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Broken Bodies, Challenged Identities: Indian Soldiers, Disability and Colonial Medical Bias in World War I

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Abstract

Indian soldiers who participated in World War I endured significant hardships, including post-traumatic stress disorder (PTSD) and amputations as well as inadequate medical treatment rooted in the racial biases and hierarchy notions of British colonial governance. This research aims to investigate how physical and psychological trauma, along with the treatments they received during wartime — a crucial military function — transformed or challenged the identities of Indian soldiers, who served as a part of the instrumental institution that upheld the British Empire. Specifically, the study addresses the following questions: What types of disabilities did Indian soldiers suffer from? How were their disabilities perceived and treated? Lastly, how did Indian soldiers cognise their disabilities in relation to their identities as soldiers?

To answer these questions, the research draws on archival sources from the India Office files, including 'Reports of the Censor of Indian Mails in France', 'A Report on Kitchener Indian Hospital, Brighton' and 'An Analysis of 1,000 Wounds and Injuries Received in Action'. Through this examination, the paper seeks to provide a nuanced understanding of how Indian soldiers navigated the challenges to their identities amidst the profound physical and psychological impacts of warfare.

Keywords: disability, Indian soldiers, PTSD, shell shock, amputation, prosthesis

Broken Bodies, Challenged Identities: Indian Soldiers, Disability and Colonial Medical Bias in World War I

Indian soldiers played a crucial role in maintaining British hegemony in their colonies, a role that intensified during World War I. As the war escalated beyond the capacity of the British military, colonial armies, including the British Indian Army, were deployed to the Western Front. Many Indian soldiers were from the middle peasantry, valuing *izzat,* and were often selected from the British-designated 'martial races' (Mason 1974).[1]

The Indian soldiers' performance was instrumental in turning the tide for the British Army, which was struggling on the frontlines (Morton-Jack 2014). However, the toll of war began to take its effect on morale. Indian soldiers' significant casualties and physical and mental exhaustion, coupled with high rates of hospitalisation, severely impacted their readiness. While their victories in the battles were crucial, the cost of these campaigns such as physical and mental disorders ultimately continuously tormented Indian soldiers.

The conclusion of a battle does not necessarily signify the onset of peace, particularly in the psychological realm. While the physical displacement of Indian soldiers from the frontlines might have offered a form of relief, it did not equate to mental liberation. Many soldiers who escaped the immediate dangers of battle continued to endure the psychological scars wrought by their experiences. These soldiers, though physically removed from the frontline, were not exempt from the enduring mental toll of warfare, as the battle experience left indelible marks in the form of both physical and psychological disorders. Conditions such as post-traumatic stress disorder (PTSD) and amputations were among the unavoidable consequences for many of them.

Diagnosis of PTSD — Notion of Shell Shock

The most prevalent disabilities among Indian soldiers were PTSD and the amputation of limbs. Although these two afflictions will be addressed separately, they are in fact two distinct manifestations of the same profound suffering brought about by the shared experience of war. PTSD in Indian soldiers often resulted from severe physical injuries such as limb amputations; however, it is equally evident that the psychological trauma itself, frequently manifesting through self-inflicted injuries, often led to the need for amputation. These concurrent disorders, stemming from the same source, war, persisted long after the cessation of hostilities, exacerbated by inadequate treatment and misunderstandings on the part of British authorities.

The term shell shock, as defined in contemporary medical literature, was not initially conceived or understood in the same terms at the time of its origin.[2] As Peter Leese has noted, shell shock encompassed a complex set of symptoms, describing the physical and mental devastation caused by industrial warfare, including the bombardment of trenches, the suffering and death of soldiers and the subsequent mental toll on those who participated in the conflict (Leese 2002).

Although Major Charles Myers was the first to use the term shell shock, he preferred the designation NYD (Not Yet Diagnosed — Nervous) (Myers 1916). In 1925, shell shock was redefined as psychoneurosis by medical authorities such as Hence Fraser and Gibbon. This evolution in terminology reflects a broader shift in medical understanding and the authorities' awareness of the psychological consequences of war, which evolved throughout the course of the conflict.

