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Grief, Moral Insanity, and Colonial Paranoia in the Native Asylums of Bengal (1860-1925)

By

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"...I found the hospital to be a nice one! The insane too were not like common insane. There were plenty of visitors like me. I also saw a few doctors for the insane. Some of them appeared like men of knowledge but some [appeared] insane! At least in the first glance I took a person to be an insane but after introduction I found him to be a doctor!"

- Bengali journal of science, late nineteenth century[1]

[1] Amit Ranjan Basu, "Emergence of a Marginal Science in a Colonial City: Reading Psychiatry in Bengali Periodicals," *The Indian Economic & Social History Review* 41, no. 2 (2004): 104.

Abstract

This project draws upon the colonial archive of Lunatic Asylum records in Bengal (1860-1925) to examine how the nineteenth-century theory of "moral insanity" perpetuated colonial paranoia regarding the native subject's latent potential for violence. While insanity was theorized differently for various subgroups of the population, the general theory of the "native psyche" was intimately intertwined with this notion of simmering, undetectable emotionality that escaped surveillance. Bengal's asylums were fragmented sites of knowledge formation, discipline, experimentation with "moral" treatment, and incarceration. Tracing the presence and omission of moral insanity and its proximate cause, grief, through the archive, I uncover a genealogy that demonstrates how racialized pathologization of emotion became embedded into twentieth-century diagnostic categories. These categories, constructed around presuppositions of violence and instability, were then solidified through repressive legalization and obscured by new, scientifically validated psychiatric terminology. Drawing on psychoanalytic frameworks, I analyze colonial paranoia as an unstable systemic logic that framed emotional instability, particularly grief, as a destabilizing affective force that threatened the colonial order. Beginning with the archive's incipient narratives in the wake of the 1857 Rebellion, I argue that this paranoia engendered an ongoing paradox between cure and confinement that deepened in response to rising nationalist agitation. The permeability of the asylum rendered it a significantly distinct space from jails, wherein colonial civilizing logics fissured under the pressure of their own internal contradictions. This tension culminated in the 1912 Indian Lunacy Act, which further entrenched the medicalization and criminalization of insanity—a process that continues to influence contemporary attitudes toward mental illness in the postcolony. Contextualized by the political resistance movements of the time, I incorporate micro-narratives and medical perspectives from the archive, critique the taxonomy of the data, and engage a range of secondary sources, including critical psychiatry, postcolonial theory, and analyses of vernacular literature from the period.

Keywords: South Asia, Bengal, Asylum, Medical Anthropology, History, Insanity, Cultural Psychiatry, Genealogy, Grief, Emotion, Affect, Diagnosis, Empire

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Introduction

Native lunatic asylums in colonial India, established in the early nineteenth century, formed a critical apparatus of colonial governance.[2] Asylums proliferated particularly in Bengal, the "cornerstone of British power in South Asia" and later the site of the first Western medical colleges.[3] Between the mid-nineteenth and mid-twentieth centuries, the colonial management of Bengal's lunatic asylums shifted significantly. Initially, asylum inhabitants were largely vagrants who were arrested by police and dubbed "dangerous" and "insane," leading to their complete exclusion from society.[4] As the century progressed, conceptions of insanity changed as it became recognized as a *curable* disease in Europe. An emergent desire to understand "native lunacy" propelled a drive to analyze the "native" psyche across axes of caste, religion, and gender. However, a paradox soon emerged in colonial policy between cure and control. While the British sought to cure native insanity as part of their civilizing mission, they simultaneously feared violent relapse that could threaten colonial rule.[5] General anticolonial revolt was criminalized and attributed to insanity. This conflation of resistance and lunacy resulted in the ongoing incarceration even of "cured" patients. Colonial ideological assumptions (which associated progress with increased incidences of complex forms of modern insanity) led to a deeply ironic fear of resistance from the very subjects they sought to "civilize."[6] The tension between the simultaneous modernization of the native subject and the increasing prevalence of insanity fed deep colonial paranoia that underpinned governance both inside and outside the asylums. The native subject was viewed as being fundamentally racially distinct and, if not already a criminal,

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[2] Shilpi Rajpal, *Curing Madness? A Social and Cultural History of Insanity in Colonial North India, 1800–1950s* (New Delhi: Oxford University Press, 2021), 5.
[3] Projit Bihari Mukharji, *Doctoring Traditions Ayurveda, Small Technologies, and Braided Sciences* (The University of Chicago Press, 2016), xi.
[4] Ibid, 21.
[5] Ashis Nandy argues that the colonizer's "latent fear" that the colonized will reject the cultural consensus of the rulers handicaps the colonizer "much more than it handicaps the colonized" (Ashish Nandy, *The Intimate Enemy: Loss and Recovery of Self Under Colonialism,* Oxford University Press, 1983, 11).
[6] In *Imperial Bedlam,* Jonathan Sadowsky explores imperial psychiatry in Nigeria and writes that the ideology of Indirect Rule is fraught with contradictions. These include recognizing the social changes incurred by colonialism while simultaneously denying responsibility for those changes (Sadowsky, 37) as well as uneasy projections of their own apprehensions, as demonstrated by debates over the effect of literacy (Sadowsky, 103).

a *latent* one with a simmering capacity for violence. Colonial authorities used types of insanity as manifest representations of this latent capacity for violence.[7] Diagnosis demanded uncovering the subject's interiority—not solely for medical purposes, but also to preemptively guard against anticolonial violence. Forms of "lunacy" and corresponding diagnostic categories continuously shifted, reflecting the colonial urge to classify despite lacking a coherent psychological vocabulary or consistent etiological theory. Amid an ongoing march toward standardization and scientific universalization, changes in the tabular data of the archives reveal an anxious oscillation between punishment, reform, and cure.

The process of formalization resulted in a slew of classifications for various types of insanity. In India, causes of native lunacy were grouped into two overarching categories: "physical" or external causes (predominantly including *ganjah* intoxication as well as heredity and epilepsy) and less common "moral" causes that originate internally (predominantly including grief in addition to fear, anger, love, and other emotions). In this thesis, I trace the shifting genealogy of "grief" in the Annual Returns of Bengal's native asylums. Through close reading of the archive from 1860 to 1930, I show how grief's mentions—and eventual conspicuous omission—reflect intensifying hypervigilance regarding native emotionality as the colonial project progressed. The eventual justifications for indefinite detention enshrined in the 1912 Lunacy Act relied on the prior theory of moral insanity—an invisible, partial, and latent form of lunacy particular to the Indian subject that could never be fully cured through medical treatment.

The archival data reveal many gaps, absences which I interpret as productively revealing diagnostic ambiguity. These epistemic unknowns surrounding the etiology of insanity represented not just a medical challenge, but a form of strategic flexibility that allowed the

[7] While Edward Said adopts Freud's terms "latent" and "manifest" to refer to unconscious versus overt representations of Orientalism, here I apply the terms to colonial understandings of unexpressed versus expressed native subject interiority.

expansion of colonial discretionary power. Diagnoses could be leveraged at will, depending on the paranoia or leniency of a given superintendent. Here I use paranoia not referring to individual affect, but to identify a systemic colonial logic that interpreted emotionality as a potential trigger for violent rebellion. Grief in particular appeared as a diagnostic proxy for this projected "manifest" violence. In Fanonian terms, the colonized subject becomes a dehumanized "psychophobic object" onto which colonizers project their own insecurities.[8] This necessitated constant surveillance of the subject's interiority to preempt the collapse of imperial order.[9] The implication that such latency was potentially universal among subjects stoked colonial insecurity.

In the context of U.S. pacification in Vietnam, Kurt Jacobsen distinguishes between "developmental" and "repressive" aspects of counterinsurgency.[10] The former include programs like education or public health aimed at the overall population, whereas the latter involve punishing extremists. However, this presents a bind: "you don't pacify criminal gangs… you pacify entire populations who you know very well don't want you around."[11] The developmental-repressive binary offers a useful lens through which to understand Bengal's native asylums, which were construed as developmental but in actuality tensely hovered between cure and carcerality. The colonial state, like the counterinsurgent state, was forced to maintain a delicate balance between managing public perception and continuously disciplining a population perceived as inherently unstable. This tension was reflected in the unique character of the lunatic asylum. Multiple scholars have argued that the native lunatic asylum was not a "total institution" in the Foucauldian sense as there was never a "Great Confinement" of lunatics in India.[12] In contrast to other colonial institutions like hospitals and jails, Bengal's asylums contained a

[8] Megan Vaughan, "Madness and Colonialism, Colonialism as Madness Re-Reading Fanon. Colonial Discourse and the Psychopathology of Colonialism," Paideuma 39 (1993): 47. Citing Frantz Fanon's Black Skins, White Masks, 1986: 154.
[9] In some ways, this collapse was unconsciously understood to be inevitable due to the contradictions in the internal logic of colonialism, leading to a continuous imagining and perhaps even unconscious desire for the fall of the empire.
[10] Vaughan, 4.
[11] Jacobsen, 5.
[12] Biswamoy Pati and Mark Harrison, *The Social History of Health and Medicine in Colonial India* (Routledge, 2009), 5.

relatively small proportion of the population even at their zenith.[13] Colonial expectations asserted that insanity would be more prevalent in the metropole than the colony because civilization "induce[s] burdens on the brain" while "the lesser civilized races lived simply."[14] Nonetheless, authorities remarked that a very small proportion of the native lunatic population actually found themselves in the asylums—those who were homeless, dangerous, or incurable.[15] This meant that swaths of the native lunatic population were either cared for at home, at large, or currently presenting as sane.[16] The specter of unconfined lunatics troubled colonial authorities, as the number of "insanes" reported in censuses far exceeded the number confined.[17]

Reflecting their liminal status between cure and confinement, the walls of the asylum were more permeable than Foucault's "total institution" would imply. Anouska Bhattacharyya's intervention shows that nineteenth century Bengal asylums entailed a surprising amount of interaction with the outside world due to fragmented institutional policy, a large number of Indian staff, and hybridized knowledge formation.[18] Relatives were allowed to visit and interact with inmates more regularly than at jails in later years. Debjani Das reinforces this characterization, noting that Bengal's asylums were not solely disciplinary sites, but also spaces in which to "understand insanity as a disease and implement various treatments for its remedy."[19] This experimental mindset paralleled the quest for knowledge of lunacy in England. By focusing on the colonial asylum as a laboratory more so than a total disciplinary arena, I emphasize how colonial projections were continually rearticulated. Dynamic exchanges with the Bengali population and ongoing correspondences with authorities in England reflect complex

[13] Meghan Vaughan has also highlighted the lack of a Great Confinement in Malawi, showcasing the potential limits of this Foucauldian frame in colonial contexts more generally (Sadowsky, 3).
[14] Rajpal, 148.
[15] Annual Report of the Insane (Lunatic) Asylums in Bengal, Annual Report of 1871, 37.
[16] Superintendent A.J. Payne, Annual Report of 1871, Dullunda Lunatic Asylum, 37.
[17] Ibid.
[18] Anouska Bhattacharyya, "Indian Insanes: Lunacy in the 'Native' Asylums of Colonial India, 1858-1912" (2013), http://nrs.harvard.edu/urn-3:HUL.InstRepos:11181217, 17.
[19] Debjani Das, *Houses of Madness: Insanity and Asylums of Bengal in Nineteenth-Century India* (Oxford University Press, 2015), 5.

co-constituencies between colonial authorities, general subjects, and asylum inmates. Indeed, this porosity would later provide space for interaction with Bengali scientific discourses, hybrid healing modalities, and anticolonial critique—revealing the self-fulfilling nature of colonial paranoia.

Definitions and Periodization

As mentioned above, the archive contains a variety of "moral causes" of insanity which shift somewhat over time (they read as a list of emotions including fear, love, jealousy, and anger), but grief consistently appears with the highest frequency. Contextualizing the term "moral insanity" permits a clearer understanding of "moral causes" (which are never explicitly defined in the archive). "Moral causes" entail two dimensions: (1) adherence to moral principles (in this case, Western colonial virtues of self-conduct and ethics), and (2) internally restrained emotional regulation. In the 1830s, "alienist" James Cowle Pritchard coined the term "moral insanity" as a form of "partial" insanity: derangement which left "the 'intellectual faculties intact' while the 'moral and active principles of the mind' were 'strangely perverted and depraved.'"[20] While talking and reasoning appears normal, he wrote, one's "internal character is deeply afflicted" as the "power of self-government" is lost.[21] This is a frightening prospect: a visibly "sane" patient may in fact be deceptively harboring a dangerous, unanchored interior. Violence may imminently spill forth, whether against the self (typically non-criminal lunacy) or others (criminal lunacy).

Thus, the category of "moral insanity" ties emotions to lunacy in a way that implicates one's character and ethical faculties. Linking affect to violence, it introduces a peculiarity in diagnosis whereby symptoms *by definition* may be undetectable by the physician. This situation is ripe for

[20] David W Jones, "Moral Insanity and Psychological Disorder: The Hybrid Roots of Psychiatry," *History of Psychiatry* 28, no. 3 (September 2017): 263–79, https://doi.org/10.1177/0957154X17702316. 266.
[21] Ibid.

colonial paranoia, whereby one is surrounded by apparently insipid subjects that may actually be on the brink of eruption. Moral insanity thus provided a diagnostic vocabulary for the colonial fear of the subject's unknowable interiority. The alienist was meant to impute understanding on the native psyche to predict behavior. Grief, fear, and other moral causes thus represented more than simple emotions—they were possible symptoms of brewing insurrection.

Despite the division between physical and moral insanity, the bifurcation remained perpetually contested.[22] Indeed, "degeneration blurred the difference between moral and physical causes," serving as a common denominator for all types of insanity.[23] Imperially defined "degeneration" thus lay at the core of asylum logics. For example, considering masturbation a vice, but genital mutilation of asylum inmates a rational and even curative response in the nineteenth century reveals both the exercise of disciplinary power and the anxiety around regulating physical bodies through mechanisms of colonial morality.[24]

While diagnoses were unstable and lacked rigorous definition, their rigid character reveals a determination to categorize. Authorities grouped asylum inmates by caste, occupation, sex, and diagnosis and bifurcated them into "criminal" and "non-criminal." Perusing these tables is unsettling not only because the categories are never explained, but also because there is no mapping between causes and diagnoses.[25] Furthermore, a huge fraction of inmates (sometimes over half) receive no diagnosis at all, resulting in many tables with largely empty cells save for the columns labeled "Unknown." Sometimes, a superintendent would remark that these tables were "useless," raising the question of what they were really for—concrete medical treatment or the fragile illusion of control?

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[22] Rajpal, 99.
[23] Ibid.
[24] Mills, 3.
[25] The physical and moral causes given are not mapped directly onto corresponding diagnostic categories or symptoms. Grief is a cause among both criminal and non-criminal lunatics; rather than associating it one-to-one with melancholia (as today's reader might assume) we cannot ascertain exactly how many cases associated with grief were the purported cause of mania or other diagnoses.

Rather than a flaw in the classificatory schema, this ambiguity operated as a strategic buffer. Unclear or absent diagnoses allowed the flexibility to detain, neglect, or reframe patients as needed, shielding colonial doctors from accountability. Beyond administrative confusion or carelessness, this vagueness reflected the assumption that native minds were often too opaque, unstable, or alien to interpret—a rationale that could justify both medical disengagement and indefinite confinement. Despite ambiguity, the archive reveals clear shifts in how insanity was conceptualized across the decades. One can trace the theorization of insanity from 1870 to the early twentieth century as marked roughly by three phases: (1) primarily a symptom of social deviance (a phenomenon that started in the early nineteenth century, before the present archive, into the mid-1870s), (2) a *moral* issue that necessitated behavioral treatment rather than brute force to mold the psyche (mid-1870s to early 1890s, although violent lunatics remained an exception) and (3) a decidedly medical disease as psychiatry coalesced as a discipline from the 1890s onward. Despite significant changes in the classifying taxonomy of insanity over time, the ideological underpinnings of moral insanity continued to influence attitudes toward cure. After 1900, categories of moral insanity transformed and were largely subsumed by physical causes. Underlying logics that pathologized grief and other emotions persisted in the new taxonomy and were used to validate long-term incarceration, particularly after the 1912 Lunacy Act.

