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International Perspectives, 1840–2010

Edited by
Angela McCarthy
and Catharine Coleborne

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Angela McCarthy and Catharine Coleborne

1 Introduction

Mental Health, Migration, and Ethnicity

Angela McCarthy and Catharine Coleborne

Until fairly recently, international scholars working in the field of the histories of mental health have privileged national episodes and sites in the histories of institutions and institutional confinement, particularly through the eighteenth- and nineteenth-century eras, with some work focused on the twentieth century.[1] 'Mental health' has been defined largely through institutional confinement because of the large number of accessible archival materials relating to the nineteenth century, with historians focused on studies of single institutions, often plotting demographic patterns of confinement for hospitals, as well as assessing their place in the wider contexts of mental health policy and changes over time. Several volumes of collected essays examine national contexts for mental health, including studies of Canada, Australia, Wales, and Britain more widely.[2] Another wave of edited volumes locates the study of institutional confinement as a global phenomenon, with studies of international perspectives on the worldwide trends for mental health hospitalisation, studies of European approaches to psychiatric treatment inside institutions, a volume which considers the way psychiatry was bound up with practices of 'empire', and most recently, a volume which situates the study of institutional mental health inside the approaches of transnational and comparative histories of psychiatry.[3]

Yet despite the new and developing attention to looking *across* sites at similar and divergent practices and at shared knowledges of mental health, the subject of migration has received far less specific attention than these other strands of inquiry outlined above. There have been exceptions, specifically those contributed by American historians and studies. Richard W. Fox, for instance, used a sample of 1,229 case histories in his book *So Far Disordered in Mind: Insanity in California, 1870–1930* (1979) to identify, inter alia, the social backgrounds and behaviour of the insane. His methodology and analysis are therefore important to us, particularly his stress on age as a factor in explaining the over-representation of the foreign-born among the insane.[4] In this sense he reiterates Benjamin Malzberg's identification of age as an important component when examining asylum admissions.[5] Gerald N. Grob, meanwhile, made some of the most important critical interventions in the American literature between the 1960s

and 1980s. His work in *Mental Illness and American Society, 1875–1940* (1983) explores issues of hostility and fear towards new immigrants and minority ethnic groups in the period he investigated. In an earlier work, *The State and the Mentally Ill* (1966) which focused on a Massachusetts hospital, incorporation of foreign-born inmates, including the Irish, formed part of his analysis of patient populations.[6] Yet inside existing studies of Britain, and the white settler colonies we include—Canada, Australia, New Zealand, and Fiji, as well as numerous studies of India—immigrants themselves mostly appear in the discussion as subject to colonial economies, or as 'at risk' populations because they allegedly lacked familial networks and were often among the very poor. The social and geographical origins of patients at specific institutions also receive some attention, as does their ethnicity, an important aspect of this volume, as we discuss below.

We argue, then, building on the range of ways that the histories of mental health has been represented, that migration ought to be considered as a particular focus of a new generation of inquiries into mental health and institutional confinement. Here, we place special emphasis on a few themes emerging from recent collaborative research, including the relationship between mental health and migration itself; the analytical category of ethnicity inside institutional populations, including questions surrounding ethnicity and institutional confinement; and the significance of the migration of intellectual ideas and trends in psychiatry, as well as personnel. Overall, we elaborate on the ways that contributors to this volume tackle these various themes, as well as others, using a variety of tested and new approaches to the analysis of their sources.

In this way we contribute more broadly to the field of migration studies, in which many analyses focus on successful migrants and their contributions to new societies, or emphasise the discrimination and prejudice migrants encountered. More recent investigations draw on concepts such as transnationalism and networking to highlight the ties between the homeland and the respective diasporas.[7] A further key aspect of the extant historiography is a focus on individual migrant groups, with explicit comparative investigation rarely undertaken.[8] Several works encompass diverse 'types' of migrants including settlers, entrepreneurs, soldiers, women, juveniles, and appropriate to this volume, medical personnel. Such individuals were among a vast outpouring of around 60 million people leaving central and western Europe for overseas shores during an era of mass migration between 1815 and 1930. Among the largest flows were 11.4 million from Britain, 9.9 million from Italy, 7.3 million from Ireland, and 5.0 million from Austria-Hungary.[9] In addition, beyond a focus on human mobility, the migration of ideas is also increasingly examined by historians.[10]

But what do we know about those who struggled with their relocation abroad? Previous investigations of the relationship between migration and mental health predominantly appear in the work of epidemiologists, transcultural psychiatrists, and social scientists, but with a particular focus

on the twentieth century. Malzberg, for instance, examined first admissions to mental hospitals in New York State. He found that although the rates of foreign-born admissions varied according to how long they had been in the country (with the most recent arrivals more likely to be institutionalised), high rates of first admissions among the foreign born compared to native born were skewed by scholars by failing to account for age discrepancies.[11] Transcultural psychiatrists Roland Littlewood and Maurice Lipsedge are sceptical about the stresses generated immediately after migration, claiming that strains may be greatest some years after relocation when 'new life in the adopted country has fallen short of expectations'.[12] In this volume, Angela McCarthy considers this issue among a sample of New Zealand's foreign-born patients in Dunedin's public asylums, and similarly finds that migrants were more likely to be admitted several years after settlement.