During World War I, the medical system for Indian soldiers was designed to categorise patients for treatment, distinguishing between those fit for frontline duty after rehabilitation and those deemed unfit, who were either sent to convalescent homes or repatriated to India. These patients

were classified based on their recovery progress, with distinctions made between those considered 'ultimately fit' and those with 'light injuries' (Lawrence 1915).[3] However, the categorisation of mental health cases, particularly those suffering from shell shock, was marked by a significant lack of understanding. As a result, soldiers afflicted with PTSD were often neglected, with many not receiving adequate treatment or compensation, due to the British authorities' inability to properly diagnose and address mental health issues (Shephard 2000). Furthermore, even after PTSD was recognised, the medical system's approach appeared driven by a desire to minimise claims for medical benefits and pensions, a reflection of the military's primary concern with the return of soldiers to active service, rather than their psychological well-being.[4]

The initial definitions and treatment of shell shock were shaped by pragmatic concerns, as the British military sought to minimise institutional disruption. The diagnosis of shell shock was thus based on pragmatic criteria, which emphasised a soldier's ability to return to the front rather than the psychological condition itself (Leese 2000: 59).[5] Furthermore, many symptoms of shell shock, such as disobedience or fear-based reactions were interpreted as personal failings, such as cowardice or unsoldierly behaviour, rather than as the psychological consequences of warfare. The British authorities were keen to suppress any perceptions of shell shock as a widespread, debilitating condition, fearing it could undermine morale and provoke demoralisation (Leese 2000: 59). These misinterpretations of psychological trauma contributed to the tragic fates of soldiers suffering from PTSD.[6]

Racial bias further compounded the medical treatment of Indian soldiers (Buxton 2018).[7] Sir Evelyn Berkeley Howell, chief censor of private military correspondence, examined the letters of Indian soldiers and concluded that the psychological issues they expressed were

indicative of inherent ethnic or tribal traits (Buxton 2018). Howell's assertion reflected a racialised view, dismissing the possibility that Indian soldiers might suffer from the same psychological afflictions as their British counterparts (Howell 1916).[8] Sir Bruce Seton's subsequent report on self-inflicted injuries among Indian soldiers countered this claim. While Howell argued that these phenomena of self-infliction were caused due to inherent racial traits of the Indian Army, thereby explaining their apparent prevalence among Indian soldiers, the actual data revealed a different picture. According to the Seton's report, only 6 out of 1,000 cases involved self-inflicted injuries, indicating that such instances were rare. Moreover, this incidence rate was comparable to that observed among British soldiers. The report clearly disproved the baseless assumptions underlying Howell's conclusions (Seton, 1917).[9] Unfortunately, Seton's report was classified as 'Top Secret' and was not made available for public scrutiny in the colonies (Sehrawat 2009).

Despite this, the British authorities were eventually forced to acknowledge that Indian soldiers faced genuine psychological issues resulting from the trauma of war. However, the prevailing colonial mindset maintained that colonial subjects, such as Indian soldiers, were inherently incapable of suffering the same psychological consequences as the British. Montague David Eder, a medical officer in the Royal Army Medical Corps, espoused a racist and colonial view of psychoneurosis in his 1917 work *War-Shock: The Psycho-neuroses in War: Psychology and Treatment*. Eder argued that psychoneurosis occurred among individuals who were either 'intrinsically below the level of civilization' or 'morally ahead of their age' (Eder 1917).[10] This bifurcated explanation fit within the imperial framework and allowed the British authorities to maintain the racial hierarchy that underpinned their colonial rule.

The approach of medical officers during the war was primarily focussed on enabling soldiers to return to the battlefield as quickly as possible.[11] The role of medical officers, while ostensibly medical, was framed within the broader military context, where their duty was to restore soldiers to combat readiness. As a result, the psychological aspects of shell shock were often treated as secondary concerns (Shephard 2000). Contrary to the common belief that medical officers might prioritise the psychiatric symptoms of their patients, they were generally indifferent to psychological analysis (Leese 2002).

In the early stages of the war, shell shock was not officially recognised as a medical condition, and although some officials, such as Lawrence, attempted to raise awareness of its significance, their efforts were largely undermined by the authorities' ignorance and misguided policies. Unfortunately, their attempts to address the issue were largely unsuccessful (Lawrence 1915).

Treatment of PTSD

The process of understanding and treating shell shock during World War I was both complex and fraught with challenges. Treatment strategies for affected soldiers were characterised by a wide range of experimental approaches, as evidenced by reports such as the one from Kitchener Indian Hospital, which sheds light on the practices used to address mental health issues among Indian soldiers.