This periodization is a heuristic that should not be taken as strictly defined. I loosely use them to organize my argument and illustrate broad changes in colonial perceptions through the archive. First, I will provide some background on the terminology used as well as historical context for the construction and proliferation of lunatic asylums in nineteenth century colonial Bengal. Elaborating on the initial conceptions of moral insanity in Britain and Europe, I will illustrate how it was interpreted in the colony from roughly 1860-1880. Second, I will explore

how the advent of "moral treatment" in Europe influenced conceptions of native "moral insanity" from the late 1870s to 1900. I use excerpts from this period to show how portrayals of grief and moral insanity shifted along with notions of treatment that linked labor and bodily discipline to a cured, self-regulating subject in an effort to curtail deviant behavior. Third, the "medical turn" around 1900 illustrates a sharp change in diagnostic formulation. Finally, I discuss the impact of the 1912 Lunacy Act on corresponding medicalized discourses. Thereafter, the "medicalization of colonial power" became further entrenched as insanity continued to be tied to legality and lifelong incarceration, now with greater urgency in the face of rising nationalist agitation in the early twentieth century.[26]

The Language of Taxonomy and "Native Lunacy"

It is important to establish some priors regarding the language used in the archive. Borrowing James Mills' framing of colonial asylum records, it is critical to note that the primary sources do *not* transparently record events and objective scientific data.[27] As Mills argues, uncritically accepting the classifications of individuals "would simply be complying with the power relations of the period."[28] Rather, these data *produced* new ways of seeing Indian subjects through representations that themselves justified colonial intervention.[29] Rather than taking this information as reflecting medical diagnoses grounded in objective reality, I critically analyze methodologies of the archive as manifestations of colonial anxiety. Specifically, I argue that these data articulate paranoia regarding criminality and rebellion. More broadly, they entrench the epistemological authority of Western scientific modernity.

[26] The "medicalization of colonial power" is a phrase used by Waltraud Ernst across works.
[27] James H. Mills, *Madness, Cannabis, and Colonialism: The "Native Only" Lunatic Asylums of British India 1857-1900* (Palgrave Macmillan, 2000), 5.
[28] Ibid, 2.
[29] Mills, 4-5.

For Fanon, colonialism itself is a psychopathological structure that distorts the formation of subjectivity for colonized *and* colonizer alike.[30] This psychic distortion is revealed in the classificatory language of the archive, in which colonial surgeons attempt to fix native behavior within rigid yet ill-defined categories. As Fanon writes, the colonized are "sealed within a crushing objecthood," here defined as particular diagnostic labels. Yet, this objecthood is itself shaky: there is both a lack of detailed classificatory symptoms and "no evidence that categories like 'mania' or 'melancholia' were stable ones," indicating repeated admission by authorities that their own narration was both unreliable and inconsistent.[31] Diagnoses "sealed" the patient into a fixed identity, spatial confinement, and particular mode of "cure." On the other hand, the frequent deployment of "Unknown" as a diagnosis (sometimes over half of all patients) left them liminally subject to indefinite neglect. Thus, diagnostic instability was not simply a result of inadequate information, but a deliberate feature of the system. The elusiveness of etiology, while framed as an empirical challenge for the "alienist," functioned as strategic elasticity. In refusing to tie causes to consistent symptoms, colonial doctors retained power to retroactively classify deviance as pathology, continuously shifting the criteria for confinement and various modes of restraint and treatment. Thus, diagnostic ambiguity was not simply a medical failure, but an opportunistic tool that justified continued expansion of the asylum apparatus. Mirroring Ian Hacking's "looping effect," diagnostic classification grew to be self-reinforcing: each act of diagnosis legitimized further intervention.[32] Colonial paranoia escalated in a recursive loop, echoing the lament of a Vietnam War correspondent: "the more we won, the more we lost."[33]

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[30] Vaughan, 47.
[31] Ibid, 21.
[32] Ian Hacking, "Kinds of People: Moving Targets: British Academy Lecture," in *Proceedings of the British Academy, Volume 151, 2006 Lectures*, ed. P. J. Marshall (British Academy, 2007), 286, https://doi.org/10.5871/bacad/9780197264249.003.0010. Although Hacking's "looping effect" refers to the impact of diagnoses on patients, here the recursion occurs in the psyches of the diagnosers.
[33] Jacobsen, 2.

The Peculiar Nature of Native Insanity

In the 1877 Annual Report, Sgn-Gen. Beatson wrote that insanity was probably much less prevalent in India than in Britain "on account of being, as a general rule, most common in civilized countries."[34] An 1877 Resolution noted that the English metropolitan population was exposed to more "sustained" mental activity, leading to strained faculties and "more complex and less tractable forms" of insanity compared to the native of Bengal.[35] Native insanity was thus construed as both rarer and simpler. This argument was not merely environmental, but also relied on racial biological differences. In the 1871 Annual Report of the Dullunda asylum, the Superintendent posits that the European psyche has an equal mixture of the intellectual and the emotional, the "Negro" has more of the emotional than of the intellectual, and the Indian native has "far more of the intellectual than of the emotional." He describes the "Psychological peculiarities of the natives of India" in Fig. 1.[36]

"European-only" asylums served different purposes from the native asylum's goals of detention, study, and surveillance. British soldiers were sent to the European asylum at Bhawanipore before being shipped back to England for treatment in order to shield from public view behavior that was "unbecoming" of the racial ruling class.[37] Even as temporary accommodation, the conditions of European asylums were superior, further highlighting racial hierarchy in the colony.[38] However, spatial segregation wasn't absolute: upper-class Europeans had European attendants at Bhawanipore, while "pauper lunatics" were sometimes overseen by Indian staff. For many of the latter patients, this was a disgrace, and they actively preferred

[34] Annual Report 1877, 9.
[35] Annual Report 1876, Resolution, 20th October 1877.
[36] Annual Report 1872, Dullunda, 36. The analogy to "the dementia of Europe" here shows that although symptoms of insanity were not fully distinct between the two races, underlying causes were.
[37] Ernst, *Mad Tales from the Raj,* 38.
[38] Ibid, 21.

chains to "being subdued" by a native.[39] Furthermore, sometimes poor European patients were temporarily placed in native asylums.[40] Thus, racial segregation occasionally blurred under Victorian class structures. In parallel, differing classifications of insanity dovetailed when it came to "European" versus "native" conditions.[41] Nonetheless, certain perceived racial differences remained stark. At Bhawanipore, moral insanity was not mentioned at all in the 1877 report, while physical factors like "sunstroke," "injury to head," and "intemperance" were.[42] Moral insanity, however marginal, was inseparable from the psychological "peculiarity" of Indians. This pushed the borders of European taxonomies of lunacy, resulting in ad hoc formulations by colonial doctors. Especially when conceptualizing practices such as spirit possession, mourning rituals, or sorcery as "totally different patterns of experience and order," they "found it difficult, given the variety of local patterns… to fit them into restrictive categories already identified in European hospitals."[43] Rather than discovering universal human illnesses, the peculiarity of the native rendered Indians subject to distinct, sometimes unclassifiable syndromes. These differences were not value-neutral but inferior, rooted in causes that implied moral degeneracy and biological inferiority.

As a consequence of observing depression and suicide among both "Mahomedans" and "Hindoos," J. Campbell Brown reinforces the attenuated, hidden nature of native insanity: "natives are more under the influence of emotion than Dr. Bird's remarks would indicate…. [Probably,] emotional manifestations of [natives] are milder than those of Europeans and Negroes…"[44] The idea that hidden emotions might actually be more prevalent than authorities had imagined would only amplify paranoia. This paints a contrasting picture between the subtly

[39] Das, 92.
[40] Ibid, 47.
[41] European versus Indian was not the only racial division; people of mixed-race descent appear in later records as "Eurasian."
[42] Annual Report 1877. Resolution No. 436, 36. These causes emphasized the "alien" tropical environment as driving European insanity.
[43] Rajpal, 160.
[44]Annual Report 1872, l Report 1872, 21. [108] Annual Report 1873, 15.

insane native and the more dramatic European lunatic, whose symptomology renders them easier to detect, manage, and control. Several colonial doctors considered "native" insanity to be "less expressive" compared to the European variety, invoking the idea of undetectable danger.[45]

This apparently inherent feature of Indian insanity amplified the difficulty in detecting violence; this peculiarity of the native thus provided firm justification for monitoring and surveillance. This was veiled in the form of medical evaluation in the 1872 Annual Report of the Dullunda Asylum, which states: "Wanting [in] intellectual and emotional intensity, and [being] less demonstrative than European insane, it is not always apparent at what period an insane native becomes sane."[46] Because a native may "slip into health unnoticed," a monthly evaluation was proposed to "rigidly examine" a patient's mental condition.[47] The characterization of native insanity, therefore, did not solely describe fundamental differences, but animated the need for colonial oversight. Paranoia and suspicion were institutionalized in the managerial flows of the asylum, giving doctors a regularized monitoring structure to mediate their own paranoia. Further, this difficulty in detecting cure was reflected in the frequent readmission of patients.[48] If an inmate had a violent history, authorities were reluctant to release them even if their symptoms appeared resolved.[49] Cure, then, seemed to be less of an objective medical state and more like the vanishing point of a perpetually renewable threat assessment left to individual whim.

In the colonial imagination, "subtle" forms of emotional insanity would only be intensified by civilization. In *Civilization and its Discontents*, Freud argues that modernity requires repressing instincts, yet falters in the case of more *undetectable* urges: "Civilization [cannot] lay hands on the more discreet and subtle forms in which human aggressions are

[45] Das, 32.
[46] Annual Report 1872 Dullunda, 36.
[47] Ibid.
[48] Annual Report of 1877, No, 436 B.G. 1877 (5)
[49] Das, 32.

expressed."[50] This difficulty fed the colonial state's paranoid fixation on the interiority of the colonized subject and the limits of the imperial apparatus. Under this framework, grief was sublimated as moral insanity as a form of repression. While Freud links repression to the maintenance of order, Vaughan illustrates how the specific complexity of colonial racial and social boundaries in India and Africa heightened anxiety: "their very instability [gave] rise to the anxiety which insisted on fixity… the very complexity of social change in colonial societies [gave] rise to attempts to rigidify and simplify."[51] The asylum's rigid yet simultaneously indeterminate diagnostic tables reflect this anxious attempt to cleanly define native psychology.

In addition to being racialized, asylum logics were gendered. Following the establishment of the Insane Hospital of Calcutta in a new building in 1815, males and females were segregated for the first time.[52] This was not simply to "guard issues of morality," but "gave birth to the beginning of the understanding of female insanity as separate from male," subsequently resulting in divergent modes of treatment and new gendered conceptions of cure.[53] The overidentification of insanity symptoms with patriarchal expectations again highlights the tension between cure and control: medical practitioners, by developing particularly "female" maladies, reinforced the subject's social position. Although gendered divisions were present in European asylums as well, the Indian female subject was treated differently. Hysteria is not a popular diagnosis in colonial records despite its vast prevalence in Europe because it was considered "an illness of civilized, urban, and sophisticated women" that did not square with largely poor, "dangerous" asylum inmates.[54] Native insanity in the early stages of Crown rule thus stood directly in contrast with civilization and modernity, and was mediated by patriarchal, casteist, and classist expectations.

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[50] Freud, 35.
[51] Vaughan, 48.
[52] Das, 48.
[53] Ibid.
[54] Rajpal, 226. In *Daughters of Parvati,* Sarah Pinto explores the prevalence of the hysteria diagnosis in post-Independence India. This could be interpreted as a form of mimicry reflecting aspirations toward Western modernity. In Pinto's terms, however, hysteria exemplifies a "disorder of performance"—not so much a lingering anachronism, but rather the result of a process of local cultural formation. The transformation of diagnostic categories after Independence and popularity of psychoanalysis in India presents a rich area of study beyond the temporal limits of this archive.

1800-1870: Proliferation of Asylums in Bengal

In this section, I situate the expansion of asylums in Bengal in relation to the rebellion of 1857, which was unprecedented in scale. While asylums were mostly private at the beginning of the 19th century, the government had supplanted this trade by 1857. The archival documents include reports from medical superintendents who had just taken up their new posts in recently constructed native-only lunatic asylums. The purpose of asylums began shifting from confinement toward diagnosis and cure. At this stage, the documents contain ample commentary alongside the tabular data, such as in Fig. 1. These early asylums were constructed alongside the consolidation of Crown authority, at a time when the foremost goal was preventing a recurrence of 1857 at all costs. Thus, paranoia was encoded into the spatial design, theoretical formulations, documented commentary, and patient interactions of the early asylum system.

Aftermath of 1857

The oldest asylum in India was constructed for European military personnel in the 1780s.[55] In the early nineteenth century, following increased use of asylums in the metropole, the Medical Board began constructing private native asylums in India. The government fully took over the management of lunatics, eliminating this "private trade," in 1856.[56] The asylum population subsequently ballooned in the years following the 1857 Rebellion. The total patient population grew by 83% in 15 years, increasing 60% between 1865 and 1875 alone;[57] Bengal had the most asylums of any administration in India.[58] Vagrants, beggars, and other "socially dangerous people" were dubbed insane by policemen who arrested and admitted them into

[55] Das, 35.
[56] Ernst, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800-58*, 2010, 32.
[57] While population intake peaked in the later decades of the nineteenth century, they still did not contain a significant proportion of the general population.
[58] Mills, 13.

asylums by recommendation of the Magistrate.[59] This deviant population was spatially segregated from the rest of society, often in abandoned jails, indicating an overt carceral motive rather than any pursuit of cure.[45] Reflecting this seclusion, asylums were initially located on the outskirts of town.[60] During this time, emphasis was not placed so much on the mental causes of insanity, but rather on treatment for "derangement of mind" that focused on physical symptoms by providing food, clothing, and various tonics.[61] Indeed, case notes relate far more to the patient's body than to their psychological states.[62] Because of the difficulty in diagnosing insanity, colonial doctors used their authority to judge whether a person's behavior "suited the racial attitudes" or "complied with gendered and community rules" of the time.[63] Coercive tactics disguised as scientific therapies were designed to punish "abnormal" patients; in fact, "treatment" and "punishment" were often used interchangeably in early colonial records.[64]

The 1857 Rebellion marked a turning point with regard to general colonial governance and population regulation. Shortly thereafter, rule over India was transferred from the Company to the Crown.[65] The coordinated uprising illustrated the potential of "unexpected and violent resistance."[66] Following the "mutiny," Indians writ large were suspected of possible criminality and revolt. Apprehensive of further resistance, British officers developed intentional strategies to limit mobility and more closely surveil the population.[67] Bhattacharyya cautions against overstating a causal link between the Rebellion and the India Lunatic Asylum Act of 1858, given that the latter had been in the works prior to 1857.[68] However, its ensuing effects nonetheless enhanced the Crown's agenda of preempting future resistance. Specifically, the Rebellion

[59] Das, 47.
[60] Das, 75.
[61] Ibid, 28.
[62] Mills, 29.
[63] Rajpal, 8.
[64] Mills, 104.
[65] Bose and Jalal, 97.
[66] Mills, 101.
[67] Ibid, 75.
[68] Bhattacharyya, 7.

provided a justification for the formation of theories of native insanity in order to explain the mass violence as madness (never mind the brutal violence that was exacted in response). A fragmented asylum system was gradually becoming officially institutionalized. Surgeons and superintendents new to the specialization of "native lunacy" strove to establish authority despite relatively nascent expertise.

Sugata Bose and Ayesha Jalal write that the rebellion "only served to harden… lines of racial animosity."[69] "Even relatively temperate officers" found death by hanging too lenient; villages were torched simply because they were close to rebel centers.[70] The restructuring of the armed forces exemplified new levels of paranoia: "upper-caste recruits from Gangetic north India were no longer deemed trustworthy."[71] 1857 was thus a watershed moment in the fomenting of colonial hypervigilance, simultaneous with the colonizer's own propagation of mass violence that left psychological wounds for decades to come.[72] Mills describes a post-1857 intensification of physical segregation; social and cultural spaces were entirely reconfigured to enforce greater distance between Indians and Europeans.[73] Some patients, despite having been declared cured, were held in the asylum for decades due to the fear of latent potential violence against colonial authorities.[74] Incarceration was therefore linked to limiting "the violent surprises that the indigenous communities could throw at British rule."[75] 1857 thus marked a pivot point in repressive tactics regardless of whether the legislation was a direct response to the Rebellion.

