox, one of whom was a chef of the Waziristan Field Force. He wrote, 'The combination of bizarre conduct with a clear consciousness and good apprehension of surroundings and perhaps a good memory can only be regarded as a dissociation of mental structure in such a way that the dissociated portions regress to earlier levels of mental life. This disordered conduct persists for a considerable time until the patient may revert to his normal conduct and adapt himself satisfactorily'.[69] With Jungian overtones, one can evidently notice the use of dissociation to refer to the regression to earlier levels of mental life showing colonial biases being internalised in Indian psychiatry reflecting the Indian's inability to detach from its cultural primitiveness. The period from 1930 to WWII demonstrated a marked increase in incarceration in mental asylums of political dissidents. Sending political activists to a 'madhouse' rather than a prison could play a role in humiliating and discrediting them.[70] As WWII approached, British psychiatrists left for Europe, and their vacancies were filled by Indian superintendents in psychiatric wards. During this time, civilian psychiatry also had a split from its military counterpart, particularly after the end of the war, when returning soldiers from the War overwhelmed existing military resources.[71]

The genre of studies such as the one by Seton had a particular resonance within Indian psychiatry during WWII, especially after the partition of India, except that the patient's demand to incorporate the subjective experience of war into the work of diagnosis can be seen much more prominently than before. Having a large number of cases and serialising them for inferences and deductions as opposed to having extended descriptions remained an important component of psychiatric studies in India. However, this is accompanied by a parallel move towards recovering the social experiences of patients by psychiatrists, because the colony moves towards independence in 1947. Writing about the social experience of patients began to proliferate, because attempts were made to capture the relations between combatants as well as with relatives and family, which might have caused them to develop mental illnesses.

The *Indian Journal of Psychiatry* was founded as the *Indian Journal of Neurology and Psychiatry*, and was the brainchild of the Indian Psychiatric Society, which itself was created in 1947 during the Indian Science Congress meeting held in New Delhi. Munro, who used to advise the Indian Army on matters related to psychiatry, invited remaining psychiatrists who were of a military background to 'constitute an association for the cause of mental health in the country'.[72] The creation of the society had undergone

[67]B. Bhattacharjya, 'On the Wartime Incidence of Mental Diseases in the Indian Army', *Indian Journal of Psychiatry*, 1, 2 (1949), 51–5; Waltraud Ernst, *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India* (London: Anthem Press, 2013), 21.

[68]Bhattacharjya, *ibid.*; *op. cit.* (note 17).

[69]Frank Noronha, 'Observations on Cases of Dementia Praecox', *The Indian Medical Gazette*, September 1925.

[70]Ernest, *op. cit.* (note 67), 39.

[71]See James Mills, 'The History of Modern Psychiatry in India, 1858–1947', *History of Psychiatry*, 12 (2001), 445.

[72]R.C. Jilaha and Prerna Kukreti, 'Psychiatry in India: History and Current Status', *Indian Journal of Psychiatry*, 60, 2 (2018), S218–23.

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fissures, because the partition of India took place in 1947. Colonel Dhunjibhoy, who had been elected as the founding president of the society, migrated to the newly founded neighbouring country of Pakistan. He also resigned as the fellow of the society, because Nagendra Nath De took over as president in 1948. The first Annual Conference of Indian Psychiatric Society, held at Patna on 2 January 1948, was attended only by ten delegates, because the English psychiatrists had already left the country after the independence of India.[73] I would like to point to two aspects about medical cases published after Partition, and how they had inherited from earlier colonial practices: first, they had been impacted by a separation of psychiatric institutions between India and Pakistan where the framework for psychiatry in both newly founded countries had a colonial and particularly military history; second, psychiatry even after partition had to rely on its origins in the imperial military, both to define itself as an independent institute, but also interestingly to separate itself from its colonial heritage.