The riginal plan of relocating Indian soldiers was to move them from Marseilles to Egypt, and then from Egypt to India. This plan had to be modified since the French government refused to transport these Indian soldiers due to financial reasons. In addition to that, pre-existing trench hospitals in Rouen, one of the most humid and cold places in Northern France, were far from

being desirable in terms of treating these soldiers who already had suffered the cold weather and frostbites in the trenches. Hence the idea of establishing and fortifying Indian Hospitals in England inevitably emerged (Hewitt 1915). Considering the harsh environment of the trenches and convenience of transportation that was required to re-locate the patients from the trench hospitals in France, Indian Hospitals were supposed to be established in a relatively warm area of Britain. As a result, Brighton was considered the best place for establishing hospitals in this regard.

In January 1915, three Indian General Hospitals opened as the Kitchener Indian Hospital, each of them having nearly 600 beds.[12] It was recommended that 1,000 more beds be built on the adjacent ground of the racetrack in the region, either in huts or tents. In 1915, there were 1,200 patients admitted to the hospital. In order to demonstrate 'respect' for Indian culture, certain hospital amenities were separated in accordance with the basis of segregation. It should be noted that the term 'respect' was frequently used by British authority personnel not only to explain the intention of providing cultural and religious space for Indian soldiers, but also to justify the scheme of perpetual separation within the hospitals, if not the authorities were self-indoctrinated to believe that the separation was truly to show respect for Indian culture.

The British Empire's policies in military hospitals for Indian soldiers systematically institutionalised segregation based on religious and caste identities. This segregation was evident in various aspects of the hospital environment, including the provision of culturally appropriate facilities; allocation of minor resources such as utensils, water pipes and culinary staffs, and kitchen spaces divided along religious lines.

This segregationist approach was not confined solely to culinary operations but also permeated recreational and social spaces. The hospital featured two dining halls for patients able

to dine outside of the wards and a spacious recreation room, furnished in an oriental style and equipped with gramophones, newspapers, playing cards, chess, and other amusements. Notably, one section of the recreation room was reserved exclusively for Sikh patients, while a separate room was designated for Muslims. Undeniably, the system that deliberately blocks opportunities for seamless communication among people of varying castes and religions — ultimately breeding isolation — would have done little to help the mental recuperation of soldiers already suffering from the traumatic aftermath of brutal combat experiences. The authorities, clearly, were not attuned to the quiet, unspoken needs of the psyche, instead focussing their efforts on the tangible, visible structures — treating mental distress as if it were merely another part of the physical framework to be managed.

The hospital contained a designated lunatic asylum with two wards, each holding eight patients in padded cells, and a total capacity of only 20 patients (Seton 1916).[13] In an effort to prevent self-mutilation, the wards were equipped with reinforced walls, featuring thick wire gauze and special locks that allowed the doors to be opened by no more than four inches at the top and bottom. Although the report from Kitchener Indian Hospital often highlighted the quality of its facilities, there is insufficient evidence to determine whether such architectural measures had a tangible impact on decreasing the occurrence of self-mutilation. (Seton 1916).

The management of mental health cases at Kitchener Indian Hospital necessitated the implementation of basic treatment facilities, categorised under three distinct types of mental conditions: Traumatic, Acute Mental Disease and Obviously Low Mentality. The category of Traumatic was described as encompassing conditions resulting from head injuries, including mania and hysteria following severe trauma. Acute Mental Disease included diagnoses such as mania, melancholia and other forms of acute psychological distress. The category of Obviously

Low Mentality encompassed more severe and chronic conditions, including idiocy and chronic delusional insanity (Seton 1916). The manner in which J. B. de Winter Molony, a medical officer at the hospital, classified mental patients raises significant concerns, particularly given the later reclassification of hysteria as 'Not Yet Diagnosed (N.Y.D.)' to avoid the stigma of shell shock. Molony's classification also mirrors many of the symptoms associated with PTSD, particularly the categorisation of individuals as susceptible to psychological collapse from minor mental strains.

In terms of treatment, the prevailing approaches included exercise, fresh air and nutritious meals, although the expectation that pharmacological interventions would provide effective treatment was not realised (Seton 1916).[14] Alternative treatments, such as hot water baths and doses of calomel were administered, with a 20-grain dose considered effective for some cases (Seton 1916). However, the extent to which these treatments satisfied the needs of Indian soldiers remains unclear. Despite these varied therapeutic attempts, the final response to shell shock in the Indian context was notably influenced by institutional and administrative priorities, rather than by a comprehensive understanding of the psychological condition.