Shilpi Rajpal writes that the violence of colonialism "provoked the colonized subjects to resist the establishment. The state regarded these forms of resistance as markers of insanity and

[69] Sugata Bose and Ayesha Jalal, *Modern South Asia: History, Culture, Political Economy* (Routledge, 1998), 95.
[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] Mills, 80.
[74] Ibid, 77.
[75] Mills, 79.

punished the so-called deviant for fighting back."[76] As such, specific types of people were targeted to be imprisoned in the asylum; resistance was conflated with a racial pathology that appeared to be spreading. Fakirs and religious mendicants were often arrested and sent to asylums.[77] Particularly after 1857, new surveillance emphasized suspicion of Sufi religious orders, temples, and monasteries as sites of potential resistance.[78] Furthermore, alongside the implementation of the repressive Criminal Tribes Acts of the 1870s, "troublesome" tribal leaders were often disposed of in asylums for "pacification."[79] The mobility of tribes presented a particular threat to the colonial administration since "vagrant" populations were difficult to tax and surveil.[80] The mapping of populations, whether through the census or asylum classification system, used knowledge about various peoples "which were thought to pose a threat to settled rule by searching for physical correlations to *moral* or behavioral patterns considered problematic for government."[81] Thus, doctors attempted to correlate threatening behavior with physical symptoms, reflecting a desire for detectability.

As insanity was being theorized, colonial authorities developed an "obsession with linking insanity and violent crime."[82] Thus, as asylum populations grew, a distinctive "violent criminal madman" was constructed as distinct from a criminal in jail.[83] This construction necessarily pathologized local religious, tribal, and cultural ways of being. Jacobsen highlights a conundrum of this approach: how does one eliminate extremists without alienating the population writ large?[84] This dilemma, in the context of Bengal's asylums, can be understood as the need to continuously differentiate between the violent criminal lunatic and the colonized

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[76] Rajpal, 168.
[77] Rajpal, 158.
[78] Rajpal, 160.
[79] Ernst, Waltraud. *Colonialism and Transnational Psychiatry: The Development of an Indian Mental Hospital in British India, C. 1925-1940*. London ; New York: Anthem Press, 2013.
[80] Mills, 74.
[81] Ibid 34. Emphasis mine.
[82] Ibid.
[83] Mills, 81.
[84] Jacobsen, 10.

subject in general. In the asylum, colonial authorities attempted to strategize in the face of massive overcrowding; criminal lunatics slowly but surely began to outnumber non-criminal lunatics (Fig. 2).[85] However, while asylum authorities sought to focus on violent criminals, underlying psychological theories of the "native" rendered the entire population inexpressive and therefore suspicious. Attempts to pacify increasing swaths of the population, while ignoring structural causes of discontent such as poverty and colonization itself, only further alienated subjects. The increased emphasis on criminal lunatics, however, paved the way for a particular form of spatialization and classification which I turn to next.

Stratification on the page and in space

Various axes of stratification in the asylum records (caste, sex, race, occupation, and religion) represent both biological and social divisions that were reified spatially in the organization of inmates. Differences in custom and social practices were thought to be symptoms of underlying biological differences, producing lunacy that varied by social group. Surgeon James Wise of the Dacca Asylum wrote that different customs, occupations, and even diets between castes were directly related to the causes of insanity.[86] Thus, patients were segregated into different types of rooms (dorms, wards, cells) that corresponded to different categories of illness and were treated accordingly.[87] In this section, I explore the conflation of social custom and biology and the ensuing effects of overcrowding in the asylums.

[85] Annual Report 1872, 4.

[86] Das, 23. In order to better understand these differences, Surgeon Wise went beyond the asylum and investigated surrounding localities to aid in his etiological understanding. In the 1872 Annual Report, J. Campbell corroborated this, writing that "A true knowledge of causation of insanity can only be obtained from a very careful investigation of particular cases [and] an extensive knowledge of the social peculiarities and practices of individuals and communities" (21). Thus, theorization within the asylum was inextricable from the anthropological inquiry into Indian society writ large. For example, Hindu and Muslim healing practices observed outside the asylum were belittled and subsequently pathologized as markers of delusion or insanity (Rajpal, 157).

[87] Das, 28-29.

According to anthropometry and phrenology, popular theories in the Western imagination of the time, "moral character is rooted in the body" and racial differences had a concrete physical basis.[88] In Bengal's native asylums, body measurements were used to assess "cranial capacity and mental capabilities."[89] Post-mortem dissections revealed physical issues such as "brain lesions" were interpreted as manifestations of both physical and moral insanity.[90] Etiological claims were increasingly couched in legitimating medicalized discourse that pointed to bodily "faults," confirming racial inferiority at both genetic and social registers. "Basic characteristics" of Indian society were dubbed pathological and measured against the modern European way of life.[91] Colonial officers were invested in categorizing India's "various peoples" for efficient administration,[92] and emphasized the centrality of caste categories as a way to map Indian society.[93] The classification and characterization of individual inmates became generalized to the inherent nature of entire castes and localities, who each took on a particular set of attributes in the colonial imagination. For instance, *ganjah*-smoking, by far the most popular "cause" of insanity, was portrayed as a "Hindoo vice,"[94] while "Mahomedans" allegedly preferred the "more stupefying effects of [opium.]"[76] Ensuing segregation strove to "emphasize to the inmates… that observance of [religious] divisions ought to be maintained."[95] Caste hierarchies were also preserved, as indicated by the repeated mentions of "respectable" upper-caste natives in the records,[96] the spatial division of inmates by both mental disorder and caste, and the hiring of a

[88] Ibid.
[89] Ibid, 34.
[90] Mills, 32.
[91] Rajpal, 24.
[92] Mills, 34.
[93] Mills, 49.
[94] Hindus were overall characterized as a race "careless of the present, and without any anxieties of the future" (Rajpal, 158).
[95] Mills, 122.
[96] In some ways, India's backwardness was framed as a pathological regression and downfall from ancient times. Indian culture itself was described as "living through a particularly debilitating senility," thus conflating the entirety of Indian civilization with insanity (Nandy, 18). This was another way in which the logics at play here extended beyond the immediate space of the literal asylum.

Hindu water carrier for Hindu patients.[97] The active reification of social hierarchies in asylum spaces was consistent with the "divide and rule" policy of the colonial government as a whole.

Throughout the century, overcrowding blurred diagnostic boundaries, as the number of inmates almost always outnumbered the target for which the space was initially designed.[98] Homogenized and crammed together, individuals were further dehumanized and erased. Often, rooms were combined into enlarged cells—not only hindering proper "treatment," but exacerbating the spread of illness.[99] Almost every superintendent cited overcrowding as the cause of increased mortality throughout the nineteenth century.[100] Carelessness proved fatal; purported attempts to resolve dingy conditions by creating air holes led to rainwater and cold air seeping in, causing illness and death.[87] Generally, women's rooms were more crowded, courtyards more confined and unshaded, and ventilation even worse.[101] In one instance, however, authorities directly attributed the disproportionate number of deaths in the male wards to "the excessive aggregation of human beings in a limited space."[102] The ensuing jumbling of patients rendered the clean, constructed taxonomic data largely moot in practice, leading to difficulties in "proper control and treatment."[103]

Asylums were continually built, rebuilt, moved to different sites, or extended.[104] "Large populous asylums" were loudly condemned in Europe and increasingly in India as well, but these measures to fix the problem were ultimately insufficient.[105] Already overcrowded district jails made conversion proposals unviable.[106] The apparent motivation for addressing spatial

[97] Mills, 222.
[98] Ibid, 48.
[99] Ibid, 64.
[100] Ibid, 48.
[101] Ibid, 56.
[102] Annual Report, R. Cockburn, Esq, 1874 (13).
[103] Das, 24.
[104] Ibid, 55.
[105] Das, 219. In the Annual Report of 1873, the Superintendent of the Dacca Asylum wrote that he was making "an earnest and forcible appeal for better accommodation for the lunatics of Eastern Bengal" (21).
[106] Resolution on the report on the insane asylums of Bengal for 1874. Calcutta, the 9th November 1875. Lieutenant-Governor of Bengal, J. Crawfurd (1).

constraints was not simply the necessity for hygiene, but also the implications for being able to assess causality: "as long as any overcrowding exists, it is impossible to estimate the share which other insanity conditions may exercise in causing the excessive sickness and mortality to which lunatics are liable."[107] Hindrances to knowledge formation were thus inbuilt in the physical designs of asylums and exacerbated by officials' admission decisions. Caught between criticism of overcrowding and increasing financial constraints, superintendents continued to advocate prioritizing the admission of criminal lunatics. Although magistrates and police officers sometimes disposed of "troublesome" people by calling them dangerous in their case histories without any further specification, authorities exhorted them to stop, reflecting a drive to capture and incarcerate those with the highest propensity and potential for violence.[108]

Overall, the asylums in the 1860s and early 1870s were not "total institutions." Knowledge of each individual's clinical condition was largely absent until new examination rules were implemented; even then, a total lack of uniformity in diagnosis and analysis rendered much of the recorded data ineffective. Overcrowding also presented a huge difficulty in properly studying individual cases. Many were simply subdued physically rather than studied with the intent of cure. Inmates were largely dehumanized as blocs to be dealt with according to their collective social identities. However, the narrative descriptions of individual case histories and justifications for their arrests occasionally contain specific detail. I turn to some of these individual accounts next.

Narratives of Grief and Violence

The Annual Reports of the early 1870s contain various episodic narratives that stand in stark contrast to the more technical, bare documents of the later twentieth century. While most

[107] Annual Report, R. Cockburn, Esq, 1874 (5).
[108] Annual Report 1880, 1.

cases were attributed to physical causes (physical 52.4%, moral 9.6%, no cause assigned 37.9%),[109] usually intoxication by *ganjah*, spirit, or opium, moral insanity was described as more intractable: "*Ganjah*-caused insanity appears to be more curable and less fatal… insanity caused by moral influences gives a lower recovery rate and higher death-rate [than] physical causes."[110] In 1871, the top causes of moral insanity were listed as grief, anger, and fear.[111] Turning to specific cases can help visualize these apparently intractable predicaments to which death was framed as the last remaining cure.

While today's definition of "grief" entails a general emotional response to loss with a long temporal arc, in this archive it takes on a particularly charged, immediate, and volatile quality. "Grief" appears to have had a more open-ended definition that relates to any emotional outburst (often violent) that was apparently triggered by some form of loss. Specific narrative accounts of grief are often tied to domestic losses:

> "Grief caused madness in 16.53 per cent of the total cases treated. Of 62 cases, 36 were males and 26 females. The most common causes of great grief were the death of relatives, loss of property and of law-suits, and domestic troubles, such as the desertion of husband from wife."[112]

There were two cases of "grievous hurt" described in the Moydapore Asylum in 1872 as a result of such domestic troubles:

> "He believed his wife had an intrigue with his brother, whom he (the insane) severely beat. The cause in this case is set down as hereditary, though it looks much more like jealousy. The second left his wife for the sake of a Mussulman. Her friends abused him. He turned Mussulman to improve

[109] Annual Report 1871, 40. 290 cases referred to in total. "These figures do not represent the exact proportion, but they approach correctness."
[110] Annual Report 1873, 15.
[111] Appendix - Circular Memorandum No. 105, 26th Dec 1871; K. McLeod - Off. Secy., Inspire Gene. Of Hospitals, Indian Medical Department, 89.
[112] Annual Report 1874, 14.

> matters, but they threatened, bothered, and at least beat him, which altogether ended in his becoming insane, and very violently so. The cause in this case is set down as grief."[113]

Proximate circumstantial triggers are highlighted over underlying causal mechanisms. Emotions themselves were linked to insanity over possibly underlying general conditions. Fear, another moral cause of insanity, was associated with imaginary sightings of ghosts and evil-spirits: "*Bhuts* and *dynes* are familiar objects of terror with the lower classes of this country.[114] Again, emotions remained charged with cultural specificity and explained by social identity.

Occurrences of infanticide sometimes brought women into the asylum after being acquitted on grounds of insanity. In one example, a woman killed a child by throwing it to the ground. Shilpi Rajpal notes that such cases were likely influenced by socioeconomic factors and patriarchal pressures rather than homicidal mania.[115] She describes a case of infanticide that was later diagnosed as melancholia: "the woman's delusions were supposed to have resulted from her feeble mind…. In the second case, the woman's grief was the result of her overt emotions."[116] Grief was thus understood as more than a unitary emotion; it was the manifestation of excessive affect. Rajpal notes that in both cases female insanity was linked to biology, totally neglecting "displacement and social factors such as the insecurities of widows and unwed women."[117] Because these particular violent acts were attributed to uncontrollable gendered aspects of biology, they were ultimately decriminalized. This reflects the colonial conception that female behavior out of step with idealized material roles reflected underlying pathology.

What can these micro-narratives reveal about how colonial authorities understood "native" emotional states? In one case, specific circumstances are used to surmise internal

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[113] Annual Report 1872, 112.
[114] Ibid.
[115] Rajpal, 154.
[116] Ibid.
[117] Ibid.

emotional states (jealousy versus heredity) and in others, gendered assumptions are imputed. Either way, finding causation entailed projecting onto the interiority of the subject's psyche. Grief could be internally or externally triggered, but ultimately came down to a deficiency in the individual's psyche leading to violence either externally directed (harm or murder due to mania) or internally directed (melancholia). Gendered and religious assumptions about emotionality within patient case histories connect the stories of patients' lives to broader discourses about native psyches. At the same time, the uncertainty around causality owing to the very commonplace nature of these same patients' lives was a recipe for etiological anxiety. The exact triggers of emotional "breakdown" could never be fully known and guarded against. The first Moydapore case was declared sane since admission, yet was still kept in the asylum out of caution. Grief, however general a term, was understood in the colonial imagination as an exceptionally dangerous and volatile form of latent violence. Ultimately, grief is significant because (1) resulting moral insanity is characterized as uniquely intractable, (2) the narratives show it to be volatile and violent, and (3) it is unpredictable and physically invisible, uniquely stoking paranoia.

The Moral Turn to Disciplinary Cure (1875-1890)

> *"Of the moral causes, grief is almost the sole and principal one."*
> *"Of the moral causes, grief was the most marked one."*
> - Moydapore and Berhampore Asylums, Annual Returns of 1876.
>
> *"Among the moral causes grief is the chief."*
> - Esq. A. Hilson, 1889.

As physical restraint was increasingly condemned, doctors adopted "moral" disciplinary techniques such as labor and solitary confinement around the mid-1870s. New treatment

strategies thus prioritized molding individual ethical interiority through the body over physical punishment for criminal and non-criminals alike. Although moral insanity continued to be perceived as the most intractable form, with grief its primary cause, labor presented a potential and even preventative measure that simultaneously helped the colonial economic agenda. Civilizing increasingly overlapped with cure defined ethical alignment with the modern virtues of labor and self-regulation. Paranoia, however, did not disappear—if anything, a not-so-invisible hand was now required to hold the new labor market apparatus together.

Labor, Modernity, and Moral Management

In Europe, Pinel's act of unshackling the insane in the late eighteenth century had a rippling (albeit lagging) effect in attitudes toward physical restraint in India.[118] While restraint was still practiced in some asylums, by the late 1870s it was increasingly condemned in favor of "moral treatment."[119] Here, morality takes on a dual meaning: (1) it concerns itself with emotionality and subjective interior states, (2) a primary goal is the internalization of a particular *moral* code—in this case, one aligned with colonial ideology and an emergent capitalist work ethic. Observation and control mechanisms were used to "enable lunatics to develop their willpower and allow them to differentiate between right and wrong."[120] The goal was to implement moral discipline until eventually internal restraint and self-regulation replaced external restraint.[121] Thus, the patient would not simply obey, they would *internalize* a moral order "which was constructed to reflect an idealized version of the social order outside of the walls of the asylum."[122] This theory thus assumes that it was possible to mold inmates into pliant,

[118] Pinel pioneered reforms in the treatment of the mentally ill, advocating against methods like bleeding and purging in favor of compassionate therapy, although the former continued to be widespread in the colony for decades.
[119] This largely depended on the position of individual superintendents.
[120] Rajpal, 101.
[121] Mills, 105.
[122] Ibid.

self-governing subjects. This "humanitarian" approach legitimized the incarceration of non-criminal lunatics in need of moral reform, which was a strategy "devised by the authorities during the period to control the Indian population and to limit its potential for disorder."[123] Moral treatment could bridge the paradox between cure and control; if ethical manipulation of native subject formation succeeded, both aims might simultaneously be achieved.