Brocklesby Davis who studied 434 Indian soldiers suffering from psychosis evacuated from the South-East Asia Command Theatre of War, described a patient as having reported, 'I received a letter from home saying my father had died and there is nobody to look after my family affairs. I applied for leave but I was told that it could not be granted, after that I went mad'. This was followed by an accident which led the 'collapse of the patient's whole mind'.[74] By this time, psychiatric evaluations involved 'discussing with patients their domestic affairs, getting them to write letters home and helping them to face the future' signalling demobilisation and the return of the soldiers to their families.[75] One soldier learned that monsoon rains had ravaged his village and several kin had lost their lives and was refused a leave after which he lost his sanity.[76] Electroconvulsive therapy (ECT) still remained an option, and it was considered that the alternative of insulin shock therapy had little efficacy on the Indian body, with Indians requiring far greater insulin than their British counterparts. Yet there is also evidence of Indian patients refusing to receive ECT.[77] Symptoms, including delusions, represented the effects and resistance to colonial rule as in the case of one person who threatened that the British government should promise certain things, or he would send the British out of India.[78] However, there remained an emphasis on using caricatures about social groups to predict illness, with total breakdown considered low among martial races, denying them a full diagnosis by using justifications such as 'schizophrenias of Indians and Gurkhas troops being less serious from a prognostic viewpoint than similar states in British troops' with majority considered to have recovering as soon as ECT was administered.[79] Military epidemiology even to predict the impact of anti-syphilitic treatment among Indian troops classified populations through ethnic identifiers such as madrassis, marathas and 'others'.[80]

Colonised under the Indian Army

During WWII, one can observe an even more intense form of disciplining of soldiers, this time largely under Indian commanders. Symptoms reflected anxieties with being under a colonial structure even after independence. In a paper presented at the First Annual General Meeting of the Psychiatric Society at Patna in January 1948, a retired doctor of the Indian Medical Services (IMS), the medical wing of the Indian Army, discussed several cases of the 'psychopathic personality' in the Indian Army.[81] Instead of a

[73] *Ibid.*

[74] R. Brocklesby Davis, 'A Study of War Psychosis in Troops of the Indian Army', *Indian Journal of Neurology and Psychiatry*, 1, 4 (1949), 160–81.

[75] *Ibid.*

[76] *Ibid.*

[77] *Ibid.*

[78] *Ibid.*

[79] A.H. Williams, 'Psychiatry in Jungle Warfare', *Journal of the Royal Army Medical Corps*, 93, 2 (1949), 75–79.

[80] L. Krainer *et al.*, 'Arsenic Encephalopathy in Indian Troops', *Journal of Neurology, Neurosurgery, and Psychiatry* (1946).

[81] A.N. Mukherjee, 'Psychopathic Personality in the Army', Read at the First Annual General Meeting of Indian Psychiatric Society, Patna (1947).

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focus on the impacts of the recent partition, this article focused on the impacts of WWII on the mental health of returning soldiers, to foreground the basis of psychiatry in a newly founded state. Drawing upon experiences from the military, he writes, 'In the Army it is not possible to get a history of the patients' childhood either at home or at school, otherwise it would have been evident that these (psychiatric patients) were not very pleasing from the very beginning'.[82] The relationship between preservice history of psychiatric morbidity and psychiatric battle casualties, thought to be held as continuous at one point, was put to test during the Second World War when returning soldiers began to be medically screened for overall fitness. This meant that soldiers were no longer required to have pre-existing mental health conditions to be psychiatrically morbid. This resulted in making recruitment much more flexible than it had been the case before. Borderline cases created a particular problem in ascertaining in advance how the soldier would react to unfamiliar situations. This was compounded in the context of Indian military psychiatry where it was difficult to ascertain preservice mental health as a cause of psychiatric ailments developed among returning combatants.[83] These returning members had been divorced from the wider kin and no longer had their words trusted in psychiatric wards. Issues of mental health were simply considered as the soldier's inability to adapt to different environments both in the civilian and the military context. The decision about diagnosis remained tied to whether or not a person could be turned into a dutiful soldier. For instance, about the psychopathological type, Mukherjee (1947) wrote:

> In order to commit something which usually goes against the proper discipline they fall victim before the commander of the unit and are liable to punishment. To escape their punishment their talents guide them to adopt some other abnormal procedure which further causes resentment of the superior office. Finally, after constant trouble with different units, they are invalidated out of the army.[84]

Tropes of malingering still remained relevant. Here, medical diagnoses exist almost alongside the question of invalidation from the army, as well as a failure of a soldier to comply with orders given by superiors, which were often based on wide-ranging issues including those of sexuality. The diagnosis reflected the resistance against military authorities most pronouncedly and was a product of negotiations within the military hierarchy. The first case in the article is that of a head clerk of a unit, who had problems with his *subcharge*, the immediately superior officer, another Viceroy Commissioned Officer of the rank of subedar major. The head clerk commented that the *subcharge* was no good, and that the latter had been promoted to the present rank due to favouritism, a fact that the former did not appreciate. He first began to defy the subcharge, but later began to avoid his office work, so that his subcharge could be blamed for it. He became more rebellious with time and was presented to the commanding officer on the account of his insubordination. This is how the case proceeded:

> Later he developed rebellion against the commanding officer, whom he believed to be unjust and partial. Then he began to write against the Commanding Officer directly to the Area Commander and also to the General Headquarters. This sort of direct letter addressed to the highest authorities caused suspicion that he might be a case of psychiatric illness and was sent to the hospital for investigation.[85]

Attempts to overriding hierarchy was thus seen as 'pathological'. Having been diagnosed as a case of 'psychopathic personality' for his 'emotional abnormality', he was claimed to be 'unstable, quarrelsome and discontented with his position and unable to adjust to the environment'. He was later invalidated out of military service. Notice how the question of invalidation from the military plays a role in medical diagnosis

[82]*Ibid.*, 56.
[83]Edgar Jones and Simon Wessely, *Shell-Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (Routledge, 2005), 191–3.
[84]*Op. cit.* (note 81), 57.
[85]*Ibid.*, 58.

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here, where the disease category emerges simply as a by-product ie. after the possibility of improvement via punishment has been ascertained. One can track the relationship between punishment, diagnostic categories and the question of invalidation in some other cases as well. The second case is of another soldier, 'a boarded-out case' awaiting disposal. The mental ward in which he was admitted had a lawn, and one of the nurses used to frequently walk through it. The patient protested about the nurses going through the lawn. One day, even after the nurse had been prohibited by him, she still crossed the lawn, and the soldier began to scream at her. This act was reported to the medical officer, who, after conversing with the patient, found that the latter was a 'normal' man, because he had 'deliberately' abused the nurse. This was later reported to the commanding officer, who immediately shared his belief that psychiatric cases were malingerers unless *gross signs of insanity* are present. The patient was considered *rogue* rather than insane, a throwback to British medicine's treatment of injured Indian soldiers in WWI. When inquired about why he was acting that way, he replied that he did so due to his grievances with military service overseas. The grievance or revolt appears, for the first time, as visibly. The colonel mentioned that the board proceedings would be cancelled and that the soldier would be punished, to which the soldier replied furiously, 'You big people do not look after our welfare but simply want to punish us. Very well, do so, shoot me here'.[86] Mukherjee continues, 'Then he slipped upon his own chest, in a moment he kicked the Commanding Officer's table and picked up a pen knife from the Commanding Officer's table and suddenly made an incision along his own chest and abdomen ranging from 8 to 10 inches, causing profuse bleeding for which several stitches had to be given'.[87] Upon experiencing the scene, the commanding officer figured that the person was not 'emotionally stable' and no amount of punishment would make him fit for service. We understand from the case that the soldier was considered mentally fit even with his rogue tendencies which were considered to be a result of indiscipline, but it was only when he grievously harmed himself that he was given a diagnosis and invalidated.

Another case is that of an officer who had homosexual tendencies and routinely compromised the discipline of the unit. For the commanding officer, he was 'mentally deranged'; however, upon being received by the hospital, he was labelled as a case of psychopathic personality. As a British officer, he would have to be transferred to another hospital for further observation, where it was noticed that he, in fact, did not have any psychiatric disability and was fit for duty. However, the commanding officer personally visited the hospital, to inform the medical staff that the officer was a 'source of trouble and bad influence to the unit'.[88] The relationship between combatants and their medical officers has been a point of contention in the histories of WWI and WWII. For instance, Mark Harrison argues that some of the existing studies on allied medical services 'tend to exaggerate the role of the medical officer vis-à-vis his combatant counterpart'. He argues that these studies also exaggerate the military importance of the medical contribution to the war effort which, though considerable, was less marked than the official histories would have us believe.[89] For others writing about the history of psychiatry in WWII, the medical staff and their combatants, in fact, collaborated, because it was in the interest of the line officers to know more about their men in order to discipline them, which is why they were more welcoming of the role of the psychiatrists than their superior commanding officers.[90] One can notice how medical complaint was tied to the insistence about the unruly behaviour of a subordinate by a superior, which meant that even if the soldier was not psychologically unfit, the potential of baleful influence upon his unit resulted in collusion between medical staff and the officer to render him mentally ill. These cases provide a useful entry point to understand how the voice of the patient arises mainly in the form of a grievance or a form of a protest, but is silenced, as a 'decision' about whether the patient is a malingerer and required

[86]*Ibid.*, 57.
[87]*Ibid.*, 58.
[88]*Ibid.*, 60–1.
[89]Mark Harrison, 'Medicine and the Culture of Command: The Case of Malaria Control in the British Army During the Two World Wars', *Medical History*, 40 (1996), 437.
[90]R.H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War* (New York: Columbia University Press, 1948), 10–11.