The report reveals that all mental cases were transferred to India when they recovered physically, not mentally, since the War Office believed that shell shock was contagious, spreading demoralisation. Given the severity of demoralisation, the office intended to repatriate Indian patients as quickly as feasible. As a result, a remedy to this problem was very quickly provided, albeit incorrectly diagnosed. Lawrence argues that returning Indian soldiers to India is a preferable alternative (Lawrence 1915). Rather than finishing their treatment for mental illnesses, the British authorities preferred to send Indian mental patients to India, tossing the responsibility to oversee the care to the provincial administration and the Indian government.

Treatment and Rehabilitation for Amputees

As the war intensified, the number of soldiers suffering from severe injuries, particularly amputations, increased significantly. Among these casualties, limbless soldiers were particularly problematic for the British authorities, as the visible presence of amputees, especially from colonised regions such as India, was perceived as a potential source of public unrest. Consequently, the introduction of artificial limbs emerged as a practical solution to address both the physical needs of the soldiers and the potential social implications of their disabilities.

The British authorities' plan included the creation of a major facility at Deolali, which would serve as a hub for the production of artificial limbs. This facility was to be staffed by a team of professional prosthetists, massage therapists and electrical technicians who would assist in the rehabilitation and fitting of prosthetic devices.[15] Limbless Indian soldiers were to be transported to Deolali once they were deemed physically fit for prosthetic installation.

The manual 'Artificial Limbs', written by French specialists Auguste Broca and Charles Ducroquet, provided a technical guide for the construction and fitting of prostheses. The book emphasised the use of wood as the primary material due to its durability and strength. However, Lawrence and Keogh's correspondence reveals that British medical officers of the Indian Medical Service (IMS) were sceptical about the efficacy of elaborate prosthetics.[16] Their views reflected a broader concern with cost-efficiency, prioritising basic functionality over the comfort and long-term well-being of limbless soldiers reintegrating into civilian life. The selection of prosthetic manufacturers involved a lengthy process, which included official exhibitions to ensure the quality of the products. One notable exhibition at Roehampton House in London highlighted the ongoing efforts to improve prosthetic devices while also serving as a fundraiser

for Queen Mary's Convalescent Auxiliary Hospitals. The high demand for prosthetic limbs during the war outpaced supply, causing delays that affected soldiers' welfare and raised concerns about British military image, as noted by Sir W. Watson Cheyne.[17] The Roehampton exhibition underscored the British authorities' focus on functionality over aesthetic considerations, largely due to the financial constraints imposed by the war effort.[18]

The introduction of artificial limbs made from advanced materials such as duralumin, a lightweight and durable metal, represented a significant innovation during World War I. The Desoutter limb, developed by aeronautical engineer Charles Desoutter, became one of the most popular prosthetics due to its superior construction. Desoutter's design, which replaced traditional wooden prostheses with metal ones, was based on modern engineering principles aimed at enhancing both comfort and functionality. While these limbs were available to British soldiers, they were largely inaccessible to Indian soldiers as Desoutter's company did not secure a contract with the Ministry of Pensions until 1921, by which time most Indian soldiers had already been repatriated to India (Baird 1924). Nevertheless, limbless Indian soldiers were typically provided with wooden prosthetics, which were often described as inadequate in terms of both functionality and comfort. As one Indian soldier lamented, 'They have given me a leg, but it is made of wood, and vile. I cannot walk… There is nothing left of me. I have lost a hand and a leg. What am I to do?' (Omissi 1999). This sentiment was echoed by many limbless soldiers who found the wooden limbs difficult to use, leading to widespread dissatisfaction.

A prosthetics programme was officially established by the British authorities in 1917, with amputees sent to Bombay for fittings and measurements. Specialised orthopaedic appliances were crafted and skill trainings were provided at the Cawnpore Hospital. The term 'invalided' was used by the British to describe these disabled soldiers, a label that reflected both their

physical and social status. Many limbless soldiers were sent back to India to undergo the prosthetic-fitting process and they received the artificial limbs, as shown in the table.

Table 1: Quantity of Artificial Limbs (Lawrence 1917)

Surgical Factory at Bombay

Total number of workmen in Factory 185

Artificial legs 190

Artificial arms 38

Artificial feet 16

Pin legs 3

Steel Support 4

Orthopaedic boots Surgical boots and Boots for flat feet Special boots 112 pairs

Pin legs of all kinds supplied to date 135

Orthopaedic Appliances for War hospital, Cawnpore.