The Annual Returns of 1877 highlighted the regrettable fact that criminal and non-criminal lunatics were confined together in the same asylum, although the best authorities in England and every other country are opposed to such a practice.[124] Sgn-Gen. Beatson advocated a separate asylum for criminal lunatics due to the fear of recurrence of homicidal mania: "...some criminal lunatics are unusually dangerous, [in England] restraint and seclusion appear to be resorted to in order to tame them [which] would hardly be required for ordinary insane patients."[125] As financial pressures mounted, the government amplified orders to admit dangerous patients rather than "simple" cases of melancholy, idiocy, and imbecility which were "not allowed to become burdens on the State."[126] Beatson, meanwhile, wrote that "modern ideas" of insanity "require that an asylum should be as little-prison-like in appearance as possible."[127] Given that a separate criminal asylum was cost-prohibitive, this therefore presented a tension between wanting to modernize and humanize, and zeroing in on the criminal population who were rendered a constant exception to humanitarian treatment.

In response to this predicament, moral treatment was presented as a successful method for managing both criminal and non-criminal lunatics. In 1878, Lt-Gov. Cockerell wrote that an English Criminal Lunatic Asylum had seen "very beneficial results" from giving lunatics work

[123] Mills, 79.
[124] Annual Report 1877, No. 436, 1.
[125] Ibid.
[126] Annual Report 1878, 14th April 1879, 16.
[127] Ibid.

and a small amount of money as a reward for "trifling indulgences and comforts."[128] Such a reward system was tested in the native asylum. The capacity to work was directly connected to cure. Mills writes that being able to work and be governable, in contrast to experiencing fluctuating and unpredictable emotional states, indicated sanity.[129] In the early 1870s, asylum "employment" was described as more voluntary than coercive, leaving "nothing to be desired."[123] However, as Debjani Das notes, "the grueling nature of physical tasks, especially for unwell patients, indicates that force was definitely used."[130] This excerpt describing an inmate's death shows that resistance was present:

> "The deceased knocked down his work overseer, and when he was trying to strangle him, a lunatic who was close to him inflicted a blow on the head with a piece of wood used in the oil-mill, thereby fracturing the skull. The injured man died shortly afterwards. The matter was enquired into by the Commissioner, and no blame was attributed to anyone for the man's death."[131]

Aside from hard physical labor, moral management gave rise to solitary confinement as an alternative to mechanical restraint. 1872 Dullunda Asylum records include a proposal to stop physical restraint in favor of seclusion.[132] Despite high mortality, solitary confinement occurred in small, dark unventilated rooms.[133] "Observation" translated to hiring a large number of attendants and (largely Indian) asylum staff who engaged in "officious intrusion into the personal space of the patient" and "were usually appointed all through day and night for the constant surveillance on the inmates" up until the 1870s when more breaks were allowed.[134] Therefore,

[128] Annual Report 1877, Resolution, 3rd August 1878.
[129] Mills, 36.
[130] Das, 110.
[131] Annual Report 1880, 8.
[132] Annual Report 1872, Dullunda Asylum, 36.
[133] Das, 69.
[134] Ibid, 247-48.

while specific modes of physical violence were apparently supplanted and declared to be outdated, new "humanitarian methods" were not necessarily less violating or traumatic.

Intentional strategies were adopted to instill paranoia in asylum inmates. Patients often broke the weak iron fastenings on their doors and windows to attempt escape, and officials responded by shackling these inmates and placing windows at higher heights.[135] However, in 1873, the Dullunda Asylum Superintendent wrote that he did not believe that a lunatic asylum should be surrounded by "impassable walls" because the *potential* for escape resulted in greater vigilance by attendants: "Possibility of escape [is] a most useful aid to administration, and should be kept within due limits, but never entirely removed."[136] This strategy reflects a deliberate approach to asylum design involving hierarchical disciplinary system working on the psyches of attendants as much as inmates. By producing a constantly tense state in which escape and resistance was possible but continually crushed, colonial power asserted itself in a way that constantly generated and escalated paranoia in inmates and authorities alike. The deliberate choice to establish the asylum not as a total institution, but one with leaks in authority, served to simultaneously increase the obedience of attendants and exacerbate the anxiety of escape and disobedience as constantly hovering specters.

Colonial modernity was accompanied by the desire to mold colonial subjects into active and willing participants in the new political economy. The majority of asylum inmates were criminalized for being in "wilful poverty," that is, not voluntarily participating in what the British demarcated as "the benign self-regulating mechanisms of the economy" essential for a 'healthy, wealthy, and well-ordered polity.'[137] As labor became an increasingly adopted therapeutic practice, the moral worker was equated to a compliant, deferential person aligned with colonial

[135] Ibid, 64.
[136] Annual Report of 1873 of the Lunatic Asylums of Bengal, 24.
[137] Ibid, 74.

ethics of efficiency, productivity, and conformity.[138] At this time, relief from work continued to be withheld: "No effort seems to be made, [to] provide lunatics with recreation or amusement."[139] "Civilizing" tasks followed a gendered division of labor (with women spinning, cleaning, and cooking while men cultivated land, did hard farm labor, and manufactured).[140] The physical ability and mental or *moral* willingness to perform labor became a proxy for cure. Authorities wanted the asylums to be increasingly self-sustaining as inmates worked the gardens, cleaned, and built the very beds they slept on. Perhaps creating the illusion of a self-perpetuating system psychically distanced colonial authorities from their own roles.

As this emphasis on moral treatment suggests, medicine gradually reclaimed its threatened jurisdiction over the domain of madness through a process of increasing psychiatrization.[141] Mills writes that during the nineteenth century, doctors in Europe struggled to "assert their authority over the psyche" over contesting groups in the field of psychological well-being, like the clergy.[142] Dr. Nanney of the Madras Asylum, for instance, argued that the divisions between physical and moral are "merely arbitrary" in 1878/9, and theorizations of insanity as a "purely physical disease" started to gain traction.[141] Under this notion, the *causes* listed in the returns were "at most an exciting fact/occasion on which lurking disorder becomes outwardly manifest."[143] Physicians turned to post-mortem examinations in search of physical lesions,[144] further bolstering the idea that the substrate of madness was biological. Moral conceptions of insanity slowly gave way to increased medicalization around this time, and moral causes like grief were increasingly interrogated as symptoms rather than true causes of insanity.

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[138] Mills, 38.
[139] Annual Report 1872, 27th June 1872, 18.
[140] Rajpal, 114.
[141] Mills, 33, citing Andrew Scull.
[142] Ibid, 51.
[143] Ibid.
[144] Ibid.

Increasingly Unstable Etiology

Etiological anxiety deepened as doctors grew increasingly concerned with the lack of reliable data. In this section, I address three main factors that heightened paranoia during this period: the ambiguity of moral causes, inadequate surveillance beyond the asylum, and inconsistent documentation across asylums that rendered broader theorization nearly impossible.

As in the previous period, *ganjah* and spirits continued to be reported as the primary causes of lunacy while other cases were "ascribable to grief, mental anxiety, and other moral causes."[145] *Ganjah* intoxication was viewed as the "most hopeful cause,"[146] reaffirming the relative intractability of moral insanity. However, etiology continued to prove elusive. Sgn-Gen. Payne wrote in 1882 that "grief is alleged as the cause of many [cases] which are really due to the method [of intoxication] employed to solace it."[147] Intoxication, seen as a temporary physical cause, was increasingly treated as a proximate factor over deeper, internal causes like grief. Previously, doctors advocated the confinement of such persons beyond the duration of their intoxication because otherwise they would be "likely to resort to evil practices."[148] However, this was questioned around 1889, when Dr. Payne wrote that the "harmless passing influence" of temporary intoxication may have inaccurately increased the criminal population.[149] Payne also requested a system of increased surveillance for dangerous and violent lunatics versus "harmless and quiet individuals."[150] This commentary shows the desire to more specifically target and divert resources toward managing violent lunatics who had longer, more deeply seated conditions, honing in on the definition of "criminality."

[145] Annual Report 1878, 24.
[146] Annual Report 1878, 14th April 1879, 17.
[147] Annual Report 1881, 7.
[148] Annual Report 1889, 5.
[149] Ibid.
[150] Ibid, 10.

The taxonomy of causes remained intact in this period despite increasing discomfort with their ambiguity. Moral causes included grief, fear, anger, jealousy, love, religion, dream, litigation, and debt. Payne wrote in 1883 that of these moral causes "I can say nothing. Their names allow too much scope for fancy to admit of their being brought under criticism as a statistical explanation."[151] The 1889 returns described moral causes as "fanciful."[152] Although interior emotionality continued to be imputed and narrativized, medical authorities displayed increasing skepticism of this approach.[153] Notably, a plurality of cases continued to be admitted with cause unknown. 448 cases were attributed to physical causes in 1884, 134 to moral causes, and 557 not ascertained; Esq. Cowie wrote that the alleged causes "bear the stamp of mere guess-work."[154]

For all the concern regarding recurrent insanity, at this time there was still no clear way to identify re-admissions. Cowie wrote that first admissions are continually mixed up with recurrent insanity: patients discharged as cured "from our asylum [return] as a separate and distinct individual each time."[154] He notes that it would be "highly interesting" to ascertain what happens to discharged patients: do they return to occupations or die soon afterward?[155] Concern with causation thus grew increasingly linked with the need to monitor patients even after release. Monitoring recurrent insanity would allow authorities to take more caution and control over relapses, reflecting further extension of paranoid surveillance beyond the asylum walls and even beyond the temporal limits of a given illness.

The bifurcation between "chronic" and "acute" was laden with problems. In some asylums, acute mania was re-classified as chronic mania after months, in others a year may

[151] Annual Report 1882, 5.
[152] Annual Report 1889, 8.
[153] Annual Report 1884, 7.
[154] Annual Report 1884, 3. This not only reflects difficulty in identifying recurrence, but highlights the total lack of individual identity ascribed to patients. Whether entering or exiting the asylum, they were not given unique identifiers which allowed them to pass in and out unnoticed as a particular person.
[155] Ibid.

elapse, and in others still re-classification never takes place at all.[156] However, 1887 marked a turning point due to a new edition of the nomenclature of diseases put forth by the Royal College of Physicians in London, wherein diagnostic distinctions based on duration or intensity were abolished for more uniformity.[157] Despite these changes, *causes* remained largely intact, from physical (masturbation, intemperance, heredity, epilepsy, childbirth) to moral (grief, love).[158] Curiously, though, 'domestic trouble' is listed under "physical causes" across decades. The classifying taxonomy, for all its divisions, continued to reflect internal contradictions. Authorities knew this, continuing to lament how little confidence could be placed in the alleged causes of insanity.[159]

Amid this uncertainty, categories continued to be contested according to racialized theories. Common symptoms between melancholia and dementia (both less prevalent than mania), proved the distinction continually difficult to draw.[160] Cowie says that with melancholia the mind is "so completely occupied by one thought of fear or misfortune or sorrow that it leaves no room for any other consideration," while with dementia "the mental faculties are so degraded as to be incapable of being roused to an appreciation of what is taking place."[161] Such distinctions, given similar symptomatology from external observation, rely on heavy assumptions regarding the subject's interiority. Symptoms themselves were racially particular. The discussion of diagnoses in the 1885 Returns reaffirmed the particularity of native mania: "The prevailing type of insanity in this part of India [is] manifested by eccentricity, loquacity, and general joyfulness and absurdity of demeanour, generally without delusions and with no loss of intelligence."[162] Once again, "eccentricity" is measured against an arbitrary colonial norm and

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[156] Annual Report 1880, 6.
[157] Annual Report 1887, 6.
[158] Ibid.
[159] Annual Report 1877, 6.
[160] These common symptoms included disregard of surroundings, solitary habits, and silence or reluctance to speak.
[161] Ibid.
[162] Annual Report 1885, 3.

relies on racialized stereotypes, particularly of the native being generally inexpressive and insipid. These assumptions persisted and were gradually subsumed by medical discourse. The next section shows how nomenclature revisions from England and a strong demand for more uniformity and reliable documentation further medicalized the diagnostic process.

The Medical Turn and Nascent Psychiatric Apparatus (1890-1900)

In concert with the development of updated scientific taxonomy in Britain and Europe, colonial psychiatry was characterized by a growing effort to formalize and cement medical authority by the 1890s. Frustrated by decades of etiological uncertainty and institutional fragmentation, colonial physicians increasingly sought to fold their practices into the emerging and ideologically legitimized field of psychiatry. This "medical turn" did not resolve the paranoia and contradictions of the colonial asylum, but rather shrouded them in a new medical discourse. Structural conditions such as poverty, gender-based violence, and colonization itself were determinedly swept under the expanding umbrella of clinical symptomatology that was being "discovered" within the individual psyche.

Despite the aforementioned nomenclature changes, diagnosis continued to pose a problem in both English and Indian asylums—despite the "means" for doing so being "much better" in England.[163] Inspector-General A. Hilson reported in 1889 that there was "not as much uniformity in returns as desired."[164] Notably, "mental disease" gradually started to replace "insanity" in the archive. Hilson wrote: "...it is probable that until some authoritative definition is obtained of the various forms of mental disease, not much progress [will] be made."[165] This

[163] Annual Report 1891, A. Hilson, 5.
[164] Annual Report of 1889. A. Hilson, 3.
[165] Ibid.

sentiment was echoed by J.G. Pilcher, Inspector-General in 1892: "The classification of patients suffering from mental disease is beset with difficulties, not only on account of the complexity of the symptoms, but because they vary in the same individual from time to time. It would lead to no practically sound results to lay down any rule for guidance in classification, and it is better to leave the question to the intelligence of officers in charge of asylums."[166] Attempts to generate universalizable systems, therefore, were continuously frustrated by individual variance. The enormous uncertainty due to individual particularity further amplified anxiety; despite admitted incoherence in the system, patients were now required to be rediagnosed and potentially reclassified every year.[167] Using the case-by-case approach, individual superintendents justified detaining those "regarded as sane… as a precautionary measure which their previous history makes it advisable to adopt."[168] Detaining a medically sane individual on the basis of latent violence relied on the logic of moral insanity. Although increasingly reframed in terms of brain-based pathology, colonial officials remained haunted by unobservable emotional causes like grief that could contain latent violence—an interpretive logic that, amid ongoing diagnostic uncertainty, consistently justified erring on the side of further incarceration.

The taxonomy of disease classification changed significantly after the nomenclature revisions. Certain mental diseases were designated as "toxic," dividing columns into heads and subheads (Fig. 3).[169] New types of insanity included hypochondriasis, dementia, idiocy, puerperal insanity, epileptic insanity, toxic insanity, insanity from brain disease, and consecutive insanity.[170] Grief remained the chief moral cause alongside anger, fear, jealousy, litigation, love, anxiety, religion, poverty, study, loss of property, debt, and dream.[171] The inclusion of "poverty" and

[166] Annual Reports of 1892. Report - No. 3011. From Pilcher to Sec of Govt of Bengal, Financial Dept. Calcutta, 23rd March 1893, 4.
[167] Annual Report 1892, 4.
[168] Annual Report 1891, A Hilson, 5.
[169] Annual Report 1893, No. 3011, 4.
[170] Annual Report 1889, 27.
[171] Ibid, 29.

"debt" as causes of moral insanity illustrates continued emphasis on individual pathology over material conditions. Grief continued to *not* be included in the causes of European insanity, rendering it a continuing native form of emotional volatility.[172] By 1897, however, moral causes were grouped together and collapsed into a single column; grief no longer appeared in the Appendix (Fig. 4).[173] The prior listing of emotions under moral causes, however, gives us an idea of how moral insanity continued to be defined. This conception seems to have remained intact despite the new form, as there was no commentary on the change triggered by the new nomenclature from English medical authorities. Forms changed further in 1900 (see Fig. 5).