McCarthy therefore makes an important contribution, for studies of nineteenth-century migration and mental health are somewhat fleeting. From a Canadian perspective, David Wright and colleagues suggest that migration is often downplayed as a factor in asylum committals, despite migrants being suspected of mental illness because of their strange appearance, habits, lack of language skills, and lack of kin resources.[13] The applicability of these findings to diverse ethnic groups in distinct locations remains to be seen, recent research having demonstrated the movement of Irish migrants, especially, in robust networks of family and friends.[14] Other studies of migration typically focus on internal movement, particularly from rural to urban areas. Andrew Scull and John Walton, for instance, perceive a link between long-distance migration and committal.[15] Still other scholars refute any correlation between long-distance migration and admission to the asylum.[16] More recently, Joseph Melling and Bill Forsythe, in their study of the Devon Asylum, suggest that more settled individuals were increasingly likely to be admitted to asylums than recent migrants or migrants with sustained mobility.[17] In this volume, Jacqueline Leckie points to those indigenous Fijians classified as insane who had been 'wanderers' outside their villages and become destitute, not only in a material sense but also in a social sense.[18] Akihito Suzuki also engages with this theme in his study of psychiatric hospitals in Japan. In particular, he focuses on the urban-rural 'loop', encompassing young migrants sent back to cities where they became disabled and unable to work and support themselves, before returning again to the households of their parents or relatives in native countryside villages. In this way, he incorporates the striking differences between institutional provision in urban areas and the care provided in rural households.

Yet as McCarthy indicates in this volume, the migration process does not necessarily result in asylum admission, for not all migrants were institutionalised. Nevertheless, examination of case book records and official asylum and immigration documents reveals an acknowledgement by patients, their family and friends, and medical authorities that anxieties relating to

the migration process could result in institutionalisation. McCarthy's work also draws attention to areas of analysis little studied among migration and madness including the role of the voyage and migration pathways. The voyage also appears in Leckie's study of Indian indentured migrants bound for Fiji in the later nineteenth century. There, she argues, migrants of all backgrounds were displaced due to physical dislocation and 'profound shifts in their cultural worlds', resulting in institutional confinement, repatriation, or suicide.

Movement from overseas destinations to new countries is not, however, the only process of migration that scholars of mental health have explored. The subjects of return migration and repatriation are also noteworthy. Littlewood and Lipsedge queried whether mentally ill migrants were encouraged to voluntarily return home 'in the belief that the illness is caused by the stresses of migration and that the patient will recover back in his original country'.[19] Return migration remains under-examined in this volume and in migration studies as a whole,[20] although Leckie points to the repatriation of the insane from Fiji, and McCarthy highlights briefly the critical role of family and friends as instrumental in the relocation of patients from New Zealand.

While some migrants experienced mental health issues in their new homelands, other migrants were employed as psychiatric staff to care for patients.[21] These psychiatric workers were among a range of medical personnel migrating globally to provide general health care. A particular contingent of workers, 200 'suitable girls' assisted from Britain in 1946, is the focus of Kate Prebble and Gabrielle Fortune's chapter. Situating their analysis within a framework that incorporates immigration policy, the professionalization of nursing, and domesticity, Prebble and Fortune contend that unqualified women with no previous history of employment in the psychiatric sector were best suited to psychiatric work.

Male superintendents in the nineteenth century feature in Elspeth Knewstubb's analysis of Ashburn Hall, New Zealand's only private lunatic asylum. As Knewstubb argues, these men were products of their time both culturally and intellectually, with a range of cultural, social, educational, and employment attitudes and influences at play in their diagnoses, treatment, and general comments about patients. In this sense, Knewstubb's work focuses on the migration of ideas, arguing that rather than an assumed movement of ideas from England to New Zealand, a range of international influences were present, particularly French and Scottish. The doctors' intellectual influences are further nuanced by the mobility of ideas in medical circles through publications and correspondence between practitioners. In this way Knewstubb adds to the work on the circulation of medical theory, as evident in Crowther and Dupree's exploration of the global dissemination of Joseph Lister's theories and insights about antiseptics.[22]

The mobility of ideas is also covered by Maree Dawson in her study of diagnoses made at the Auckland Asylum in New Zealand. Drawing on case

books, medical journals, text books, and government reports, she considers whether there was an Empire-wide conception of identifying congenital idiocy and how these ideas were disseminated through the 'organs' of the profession. Dawson's study points to the diagnosis of congenital idiocy which legitimised fears of racial degeneracy and the inherited nature of mental disease across the British Empire, particularly in 'white settler' colonies. As Dawson indicates, however, differences in localised social concerns are reflected in diverse ideas about congenital idiocy and various ways of treating the condition, in a medical sense. But concerns about a 'degenerate residuum' were part of wider discussions of national efficiency which permeated the British Empire.