Drop table with lever and straps for exercising wrist 1

Apparatus for exercising fingers 1

Weighted wheels on stand for exercising the shoulder joint 1

Adjustable crutch support 1

Apparatus roller with grip handles for exercising hand, left 1

Apparatus flexation and extension of elbow 1

Apparatus roller with grip handles for exercising hand, right 1

Apparatus for rotating ankle joint and foot 1

Apparatus for movement of elbow 1

Apparatus for movement of knee 1

Apparatus for wrist circumduction	1
Apparatus lever flap table for exercising and straightening knee	1
Apparatus large for exercising shoulders and arms	1

The most commonly requested prosthetics were artificial legs and arms.[19]

Lawrence was informed of the plans to establish an institute at Deolali where artificial limbs tailored to the Indian context would be provided. The IMS officers believed that the ideal prosthesis should be one that could withstand the harsh conditions of rural Indian life. To this end, a prosthetic limb manufacturer with a substantial customer base was invited to Deolali, and an experienced orthopaedic surgeon was dispatched to serve as a temporary consultant. Lawrence, reflecting the prevailing mindset, suggests that a cost-effective prosthetic solution capable of withstanding the rigors of village life would be the 'best arrangement' for the amputated Indian soldiers (Lawrence 1915). This decision reflects the British authorities' emphasis on durability and economy, which justified the provision of lower-grade prosthetics to Indian soldiers, often at the expense of functionality and comfort.

The authorities had a distinct view on the issue of rehabilitation. Lawrence proposes the assignment of combatant officers to oversee rehabilitation at the Convalescent Depot and advocates for the inclusion of drill and physical exercise in the rehabilitation programme. Although Lawrence acknowledges that the depot should be under the supervision of medical officers, his approach is rooted in a pragmatic, yet unsympathetic, military ethos. He believes that incorporating military training into the rehabilitation process would help amputated soldiers regain a semblance of functional normalcy, aligning with his broader view of soldiers' reintegration (Lawrence 1915).

While attempts to treat PTSD were hampered by ignorance and racial prejudice, the approach to treating amputees was similarly harsh, primarily driven by the British government's desire to minimise financial expenditure. Lawrence supports the establishment of a prosthetic manufacturing facility at Deolali[20] as it promises to reduce the costs associated with hospitals and rehabilitation in England. His endorsement is bolstered by the opinions of IMS officers, further cementing the decision to locate the institution in India (Lawrence 1915). This strategic choice reflects the broader colonial tendency to shift the responsibility for the care of wounded soldiers onto the colonial territory. The primary objective of providing artificial limbs was to enable amputees to resume daily activities with minimal difficulty. However, the types of daily tasks that could be performed post-amputation were necessarily different from those before the injury. This recognition prompted the British authorities to develop rehabilitation programmes at Convalescent Depots.

The British authorities adopted a rigid and utilitarian approach to the rehabilitation of amputated soldiers, often labelling them as ‘invalided’ or ‘useless’. There was a pervasive concern about the duration of treatment at Convalescent Homes, driven by the objective of minimising the financial burden on the British government. In line with this goal, Lawrence recommends that soldiers be transferred to Milford’s Reinforcing Depot after a brief period at the Convalescent Depot. He argues that three weeks is sufficient to assess whether a soldier is fit for frontline service, and thus soldiers should not remain in the Convalescent Home for longer than this period (Lawrence 1915).

While the official narrative from the British authorities emphasised physical recovery and the issue of returning patients, the soldiers’ personal letters reveal a far more complex reality. These letters suggest that the true struggles of the soldiers transcended the mere practical

concerns of prosthetic use, involving a profound process of redefining their self-identity and sense of purpose in the aftermath of their injuries.

Identity Struggle

Prior to experiencing PTSD or undergoing limb amputation, the identities of these individuals were predominantly defined by their professional roles as soldiers. This assertion is supported by numerous personal letters written by Indian soldiers, which reveal the centrality of their military identity in shaping their sense of self. The following letter serves as a compelling example, illustrating how deeply their professional roles were intertwined with their personal identity and perceived societal value. '…though we are a caste superior in many ways to others, we are inferior just because we are not soldiers' (Omissi 1999).[21]

The letter above exposes that they believed that their identity as soldiers granted them a superior position. Given that the sense of superiority was intrinsically tied to their identity as soldiers, it is reasonable to infer that the loss of the physical capacity required for their role would have had a profound psychological impact to these soldiers. The sentiment expressed in their letters sharply contrasted with the British authorities' perception of their situation. One soldier's letter poignantly illustrates this struggle:

…Alas! What am I to say about myself, that would be fit to write? There is nothing but my corps left. They have cut off the whole of one leg, and one hand too is useless. What is the use of my going to India thus? …They have given me a leg, but it is made of wood, and vile. I cannot walk. …There is nothing left of me. I have lost a hand and a leg. What am I to do (Omissi 1999)?[22]

This expression of despair highlights the emotional turmoil experienced by the soldiers, which was often disregarded or overlooked. The development of a post-injury self-identity was a critical issue for Indian soldiers, as their circumstances necessitated the redefinition of their purpose in life. As they were classified as 'invalided', they were required to relinquish the careers that had once sustained their lives and social standing.

