

The Emergence of 'Christian Psychiatry' in Post-Independence India¹

In my current research I am working on three projects, under the umbrella title of 'The Co-Evolution of Religion and Mental Health in India and Japan, 1930s – the Present'²: the life and work of the devout Buddhist and 'father of Japanese psychoanalysis', Heisaku Kosawa; the work of a small handful of European and Indian Catholics who promoted a psychologized form of contemplative Christianity in early post-Independence India; and the concept of 'Christian psychiatry' as it evolved in India and Japan from the 1940s onwards, particularly at three key institutions in Lucknow, Vellore, and Tokyo.³ This paper focuses primarily on the Christian psychiatry project but in doing so addresses core questions which stretch across all three themes, particularly in relation to the historical evolution of 'psychologized spirituality'. I use this term to refer to modern forms of belief, behaviour and belonging which tend to eschew traditional religious institutions, hierarchies, communities, and systems of knowledge and revelation in favour of an emphasis upon the surveillance and transformation of practitioners' internal lives, utilising psychological concepts and techniques in the process. Lay leadership of relatively small groups, meeting at regular intervals, is a common feature of this type of spirituality, with professional Religious – often from monastic backgrounds – fulfilling a consultative role. Examples of this sort of psychologized spirituality include the late twentieth-century resurgence and reworking of the Christian contemplative tradition⁴; new formulations of Zen and Tibetan Buddhism mostly postdating Japan's modern encounter with western philosophy and psychology⁵ and China's annexation of Tibet, respectively; a range of syncretistic and non-traditional formulations drawing on gnostic and psychological ideas – Carl Jung being a favoured point of reference⁶; and finally techniques and organizations associated with the vast popular psychology literature epitomised by M. Scott Peck's bestselling 1978 publication, *The Road Less Travelled*.⁷

Building on a definition of spirituality formulated by Steven Sutcliffe, one might describe this psychologized form as an expressive and holistic mode of personal behaviour

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² See www.religionandmentalhealth.co.uk.

³ The Nur Manzil Psychiatric Center, Lucknow; the Mental Health Centre, Vellore (part of Christian Medical College); St John's Hospital Sakuramachi, in Tokyo.

⁴ See, for example, the organizations World Community for Christian Meditation and Contemplative Outreach.

⁵ See Robert H. Sharf, 'The Zen of Japanese Nationalism', *History of Religions*, Vol. 33, No. 1 (Aug., 1993), pp. 1-43.

⁶ A useful introduction here is J.J. Clarke, *Jung and Eastern Thought: a Dialogue with the Orient* (1994).

⁷ M. Scott Peck, *The Road Less Travelled: A New Psychology of Love, Traditional Values, and Spiritual Growth* (1978).

directed towards authenticity of being, relationship, and understanding.⁸ I use the word ‘authenticity’ to point to two common traits in psychologized spirituality: the privileging of a personal, perspectival sense of truth (often with demanding implications for ethical conduct) over objective knowledge claims, and a critique of ‘inauthentic’ living – i.e. living at odds with reality, whether one realises it or not.⁹ It is tempting to seek to define this sort of spirituality in contradistinction to ‘religion’, but as the popular slogan ‘spiritual, not religious’ suggests, such a distinction is often more polemical and/or self-representational than it is usefully analytical. In fact, there is significant overlap between spirituality and religion – from a complex and varying usage of the word ‘spirituality’ and its cognates in European languages stretching back many centuries in Christian tradition, to a substantial sharing, in recent decades, of content and presentational strategies between new spiritual movements and established churches and other religious institutions.

There have long been concerns about the socio-political and individual mental health implications of psychologized spirituality, together with opposition from within established religious traditions such as the Catholic Church towards what they see as just the latest incarnation of ‘quietism’ – a view of philosophy or religion as primarily therapeutic or transformative of consciousness, amongst the most often-cited instances of which are major Asian traditions such as Buddhism, the ancient Stoics, and modern western individuals and movements from the French mystic Madame Guyon in the seventeenth century to Contemplative Outreach in the early twenty-first.¹⁰ A related critique was offered in the post-Independence Indian context by prominent Christian thinkers who worried that European Catholics seeking an accommodation in the 1960s between contemplative Christianity and the spirituality of the Upanishads risked blunting or even undermining the radical approach to social justice for which a great many Indian Christians valued the gospels.¹¹ Christopher Lasch’s *The Culture of Narcissism* in 1979 noted a general turn inward in American culture, linking it to a sense of failure and resignation in society where ‘external’ – i.e. social and political – problems were concerned. More recently, Jeremy Carrette and Richard King’s *Selling Spirituality* included the claim that the stripping down and repackaging of religious traditions in privatised, psychologized form risks turning believers into unwitting consumers, vulnerable to sophisticated forms of advertising that target their spiritual aspirations and self-image.¹²

⁸ Sutcliffe’s definition runs as follows: ‘an expressive and holistic mode of personal behaviour encouraging strategic interaction on the part of the practitioner between natural and supernatural realms’. Steven Sutcliffe, ‘Wandering Stars: Seekers and Gurus in the Modern World’, in Steven Sutcliffe & Marion Bowman (eds), *Beyond New Age: Exploring Alternative Spirituality* (2000), p. 19.

⁹ See, for example, the teaching on ‘awareness’ of the Indian Jesuit, Fr Anthony de Mello, much of whose work was criticized by the Catholic Church’s Congregation for the Doctrine of the Faith. Anthony de Mello, *Awareness: the Perils and Opportunities of Reality* (1990).

¹⁰ The Catholic Church sought to respond to a late twentieth-century shift towards forms of prayer and meditation derived at least in part from Indic traditions with a ‘Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation’, in 1989. For a commentary on the significance of this Letter, see John Borelli, ‘Reflections on “Letter to the Bishops of the Catholic Church on Some Aspects of Christian Meditation”’, *Buddhist-Christian Studies*, Vol. 11 (1991), pp. 139-14.

¹¹ See, for example, M.M. Thomas, *The Acknowledged Christ of the Hindu Renaissance* (1969) and *The Christian Response to the Asian Revolution* (1965).