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punishment, or considered mentally unfit to serve and thus to be invalidated has to be made. Outside the colonial army, especially as partition approached, courts debated whether mental illness could be grounds for incarceration, with transfer from one asylum to another taking place through bureaucratic backlogs, and patient voicing frustrations with the delays.[91] The precedent for this has been set by military law, which had instituted that a person could be considered 'guilty but insane', requiring him to recover in an asylum before sentencing, a period which could be extended indefinitely.[92]

Psychiatry on the eve of partition

According to *Ibrat Kada* a fictionalised account of actual psychiatric cases from the Giddu mental asylum in Hyderabad (in present-day Pakistan) written by Sheikh Ibraheem Khalil, the psychiatric ward itself became a place where many of these social relations were revisited and re-enacted during routine observations and interactions between the psychiatrist, the hospital staff and the patients.[93] The need to capture the voices of Hindu staff and patients before the Partition in 1947 and the fact that the writing could be censored by the British authorities enabled the narrative to deploy an ethnographic mode. This time it had a fictional and a poetic aura. In the fictionalised cases, the Indian soldier appears to have a haunting presence in the lives of the patients. One notable case is that of a woman who loses her sanity when the love of her life enrols in the Imperial Indian Army for WWII and returns with a British woman. The woman had asked her best friend to accompany her beloved to the war. The story of betrayal and of the ghostly presence of soldiers among patients betrayed by their loved ones who left for war is a common part of pathological behaviour observed by Khalil. In another case, a request is made to the asylum to accept a soldier by the senior officer to prevent the former for being penalised for his disobedience in the army. Another case is of a soldier admitted to the asylum whose brother-in-law deceives the British by colluding with Afghans across the borders and is sentenced to death which leads to the patient's beloved committing suicide due to the loss of family honour. In the shift from the management of injuries during WWI to Indian psychiatry during WWII, the Indian soldier retained a spectral presence in the diagnosing of mental illness even among civilians. Other Urdu fictional accounts satirically captured the exchange of mentally ill between Pakistan and India, with some patients' condition worsening, because they tried to figure out what life would look like in Independent India and Pakistan, echoing Sarin and Jain's insight, that the partition of geography was accompanied by the partitioning of the mind.[94]

The newly established Indian Psychiatric Society continued to publish research and cases from the early 1940s after the *Indian Journal of Psychiatry* was established. Many of these publications drew upon research and experiments conducted before the partition of India, particularly during the Second World War and in the context of military psychiatry. This meant that even as Indian psychiatry attempted to establish itself as a civilian institution, it encountered difficulties detaching itself from its military origins, because WWII cases shaped post-partition psychiatry. This explains why there was such a blatant neglect of the traumatic effects of partition in conferences or lectures.[95] Yet even by 1949, Indian psychiatrists retained the view that patient's somatic symptoms were exaggerated and dramatised, like British doctors. Still, psychiatrists encouraged the view that the family's relation with patients as well as the patient's

[91]See Ex. Rana Birpal Singh of Bhajji State V. The King Emperor, Supreme Court of India, Criminal Appeal No. 11 (1945) and Proposed Transfer to the Mental Hospital Yeravdu, of Rana Birpal Singh, Ex-Rana of Bhajji, habeas corpus application by the Rana in the Lahore Hindi Court (1941).

[92]G.W. Will, 'Guilty but Insane', *Journal of the Royal Army Medical Corps*, 71, 1 (1938), 39–42.

[93]Sheikh Muhammad Ibrahim Khalil, *Ibrat Kadah* (Hyderabad: Sindhi Sahat Ghar, 2002); Zaffar Junejo, 'The State and Mental Health in Sindh–II', *The Friday Times*, 22 November 2019. URL: https://www.thefridaytimes.com/the-state-and-mental-health-in-sindh-ii/.