The letter above vividly illustrates the soldier's despair resulting from the loss of his limbs. Similarly, other letters further underscore the psychological distress and mental anguish experienced by individuals who attained physical disability caused by amputation. These correspondences collectively highlight the pervasive emotional toll and psychological consequences of limb loss, offering a deeper understanding of a soldier's deteriorating mental state in the context of his physical and emotional suffering.

'There is nothing but my corpse left. They have cut off the whole of one leg, and one hand too is useless. What is the use of my going to India thus(Omissi 1999)?'[23]

In this instance, the soldier metaphorically refers to his own body as a 'corpse', symbolising the clear sense of dehumanisation and psychological detachment he feels due to his amputation. This grim portrayal of his body reflects the extent of his emotional and existential crisis, as he grapples with the perceived futility of his situation. Such a depiction not only shows his intense suffering but also suggests that the soldier's physical state has eroded his sense of purpose and hope, leading him to question the value of returning to India. This expression of despair reveals a deeper struggle with identity and the psychological toll of war, where the loss of bodily integrity fosters a sense of meaninglessness and disillusionment.

The letters of Indian soldiers, particularly those addressing limb amputation and PTSD, suggest insight into the psychological effects of war and the consequential fluctuation of their identities. Prior to their injuries, these soldiers were strongly identified with their roles as warriors, which not only provided them with a sense of societal value but also conferred a perceived superiority. This strong connection between their occupational identity and self-worth is evident in their writings, in which they express the belief that their military status elevated them above others. Unfortunately, following the loss of their physical abilities, the soldiers' sense of self was drastically destabilised. The emotional and psychological devastation conveyed in their letters highlights the struggles they faced in redefining their identities after losing not only their physical faculties but also the careers and societal standing that had once defined their existence. The despair, dehumanisation and existential crisis depicted in these personal accounts expose the severe mental anguish experienced by the soldiers as they grappled with the aftermath of war.

Conclusion

This research seeks to capture the notion that the identity of soldiers in the colonial military forces of empires is challenged through the lens of 'disability'. Unlike civilians, injuries and disabilities among soldiers who have participated in warfare possess a distinct predictability. The analysis focusses on the paradoxical situation where the identity of soldiers, as members of instrumentalised institutions critical to the maintenance of the empire during the colonial period, is contested by the experience of disability arising from the war efforts central to the existence of these institutions.

The psychological and physical consequences of war for Indian soldiers during World War I are deeply intertwined. The aftermath of battle failed to guarantee the restoration of peace for these individuals. Despite being removed from the frontlines, soldiers continued to suffer from enduring scars such as PTSD and amputations, compounded by inadequate medical care and racial prejudice. These conditions reflect the harsh realities of the British colonial military system, which was ill-equipped to address the psychological trauma experienced by Indian soldiers.

The British authorities' treatment of PTSD and amputations reveals a stark indifference to the psychological and emotional needs of soldiers, driven largely by pragmatic concerns about maintaining military readiness. The misclassification and stigmatisation of shell shock alongside inadequate prosthetic care further highlight the neglect faced by these soldiers. Identity crises and a sense of dehumanisation were often overlooked, particularly when these soldiers were returned to India without adequate support or treatment.

Recognising the full extent of disabilities faced by Indian soldiers, both during wartime and in the aftermath, is crucial as the relationship between soldiers' identity and experiences of disability underscores the intricate dynamics of personal, social and cultural constructs associated with colonial military service. For many individuals in military contexts, their identity is intrinsically tied to ideals of strength, resilience and duty. Overall, the onset of physical or psychological disabilities, yet challenges these foundational aspects of self-concept, often precipitating internal conflicts, social exclusion or the redefinition of identity.