Also in 1897, manufactures involving hard labor were discontinued at Dacca and Patna. The Lieutenant-Governor decided to postpone the decision of what constitutes "suitable employment for a lunatic" pending the construction of a central asylum and "more systematic treatment."[174] Furthermore, here he writes that he is "glad to notice that greater efforts are being made to render the lives of the lunatics as happy as possible" and notes "various amusements were provided at all the asylums; musical instruments as well as pet animals were allowed to many patients, and in Calcutta some of the lunatics were taken to see the Zoological Gardens."[175] This represents a significant departure from the 1870s, when references to happiness were scant and it was explicitly mentioned that amusements were nowhere to be seen. While work continued to be encouraged ("The Superintendent says the more the lunatics work, the quieter and better they are"),[176] Sgn-Col. G.C. Ross writes of the "unsuitability of certain kinds of labor," condemning penal labor that is "prejudicial to health," especially "to those afflicted with active cerebral disease."[177] Under new medical logics, therapeutic cures grew increasingly specified.

[172] Ibid, 15.
[173] Annual Reports of 1890 and 1900.
[174] Annual Report of 1896. Resolution--No. 3601 Medl. 12th July 1897.
[175] Ibid, 2.
[176] Annual Report 1899, 20.

Docility and compliance continued to mark not just obedience, but sanity itself. Amid these changes, though not captured by the archive, Bengali responses to the asylum reveal complex negotiation, contestation, and hybridization with the colonial psychiatric apparatus. I turn to the ways in which some Bengali elites appropriated scientific discourse as anticolonial critique in the following section.

Responses in Bengali Scientific Literature

When reading the colonial archive, the silence of the subjects echoes across the pages. While the stories and perspectives of those institutionalized are distorted, inaccurate, or wholly invisible, various strata of Bengali society were actively responding to the physical and psychical presence of the asylums. While not my primary focus, it is critical to at least highlight a glimpse of parallel Bengali scientific thought. Rather than a unidirectional process of projection, colonialism should be read as a multivalent and dialectic process.[177] In this case, the asylum system was largely upheld by Indian staff and attendants, and ideologically legitimized by various strands of academic and scientific thought.[178] How was Bengali society hybridizing, rejecting, and/or incorporating nascent Western psychiatric principles? To what extent were asylums viewed as a disciplinary project, and did this affect anticolonial critique? How did class and caste affect stigma around the asylum? In this section, I describe the intelligentsia's reaction to the asylum couched in emergent anticolonial rhetoric.

Asylum authorities clearly did not appreciate being burdened by the "flotsam and jetsam" who did not have families or friends to take care of them.[179] Firmly rejecting welfarist obligations, the archive continuously fixates on finances, ways asylum labor could strategically

[177] Vaughan, 48.
[178] Ibid.
[179] Annual Returns 1903, 3.

mitigate costs, and the uselessness of patients who were unable to pay. In the twentieth century, however, Indian middle classes began to utilize the asylums.[180] This challenged a diagnostic system that had previously focused largely on medicalizing poverty itself. Authorities were incentivized to take in these higher-paying patients (many from "respectable" families with caste and class privilege), noting the "greater confidence" in asylum institutions.[181] However, it is important to note the anticolonial critiques and hybrid discourses that emerged alongside this legitimization.

While there is a paucity of sources on Indian attitudes of the time, Amit Ranjan Basu's study of psychiatry in Bengal periodicals in the early twentieth century sheds significant light on Bengali scientific discourse. Basu explores the relationship of new institutions of western medical education and science with the Bengali *bhadralok* or elite intelligentsia. While the discourse of asylum psychiatry was "hardly visible in print-culture, especially in Bengali,"[182] articles on psychiatry grew increasingly prevalent in the twentieth century. A 1900 lecture at the Calcutta Medical School inverted the colonial narrative, saying that with the process of civilization (or colonization) the "nervous system is changing and the incidence of nervous diseases are increasing…. The activity of [the] brain has increased. We [now] see many cases of insanity… neurasthenia and hysteria."[181] Some Indian doctors were acutely aware of the inadequacy of English treatment: "[W]e have forgotten all the natural rules for taking care of the body since we have become civilized…. For diseases that generate in Bengal, one can never get a fully desired result by using medicines from the systems of a cold and foggy western country."[183] This gave rise to arguments for using Indian methods, such as yoga and pranayama,

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[180] Rajpal, 172.
[181] Annual Report 1905, Resolution No. 594T.-Medical. Darjeeling, 18th May 1906, 1.
[182] Amit Ranjan Basu, "Emergence of a Marginal Science in a Colonial City: Reading Psychiatry in Bengali Periodicals," *The Indian Economic & Social History Review* 41, no. 2 (2004): 119.
[183] Ibid, 130.

for treating insanity. Linguistically, in a scientific journal insanity was conceptualized as *Citta Bikriti* (deformation of mind) as opposed to *unmattata* (madness).[184] Thus, medicalization was also being incorporated into Bengali discourses, yet they were distinctly hybridized.[185] Bengali scientific discourse was far from monolithic, and internal debates between scientists trained in Western medical colleges and Ayurvedists proliferated. These vernacular discourses took shape in the context of broader, emergent nationalisms.

It is important to overlay these late nineteenth century shifts with the anti-colonial political developments of the time. Throughout the century, the Bengal Renaissance was characterized by sharp socio-political critique and advocacy for various reforms. The formation of the Indian National Congress (INC) in 1885 reflected this desire for political representation and reforms at the all-India level. At the turn of the century, racial discrimination alienated many Indians at lower levels of the bureaucracy, who defected to the nationalist movement.[186] The 1899-1900 "great tumult" of the Munda tribe on the Bengal-Bihar border occurred at the same time that the educated urban elite was beginning to mobilize, reflecting resistances across lines of class and caste.[187] The Partition of Bengal in 1905, though later annulled, further intensified anticolonial sentiment in the region.[188] Ensuing boycotts of British goods and the drive for self-rule, although nonviolent, certainly heightened colonial anxieties. In the ensuing years, the internal debate between nonviolence and militant resistance within the nationalist movement likely only augmented British paranoia and hypervigilance.

Of course, the collective anxiety and trauma surrounding Partition and other colonial declarations is not documented in the colonial archive. However, there are at least some

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[184] Basu, 131.
[185] Projit Bihari Mukharji probes this hybridization in his work on Ayurveda's "techno-modernity" and its subsequent dissemination into international circles (Bihari Mukharji, 25).
[186] Bose and Jalal, 99.
[187] Ibid, 107.
[188] Ibid. 118.

examples of psychiatric discourse that specifically name the effects of colonialism. Sureschandra Baksi wrote "The forceful impact of European civilization has made human struggle for life so tough that an increase in *citta bikriti* is not unusual."[189] While Baksi retained the colonial assumption that poverty eroded morality and initiated insanity, he inverted the causal logic by attributing the root cause of such poverty to colonial exploitation itself.[190] Critiques of colonial psychiatric ideology, if not of asylums themselves, were therefore present in vernacular Bengali discourse, likely pressuring asylum authorities in some way.

While asylum records do not explicitly mention ongoing political events or engagement with Indian medical thought, it is important to interpret these gaps in the archive via an understanding of Bengali society at the time. More research is necessary to understand particular perceptions of the asylum system—for example, what exactly led to the increase in middle-class families admitting members to state asylums?[191] Though beyond the scope of this work, integrating the literary and cultural production of the Bengal Renaissance and the *swadeshi* movement could yield a more robust and multidimensional understanding of psychiatry's reception and resistance in colonial India.

1900-1925: Marching Toward Legal Enshrinement and a Central Asylum

1900-1912: Medicalization, Uniformity, and Centralization

According to the 1900-02 Triennial Report, in 1903 moral causes made up 14.03% of all cases in contrast to 32.37% physical causes and a whopping 53.6% unknown. Since the threshold for "knowing" the cause of insanity appears prohibitively high, any attempt to assign a moral or

[189] Basu, 131. Here Baksi clarified that 'civilization' simply referred to the present society; he was not implying that pre-colonial society was uncivilized.
[190] Ibid, 132.
[191] Mills has argued that some socioeconomically deprived individuals self-admitted into asylums to receive food and shelter, illuminating one potential underside and symptom of desperation under colonialism that is not elucidated in the archive (Ernst, *Colonialism and Translational Psychiatry,* 99).

physical cause constituted an active interpretive decision that reflected both diagnostic guesswork and the ideological priorities of the institution. Despite the severe difficulty of causal diagnosis, some cases were cautiously diagnosed. The uncertainty and hesitation hovering around these declarations is clear in the continuous caveats, dismissals, and skeptical commentary of their own data. The Lieutenant-Governor, aware of these significant discrepancies, repeatedly called for more enquiry into the personal circumstances of each lunatic to ascertain the cause behind their "loss of reason."[192] As previously illustrated, these "personal circumstances" were highly individualized and divorced from structural factors. This again demonstrates the tension between generalizability and case-by-case accuracy—the uncertainty that once allowed strategic evasion has, by now, fomented anxiety in the face of increasing demands for objectivity and universality. The Triennial Report of 1903-05 shows "Worry and excitement" as a physical cause.[193] The physical-moral bifurcation had always been fuzzy, but this represents the absorption of superficially emotional categories into a supposedly objective psychiatric framework, disguising continuity under the epistemologically upgraded taxonomy.

The returns of 1902 combined the results with European lunatics for the first time. This may have been a simple matter of streamlining documentation, but such a shift represents a drive toward more statistically valid scientific data that was commensurable across races. Although racial differences continued to be assumed (sunstroke, for example, continued to be an affliction particular to the European-only Bhawanipore asylum), this change was symbolic of greater consolidation and institutionalization of Bengal's asylums as a cohesive system under colonial control. Explanations for differing incidences began to take on more environmentally rooted rationales rather than overt theories of racial difference. For example, in the case of "general

[192] Triennial Report 1900, 1901, 1902. Resolution No. 1731 Medl. Calcutta, 6th April 1903.
[193] Ibid, 27.

paralysis of the insane," a common diagnosis in Europe that was virtually absent in India, authorities wrote: "Recent discoveries attribute a microbial origin to this form of insanity."[194] In 1907, the Berhampore Superintendent re-classified many cases of mania, melancholia, and delusional insanity: "he finds that heredity plays a very leading part in the causation of a large number of cases."[195] This further reinscribes the notion of natives as biologically, even genealogically, predisposed to native varieties of insanity. The same Superintendent engaged in prolonged correspondence with the officers who had arrested various lunatics, obtaining additional contextual information to determine previously unknown causes and quell this ongoing etiological uncertainty.[196] The now expanded diagnostic tables overtook the authority of the alienist specializing in native insanity: the modern colonial state's psychiatric authority was now more consolidated, unitary, and legitimated by the most modern scientific discourses. Despite increased systematization and the rise of new scientific technologies, however, a cohesive and predictive etiological theory remained elusive. This system continued to unsettle medical authority even as they doubled down on its legitimacy.

1912-1925: From The Indian Lunacy Act to Swadeshi

In 1907, the rate of recovery was reported to be 6.54%.[197] Considering the emphasis on modern treatment and cure, this seems rather dismal. The intractability of cure, rather than showcasing the ineffectiveness of the asylum endeavor, was used to justify its continued expansion in order to seclude these hopeless cases. In 1912, the asylum population continued to increase while recoveries only decreased, purportedly due to the accumulation of "incurable"

[194] Triennial Report 1903, 1904, 1905, 4.
[195] Annual Report of 1907, Resolution No. 3446 ½. 20th March 1908, 3.
[196] Ibid, 2.
[197] Annual Report 1906, No. 3032. Calcutta 3rd April 1907.

chronic cases.[198] This language of "incurability" and "hopeless cases" occurred alongside the passage of the Lunacy Act of 1912.[199] The Act emphasized public safety through the long-term detention of individuals declared insane, further institutionalizing the segregation of the (allegedly) mentally diseased and formalizing the asylum as a primary site of long-term confinement. This legislation amplified the power of doctors in having a say in who could be confined and for how long, formally cementing the medicalization of colonial power. Bhattacharyya writes that unlike the "hesitant" Lunacy Acts of 1858, the 1912 Lunacy Act represented a more "efficient and assertive state attitude to consolidate the management of lunatic asylums in the subcontinent."[200] The more colonial paranoia deepened, the more such assertive measures were made necessary by the state's own logic.

Nomenclature transformed again in 1912, as the tables were significantly enlarged.[201] In the new Appendix, "moral insanity" is now a type of insanity. Among the new "Aetiological Factors" (Fig. 6), "mental instability" appears with a sub-heading of "moral deficiency," although this row remains blank.[202] "Mental stress" is also a new category, with sub-categories of "sudden" or "prolonged." "Mental" has thus in some ways subsumed "moral," becoming the new ground for etiological analysis of emotional states in the newly medicalized system and replacing earlier logics rooted in the physical body or social custom. Yet, the methodology remained defective. Col. G.F.A. Harris pointed out that there was no means of showing "side by side predisposing and exciting causes of a case," which was necessary for the table to have any value.[203] A 1918 resolution echoed this sentiment, asserting that the agencies sending lunatics to asylums paid no attention to the information regarding "causation, habits and associated

[198] Triennial Report 1909, 1910, 1911, 1-2.
[199] Ibid, Resolution No. 665T, 18th June 1912.
[200] Bhattacharyya, 179.
[201] Annual Report 1912. Resolution No. 459C. Calcutta 8th April 1913.
[202] This replaced the section heading of 'causes.' Causes were now subheadings divided into 'predisposing' and 'exciting' causes.
[203] Ibid.

conditions" required to diagnose and treat cases.[204] For instance, most cases at Dacca were ascribed to heredity while *ganjah* predominated at Berhampore, leading authorities to suspect a continued lack of uniformity across asylums.[205] Until the Government's steps for revising the statement could be followed, they complained it would be a waste of time and energy to attempt to criticize the figures."[206] The conundrum of etiology and corresponding anxiety thus persisted, even as the diagnostic authority of medical professionals was enshrined in legislation.

The total disappearance of grief and other emotions as moral causes was now complete and obscured by more objective-seeming terms connected to modern medical categories. Gendered biases continued; "loss of child" and "domestic worry" were listed as physical causes of insanity in 1912.[207] Despite continued confusion around physical, mental, and moral factors, language in the archive noticeably shifted to speaking of "mental" disease and conditions.[208] In the Triennial Report of 1912-14, Col. Harris writes, "The mental condition of the lunatics (assuming that the mind is the seat of their disorders) was not left to chance. It received due, and I may say, special attention from the asylum authorities along with the care of their bodies."[209] Harris noted that "minds and bodies" continued to be engaged in suitable industrial employment "with great therapeutic value," and "a great variety of amusements" were provided in the asylums as well.[210] As medicalization proceeded, concerns of subjective interiority were reframed in terms of the "mental." Knowledge and control of interior psychic workings now fell firmly under the purview of doctors. Division between mind and body, however, persisted.[211]

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[204] Triennial Report 1915-17, No. 6650 20th Apr 1918.
[205] Ibid.
[206] Annual Report 1912. No. 4621 Calcutta 15th Apr 1914, 3.
[207] Triennial Report 1909-11, 21.
[208] This continued in subsequent years. In 1921, *ganjah* continued to be the predominant aetiological factor at 22.56% of cases, but was now followed by mental stress (14.63%), heredity (7.99%) and mental instability (6.99%). As discussed above, these labels appear to have subsumed "moral insanity." Their relative prevalence shows the widespread nature of somewhat intangible mental disease, originating in either the genetic makeup or psychological deficiency of the individual.
[209] Triennial Report 1912-14, by Col GFA Harris, 9. Emphasis mine.
[210] Ibid.
[211] Basu, 110.

The decline in cures was now looked upon as an odd marker of success. Col. Harris wrote in 1915 that the combination of decreased cures and increased admissions shows that "care has been taken to refrain from sending the less serious cases of lunacy to the asylums, and that the asylum population consists mainly of cases in which a cure is almost hopeless."[212] This statement reveals the new prioritization of severe cases. The use of "almost" also crucially reveals that while recovery may not be the primary motive (justifying long-term incarceration), even the marginal possibility of cure justified confinement. Its possibility however remote, ideologically justified indefinite detention—reframing incarceration as care rather than control. The tension between confinement and cure could be somewhat resolved by this logic.