[94]Saadat Hasan Manto, 'Toba Tek Singh (Translated by Robert B. Haldane)', *Mehfil*, 6, 2/3 (1970), 19–23; Alok Sarin and Sanjeev Jain, 'Setting the stage: the partition of India and the silences of psychiatry', in Jain and Sarin (eds), *The Psychological Impacts of the Partition of India* (Sage, 2018) 1–12.

[95]Sarin and Jain, *ibid.*

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perception towards the family played a central role in the onset of illness.[96] One example for this is provided by Kirpal Singh of the IMS, who talked about the easy recovery of hallucinating soldiers to return them to battlefront, reinforcing the idea that the North-Western Indian was less prone to illness. Yet Singh showed much less suspicion towards malingering, and discussed multiple causations, physical and emotional, as a source of distress, with hysterical symptoms being impacted by domestic relations, such as being unable to pay bride-price and having the fear that fiancé might be married off elsewhere.[97] In independent India, Nagendra Nath De was also a proponent of birth control reflecting the new biopolitics of family planning. De considered the impacts of ligation on mental illness such as delusions of jealousy among men. He used the assumption that since most men were polygamous, they were likely to remain suspicious about their wives as polyandrous. According to him, this suspicion could be exacerbated after ligation as men were likely to think that since women could not become pregnant, they could have sex with any man outside marriage.[98] After Nagendra Nath De, who had worked closely with military psychiatrists in places such as Ranchi Mental Hospital, took over as the president, he published his own research in which he had conducted a series of histamine and insulin treatments on schizophrenic patients.[99] De was making a case for a shift from earlier electric shock therapy to a more humane method of treatment. At the same time, he was drawing attention to the meagre resources dedicated to mental health particularly in the wake of the transfer of power to governments in India and Pakistan. Many young psychiatrists of the IMS had turned to general practice due to the lack of opportunities for clinical work, as well as the 'distinctly jail-like' conditions of psychiatric wards which repelled many young aspirants.[100]

The article which drew from the research he had conducted over the past few years was based on twenty patients of schizophrenia who were injected with insulin at regular intervals, each time with an increased dosage. By 1946, patients had been tracked for over 4 years on 6-month intervals. The follow-up cases allowed De to take note of remissions and relapses of symptoms experienced by patients. Although the cases have a remarkable similarity to those of Seton's as shown earlier, they also describe the person's social interactions, along with when the doses of insulin were given and when they were raised. Still the impacts of partition on families remained neglected. The meter of their improvement was taken as how well they had adjusted in their social milieu after taking their doses. Earlier in WWI, the concern faced by the imperial army was the pressure experienced by soldiers in adjusting to the environment and conditions of warfare, where their return to the battlefield from the hospital had to be ensured in the most expedient manner possible. By the end of WWII and on the eve of Partition, the concern of psychiatry had shifted to adjustment to social relations. The first paragraph in each case is about the potential to inflict harm to others, including family members, whether or not the person spoke in monosyllables, and lastly whether or not one confused self-identification with that of someone else, say, a sibling. On the one hand, there were identifiers such as 'laughs without reason, without any reservation and without any consideration whether he is alone or in the midst of known or unknown persons'. On the other hand, there are signs of improvement shown such as, 'Occasional aggressive attacks to wife, brothers and servants, formerly more frequent, now once or twice a month'.[101] In examples like these, we can see how the improvement of the patient is gauged through whether or not they had begun to live in harmony within a set of kinship relations.

Another female, a catatonic type, developed her symptoms after the death of her newborn, and lost all her capacity to function independently. De mentions, 'She said there was a big animal inside her head,

[96]Alfred P. Solomon, 'Symposium on Low Back Pain: The Psycho-Somatic Viewpoint', *Digest of Neurology and Psychiatry* 1, 4 (1949), 198–202.

[97]Kirpal Singh, 'Psychiatric Practice Amongst Indian Troops', *The Indian Medical Gazette* (1946), 396.

[98]Nagendra Nath De, 'Mental Effects of Ligation Operation', Read at the Scientific Session of the XIII Annual Conference of the Indian Psychiatric Society, Calcutta (1960).

[99]Nagendra Nath De, 'Histamine and Insulin Treatment of Schizophrenia', *Indian Journal of Neurology and Psychiatry*, 2, 2 (1950), 35–46.

[100]See E.A. Bennet, 'Psychiatry in India and Pakistan', *Mental Health (London)*, 8, 1 (1948), 2–5.

[101]*Op. cit.* (note 99), 36.