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[1] The term *izzat*, a significant and widely recognised concept in the Indian military tradition, is often translated as honour, reputation or prestige. This notion has historically served as a powerful impetus, inspiring Indian men to voluntarily enlist as soldiers and display remarkable valour on the battlefield. For these individuals, the role of a soldier and the opportunity to fight alongside their comrades represented the pinnacle of honour and a deeply esteemed achievement in their lives. Martial race theory has been the core of military recruitment system during the colonial era. Certain groups the British believed had superior fighting qualities. These groups included communities such as Punjabi Muslims, Sikhs, Pathans, Rajputs, Dogra and many other communities mainly based on North-West frontier of India.

[2] Here the term 'PTSD' and 'shell shock' are used as interchangeable synonym. Officially, the term 'PTSD' came into use during 1970s as an after-effect of veterans attained from the Vietnam War. There can be a question of whether it is appropriate to apply the notion of PTSD to the era when the term was non-existent. Nevertheless, the term PTSD and shell shock are used as interchangeable synonyms following the definition of the American Heritage Medical Dictionary. The American Heritage® Medical Dictionary Copyright © 2007. 'Post Traumatic Stress Disorder Resulting from Wartime Combat or Similar Situations, Especially as Experienced by Combatants in World War1', Boston: Houghton Mifflin Company.

[3] To understand the diagnosis and treatment of mental patients, it is important to examine the medical system for Indian soldiers during World War I, where there was an awareness of the need to categorize patients based on their conditions, as reflected in a letter to Lawrence. The patients who were sent to the Convalescent Home could be categorised into two groups; one was considered by the Medical Boards as 'fit for the Lines of Communication' or the 'Front' after undergoing massage or other treatment at the Convalescent Home. The other group was cases of invalided Indian soldiers, but who were not classed as 'Cot Cases'. These relatively minor case patients with light wounds were sent to the Convalescent Home to await transferring for India and thus resting in hospital. The Indian soldiers who were having serious physical injury were staying in the Hospital. The patients who were sent to the Convalescent Home again were divided into two groups; 'ultimately fit' and 'lightly injured'.

[4] Whatever the disease or symptom was, ideal methods of treatment meant not only effective but also short treatment to make patients go back to their original position as soon as possible, and that position was nowhere but trench. The shell shock was perceived by the Government and the Army within this context during the whole period of the war.

[5] Ibid.

[6] Regarding these tormenting circumstances caused and deteriorated by misconception of shell shock, Lees is giving an example of distressing scenes that one sergeant had to undergo. After surviving heavy shelling in March 1915, Sergeant C. moved to another position and was knocked to the ground by an explosion nearby, which he later recovered from. After being discharged from the army, he was admitted to C.S. Myers' shell shock wards at Boulogne, where he was diagnosed with 'nervous debility'. After going through these harrowing ordeals, he was ordered to report back to the frontlines.

[7] Even in 1930, in the meeting held by Royal Medico Psychological Association, the statement claiming shell shock was non-existent could meet still concurrence by Major J.E. Dhunjibhoy from the Indian Medical Service.

[8] Indian army soldiers' sacrifice has been often unnoticed because of many reasons such as relatively less number of fatalities, or from the non-Caucasian colony, yet when it comes to the each participated soldier's realities of the war, they were as painful as of any other soldiers participated in the war. Frequent death of Indian comrades was another factor to create impact on Indian soldiers' mental health. The despair of Indian soldiers caused by brutal circumstances is described in details with their forthright tones of their letters. One of the letters was written by the soldier who had lost many of his comrades including the officer who was in charge of his troops. According to the letter, his regiment was almost exterminated except for 40 men. Other extreme case he gave number was 4 survivors in one regiment. The letter ended with his despairing comment. 'In one hour 10,000 men are killed. What more can I write?' Howell's approach eventually failed since the contents of the letters were based on the experience of the regiment, not the community of the soldiers. His direction of approach was unable to fulfill his expectation based on colonial intention. As a result, he came to apply stereotypes created by another type of racial bias such as deception, disloyalty, cowardice, and the result of flattened iniquities, self-infliction and malingering.

[9] For example, injuries which can impact the patients' lives, civilian lives were considered unintentional wounds. Injury on inaccessible area was also exempted for its infeasibility. As a result, patients who had wounds on head, face, neck, chest, abdomen, perineum, and back were eliminated from suspicion. Patients who injured through bayonet, trench falls and gassing were removed from the list. Only six soldiers were self-injured amongst 1,000 patients.

[10] Clearly, he indicated the latter as British patients while the former one was to refer Indian patients. He argued that 'conscious and unconscious selves' of those people who are 'ethically in advance of their age' are always at odds with one another. As a result of these internal conflicts, the patients tend to face instability of equilibrium.