Colonial paranoia was proven right in 1919, a political inflection point as important as 1857. Angered by the passage of the Rowlatt Act, which allowed the British to detain Indians without trial, Gandhi stoked a pan-Indian response.[213] Already feeling the repercussions of the first world war, the population revolted in the first major all-India agitation in 1919—the largest display of resistance since 1857. The *swadeshi* movement of the previous two decades "paled in comparison with the sheer ferocity" of 1919, as did the ensuing violent crackdown.[214] From 1919 to 1922, peasant uprisings spread across India. Bose and Jalal write that Gandhi's promise of swaraj within a year "had an immediate psychological impact" and "aroused millenarian hopes in the remotest villages of India."[215] This marked a pivot point in the psychical dynamic of British colonization. The events of 1919 validated the worst fear of the British: that 1857 would repeat with a vengeance. Early 1922 also marked the peak of a new boycott, one that far surpassed the effectiveness of 1905.[216] As colonial paranoia was affirmed, the surge in nationalist

[212] Triennial Report 1912-14, Resolution No. 80T-Medl. Darjeeling, 31st May 1915.
[213] Bose and Jalal, 137.
[214] Ibid, 137.
[215] Ibid, 140.
[216] Ibid, 141.

activity coincided with further efforts to rationalize long-term confinement (across the Empire, in asylums and jails) to reassert control. This invocation of "hope" in the burgeoning Indian psyche stood in ironic tension with the diagnostic disappearance of "grief"—suggesting that the increasingly bold articulation of political aspirations may have begun to spur cracks in the colonial psychiatric framework that had relied on an individualized conception of native pathology despite anxiously anticipating collective violent action.

These developments occurred alongside the long-awaited construction of a central asylum. Speaking of the idea in 1896, Sgn-Col. Hutcheson wrote: "The main object of the confinement of the insane is the classification and careful treatment of the individual according to his or her mental defect or aberration and pronounced habits [by] systematic study of each case by an expert staff..."[217] The Secretary to the Government of Bengal wrote in 1912 that this "first class" central asylum would include a "skilled alienist" who "could apply modern methods of treatment."[218] A large central asylum was finally established at Ranchi in 1918. After officials in Bihar and Orissa protested the admission of Indian Christians, the Government of India defined initial eligibility for Europeans, Americans, and "persons of mixed blood whose habits are those of Europeans."[219] In 1925, however, European patients were sent to Bhawanipore, while the Berhampore and Dacca "Mental Hospitals" were closed and emptied out. Those native patients were shipped off to Ranchi, now Bengal's first central native lunatic asylum.[220] Major-General R. Heard wrote in 1925 that at Ranchi the climate and amenities were superior to the previous hospitals, and the standard for treatment surpassed "what was possible in the old asylums in Bengal."[221]

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[217] Annual Report 1895, 18.
[218] Triennial Report 1909-11. Resolution - NO. 665T - Medl. H.S. Stephenson, Secretary to Government of Bengal.
[219] Annual Report 1919, Majpr-Gen. R. Heard. Resolution No. 7944, Calcutta 4th May 1921.
[220] Ibid, 2.
[221] Ibid.

Importantly, in 1922 the nomenclature of "lunatic asylums" was changed to "mental hospitals" in accordance with the Indian Lunacy (Amendment) Act of that year.[222] Lt-Col. McCay wrote: "This change is a great advance towards the progress of the infant science of Psychiatry in this country and will encourage workers to take a scientific interest in their works."[223] The explicit naming of the nascent *science* of psychiatry displays the extent of medicalization. The change in nomenclature appears to be a marketing response to the "hopelessness" of cure, as authorities believed that the "stigma attached to the name 'Lunatic Asylum' prevented curable patients entering these institutions and thus deprived them of specialist treatment."[224] The rebranding of "lunatic asylums" to "mental hospitals" functioned as a strategic attempt to reframe psychiatric incarceration, now marketed as therapeutic, respectable, and accessible, despite the unchanged reality of minimal recovery. The fact that this rebranding occurred amid such political volatility suggests that the asylum remained a key site through which the now gradually fracturing empire anxiously grasped for legitimacy. The aim was that patients would approach the hospital at the early onset of their disease such that "the usefulness of these institutions [will] be increased." Expanding the discourse of cure, the asylum aimed to open its doors to wide swaths of the population (not least, those who could afford to pay). In 1923, the report mentions an "amusement fund" consisting of public subscriptions and donations for patients.[225] Thus, a relationship between the interior of the asylums and the public was also established, as the asylum became a visible site of simultaneous charity, confinement, and cure.

Post-1919 anticolonial mobilizations, particularly in Bengal, opened the door for the dissolution of British rule in India. In 1927, two years following the end of the present archive,

[222] Annual Report 1922. No. 9528 - Calcutta, 26th June 1923.
[223] Ibid.
[224] Triennial Report 1921-23. No. 16760 - Calcutta, 7th Nov 1921.
[225] Annual Report 1922. No. 9528 - Calcutta, 26th June 1923.

the British announced the formation of the all-white Simon Commission to the immense chagrin of nationalists.[226] In Bengal specifically, revolutionary activity abounded. In the Meerut Conspiracy Case of 1929, thirty-one Bengali labor leaders were jailed for conspiring to overthrow the government.[227] In the same year, Gandhi finally accepted the idea of *purna swaraj,* full independence, at the Lahore session of the Congress.[228] The worst nightmare underlying British paranoia was actively expressed in the form of a pan-Indian drive for full independence. The colonial attempt to resolve the paradox of cure and confinement with a move toward the latter only incited the spirit of anticolonial resistance. Certainly, Indians themselves participated in the project of colonialism—in the asylums, elites and others alike worked as asylum staff. However, by the 1930s, Indians had become massively alienated from the colonial project writ large across religious, ethnic, caste, and class lines.[229] As the colonial civilizing mission unraveled, the fragile logic of the asylum was increasingly laid bare.

Conclusion

In Fanonian terms, colonialism itself is psychopathological.[230] The mechanism of colonial projection "operated at a social as well as at an individual level."[231] As Rajpal writes, the madness of the colonial system is predicated upon its underlying coercive power structure: "The colonial state's irrationalism was streamlined and rationalized through the creation of the psychiatric power that was backed up by the whole legal, medical, and judicial systems."[232]

[226] Ibid, 142.
[227] Ibid, 144.
[228] Ibid.
[229] The creation of the All-India Muslim League that eventually resulted in the formation of Pakistan shows that this alienation did not present a united front. Internal cleavages certainly persisted throughout the period. For more, see Julian Strube's (Anti-)Colonialism, religion and science in Bengal from the perspective of global religious history (2022).
[230] Vaughan, 47.
[231] Ibid, 47.
[232] Rajpal, 172.

Through colonial rule, people of the subcontinent suffered vast losses in terms of freedom, wealth, man-made famine, and more. It is revealing that grief, the natural response to loss, was the very thing that was described as uniquely native pathology following the advent of Crown rule in India. Whether as a mass projection of colonial guilt or the result of racialized theories, colonial attitudes toward "grief" in the native population reflect deeply embedded racialized assumptions regarding the Indian body, psyche, and behavior across axes of gender, caste, religion, and class.

While physical causes of insanity vastly predominated, particularly *ganjah* smoking, they were easy to cure and ultimately necessitated a short tenure in the asylum. Moral causes, on the other hand, reflected fundamental character flaws - ones that needed to be either reformed or controlled through perpetual incarceration. As the institution focused increasingly on criminal lunatics, it faced a paradox: how could they handle cure, the purported goal of the asylum project, given subjects who contained a continuous latent potential for violence? Anxiety around the "cured" Indian subject as "free" was exacerbated in tandem with growing anticolonial resistance movements. This paranoia was compounded by colonial beliefs that grief and emotional instability were symptoms of moral derangement—a violently excessive emotionality that destabilized individual self-control and undermined the tense colonial social order. Fanon's assertion that psychophobia can only be overcome through the "transformation of individual pain into political violence" resonates with the intensifying colonial anxiety during the early twentieth century. The asylum's diagnostic ambiguity, once a tool of control, increasingly reflected the very instability it sought to suppress—an unsettling that was now amplified by the political force of a mobilized nationalist imagination.

From the 1857 Rebellion onward, native asylums in Bengal evolved from disparate sites of fragmented authority to a more centralized, though still uncertain and uneven, system of confinement with the Lunacy Act of 1912. The shifting terrain from "moral" to "mental" indicated continued ambiguity, and newly legitimated psychiatric frameworks remained forced to contend with low rates of therapeutic success. Such perceived intractability was attributed to the chronic character of mental illness. Tracing grief and moral insanity in the archive in these years shows that shifting attitudes toward the native psyche resulted in heightening contradictions between confinement and cure. Medicalization slowly obscured racial logics, which were increasingly hidden in the guise of modern scientific categories. The gradual expansion of medical authority eventually set up the conditions justifying the indefinite confinement of patients while simultaneously publicizing a project of benevolent cure and advanced modern research.

This project is a starting point that opens up scope for further exploration of the history and legacies of colonial psychiatry, pathology, and emotion in colonial Bengal. To be sure, colonialism was not a "one-way process of projection"[233]; native subjectivities should be uncovered through sources other than the colonial archive. A more Bengali subject-focused understanding could build upon Basu's work by examining not only Bengali scientific writings, but also literary, cultural, and aesthetic products of the Bengal Renaissance. Religious practices and behaviors, such as the highly pathologized trances of religious leader Ramakrishna Paramhansa in the nineteenth century, and their relationship to conceptions of suffering and insanity could also be explored. Further inquiries might consider Girindrasekhar Bose's correspondence with Freud, Sudhir Kakar's 'Indianized' psychoanalysis, and the Hindutva

[233] Vaughan, 48.

co-optation of wellness practices. Approaches to colonial psychiatry in other parts of the Empire might serve as salient points of comparison as well.

While the story of this present project culminates in 1925, the physical and psychical specters of the colonial asylum persisted long past Independence. The pathologization of grief echoes in the 2022 addition of prolonged grief disorder in the DSM,[234] as well as the presence of grief-related disorders in the ICD.[235] At Ranchi, the very same asylum building still stands, now under the name of the Central Institute of Psychiatry. Arguably, much of colonial violence remains unmourned among Indians in the subcontinent and diaspora alike (especially the 1947 Partition for Bengalis and Punjabis). Deeply internalized intergenerational shame regarding emotion contains leaks and traces of the colonial history examined here. Contemporary discourses around emotionality and violence would do well to remember these genealogies and place trauma symptoms in political context. Hybrid theories of mourning might emphasize the nonlinearity of healing, the porosity of affect, and the need to treat the patient and all their latent selves with hope and compassion. These phantasmic yet living histories reverberate across theory, therapy, and the affective architectures of everyday postcolonial life.

দুঃখ, দুর্দশা, খেদ, বিলাপ, শোক, শোচন

Bengali words relating to the textures of grief, loss, sorrow, mourning

[234] Joanne Cacciatore and Allen Frances, "DSM-5-TR Turns Normal Grief into a Mental Disorder," *The Lancet Psychiatry* 9, no. 7 (July 1, 2022): e32, https://doi.org/10.1016/S2215-0366(22)00150-X.
[235] International Classification of Diseases.

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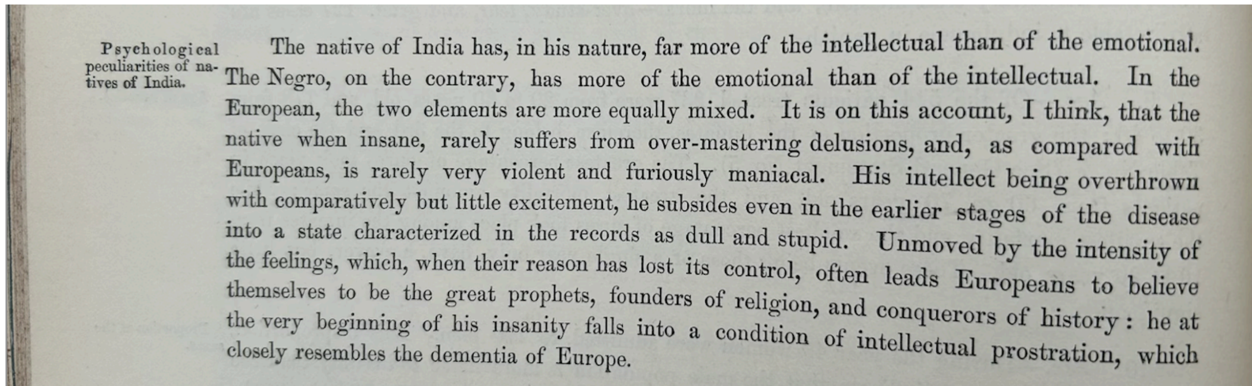
Appendix

Figure 1: Psychological peculiarities of the natives of India (Dullunda Asylum, 1872)



Psychological peculiarities of natives of India.

The native of India has, in his nature, far more of the intellectual than of the emotional. The Negro, on the contrary, has more of the emotional than of the intellectual. In the European, the two elements are more equally mixed. It is on this account, I think, that the native when insane, rarely suffers from over-mastering delusions, and, as compared with Europeans, is rarely very violent and furiously maniacal. His intellect being overthrown with comparatively but little excitement, he subsides even in the earlier stages of the disease into a state characterized in the records as dull and stupid. Unmoved by the intensity of the feelings, which, when their reason has lost its control, often leads Europeans to believe themselves to be the great prophets, founders of religion, and conquerors of history: he at the very beginning of his insanity falls into a condition of intellectual prostration, which closely resembles the dementia of Europe.

Figure 2: Rise of criminal lunatic population (1872)

Proportion of criminal lunatics in asylum population.

Criminal lunatics constitute a little more than one-fifth of the population of asylums.

Year.	Average number of lunatics in asylums.	Average number of criminal lunatics.	Percentage.
1865	658	125	19
1866	607	112	18·4
1867	603	108	17·9
1868	675	122	18·1
1869	721	162	22·4
1870	774	159	20·5
1871	831	174	20·9
1872	903	195	21·6

The figures on the margin show that while the increase of criminal lunatics has proceeded apace with that of all lunatics, the former has somewhat outstripped the latter, and the figures indicate that criminal lunatics are gradually absorbing more of the accommodation available for lunatics in asylums.

Comparison of the statistics of

The increase in the numb

Figure 3: Types of insanity in 1871 compared to 1890

(Top: 1871, Bottom: 1890)

No. 12.

Return showing the Types of Insanity of those admitted, &c., during the year 18

1	2			3			4			5			6			7			8			9		
	105 (*a*) Mania, acute.			105 (*b*) Mania, chronic.			106 Melancholia.			107 (*a*) Dementia, acute.			107 (*b*) Dementia, chronic.			108 Paralysis.			109 Idiotcy.			&c.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Remaining																								
Admitted																								
Total treated																								
Treated under each type per cent. of total treated																								
Recovered																								
" per cent. of total treated																								
Improved, &c.																								
" per cent. of total treated																								
Died																								
" per cent. of total treated																								

Vide remark to Table No. 7.

23 | 10 | 33 | 3 | 1 | 4 | 188 | 33 | 221

STATEMENT No. VI.

Showing the types of insanity of the Lunatics in the Asylums in Bengal during the year 1890.