¹² Jeremy Carrette and Richard King, *Selling Spirituality: the Silent Takeover of Religion* (2005).

The principal health concern has been that while forms of religion rooted in community and social action might be good for us, physically and mentally, psychologized spirituality feeds or even fosters loneliness and vulnerability. Cynthia Bourgeault, an Episcopalian priest associated with the contemplative ‘Centering Prayer’ movement, acknowledges precisely this risk when she warns that ‘repression is a primary occupational hazard of the spiritual path’.¹³ At the same time, ‘spirituality’ is increasingly invoked – perhaps euphemistically in place of religion, as a nod to secular pluralism – by medical organizations interested in its healing potential. Initiatives in recent years include the National Spirituality and Mental Health Forum and the Royal College of Psychiatrists’ Spirituality and Psychiatry Special Interest Group. This represents a potentially significant cultural shift: questions of mental and emotional health pointing secularising societies back to aspects of their religious past, in a process carefully mediated by those in whose expertise – doctors and especially psychiatrists – these societies are, albeit equivocally, happy to place their trust.

The popularity and controversial nature of psychologized spirituality make it worthy not just of sociological or psychological analysis but of historical scrutiny, particularly where connections with modern Asian religion and what Nikolas Rose calls the ‘psy disciplines’ – primarily psychology and psychiatry – are concerned. This involves inquiring into the mutual shaping of spirituality and the psy disciplines, especially across the middle decades of the twentieth century. It could be argued that spirituality and the psy disciplines share common ground as ‘techniques’ or ‘practices’ of the self¹⁴, both describing and acting upon the self in a transformative way. In Rose’s words:

*Through self-inspection, self-problematization, self-monitoring and confession, we evaluate ourselves according to the criteria provided for us by others. Through self-reformation, therapy, and the calculated reshaping of speech and emotion, we adjust ourselves by means of the techniques propounded by experts of the soul.*¹⁵

In addition to ‘evaluation’ and ‘expertise’, a third useful concept in analysing this mutual shaping of psychologized spirituality and the psy disciplines is that of a desirable and discernible direction of travel:

*[This] government of the soul depends upon our recognition of ourselves as ideally and potentially certain sorts of person. The irony is that we believe... we are freely choosing our freedom.*¹⁶

‘Mutual shaping’ may refer, however, not just to the merging and sharing of concepts, terminology, and orientations, but also to potential antagonisms. How often do we see spirituality and the psy disciplines actually in tension with one another? How often do we see

¹³ Cynthia Bourgeault, *Centering Prayer and Inner Awakening* (2004).

¹⁴ These concepts come from work done by Michel Foucault towards the end of his life (see Luther H. Martin, Huck Gutman & Patrick H. Hutton (eds), *Technologies of the Self: A Seminar with Michel Foucault* (1988)), and have since been taken up by Nikolas Rose, amongst others.

¹⁵ Nikolas Rose, *Governing the Soul: Shaping of the Private Self* (1999), p. 11.

¹⁶ *Ibid*, p. 11.

one providing a refuge from the other – the disillusioned or damaged former mental health patient turning to spirituality in some form, or the spiritual practitioner/believer deciding that his or her problems might require psychiatric attention or psychotherapy? Do we sometimes see this crucial shared characteristic of self-evaluation actually creating or intensifying some of the internal problems that spirituality and the psy disciplines claim to address?

Finally, there is the rich but uncertain area of ‘meaning’ in the relationship between spirituality and the psy disciplines. How are we to model this relationship, according to the various understandings that have evolved across the period and regions covered by this research? Precisely because it is the calling into question of language, concepts, and frames of reference that motivated many of those who undertook pioneering work in linking spirituality with the psy disciplines, it is more difficult than ever for the historian to find solid, coherent ground from which to narrate and analyze the ideas involved here. Some pioneers found ideas and methods drawn from phenomenology and existentialism well-suited to the liminal nature of their enterprise, while others eschewed theory in favour of biographical or autobiographical accounts that illustrated particular points or allowed for creative speculation.¹⁷ In some cases an underlying theological or medical-scientific position was clearly cleaved to; more commonly, these established positions were called into question as a sense dawned of their inadequacy. What follows below is a provisional sketch of the life and work of someone who fell, rather interestingly, into the latter category: the Canadian psychiatrist and Christian missionary Dr Florence Nichols, working at Christian Medical College in Vellore in the 1940s and 1950s.

‘Christian Psychiatry’ in South India

While a great deal has been written in recent years on medical mission in India¹⁸, we know almost nothing about its mental health dimension. And yet there are potentially valuable insights here into Christianity’s impact upon modern Indian culture and sense(s) of self. Even missionary personnel who did not seek to invest bodily ailments with divine meaning (and there were plenty who did¹⁹) found the interpretation of neuroses – as distinct from conditions generally recognised by this time as having an organic basis, such as schizophrenia – to be rather a grey area: how were conditions that manifested themselves most obviously as problems of relationship – within a family, within a community, or more fundamentally between the patient and the world around him or her – to be understood? What was the proper frame of reference, given that Christianity has a great deal to say about relationship, community, and suffering in all its forms?

¹⁷ A prominent figure in the former category was the psychiatrist R.D. Laing, recent work on whom by Gavin Miller, Daniel Burston, and Marsha Hewitt offers useful methodological insights for the discussion of ‘meaning’ in this area. A relevant figure from within the scope of my own research is Dr Erna Hoch, who was for a time Director of the Nur Manzil Psychiatric Center in Lucknow, and who sought to bring her practice of *daseinsanalysis* into dialogue with Indian philosophical traditions.

¹⁸ See, for example, Maina Chawla Singh, ‘Gender, Thrift and Indigenous Adaptations: Money and Missionary Medicine in Colonial India,’ in *Women’s History Review*, 15:5 (2006), pp.701-17; David Hardiman, *Missionaries and their Medicine: A Christian Modernity for Tribal India* (2008); Christopher Harding, *Religious Transformation in South Asia: the Meanings of Conversion in Colonial Punjab* (2008).

¹⁹ See Harding, op cit, chapter four: ‘Living in New Traditions’.