[11] Even during the aftermath, Medical officers showed the tendency of minimising this issue as it was a concern from the department of pension; financial burden that government had to bear.

[12] The place was originally the buildings of Brighton Poor Law Institution developed from Elm Grove Workhouse, established for the purpose of providing accommodation and employment for the poor.

[13] Clearly, there were more than 20 mental patients amongst the Indian soldiers at the front.

[14] Mahsud, one of the patients, was given Bromide for four weeks at daily doses of 90 grains, but his symptoms rarely improved much.

[15] There was a transit camp in Deolali, a city in Maharashtra, for British Army soldiers and officers who were awaiting postings in other camps in India or returning to the United Kingdom. During the First World War, the area was used for the war prisoners captured from Eastern Front. Lawrence may have chosen the location as a manufacturing base partly because of its advantages, including its proximity to the port of Bombay and the fact that it had previously served as an army camp, both of which were familiar to Indian patients.

[16] Lieutenant-General Sir Alfred Henry Keogh was the Director-General of Army Medical Services during the First World War. He played a critical role in the development of systems to treat wounded soldiers, including advancements in surgery, rehabilitation and dealing with psychological trauma, such as shell shock.

[17] Surgeon-General M. W. Russell, Deputy Director-General A.M.S. stated that the conference's objective was to bring the artificial limb industry's current state into focus. The supply of prosthetic limbs during wartime was substantially different from the supply during peacetime since the issue to be explored was how the increase in demand could be met by an equal increase in supply. A resolution was passed requesting that the orthopaedic surgeons prepare a report recommending the most appropriate wooden limbs for various amputations.

[18] The result of the exhibition shows the definition of the ideal quality that the British authorities tentatively defined in terms of the artificial limbs. Considering the tone of the speech for the exhibition, it would be legitimate assumption to guess the standard of selection was very much focussed on the basic function of the prosthesis mainly due to financial reason. According to the result of the exhibition, the gold medal was presented to the J. F. Rowley Company from Chicago, whose exhibit featured a leg that was so versatile that its wearer could run upstairs and downstairs, as well as dance and jump. Mr. W.R Grossmith of London was given the silver medal in the same class, It was intended to award additional gold and silver medals for demonstrations of systems that best met the soldier's needs, taking cost into account.

[19] Official records may significantly underreport the number of limbless soldiers, as they fail to account for cases of multiple disabilities. This underreporting is evidenced by personal accounts, such as the letters from Rajwali Khan, which mention soldiers who had lost more than one limb. "There is nothing left of me. I have lost a hand and a leg. What am I to do?" Rajwali Khan to Ghulam Hussain, Kitchener's Indian Hospital, 1915 extracted from David Omissi. 1999. *Indian Voices of the Great War: Soldiers' Letters, 1914–18,* UK: Palgrave Macmillan.

[20] Although Deolali was selected as a place for manufacturing artificial limbs, specialised centre for providing prosthesis and rehabilitation programme for the limbless soldiers was introduced in 1944, the end stage of the World War II, in Pune, as the Artificial Limb Centre. The centre was aiming to provide prosthesis and rehabilitation programme for the limbless soldiers came back from the war. This means that appropriate and specialised care for limbless soldiers was systematised much later than when the need for it first arose. Although the centre was initially built in Pune, it was re-located to Kirkee in 1945 and again to Lahore in 1946. The centre was moved back to Pune in 1947 due to the partition and started re-operating with the motto, 'No wheelchairs. No crutches'.

[21] Letter from Jemadar Sultan Khan (Punjabi Muslim, 34) to Malik Fateh Mahomed Khan (Shahpur District, Punjab), France, 5 June 1917 extracted from David Omissi, 1999, *Indian Voices of the Great War: Soldiers' Letters, 1914–18*, UK: Palgrave Macmillan.

[22] Rajwali Khan (Punjabi Muslim or Pathan) to Ghulam Hussain (59th Rifles, France) Kitchener's Indian Hospital 1915, extracted from David Omissi, 1999, *Indian Voices of the Great War: Soldiers' Letters, 1914–18*, UK: Palgrave Macmillan.

[23] Rifleman Amar Singh Rawat (Garhwal Rifles) to Dayaram lhapaUyal (Garhwal District, UP)
Kitchener's Indian Hospital 1915, extracted from David Omissi, 1999, *Indian Voices of the Great War: Soldiers' Letters, 1914–18*, UK: Palgrave Macmillan.