1	2			3			4			5			6			7								
	129. Mania.			130. Melancholia.			131. Dementia, including acquired imbecility.			132. Idiocy.			135. Epileptic insanity.			139. TOXIC INSANITY.								
																Charas smoking.			Ganja smoking.			Use of bhang.		
	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.	Male.	Female.	Total.
DULLUNDA. Remaining on 31st December ...	122	45	167	9	4	13	29	2	31	...	1	1	4	...	4	...	...	...	...	...	...	...	...	...
Admitted	16	4	20	9	1	10	4	...	4	...	1	1	1	...	1	...	...	...	16	...	16	...	...	...
Total treated ...	138	49	187	18	5	23	33	2	35	...	2	2	5	..	5	...	...	...	16	...	16	...	...	...
Recovered	12	9	21	...	1	1	1	...	1	...	...	...	1	...	1	...	...	...	2	...	2	...	...	...
Improved	7	1	8	1	...	1	1	...	1	...	...	...	...	...	...	...	...	...	2	...	2	...	...	...
Died	5	...	5	...	...	...	2	...	2	...	1	1	1	...	1	...	...	...	...	...	...	...	...	...
Remaining on 31st December ...	129	39	168	17	3	20	30	2	32	...	1	1	5	...	5	...	...	...	16	...	16	2	...	2
DACCA. Remaining on 31st December ...	86	24	110	38	4	42	41	4	45	4	1	5	..	...	...	...	...	...	8	...	8	...	...	...
Admitted	18	4	22	3	1	4	6	2	8	...	...	...	...	1	1	...	...	...	24	...	24	...	...	...
Total treated ...	104	28	132	41	5	46	47	6	53	4	1	5	...	1	1	...	...	...	32	...	32	...	...	...
Recovered	8	...	8	2	1	3	...	...	...	...	...	...	...	...	...	...	...	...	8	...	8	...	...	...
Improved	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...
Died	14	1	15	6	...	6	5	...	5	...	...	...	...	...	...	...	...	...	2	...	2	...	...	...
Remaining on 31st December ...	80	27	107	33	4	37	42	6	48	4	1	5	...	1	1	...	...	...	20	...	20	...	...	...

Figure 4: Moral causes collapsed into a single column. Grief omitted.

(Top: 1890, Bottom: 1900)

Figure 5: Types and causes of insanity, 1900

(Dullunda asylum only)

STATEMENT No. VI.

Showing the Types of Insanity of the Lunatics in the Asylums in Bengal during the year 1900.

1	2			3						4						5						6			7			8			9			10		
CASES.	136. Idiocy.			137. Mania, acute or chronic.						138. Melancholia, acute or chronic.						139. Dementia, including acquired.						140. Mental stupor.			141. General paralysis of the insane.			142. Delusional insanity.			Declared to have recovered or not yet diagnosed.			Total.		
				Epileptic.			Other forms.			Epileptic.			Other forms.			Epileptic.			Other forms.																	
	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.
...LUNDA.																																				
...ining on 31st ...ember*	8	3	11	5	2	7	62	17	79	1	...	1	35	10	45	2	...	2	46	11	57	1	...	1	...	1	1	12	...	12	4	...	4	176	44	229
...ted ...	2	...	2	...	...	...	39	12	51	1	...	1	8	...	8	1	...	1	6	3	9	1	1	2	...	...	...	2	...	2	10	...	10	70	16	86
...treated ...	10	3	13	5	2	7	101	29	130	2	..	2	43	10	53	3	...	3	52	14	66	2	1	3	...	1	1	14	...	14	14	...	14	246	60	306
...ered ...	...	...	.	...	...	...	16	3	19	...	...	...	2	1	3	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	19	4	23
...ved ...	...	...	...	...	...	...	3	..	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...	4	...	4
...	1	...	1	...	...	...	6	7	13	...	...	...	4	...	4	...	...	...	2	5	7	...	...	...	...	1	1	...	...	...	...	...	...	13	13	26
...ing on 31st	9	3	12	5	2	7	(a) 79	(b) 23	102	2	...	2	35	9	44	3	...	3	(c) 49	8	57	2	1	3	...	...	...	12	...	12	1	...	1	197	46	243

STATEMENT No. VII.

Showing the alleged causes of insanity among the Lunatics in the Asylums in Bengal during the year 1900.

35

1	2			3			4			5			6			7			8			9		
CAUSES.																						PHYSICAL.		
	Charas-smoking.			Ganja-smoking.			Use of bhang.			Opium-smoking (madak and chandu)			Opium-eating.			Spirit-drinking.			All other intoxicants.			Fever.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																								
Remaining ...	...	...	...	30	...	30	1	...	1	...	...	...	4	...	4	5	...	5	3	...	3	6	1	7
Admitted— Criminal	...	...	...	3	...	3	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1
Non-criminal	...	...	...	2	1	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated ...	...	...	...	35	1	36	2	...	2	...	...	...	4	...	4	5	...	5	3	...	3	6	2	8
Recovered ...	...	...	...	3	1	4	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...	...	1	1
Improved ...	...	...	...	2	...	2	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died ...	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...

1	10			11			12			13			14			15			16			17		
CAUSES.	Heredity.			Epilepsy.			Congenital.			Heat.			Poverty.			Child birth.			Injury.			Debility.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																								
Remaining	11	2	13	...	...	...	2	1	3	1	...	1	...	...	...	...	2	2	2	...	2	...	...	...
Admitted— Criminal	2	...	2	2	...	2	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	14	2	16	2	...	2	2	1	3	1	...	1	...	...	...	...	2	2	2	...	2	...	...	...
Recovered	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...

36

STATEMENT No. VII—concluded.

Showing the alleged causes of insanity among the Lunatics in the Asylums in Bengal during the year 1900—concluded.

37

	18			19			20			21			22			23		
																PHYSICAL		
	Illness.			Syphilis.			Senility.			Acute disease.			Piles.			Defect of uterine function.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																		
Remaining ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Recovered ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died ...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...

	24			25			26			27			28			29			30			31		
CAUSES—concluded.	Administration of poisonous drugs.			Idiocy.			Overstudy.			Total physical.			Moral causes.			Total known.			Total unknown.			GRAND TOTAL.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Remaining	...	...	...	...	...	...	...	...	...	65	6	71	30	6	36	95	12	107	81	32	113	176	44	220
Admitted— Criminal	...	...	...	...	...	...	...	...	...	8	1	9	3	...	3	11	1	12	33	2	35	44	3	47
Non-criminal	...	...	...	...	...	...	...	...	...	3	1	4	2	...	2	5	1	6	21	12	33	26	13	39
Total treated	...	...	...	...	...	...	...	...	...	76	8	84	35	6	41	111	14	125	135	46	181	246	60	306
Recovered	...	...	...	...	...	...	...	...	...	5	2	7	4	...	4	9	2	11	10	2	12	19	4	23
Improved	...	...	...	...	...	...	...	...	...	3	...	3	...	...	...	3	...	3	1	...	1	4	...	4
Died	...	...	...	...	...	...	...	...	...	1	...	1	1	1	2	2	1	3	11	12	23	13	13	26

Figure 6: Aetiological factors and associated conditions, 1925 (adopted in 1912)

STATEMENT No. VII.

Showing Ætiological factors and associated conditions in the patients admitted into the Mental Hospitals in Bengal during the year 1925.

Ætiological factors and associated conditions.	Dacca.									Berhampore.									Mental Ward of the Albert Victor Leper Asylum at Gobra.									Total.								
	Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.		
	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
A. Heredity—																																				
1. Insane	10	..	10	..	..	..	10	..	10	15	1	16	..	..	..	15	1	16	..	..	..	..	..	..	..	..	..	25	1	26	..	..	..	25	1	26
2. Epileptic	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Neurotic	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
4. Marked eccentricity	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
5. Alcoholism	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	10	..	10	..	..	..	10	..	10	15	1	16	..	..	..	15	1	16	..	..	..	..	..	..	..	..	..	25	1	26	..	..	..	25	1	26
B. Mental Instability, as revealed by—																																				
1. Moral deficiency	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Congenital mental defect	1	1	2	..	..	..	1	1	2	2	..	2	..	..	..	2	..	2	..	..	..	..	..	..	..	..	..	3	1	4	..	..	..	3	1	4
3. Eccentricity	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
4. Previous attack	..	..	..	..	..	..	..	..	..	6	1	7	5	1	6	11	2	13	..	..	..	..	..	..	..	..	..	6	1	7	5	1	6	11	2	13
Total	1	1	2	..	..	..	1	1	2	8	1	9	5	1	6	13	2	15	..	..	..	..	..	..	..	..	..	9	2	11	5	1	6	14	3	17
C. Deprivation of Special Senses—																																				
1. Smell or taste	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Hearing	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Sight	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
D. Critical Periods—																																				
1. Puberty and adolescence	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Climacteric	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Senility	..	..	..	..	..	..	..	..	..	1	1	2	1	1	2	2	2	4	..	..	..	..	..	..	..	..	..	1	1	2	1	1	2	2	2	4
Total	..	..	..	..	..	..	..	..	..	1	1	2	1	1	2	2	2	4	..	..	..	..	..	..	..	..	..	1	1	2	1	1	2	2	2	4
E. Child Bearing—																																				
1. Pregnancy	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Parturition	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Lactation	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
F. Mental Stress—																																				
1. Sudden	..	..	..	17	2	19	17	2	19	..	..	..	2	1	3	2	1	3	..	..	..	..	..	..	..	..	..	..	..	..	19	3	22	19	3	22
2. Prolonged	..	..	..	..	..	..	..	..	..	5	..	5	..	..	..	5	..	5	..	..	..	..	..	..	..	..	..	5	..	5	..	..	..	5	..	5
Total	..	..	..	17	2	19	17	2	19	5	..	5	2	1	3	7	1	8	..	..	..	..	..	..	..	..	..	5	..	5	19	3	22	24	3	27
G. Diseases due to disorders of nutrition or metabolism—																																				
1. Malnutrition (in early life)	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Privation and starvation	..	..	..	..	..	..	..	..	..	..	..	..	6	2	8	6	2	8	..	..	..	..	..	..	..	..	..	..	..	..	6	2	8	6	2	8
3. Over-exertion (physical)	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
4. Sexual excess	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	..	..	..	..	..	..	..	..	..	6	2	8	6	2	8	..	..	..	..	..	..	..	..	..	..	..	..	6	2	8	6	2	8
Carried over	11	1	12	17	2	19	28	3	31	29	3	32	14	5	19	43	8	51	..	..	..	..	..	..	..	..	..	40	4	44	31	7	38	71	11	82

Showing Ætiological factors and associated conditions in the patients admitted into the Mental Hospitals in Bengal during the year 1925—*concluded.*

Ætiological factors and associated conditions.	Dacca.									Berhampore.									Mental Ward of the Albert Victor Leper Asylum at Gobra.									Total.								
	Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.			Predisposing cause.			Exciting cause.			Total.		
	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
Brought forward	11	1	12	17	2	19	28	3	31	29	3	32	14	5	19	43	8	51	..	..	..	..	..	..	..	..	..	40	4	44	31	7	38	71	11	82
H. Infective and Toxic—																																				
1. Alcohol	..	..	..	..	..	..	..	..	..	3	..	3	8	1	9	11	1	12	..	..	..	..	..	..	..	..	..	3	..	3	8	1	9	11	1	12
2. Opium and morphia	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Cocaine	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
4. Cannabis Indica	..	..	..	3	..	3	3	..	3	3	..	3	20	..	20	23	..	23	1	..	1	..	..	..	1	..	1	4	..	4	23	..	23	27	..	27
5. Acute infective diseases	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
6. Tuberculosis	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
7. Syphilis, acquired	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	1	..	1	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	1	..	1
,, congenital	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
8. Plague	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
9. Influenza	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
10. Other toxins	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	1	..	1	1	..	1	..	..	..	1	..	1
Total	..	..	..	3	..	3	3	..	3	7	..	7	28	1	29	35	1	36	2	..	2	..	..	..	2	..	2	9	..	9	31	1	32	40	1	41
I. Traumatic—																																				
1. Injuries	..	..	..	..	..	..	..	..	..	2	..	2	..	..	..	2	..	2	..	..	..	..	..	..	..	..	..	2	..	2	..	..	..	2	..	2
2. Operations	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Sunstroke	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	..	..	..	..	..	..	2	..	2	..	..	..	2	..	2	..	..	..	..	..	..	..	..	..	2	..	2	..	..	..	2	..	2
J. Diseases of the Nervous System—																																				
1. Diseases of the brain	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Diseases of the spinal cord and nerves.	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Epilepsy	..	..	..	1	..	1	1	..	1	3	..	3	1	..	1	4	..	4	..	..	..	..	..	..	..	..	..	3	..	3	2	..	2	5	..	5
4. Other defined neuroses	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	1	..	1	1	..	1	3	..	3	1	..	1	4	..	4	..	..	..	..	..	..	..	..	..	3	..	3	2	..	2	5	..	5
K. Other Bodily Affictions—																																				
1. Diseases of the blood	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
2. Diseases of the Circulatory system.	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
3. Diseases of the Valves of the heart.	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
4. Diseases of the digestive system.	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
5. Diseases of the urinary organs	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
6. Diseases of the Generative system (excluding syphilis).	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
7. Other general affections	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Total	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
L. No cause assignable—	..	..	..	29	4	33	29	4	33	..	..	..	..	..	..	..	..	..	1	..	1	..	..	..	1	..	1	1	..	1	29	4	33	30	4	3[illegible]
M. No cause ascertained—																																				
1. History defective	..	..	..	..	..	..	..	..	..	..	..	..	37	10	47	37	10	47	..	..	..	..	..	..	..	..	..	..	..	..	37	10	47	37	10	47
Total	11	1	12	50	6	56	61	7	68	41	3	44	80	16	96	121	[illegible]	140	3	..	3	..	..	..	3	..	3	55	4	59	130	22	152	185	26	211

Addendum

A1: Physical and moral causes of insanity, 1872.

(Top: Physical, Bottom: Moral)

year classified according to cause.

Other physical causes.* M	Other physical causes.* F	Other physical causes.* T	Total. M	Total. F	Total. T	Moral: Grief. M	Grief. F	Grief. T	Over-study. M	Anger. M	Anger. F	Anger. T	Religion. M	Jealousy. M	Fear. M	Debauchery. M	Debauchery. F	Debauchery. T	Love. M	Poverty. M	Loss of property. M	Failure in business. M	Domestic trouble. M	Total. M	Total. F	Total. T	Total known causes. M	Total known causes. F	Total known causes. T	Total. M	Total. F	Total. T
4	2	6	342	39	381	31	17	48	3	1	2	3	4	1	5	2	...	2	1	..	1	...	1	50	19	69	392	58	450	646	181	827
1	...	1	9	...	9	1	...	1	..	...	...	...	...	...	...	...	...	...	...	..	...	...	...	1	...	1	10	...	10	28	...	28
4	...	4	14	...	14	5	1	6	...	...	1	1	1	...	...	1	...	1	...	...	...	...	...	6	1	7	20	1	21	27	1	28
...	...	...	11	...	11	...	...	...	...	...	...	...	...	...	...	...	...	..	...	...	...	...	...	...	...	...	11	...	11	16	3	19
...	...	...	3	...	3	...	...	...	...	.	...	...	...	...	...	...	...	...	...	.	...	...	...	...	...	...	3	...	3	6	...	6
...	...	...	13	1	14	1	...	1	...	...	...	...	..	...	1	...	...	..	...	...	...	...	...	2	...	2	15	1	16	15	1	16
5	...	5	50	1	51	7	1	8	...	..	1	1	1	...	1	1	...	1		...	...	...	...	9	1	10	59	2	61	92	5	97
...	...	...	89	11	100	6	4	10	1	...	...	...	...	...	1	...	...	...	...	...	...	...	...	8	4	12	97	15	112	142	49	191
...	1	1	46	8	54	6	4	10	...	...	...	...	...	..	1	4	2	6	2	1	...	...	...	15	7	22	61	15	76	79	18	97
...	...	...	67	1	68	1	1	2	1	..	...	..	...	.	...	...	...	...	...	...	...	...	...	2	1	3	69	2	71	85	20	105
...	...	..	7	1	8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	7	1	8	7	1	8
...	...	...	16	3	19	4	3	7	...	...	...	...	...	...	...	...	...	...	...	...	...	1	..	5	3	8	21	6	27	21	6	27