One of the reasons why little scholarly work has been done in this area is that psychiatry was never a big part of medical mission during the colonial period in India. Just as medical mission itself did not get going on a systematic basis until the rise of professionalized medicine in Europe convinced mission societies that it was worth investing in, so it was not until public discussion of mental health became less taboo from the 1930s and particularly in the wake of the Second World War that these same mission organizations started to think seriously about it. In India at this point, as the work of Waltraud Ernst, Jim Mills, Christiane Hartnack, Shruti Kapila and others shows, psychiatric provision for Indians – as opposed to Europeans and other expatriates – was extremely limited.²⁰ A Government survey in 1946 found that there were around 10,000 beds for 400 million people: a ratio of one bed per 40,000 people, compared with one for every 300 in England at the time. Most of India's mental health institutions, with the exception of Ranchi and Mysore, were deemed out of date and oriented still towards custody rather than cure or care. Many Superintendents and most staff had no psychiatric training whatsoever, and the Punjab Mental Hospital in Lahore was said to be worse than most Indian jails.²¹ Christian Medical College (CMC) in Vellore, where Dr Florence Nichols had just arrived at the time the report was written, was the only Christian-run institution offering any psychiatric care whatsoever, joined four years later by the Nur Manzil Psychiatric Center in Lucknow, which was established by the American missionary Dr E. Stanley Jones.

Crucially, there was no clear blueprint at this point for what psychiatric services provided by Christian organizations and personnel ought to look like: rather, 'Christian psychiatry' emerged naturally as psychiatric, theological, and personal ideas blended with the exigencies of everyday work and care in particular cultural contexts.²² There was backing from individuals and movements elsewhere, such as the work of the Menninger brothers (Karl and William) at their Topeka clinic in Kansas, to which Florence Nichols and others at CMC frequently referred. Through an avalanche of correspondence Nur Manzil and CMC sought to keep track of the latest developments in psychiatry across the world, and sought to persuade, where possible, recognised experts to visit India and participate in professional training. Crucially, such was the lack of expertise in psychiatry that with her rare level of training Nichols enjoyed an unusually high degree of apparent autonomy in deciding upon priorities and recruiting staff, and setting her own diagnostic and therapeutic standards. Her stated aim was to integrate Christianity and psychiatry in her work in a way that matched what she saw as the needs of South Indian patients, paying particular attention to religion and family structures.

²⁰ Waltraud Ernst, *Mad Tales from the Raj: The European Insane in British India, 1800 – 1858* (London, 1991); James Mills, 'The History of Modern Psychiatry in India, 1858 – 1947', *History of Psychiatry*, 12:431 (2001); Christiane Hartnack, *Psychoanalysis in Colonial India* (New Delhi, 2001); Shruti Kapila, 'Masculinity and Madness: Princely Personhood and Colonial Sciences of the Mind in Western India, 1871 – 1940', *Past and Present*, 187 (2005).

²¹ Colonel Taylor, *Report of the Health Survey and Development Committee* (1946).

²² This being so, one might legitimately ask whether it is misleading to use the term 'Christian psychiatry' at all. However, interviews with former staff at CMC and Nur Manzil make it clear that they did in fact view their work in this period as the pioneering of 'Christian psychiatry'. Moreover, the notion that unless it is rigorously theorized 'Christian psychiatry' cannot be held to 'exist' in any meaningful sense betrays misunderstanding about how Christian psychiatrists, psychiatric nurses, and others think about and carry out their work. Chris Holland, commenting on a paper presented by the author at the Theology and Therapy Conference 2011, New College, University of Edinburgh, 9th November 2011.

Nichols' freedom at CMC needs to be weighed, however, against considerations of professional identity and financial influence operating at the hospital. Given the need of CMC for constant financial support, and its susceptibility to the medical and evangelical priorities of its backers (not all of whom were religious organizations, however), one must ask what role was being played in the evolution of 'Christian psychiatry' in India by the international charitable and Christian networks in which the subcontinent was increasingly involved in the post-Independence period. Further questions concern the place of CMC in the politics of health and mental health at a national level in India after 1947, bearing in mind the presence of India's Vice-President, Sarvepalli Radhakrishnan, at the opening of CMC's Mental Health Centre in the late 1950s, the regular stream of government correspondence seeking information and advice from CMC on the development of psychiatric care in India, and the creation of an All India Institute of Mental Health in 1954.

Dr Florence Nichols and the Mental Health Centre, Vellore

Florence Nichols was a Canadian missionary in the Anglican Church, born in 1913 and completing her medical training at Toronto University and Toronto Psychiatric Hospital.²³ Both she herself²⁴ and her mother suffered on and off from anxiety and depression²⁵, and this may partly explain her desire to work in psychiatry.²⁶ She was brought out to CMC in 1946 as Lecturer in Mental Diseases, apparently as an interim measure until a suitable male psychiatrist became available. The atmosphere at CMC at the time, which conditioned the emergence of psychiatry there to a great extent, was a combination of difficult personality politics on the one hand, and on the other the problem of establishing priorities for expansion and then persuading diverse international missions and charities – who frequently made demands of their own – to supply the requisite funding. This had been a theme at CMC since its foundation as a small clinic by the American missionary-doctor Ida Scudder in 1900. The initial \$10,000 had been supplied by a New York banker by the name of Schell²⁷, and subsequent expansion – a hospital, a nursing school, and finally the Union Mission Medical School for Women – had been achieved thanks to fundraising by Scudder and some of her close female friends and associates.

By the 1940s, CMC was one of the largest institutions of its kind in India, boasting support from missions across the world, from the likes of the Rockefeller Foundation, and from the Government of Madras. It was run primarily by western missionary doctors at this point, together with a large Indian nursing and support staff and, as was characteristic of the more expensive missionary enterprises even by the late colonial period, a significant degree of control over the institution was maintained by its overseas funders and by bodies set up to channel that funding –

²³ CMC Archives, 7th September 1945, Dr Florence Lilian Nichols Dossier.

²⁴ CMC Archives, 14th November 1949, Hilda Lazarus to Mrs Ruth H. Soward

²⁵ CMC Archives, 5th July 1951, Florence Nichols to Hilda Lazarus.