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which she thought at one time, was a big snake, and at another time a big guerrilla'.[102] The woman had also stopped taking care of her children. She received treatment between May and July and was completely recovered. For De, severe cases of hallucination did not show much improvement. In this particular category, there was a woman who had 'hallucinations and delusions of jealousy remained, as she would challenge her husband at the dead of night'. Identifiers such as relations with husbands are cited to demonstrate the emergence of schizophrenic symptoms. The series of cases conclude with a table, listing how many cases improved, remained constant or deteriorated. By 'improved', De states that he meant the degree to which a 'patient could be trusted to take care of himself in his daily life'. He suggests that 'any less degree of remission was not to be reckoned as improvement, although many of the symptoms might have disappeared', and subsequently the patient being regarded as 'unchanged'.[103] In some of these cases which combine serialisation and some description about the patient's social relations and symptoms, recovery is gauged through the patient's reintroduction into the web of social relations and concrete kinship networks, which were also sites where their illness was first detected, as in problems in the abusive relations between the husband and wife or mother and children shown above.

De's article concludes by making the case for the lack of risk involved in insulin treatment for schizophrenia, and its benefits in treating patients in hospitals where resources were meagre.[104] The emphasis is on devising methods for a humane treatment of patients who have been diagnosed with schizophrenia as civilian psychiatrists find greater space to work independently of their military counterparts. Even though some cases are descriptive, by the end of the article, there is an emphasis on showing progress or lack of progress in the form of a table to deduce the reliability of the new technique, in ways similar to Seton's study discussed earlier. The similar way in which De and Seton catalogue cases to make an argument was perhaps a consequence of close interaction that psychiatrist like De had over the past decades with the military as a consultant. However, psychiatrists were also increasingly advocating for the rights of patients. The Indian Psychiatric Society made a case for how incarceration could itself be a cause of mental illness.[105] Still, De also reproduced colonial biases towards the Indian body. Emil Gutheil, a preeminent American psychiatrist, critiqued De's overemphasis on the role of eugenics in psychiatric illness, because the latter had talked about heredity as 'one of the most important aetiological factors in disorders'.[106] De had suggested that Western psychiatric techniques could not be taken as is, because it would lead to 'artificiality and the distortion of a people's actual creativity of development'. However, Gutheil still noted De's lack of admiration for Indian psychiatry which 'could make tremendous contribution to the understanding of human personality'. Gutheil concluded that De 'gives scarcely more than a hint of the treasures of constructive psychiatric thought and wisdom that India – in turn – has to offer to the World'.[107]

Conclusion

This article gives an overview of developments in medical cases from WWI all the way up to partition of Indian subcontinent. I have attempted to show how medical reporting responded to the broader context of anti-colonialism and discontents of the empire. The article has considered the use of classificatory knowledge about Indian ethnicity used for medical ends ie. to predict the development of mental illness. I suggest that it is the soldier's experience of injury and the way it expresses betrayal by the British during WWI in Brighton Hospital, which enables us to understand how his psychological experience and voice subtly emerges in the medical encounter, only to be suppressed by documentary and scientific practices

[102]*Ibid.*, 38.
[103]*Ibid.*, 44.
[104]*Ibid.*, 46.
[105]Emil A. Gutheil, 'Abstracts from the Indian Literature: Review of Mental Health Services in India by Nagendranath De', *American Journal of Psychotherapy*, 4, 3 (1950) 577–581.
[106]*Ibid.*, 580.
[107]*Ibid.*, 581.

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of doctors deploying statistical methods to ascertain common attributes and tendencies of the Indian soldier. I have thrown light on how, in later years, military psychiatry attempted to integrate psychoanalytical techniques to consider subjective experience of Indian soldiers while also reproducing colonial biases. In the case of medical reporting in India during WWII, I have explored how the question of the diagnostic category was secondary to the question about fitness to serve, as well as whether one was able to adjust to military duty abroad or in India. The question about normality was also decided based on whether the patient was able to resume functioning in concrete social relations, such as those with comrades and superiors in the military during WWI and WWII. This was also a time when physicians and psychiatrists actively experimented with evaluating family relations and helping improve them for the soldier's mental health. Finally, I have shown that the anticipation of partition provided an opportunity to present the social experiences of the patients as causes of their mental illness a lot more prominently than had been the case before. These consisted of relations with one's kin – which became sites where the symptoms of their illness were first detected – where patient recovery was tied to the resumption of normal relations in the family with demobilisation of soldiers from war in the background.

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