	Ganjah and Bhang. M	Ganjah and Bhang. F	Ganjah and Bhang. T	Spirit. M	Spirit. F	Spirit. T	Dhatoorah. M	Opium. M	Heat and sun-stroke. M	Heat and sun-stroke. F	Heat and sun-stroke. T	Fever. M	Fever. F	Fever. T	Hereditary. M	Hereditary. F	Hereditary. T	Congenital M	Congenital F	Congenital T	Epilepsy. M	Epilepsy. F	Epilepsy. T	Affection of the Brain. M
Remained ...	256	20	276	29	6	35	1	2	3	...	3	[illegible]	2	9	13	3	16	9	2	11	17	3	20	1
Admitted. Dullunda ...	3	...	3	5	...	5	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	..	...	...
Dacca ...	4	...	4	...	...	...	...	...	...	...	...	3	...	3	2	...	2	...	...	...	1	...	1	...
Patna ...	8	...	8	...	...	...	...	1	...	...	..	...	...	...	1	...	1	..	...	...	1	...	1	...
Cuttack ...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	..	...	2	...	2	...
Moydapore ...	4	...	4	...	...	...	...	...	1	...	1	2	1	3	3	...	3	...	..	...	1	...	1	2
Total Criminal ...	20	...	20	5	...	5	...	1	1	...	1	5	1	6	6	...	6	...	...	...	5	...	5	2
Admitted. Dullunda ...	67	6	73	13	3	16	...	..	...	...	...	1	2	3	...	...	...	...	...	...	8	...	8	...
Dacca ...	25	2	27	6	1	7	...	2	...	...	...	2	1	3	7	1	8	...	...	...	4	1	5	...
Patna ...	52	...	52	6	...	6	...	3	..	...	...	3	1	4	3	...	3	...	...	...	...	...	...	...
Cuttack ...	6	...	6	...	...	...	...	...	...	...	...	...	...	...	1	1	2	...	...	...	...	...	...	..
Moydapore ...	12	2	14	...	...	...	...	...	1	1	2	...	.	...	2	...	2	..	...	...	1	...	1	..
Total non-Criminal ...	162	10	172	25	4	29	...	5	1	1	2	6	4	10	13	2	15	...	...	..	13	1	14	...
Total admitted ...	182	10	192	30	4	34	...	6	2	1	3	11	5	16	19	2	21	...	...	...	18	1	19	2
Total treated ...	438	30	468	59	10	69	1	8	5	1	6	18	7	25	32	5	37	9	2	11	35	4	39	3
Cured ...	74	8	82	13	2	15	...	2	2	...	2	3	...	3	3	3	6	...	...	...	...	...	...	1
" per cent. of total treated ...	16·9	26·6	17 5	22·	20·	21·7	...	25·	40·	..	33·3	16·6	...	12·	9·4	60·	16·2	...	...	...	...	...	...	33·3
Improved, &c. ...	35	2	37	3	...	3	...	...	...	...	...	...	...	...	2	...	2	...	...	...	2	...	2	...
" per cent. of total treated ...	7·9	6·6	7·9	5·1	...	4·3	...	...	...	.	...	...	..	...	6·2	...	5·4	...	..	...	5·7	...	5·1	...
Died ...	30	3	33	3	...	3	1	1	...	...	...	...	..	...	2	...	2	2	...	2	10	1	11	...
" per cent. of total treated ...	6 8	10·	7·1	5·1	...	4·3	100	12·5	...	...	...	...	...	...	6·2	...	5·4	22·2	..	18 2	28 5	25·	28·2	...

A2: Alleged causes of physical and moral insanity and types of insanity, 1882.

(Top: Causes, Bottom: Types)

STATEMENT No. VII.

Showing the alleged causes of Insanity among the Lunatics in the Asylums in Bengal during the year 1882.

1	2			3			4			5			6			7			8			9		
	PHYSICAL CAUSES.																							
	Ganja.			Bhang and charas.			Spirits.			Opium.			Fever.			Hereditary.			Epilepsy.			Child-birth.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																								
Remaining	38	2	40	3	1	4	3	2	5	4	...	4	7	1	8	9	...	9	...	...	...	...	2	2
Admitted— Criminal	10	...	10	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	17	...	17	1	...	1	3	...	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	65	2	67	4	1	5	7	2	9	4	...	4	7	1	8	9	...	9	...	...	...	...	2	2
Recovered	11	2	13	3	...	3	3	1	4	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	7	...	7	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	3	...	3	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
DACCA.																								
Remaining	46	8	54	...	...	...	5	...	5	1	...	1	3	1	4	13	3	16	2	1	3	...	2	2
Admitted— Criminal	3	...	3	...	...	...	1	...	1	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
Non-criminal	2	...	2	...	...	...	...	...	...	...	...	...	...	2	2	1	...	1	...	...	...	...	...	...
Total treated	51	8	59	...	...	...	6	...	6	1	...	1	3	3	6	15	3	18	2	1	3	...	2	2
Recovered	4	1	5	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
Died	3	2	5	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...
PATNA.																								
Remaining	47	1	48	2	...	2	21	3	24	1	...	1	4	2	6	1	...	1	9	...	9	5	2	7
Admitted— Criminal	4	...	4	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...
Non-criminal	10	...	10	2	...	2	3	...	3	...	...	...	1	1	2	...	...	...	1	...	1	1	1	2
Total treated	61	1	62	4	...	4	25	3	28	1	...	1	5	3	8	1	...	1	11	...	11	6	3	9
Recovered	10	...	10	3	...	3	...	1	1	...	...	...	...	1	1	...	...	...	...	...	...	...	...	...
Improved	2	...	2	...	...	...	2	...	2	...	...	...	2	...	2	...	...	...	2	...	2	1	...	1
Died	9	...	9	...	...	...	2	...	2	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2
CUTTACK.																								
Remaining	18	...	18	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...	3	...	3	...	...	...
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2	...	...	...	...	...	...
Non-criminal	8	...	8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	26	...	26	...	...	...	...	...	...	1	...	1	...	...	...	2	...	2	3	...	3	...	...	...
Recovered	5	...	5	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...
BERHAMPORE.																								
Remaining	[illegible]																							
Admitted— Criminal	[illegible]																							
Non-criminal	[illegible]																							
Total treated	[illegible]																							
Recovered	[illegible]																							
Improved	[illegible]																							
Died	[illegible]																							

1	10			11			12			13			14			15			16		
	PHYSICAL CAUSES.																				
	Injury.			Sunstroke.			Hydro-phobia.			Cholera.			Debility.			Congenital.			Debau-chery.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																					
Remaining	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
DACCA.																					
Remaining	...	...	...	1	...	1	1	...	1	1	...	1	7	...	7	3	1	4	2	1	3
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2	...	...	...	...	...	...
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	1	...	1	1	...	1	1	...	1	9	...	9	3	1	4	2	1	3
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	...	...	...	...	...	...
PATNA.																					
Remaining	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
CUTTACK.																					
Remaining	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
BERHAMPORE.																					
Remaining	[illegible]																				
Admitted— Criminal	[illegible]																				
Non-criminal	[illegible]																				
Total treated	[illegible]																				
Recovered	[illegible]																				
Improved	[illegible]																				
Died	[illegible]																				

	17			18			19			20			21			22			23		
	PHYSICAL CAUSES—*contd.*						MORAL CAUSES.														
	Heat.			Total.			Grief.			Fear.			Jealousy.			Anger.			Love.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																					
Remaining	...	...	...	65	8	73	8	...	8	2	...	2	2	...	2	...	...	...	...	...	...
Admitted— Criminal	...	...	...	11	...	11	2	...	2	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	21	...	21	1	...	1	...	...	...	1	...	1	...	...	...	...	...	...
Total treated	...	...	...	97	8	105	11	...	11	2	...	2	3	...	3	...	...	...	...	...	...
Recovered	...	...	...	17	3	20	2	...	2	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	8	...	8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	4	...	4	1	...	1	1	...	1	1	...	1	...	...	...	...	...	...
DACCA.																					
Remaining	...	...	...	85	17	102	15	11	26	2	...	2	2	...	2	...	...	...	1	...	1
Admitted— Criminal	...	...	...	7	...	7	...	...	...	1	...	1	1	1	2	...	...	...	...	...	...
Non-criminal	...	...	...	3	2	5	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	95	19	114	16	11	27	3	...	3	3	1	4	...	...	...	1	...	1
Recovered	...	...	...	5	1	6	...	1	1	1	...	1	...	...	...	...	...	...	...	...	...
Improved	...	...	...	2	...	2	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	5	2	7	...	2	2	2	...	2	1	...	1	...	...	...	...	...	...
PATNA.																					
Remaining	...	...	...	90	8	98	4	6	10	3	3	6	...	...	...	2	...	2	...	...	...
Admitted— Criminal	...	...	...	6	...	6	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	18	2	20	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	114	10	124	5	6	11	3	3	6	...	...	...	2	...	2	...	...	...
Recovered	...	...	...	13	2	15	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	9	...	9	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	13	...	13	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
CUTTACK.																					
Remaining	...	...	...	22	...	22	...	1	1	...	...	...	1	...	1	...	1	1	...	...	...
Admitted— Criminal	...	...	...	2	...	2	1	1	2	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	8	...	8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	...	...	...	32	...	32	1	2	3	...	...	...	1	...	1	...	1	1	...	...	...
Recovered	...	...	...	5	...	5	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	1	...	1	...	1	1	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
BERHAMPORE.																					
Remaining	1	...	1	33	6	39	6	7	13	...	...	...	...	...	...	2	1	3	...	...	...
Admitted— Criminal	...	...	...	11	...	11	1	...	1	...	...	...	...	...	...	...	...	...	...	...	...
Non-criminal	...	...	...	3	...	3	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Total treated	1	...	1	47	6	53	7	7	14	...	...	...	...	...	...	2	1	3	...	...	...
Recovered	...	...	...	4	...	4	...	1	1	...	...	...	...	...	...	...	...	...	...	...	...
Improved	...	...	...	...	...	...	1	1	2	...	...	...	...	...	...	...	...	...	...	...	...
Died	...	...	...	5	...	5	...	1	1	...	...	...	...	...	...	...	...	...	...	...	...

	24			25			26			27			28			29			30			31		
	MORAL CAUSES.																							
	Religion.			Dream.			Litigation.			Debt.			Total.			Total known.			Total unknown.			Grand Total.		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
DULLUNDA.																								
Remaining	...	...	...	...	...	...	...	...	...	1	...	1	13	...	13	78	8	86	78	28	106	156	36	192
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2	13	...	13	12	...	12	25	...	25
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	2	...	2	23	...	23	7	5	12	30	5	35
Total treated	...	...	...	...	...	...	...	...	...	1	...	1	17	...	17	114	8	122	97	33	130	211	41	252
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	3	...	3	20	3	23	7	1	8	27	4	31
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	8	...	8	2	...	2	10	...	10
Died	...	...	...	...	...	...	...	...	...	...	...	...	3	...	3	7	...	7	11	3	14	18	3	21
DACCA.																								
Remaining	5	...	5	1	...	1	...	1	1	...	...	...	26	12	38	111	29	140	71	13	84	182	42	224
Admitted— Criminal	1	...	1	...	...	...	...	...	...	...	...	...	3	1	4	10	1	11	10	2	12	20	3	23
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	4	2	6	6	...	6	10	2	12
Total treated	6	...	6	1	...	1	...	1	1	...	...	...	30	13	43	125	32	157	87	15	102	212	47	259
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	1	1	2	6	2	8	6	4	10	12	6	18
Improved	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	3	...	3	4	...	4	7	...	7
Died	...	...	...	...	...	...	...	...	...	...	...	...	3	2	5	8	4	12	9	1	10	17	5	22
PATNA.																								
Remaining	...	...	...	...	...	...	...	...	...	...	...	...	9	9	18	99	17	116	65	39	104	164	56	220
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	6	...	6	8	3	11	14	3	17
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	19	2	21	11	4	15	30	6	36
Total treated	...	...	...	...	...	...	...	...	...	...	...	...	10	9	19	124	19	143	84	46	130	208	65	273
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	13	2	15	3	2	5	16	4	20
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	9	...	9	1	2	3	10	2	12
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	13	...	13	10	1	11	23	1	24
CUTTACK.																								
Remaining	1	...	1	...	...	...	...	...	...	...	...	...	2	2	4	24	2	26	17	5	22	41	7	48
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	1	1	2	3	1	4	...	...	...	3	1	4
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	8	...	8	4	1	5	12	1	13
Total treated	1	...	1	...	...	...	...	...	...	...	...	...	3	3	6	35	3	38	21	6	27	56	9	65
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	5	...	5	1	2	3	6	2	8
Improved	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1	1	1	2	1	...	1	2	1	3
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	2	1	3	3	1	4
BERHAMPORE.																								
Remaining	...	...	...	...	...	...	...	...	...	...	...	...	8	8	16	41	14	55	89	40	129	130	54	184
Admitted— Criminal	...	...	...	...	...	...	...	...	...	...	...	...	1	...	1	12	...	12	4	2	6	16	2	18
Non-criminal	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	3	...	3	1	1	2	4	1	5
Total treated	...	...	...	...	...	...	...	...	...	...	...	...	9	8	17	56	14	70	94	43	137	150	57	207
Recovered	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1	4	1	5	1	...	1	5	1	6
Improved	...	...	...	...	...	...	...	...	...	...	...	...	1	1	2	1	1	2	...	...	...	1	1	2
Died	...	...	...	...	...	...	...	...	...	...	...	...	...	1	1	5	1	6	10	...	10	15	1	16

Statement No. VI.

Return showing the types of Insanity of the Lunatics in the Asylums in Bengal during the year 1882.

1	2			3			4			5			3			7			8			9			10		
	105*a*. Acute mania.			105*b*. Chronic mania.			106 Melancholia.			107*a*. Acute dementia.			107*b*. Chronic dementia.			Idiotcy.			Imbecility.			Not insane.			Total.		
	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.
Remaining ...	23	10	33	37	17	54	5	2	7	16	1	17	60	6	66	...	...	...	...	...	...	15	...	15	156	36	192
Admitted ...	21	4	25	17	1	18	...	...	...	1	...	1	1	...	1	...	...	...	...	...	...	15	...	15	55	5	60
Total treated ...	44	14	58	54	18	72	5	2	7	17	1	18	61	6	67	...	...	...	...	...	...	30	...	30	211	41	252
Recovered ...	11	3	14	3	1	4	1	...	1	...	...	...	4	...	4	...	...	...	...	...	...	8	...	8	27	4	31
Improved ...	7	...	7	2	...	2	...	...	...	...	...	...	...	...	...	...	..	...	...	.	..	1	...	1	10	...	10
Died ...	4	...	4	3	3	6	...	...	...	1	...	1	9	...	9	...	...	...	...	...	...	1	..	1	18	3	21

A3: Criminal lunatics, 1890-1900.

8. *Statement II—Criminal lunatics.*—The table below gives the main facts relative to criminal lunatics:—

TABLE IV.

Table of Criminal Lunatics in the Native Asylums of Bengal for the year 1900 and ten previous years.

YEAR.	REMAINING ON 1ST JANUARY.			ADMITTED.			RE-ADMITTED.			TOTAL.			DISCHARGED, TRANSFERRED, &C.			DIED.			REMAINING ON 31st DECEMBER.			DAILY AVERAGE STRENGTH.		
	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.	Males.	Females.	Total.
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
1890 ...	394	46	440	75	13	88	10	1	11	479	60	539	42	8	50	23	1	24	414	51	465	394·36	48·85	443·21
1891 ...	414	51	465	69	11	80	11	...	11	494	62	556	72	11	83	21	3	24	401	48	449	402·37	48·52	450·89
1892 ...	401	48	449	70	9	79	14	5	19	485	62	547	58	7	65	32	1	33	395	54	449	394·73	50·04	444·77
1893 ...	395	54	449	83	4	87	15	1	16	493	59	552	75	6	81	24	2	26	394	51	445	389·09	52·33	441·42
1894 ...	394	51	445	83	12	95	11	2	13	488	65	553	51	5	56	29	5	34	408	55	463	395·61	52·58	448·19
1895 ...	408	55	463	79	8	87	13	2	15	500	65	565	58	4	62	30	3	33	412	58	470	405·80	57·35	463·15
1896 ...	412	58	470	81	10	91	12	1	13	505	69	574	48	5	53	40	4	44	417	60	477	420·58	58·43	479·01
1897 ...	417	60	477	94	10	104	10	...	10	521	70	591	56	4	60	42	4	46	423	62	485	420·79	59·83	480·62
1898 ...	423	62	485	63	6	69	8	1	9	494	69	563	46	5	51	30	5	35	418	59	477	421·34	63·24	484·58
1899 ...	418	59	477	95	7	102	14	1	15	527	67	594	74	7	81	33	4	37	420	56	476	416·43	56·68	473·11
1900 ...	420	56	476	97	7	104	17	3	20	534	66	600	64	8	72	39	7	46	431	51	482	431·27	52·42	483·69