²⁶ Such was frequently the case with psychiatrists within (as well as outside) Christian missions, including Dr Marjory Foyle, who served for a number of years as Director of the Nur Manzil Psychiatric Center. Interview with Dr Marjory Foyle, October 2011. Florence Nichols' decision to go abroad as a missionary did nothing to ease her family situation: while in India she frequently received bitter correspondence from her father, who had resisted her intentions to leave Canada in the first place and seems to have applied a considerable degree of emotional pressure in seeking to bring his daughter back at the earliest possible juncture. CMC Archives, 20th October 1949, Mrs Ruth H. Soward (WACEC) to Dr Hilda Lazarus.

²⁷ CMC Archives, Arnold Desmond, *The Years of Fame*, p. 29.

principally an American Board in New York and a British Board in London. The two Boards were notably slow to pay Indian staff equal wages and to cede property and power to CMC itself; the former happened in 1940, the latter not until 1945.²⁸

It was a Scottish businessman, Lord Maclay, who in 1945 donated the initial £8,000 towards establishing psychiatry at CMC, leading to the recruitment of Florence Nichols. But plans for a Mental Health Centre were delayed²⁹ and Maclay subsequently withdrew the gift.³⁰ Nichols was left offering psychotherapy to private patients from Europe and the US, mostly ‘well-known missionaries’, as she put it, whose problems included what would now be called culture shock³¹, along with business people from South India³² and at one time even a Bahraini Sheik.³³ Meanwhile she was hearing rumours that no-one senior at CMC was really all that interested in psychiatry³⁴ – rumours that were partly true: the motivation of CMC’s leaders in giving consideration to psychiatric provision at this point was to try to gather in enough psychotic patients to enable the hospital’s medical students to complete the modest mental health component of their studies in-house. At present they were making the journey to Madras University, whose teaching on the topic senior CMC personnel thought inadequate and out of date. Nichols, on the other hand, wanted to offer treatment to the local community, and lobbied successfully to be allowed to attend Tamil language classes so that she could begin work in and around Vellore.³⁵

By 1949 Nichols seems to have had the impression that she was wasting her time at CMC, and asked to be allowed to return to Canada to receive further training both there and in the United States. She used the opportunity to seek out funding and prospective staff for the Mental Health Centre that she still hoped to build. One particular episode during her time away from CMC is worthy of attention: Nichols’ attempt to recruit a young Indian Christian convert from a wealthy background in Tamil Nadu, by the name of Mr Kannu V. Rajan.³⁶ Following his conversion as a young boy Rajan had trained in the Christian ministry and had spent a number of years in the US with his wife Mary, studying religion, psychology, sociology, and philosophy. By 1951, he was finishing these studies and was undergoing a training analysis with the well-known psychoanalyst Dr Frieda Fromm-Reichmann – another of whose clients was Rollo May, an influential figure in the dialogue between psychology and religion in the 1950s. Unsurprisingly, after all this study and training – the analysis alone was costing \$180 per month³⁷ – Rajan was running out of money, and Nichols thought this an opportune moment to offer him a job, as clinical psychologist at CMC. Nichols was convinced that Rajan was on his way to becoming one of the best-trained

²⁸ Desmond, op cit, p. 38.

²⁹ CMC Archives, 26th January 1949, Minutes of the Administration Committee, CMC.

³⁰ Desmond, op cit, p. 42.

³¹ Interview with Professor Abraham Verghese, CMC Vellore, January 2011. At this time, few mission societies engaged in any sort of psychological screening of missionary candidates.

³² CMC Archives, 25th January 1949, Florence Nichols to Hilda Lazarus.

³³ CMC Archives, Abraham Verghese, *The History of Mental Health Centre: Some Reminiscences*, 2007.

³⁴ CMC Archives, 10th September 1948, [unnamed] to Florence Nichols.

³⁵ CMC Archives, 29th January 1949, John Carman to Hilda Lazarus.

³⁶ CMC Archives, 25th June 1951, Florence Nichols to Hilda Lazarus.

³⁷ CMC Archives, 15th July 1951, Florence Nichols to Hilda Lazarus.

psychologists in India, in addition to which he was fluent in English, Tamil, and Malayalam and showed great promise as a future hospital chaplain.³⁸

It was particularly Rajan's combination of training in religious studies and psychology that interested Nichols.³⁹ She believed he was one of the few people truly qualified to bring psychiatry and religion together in the South Indian setting⁴⁰, noting with particular approval what she had heard of Rajan's performance in his training analysis with Dr Fromm-Reichmann – someone whom Nichols admired professionally but considered an 'anti-religionist'. Fromm-Reichmann had explained Rajan's conversion experience as the outcome of a neurotic need that had been building up over time. Rajan's response, as later related by Nichols to a colleague, was: '[Well] what else did God have to use but my neurosis? He didn't wait until I was a well-adjusted man to come to me'. Fromm-Reichmann was apparently flustered and fell back on the explanation that his 'oriental' background was responsible for this way of looking at things. 'No it isn't', countered Rajan, 'it's the Gospel, the New Testament.' He went on to quote from Paul's letter to the Romans (5:6) – 'While we were yet sinners, Christ died for the ungodly'. Fromm-Reichmann apparently brought the day's analysis to an abrupt halt at this point.⁴¹

Nichols was clearly impressed by all this, as she was by Rajan's response when asked by another analyst whether after a year's psychoanalysis he still believed in God. Rajan had replied that before undergoing psychoanalysis he had seen as though through a glass darkly – again quoting Paul⁴² – but that now he saw God 'face to face'. That answer 'thrills me,' wrote Nichols, admitting to her boss at CMC her nervousness at where her own psychoanalytic training was currently taking her and her faith: 'I am a little apprehensive lest my analyst in Philadelphia wear me down'.⁴³ Nichols saw psychoanalysis as both a valuable therapy *and* potentially a profound tool for Christian self-awareness, in the hands of the right kind of analyst. (She had her doubts, for example, about the wisdom of sending her young protégé Rose Chacko to the Menningers' clinic, since while both brothers were Christians many on their staff were 'aggressive atheists', according to Nichols, and their programme was entirely Freudian. 'I hesitate', she wrote to her superiors at CMC, 'to have a girl from a protected Christian environment like Rose run the risks involved'.⁴⁴) Nichols also seemed to endorse Rajan's view, formed in the course of his studies in religion and psychiatry, that neurosis could usefully be linked to the concept of sin – not in the sense of something deliberate and culpable, but rather an inbuilt imperfection through which God was able to work to foster that person's awareness of himself and, via ever deeper layers of himself, eventually of God. The biblical passage that Nichols has Rajan quoting as 'while we were yet sinners' is rendered in some English translations of the Bible as 'while we were yet *weak*'. These sorts of words – 'weakness', 'immaturity', 'emotional disturbance' – appear frequently in the writings of Nichols and her colleagues, operating as useful bridges between the religious and psychiatric domains.

³⁸ CMC Archives, 17th July 1951, Florence Nichols to Hilda Lazarus.

³⁹ CMC Archives, 15th July 1951, Florence Nichols to Hilda Lazarus.

⁴⁰ CMC Archives, 17th July 1951, Florence Nichols to Hilda Lazarus.

⁴¹ CMC Archives, 20th July 1951, Florence Nichols to Hilda Lazarus.

⁴² Paul, First Letter to the Corinthians, 13:12.

⁴³ CMC Archives, 20th July 1951, Florence Nichols to Hilda Lazarus.

⁴⁴ *Ibid.*

It is not yet possible to say whether Nichols had a fixed idea about the relationship between religion/spirituality and psychiatry during her time at CMC. Her writings, however, suggest that her thought here was characterised by ambiguity and inquisitiveness – in addition, possibly, to a desire for a medical-scientific platform for the defence of her Christianity – rather than any grand theoretical view. As more material on Nichols comes to light (work is currently ongoing) it ought to be possible to track her ideas in greater depth and over a longer period of time.

In the end, Rajan never made it to CMC. The institution's Director was initially supportive of Nichols' plan, describing Rajan as a 'God-send'⁴⁵, but then just a few days later she wrote to say that the CMC Committee had rejected the idea, claiming that 'some more suitable person' could surely be found 'on the spot'.⁴⁶ As it turned out, senior figures at CMC had their doubts both about Rajan and about Nichols. Responding to a complaint made by a member of the American board for CMC (solicited by Nichols as a way of challenging CMC's decision) about the 'casual... almost irresponsible attitude toward the development of psychiatry' there⁴⁷ the Director referred, rather elliptically, to information about the Rajans that rendered them unemployable at CMC.⁴⁸ It may be that Nichols was later given the details, because curiously she never made the case for Rajan again. Where Nichols herself was concerned, the Principal of CMC, Professor Kutumbiah, was uninterested in her plans for a Mental Health Centre⁴⁹ and agreed with Nichols' own mission superiors in finding her naïve and over-ambitious.⁵⁰ 'I do not believe', he wrote to the Director of CMC:

*...that psycho-analysis and other varieties of psychotherapy requiring elaborate analysis of patients is feasible [here]. I personally feel that any foreigner is unfit to undertake psychoanalysis of Indian patients as they are utterly strange to Indian conditions and Indian traditions. Besides [which], language is a great impediment. I do not think any foreigner can obtain sufficiently firm grip on Indian languages so as to be able to converse with patients and analyse [them]. I personally feel that the work of Dr Florence Nichols has to be on a very restricted scale [and that at present] she is attempting too much.*⁵¹

Nichols' Tamil was indeed quite poor, even by the late 1950s, and she relied upon other staff to interpret for her during consultations.⁵² But while it would be hard to deny the importance of language and socio-cultural context in the conduct of psychotherapy, it would be reductive to assume that this was/is all that matters. Gesture, touch – especially where medical problems are being investigated alongside mental health ones – personality, life experience, and general sensitivity all have major roles to play, their efficacy not necessarily lost in translation.⁵³ Undeniably, however, Nichols upset some of her superiors both at CMC and in her missionary organization. In the latter case, she failed to convince them of the need for all the qualifications

⁴⁵ CMC Archives, 3rd July 1951, Hilda Lazarus to Florence Nichols.

⁴⁶ CMC Archives, 7th July 1951, Hilda Lazarus to Florence Nichols.

⁴⁷ CMC Archives, 26th July 1951, Douglas N. Forman to Hilda Lazarus.

⁴⁸ CMC Archives, 31st July 1951, Hilda Lazarus to Douglas N. Forman.

⁴⁹ CMC Archives, 23rd July 1951, Principal to Director.

⁵⁰ CMC Archives, 19th December 1952, Principal to Director.

⁵¹ Ibid.

⁵² Interview with Professor Abraham Verghese, CMC Vellore, January 2011.

⁵³ I am grateful to Chris Holland, Lorna Murray, and Marjory Foyle for their comments here, based on their own experiences of care-giving across linguistic and cultural boundaries.

she was seeking in Canada and the US, leaving them suspicious that she simply couldn't face leaving her family and going back to India. For her part, Nichols found her mission society parochial, largely ignorant of her profession, and keen simply to get her back to India and evangelising on the wards at the earliest opportunity.⁵⁴

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Nichols arrived back in India in 1955 and, partly thanks to personnel changes at the top of CMC, the Mental Health Centre (MHC) was finally built in 1957. The stated aim was to pioneer what CMC's new Canadian Director, John Carman, described as 'a Christian approach to the problems of [the] mentally ill, adapt[ed] to the Indian scene by includ[ing] the family as much as possible in the understanding of and care of patients.' This entailed having family members not just staying at the Centre with the patient, but assessed as part of the problem and involved in treatment.⁵⁵ It was hoped that eventually this approach could be extended to non-psychiatric patients at CMC, whose problems might appear purely physical but which, 'in reality', suggested Carman, 'are related to their family traditions, their economic and social problems, and often to various other mental and emotional situations'.⁵⁶

Recognizing the importance of a person's environment to his or her mental well-being was hardly a brand new or controversial idea at this point in the history of psychiatry, but what sorts of judgments were being worked into psychiatric evaluation at the new MHC? In part at least, Nichols was drawing, in her work, on recent developments in Europe and America in favour of so-called 'social' or 'community' psychiatry – practices which, in their own right, involved normative accounts of what constituted healthy relationships. And indeed something similar was being tried at this time on a smaller scale by the Indian psychiatrist Dr Vidyasagar, working in Amritsar.⁵⁷ But Nichols and her team were basing their application of these new ideas on a combination of a limited engagement with South Indian society and self-consciously Christian principles of healthy family and relationships. Given that Christian mission personnel in India – Indian as well as expatriate – had long been accustomed to locating the cause of India's social problems at least partly in religious or spiritual conditions, here was a potentially complex meeting of the spiritual and the social under the aegis (or cover) of the medical-scientific 'expertise' of psychiatry. Similar things were certainly happening elsewhere in Indian Christianity: where once the stridency of missionary and convert claims, and in some cases their apparent ignorance of basic inequalities of opportunity on the subcontinent, had caused great offence, the early twentieth century saw a shift towards the use of more technical language – the emerging idiom of the economist, the social scientist, or the anthropologist – in the making of essentially the same arguments. This is not necessarily to imply cynicism on the part of missionaries or Indian Christians, and there is no evidence of this in the case of Nichols – it seems rather more the case that she had relatively little interest in the missionary side of employment at CMC. Nevertheless, the optimism of Nichols and Carman, that what they lacked in linguistic skills and detailed knowledge of local society they

⁵⁴ CMC Archives, 2nd September 1953, Florence Nichols to Hilda Lazarus.

⁵⁵ CMC Archives, 31st August 1955, John Carman to Rev McLaughlin; CMC Archives, 2nd September 1955, John Carman, note on psychiatry at CMC.

⁵⁶ CMC Archives, 2nd September 1955, John Carman, note on psychiatry at CMC.

⁵⁷ Verghese, *The History of Mental Health Centre: Some Reminiscences*, 2007.

made up for in the awareness, compassion, and sense of purpose that were part of their Christian way of being, was – and continues to be – a key part of how MHC sees its work, and will be the subject of future investigation and elaboration on this research project.⁵⁸

The diagnostic categories created by Nichols in the course of her psychiatric practice and training of future doctors is naturally of interest in this regard. She used a nine-part scheme, the first three of which are fairly unremarkable: psychoses, neuroses, and psychosomatic disorders. The final six, however, run as follows: ‘delinquents and criminals’, ‘wrecked careers and mismanaged lives’, ‘alcoholics and drug addicts’, ‘divorces’, and ‘marital and other maladjustments’.⁵⁹ One should bear in mind, of course, that the psychiatric profession in general has frequently been accused of medicalizing attitudes and forms of behaviour that societies find unacceptable, and indeed these six categories bear some resemblance to those used by British psychiatrists in India in the early part of the nineteenth century.⁶⁰ However, not only were Nichols’ categories at best badly out of date if considered from a secular point of view – and this despite her interest in north American psychiatric innovations and all her recent studies in the US and Canada – she and her successors insisted upon the religious dimension to mental health, including the deployment of the term ‘spirituality’ to engage non-Christian patients and families in dialogue and efforts to draw patients away from ‘various healing procedures... [based on] superstition and primitive belief’.⁶¹

In addition, the entire Mental Health Centre was – literally – structured around the family therapy hinted at in John Carman’s comments, above. In addition to an administration building housing offices for psychotherapy, a children’s playroom, a recreation room and ECT facilities, there were two simple, low-rise buildings designed to avoid an institutional feel, to make patients and their families feel at home, and to be capable of emulation across India in the future.⁶² One set of housing was a private ward of eight suites, each consisting of a large single room, back and

⁵⁸ This impression of a trade-off between detailed local knowledge and Christian sensitivity was reinforced by meeting Indian Christian staff at the Mental Health Centre in early 2011. These staff members clearly saw their faith as giving them a means of understanding non-Christian patients whose way of life in many ways they did not share.

⁵⁹ CMC Archives, 26th Feb 1959, Curriculum Office to Edna Gault.

⁶⁰ Conversation with Waltraud Ernst, October 2011.

⁶¹ W.A. Kohlmeyer & X. Fernandes, ‘Psychiatry in India: Family Approach in the Treatment of Mental Disorders’, *American Journal of Psychiatry*, 119:11 (1968). On the broader context of mission personnel deploying ‘science’ in their efforts to impress their audiences see Indira Viswanathan Petersen, ‘Tanjore, Tranquebar, and Halle: European Science and German Missionary Education in the Lives of Two Indian Intellectuals in the Early Nineteenth Century’, in Robert Eric Frykenberg (ed), *Christians and Missionaries in India: Cross-Cultural Communication Since 1500* (Grand Rapids, 2003). A distinction between religion and ‘spirituality’ remains in operation at the Mental Health Centre in 2011, where another of Nichols’ protégés, Professor Abraham Verghese, says that spirituality was the ‘common factor’ that made the Centre’s work possible, including the facilitation of multi-religious group therapy. Verghese insists that there was no difference between Nichols and secular psychiatrists in terms of technical ability, but what was different about her was the quality of ‘understanding’ that she brought to her work, both in terms of spirituality and a Christian sense of the meaning of suffering. This sense of suffering on Nichols’ part seems to have been more than a matter of Christian faith: she herself suffered great guilt over her mother’s depression and struggled with anxiety while at CMC (something noticed by a number of her colleagues). Interview with Professor Abraham Verghese, CMC Vellore, January 2011.

⁶² CMC Archives, 31st August 1955, John Carman to Rev McLaughlin.

front verandas, a small courtyard, kitchen, bathroom, and a toilet; rates were up to Rs 10 per day.⁶³ The other set was described sometimes as a 'rural unit' and at other times as a 'general unit', with simpler accommodation: a single room, plus kitchen and toilet. Rates here were Rs 3 per day and upwards. These suite arrangements, together with the highly variable rates, may indicate an attempt to accommodate caste and class to some extent, although neither was mentioned in MHC literature.⁶⁴ None of the rooms were lockable from the outside – a fact that staff at CMC were keen to emphasise in their publicity material as proof of their modern approach, designed to be well in advance of other Indian institutions. In addition there was a small occupational and recreational therapy building, and another for insulin shock therapy.

There is anecdotal evidence that family therapy worked reasonably well, based on an appreciation of the extended family structure that pertains in parts of South India, and its role in the individual's sense of self.⁶⁵ Both Rose Chacko and Nichols' successor as head of the Centre, Dr Kohlmeyer, produced research articles on the 'family method' for publication in psychiatric journals. Kohlmeyer, writing in the early 1960s, pointed out that it was not just a case of overcoming what he called families' 'superstitious beliefs about illness and treatment'; there was also a need to draw on the family's experience so far with the patient when making a diagnosis and thinking about treatment – as well, of course, as the main aim of repairing relationships within the family. In addition to its effectiveness in psychiatric terms, the involvement of the family in patient care helped to keep down costs at the Centre – staff costs were offset by the participation of family members in anything from psychotherapy itself to carrying the patient in for Electro-Convulsive Therapy (ECT) or insulin therapy, and taking care of him or her afterwards. Importantly, staff at CMC saw themselves as pioneering here a method of treatment for mental health problems that could be adopted at small psychiatric units attached to general hospitals across India, without the need to build large mental hospitals.⁶⁶

The only demographic not commonly seen at the Centre, according to Kohlmeyer, was the older generation. He put this down to the deep respect in which older family members were held, such that few younger members would be willing to suggest their elders had mental health problems and to refer them for treatment (self-referral was comparatively rare).⁶⁷ There were also fewer women than men being referred; probably, thought Kohlmeyer, because many people considered it not worth the money to treat female members of the family.⁶⁸ One problem with family therapy was that wealthier families tended to send servants to stay with the patient rather than family members; in other cases, as Rose Chacko pointed out, too many family members were sent or the ones who it seemed were contributing to the patient's problems refused to be part of

⁶³ CMC Archives, 2nd September 1955, John Carman, note on psychiatry at CMC; CMC Archives, 16th April 1957, Principal to Registrar at Madras University.

⁶⁴ CMC Archives, January 1958, leaflet on Mental Health Centre. Further work is required here, in relation to MHC. At Nur Manzil, under the Directorship of Dr Foyle, the minimum possible allowance was made for differences of caste, class, or religion – not least because some of the psychological problems of patients were believed to be connected to social or cultural exclusion. Interview with Dr Marjory Foyle, October 2011.

⁶⁵ See Sudhir Kakar's discussion in Sudhir Kakar, *The Inner World: a Psycho-analytic Study of Childhood and Society in India* (New Delhi, 1981), pp. 113 – 139.

⁶⁶ W.A. Kohlmeyer & X. Fernandes, op cit.

⁶⁷ Interview with Professor Abraham Verghese, CMC Vellore, January 2011.

⁶⁸ W.A. Kohlmeyer & X. Fernandes, op cit.

treatment. Nevertheless, as psychiatry moved on in the later 1960s Chacko described the rationale at the Centre in terms of the conviction that ‘all mental illness develops in a family... as a product of genetics and of social and cultural heredity’.⁶⁹

The Centre grew rapidly, from 380 patients being seen per year on an outpatient basis alone in 1957/8, rising to 650 per year by 1960, with around two-thirds of them being treated for psychosis of some kind and most of the remainder for anxiety and depression. The figures are less clear for inpatients, but most of these were diagnosed as schizophrenic, with cases also of chronic alcoholism and depression. Staff looking after the patients included Nichols with Chacko as her assistant, a house surgeon, a London-trained psychiatric nurse, around eight general nurses, two social workers, a psychologist, and various administrative personnel.⁷⁰ Nichols was swift to trial the latest techniques at MHC, with Chlorpromazine – the world’s first anti-psychotic – in use there from the mid-1950s, at a time when a great many American institutions remained sceptical.⁷¹ ECT continued to be used heavily, and was apparently difficult for younger members of staff to get used to – perhaps this was one of the reasons why a prayer session for staff was held just before they went to meet the line of patients waiting outside the ECT shed.⁷²

One form of therapy that was undoubtedly controversial at the Centre – and which precipitated Nichols’ early exit from CMC – was the use, in psychotherapy, of LSD-25. The drug had yet to acquire its counter-cultural associations at this point, and was instead thought by some to offer the most direct access hitherto discovered to the unconscious. Nevertheless, the contexts in which Nichols began to use it led to serious concern at CMC. Sometime in October 1958, Nichols tried to get hold of a trial quantity of the new drug. The initial plan was to apply for an import licence, but for some reason the Principal at CMC opted instead for contacting Dr Erna Hoch. Hoch was a Swiss psychiatrist and practitioner of *daseinsanalysis* (an existentialist approach to psychotherapy), who had been appointed Director of the Nur Manzil Psychiatric Centre just two years before. Through contacts in Switzerland, where the drug was being produced, Hoch had managed to bring out to India with her a total of 200 tablets and 50 vials of LSD, little of which had been used since she found it unsuited to her form of psychotherapy. By the time Hoch replied, offering to let the Centre have virtually her entire supply, Nichols had already secured a small amount from a colleague returning from England.⁷³ It is not clear whether Nichols received Hoch’s LSD as well, but in March of 1959 a note was sent round to senior staff at CMC by the Mental Health Centre’s administrator, a Mrs Edna Gault, that effectively ended Nichols’ career at the hospital. The note claimed that for some time Nichols had been sharing her accommodation at CMC with a Mr Peter Cooper, an Anglo-Indian from Bangalore, whose sister and mother had recently joined them. Cooper had initially approached Nichols for psychotherapy, the two at some point had become lovers, and Nichols had secured Cooper a job as a social worker at the Centre – and had then handed over to him most of her psychotherapy caseload. In the early months of 1959,

⁶⁹ Rose Chacko, ‘Family Participation in the Treatment and Rehabilitation of the Mentally Ill’, *Indian Journal of Psychiatry*, 9:4 (1967).

⁷⁰ CMC Archives, 16th April 1957, Principal to Registrar at Madras University. CMC Archives, October 1957, Unit costs.

⁷¹ Edward Shorter, *A History of Psychiatry* (1998), pp.246-55.

⁷² Verghese, *The History of Mental Health Centre: Some Reminiscences*, 2007.

⁷³ CMC Archives, January 1959, Florence Nichols to Principal.

Nichols and Cooper had started to use LSD-25 to enhance psychotherapy with their private clients, usually holding these special sessions in Nichols' home. In addition, Cooper had been administering the drug to Nichols, and vice versa, each weekend.⁷⁴

The details of these claims are difficult to verify, and it seems that potentially relevant archival material has either been lost or destroyed. Professor Verghese was surprised to find that documents relating to Peter Cooper had been found in the CMC archive, but confirmed both that Nichols had been using LSD in psychotherapy and that she had been in a relationship with Cooper at this point. The principal reason for doubting some of the specifics of Edna Gault's note is that it looks as though she and Nichols may not have got on particularly well – although that might, of course, have been a consequence of what she had discovered about Nichols.⁷⁵ In any case, Cooper was fired from CMC, taking with him most of Nichols' personal papers. Nichols had recently left for Canada to visit her mother, and although she sought to return to CMC the administration there never allowed her to do so.⁷⁶

Conclusion

It is unclear what became of Florence Nichols following her exit from CMC. Having failed to persuade her superiors to allow her back despite her achievements, and possibly musing on her own diagnostic category of 'wrecked careers and mismanaged lives', Nichols stayed away from Vellore but remained in contact via letter with supportive colleagues at the hospital. She maintained contact also with Dr Frank Lake, a missionary whom she had met at CMC and who went on to pioneer 'clinical theology' in Britain – Lake was even asked to take over Nichols' old job, but declined. The Mental Health Centre Nichols' founded flourished in the years that followed, but there remains much about these early years of 'Christian psychiatry' at Vellore that we do not yet know. How, for example, was Christian psychiatry viewed by Indian staff at CMC, by patients and their families, and by the wider community? Did the 'Christian' element make psychiatry more accessible for a population to whom it was culturally alien, in the way that Nichols and her team had hoped? Did patients and their families seek to reconcile Nichols' ideas with their own modes of healing – as seems likely, given Kohlmeyer's concerns about the need to confront 'superstition'? If so, where did they see Nichols and her colleagues as fitting into South Indian traditions of psycho-healing and 'God-men'?⁷⁷

From what we know so far, it appears that 'Christian psychiatry' during the formative years of CMC's Mental Health Centre took on three principle meanings. Firstly, a Christian psychiatrist such as Florence Nichols was painfully conscious of a dual role. Her salary was paid by a mission organization, and she was required to engage, at times, in active and open evangelism on the general wards of CMC. Although she saw this as distinct from her professional work as a psychiatrist, to what extent this was the case in practice remains open to question, particularly given the frequency with which emotional or psychological material tended to arise in conversations about religion. Secondly, Nichols believed that a Christian psychiatrist or

⁷⁴ CMC Archives, 2nd March 1959, Edna Gault to various unnamed senior members of staff.

⁷⁵ CMC Archives, 7th April 1959, John Carman to Florence Nichols.

⁷⁶ Interview with Professor Abraham Verghese, CMC Vellore, January 2011.

⁷⁷ I am grateful to Shruti Kapila for raising broader questions about the reception of psychiatry in India, and to David Washbrook for pointing me towards the God-man and psycho-healing traditions in South India.

psychiatric nurse had to be capable of a Christ-like humanitarianism and sensitivity that was qualitatively distinct both from secular mental healthcare and from the sort of care provided by medical mission personnel with no psychiatric training. She saw people with mental illness not just as requiring but actually inspiring this enhanced level of concern, sensitivity, and ability to relate – implying, on the basis of her personal experience, spiritual benefit to the healer as well as to the healed. Finally, Nichols seems to have understood some forms of neurosis – and possibly psychosis as well, though this isn't clear from the archival material so far surveyed – as a manifestation of a deeper dynamic: mental health problems were sometimes a means by which God called people to a greater awareness of themselves. This did not amount to a Christian 'third way', distinct from the two prevailing (and, at this time, often conflicting) paradigms for approaching mental illness – the neurobiological or organic, and the psychogenic – but rather Nichols seemed to think about mental illness in a way which, to some of her peers, seemed to blur the distinction between cause and meaning.

This returns us to one of the wider questions with which we began: how meaning in the interaction between religion/spirituality and the psy disciplines is construed and communicated. It is, arguably, on this that the long-term attractiveness and viability both of psychologized spirituality and of psychiatry's deployment of spirituality may rest: if these ideas tend towards making the individual the ultimate referent of meaning, they risk being left behind if and when cultural values shift away from a preoccupation with the individual and with personal choice. From what we know so far of the work of Florence Nichols and her team at MHC, the coming together of religion/spirituality and psychiatry did not necessarily imply a solipsistic trajectory: the MHC's work seems very much to have been directed at more, not less inter-personal communication – from attempts to engage whole families in the treatment process to instances of multi-religious group counselling which, with their focus on 'spirituality', sound as much like inter-faith dialogue as psychotherapy.

It is too early to be sure about any of this however, and we know as yet very little about the power dynamics between patients and staff at MHC. Despite its liberal connotations, there is nothing to stop a concept like 'spirituality' being deployed in a normative, restricted way, and this could happen all the more easily where medical and religious authority – or 'expertise', to recall Nikolas Rose's use of the term – was combined in the same individual. Moreover, although Nichols was in a fascinating and potentially pioneering position here one of the downsides was a lack of supervision and support, from which she would undoubtedly have benefitted had it been available. This shortcoming manifested itself first in a trickle of accounts from staff to CMC management about how fatigued Nichols was looking and how she was taking on too much at MHC, and then later turned into the events of early 1959 – which were no less controversial in their own day than they would be in the early twenty-first century, whether from a medical or a mission-Church standpoint. Precisely how expertise is assessed and practitioners overseen where Christianity and psychiatry come together was presumably a question that had to evolve alongside the notion of 'Christian psychiatry' itself. Without such oversight, patients might not be so much 'doubly blessed' as doubly vulnerable.

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