ETHNICITY AND MENTAL HEALTH

Indeed, the concept of 'race' or biological difference rather than 'ethnicity' has featured more readily in studies of asylums to date. This has emerged from a focus on colonial medicine and psychiatry in the past decade of studies of institutional confinement.[23] Sloan Mahone and Megan Vaughan argue that settler colonies, in particular, developed complex systems and discourses of racial difference.[24] Harriet Deacon indicates that Robben Island was established in 1846 as the earliest separate institution for the insane at the Cape, and that racist ideology and socio-economic and political conditions outside the asylum influenced racial segregation within the asylum's walls.[25] Meanwhile, in India, Waltraud Ernst highlights the existence of separate asylums for Europeans and Indians (and lower class Eurasians). She also points to further ethnic differences including asylum labour where work was seen as detrimental to Europeans but not to other patients, as well as the language applied to European patients being less derogatory than other patients.[26] Ernst fails, however, to differentiate the ethnic distinctions of India's European population. In her contribution to this volume and in her prior work on the St. Giles Asylum in Fiji, Leckie similarly elides the diverse ethnic backgrounds of European patients. She does, however, reveal various distinctions between Europeans and other ethnic groups including separate wards and superior conditions for European patients. As with Ernst, she also indicates work divides with Indo Fijians termed 'malingering' if they refused to work, whereas truculent European workers were considered of 'unsound mind'.[27] Beyond these approaches, Leckie identifies behaviours considered inappropriate among Indians, including women not customarily clothed and displays of dirty habits.[28]

Other histories of colonial psychiatry in settler colonies consider race and ethnicity by including studies of indigenous patients, rather than focusing on the vast influx of foreign-born newcomers in the nineteenth century. Robert Menzies and Ted Palys provide a rich account of Aboriginal patients in British Columbia from 1879 to 1950, arguing that mental health

institutions formed a 'complex' in which indigenous peoples became caught and confined, and in the process, defined as recipients of state care in the racialising discourses of the period.[29] Following them, in her study of Māori patients in the Auckland Asylum, Lorelle Barry locates all Māori patients institutionalised to 1900, showing how they too were subject to colonial discourses about racial difference.[30]

Some scholars, however, examine specific ethnic groups, and the Irish are striking in this regard, primarily because of their high rates of committal at home and abroad. In her contribution to this volume, Elizabeth Malcolm examines Ireland and its diaspora, surveying a wide range of explanations spanning the nineteenth and twentieth centuries to account for the disproportionate institutionalisation of the Irish. Although no definitive answer emerges, she states that the ethnicity of the Irish generated stereotyping and discrimination that may have contributed to their marginalisation. Whether, as Littlewood and Lipsedge contend, 'each ethnic group seems to have its own characteristic pattern of difficulties', such as high rates of alcoholism among the Irish (and Scots) compared with other ethnicities, is uncertain.[31] Further sustained comparative study may, however, clarify this uncertainty. Indeed, David Wright and Tom Themeles examine committals to Canadian mental hospitals in the mid to late nineteenth century and while acknowledging an Irish and Scottish over-representation, they argue that this declines over time and also differs from asylum admissions in the homelands.

By contrast with studies of patient populations, most studies of ethnicity and ethnic identities in relation to institutional confinement rarely engage with the practices or relationships of ethnicity. This is in stark contrast to the wider migration literature on ethnicity which incorporates the existence and continuity of visible signs of ethnic affiliation;[32] formal associations, networks, and communities;[33] and cultural essences. Such approaches also incorporate 'outsider' perceptions of ethnic groups as well as self-identification.[34] Within studies of madness, however, some exceptions exist including Leonard Smith's investigation of Jewish patients in the mid-Victorian asylum where 'the most direct religious or cultural dilemma they faced was in relation to food'.[35] McCarthy, meanwhile, identifies the significance of ties to place of origin, language and accent, and cross-cultural relations.[36] She likewise argues for the importance of comparing ethnicities, revealing that in a New Zealand context, at least, most ethnic groups except the English-born received some discussion of their ethnic identities.[37] In her contribution to this volume, Catharine Coleborne draws on the patient case notes of the Yarra Bend Hospital for the Insane in Victoria, Australia, from 1873 to 1910, to argue that medical and social perceptions of ethnicity generated new questions about colonial identity, susceptibility to mental disease, and racial hybridity. Building on McCarthy's work about ethnicity, Coleborne suggests that reinterpreting the archival productions around insanity, through case

books and clinical notes about patients, historians might find meanings about ethnicity and identity that were being produced at a high point of anxiety about immigration and population in the colonial setting.

THIS COLLECTION

This volume, then, blends themes that have individually but not collectively received attention. It examines the difficulties that migrants underwent in adjustment abroad through a focus on migrants and mobile peoples, issues of ethnicity and ethnic differences, and the impact of migration on the mental health of refugees. By incorporating a study of the experiences of current refugee groups along with studies of nineteenth-century 'stressful migration', the volume enables readers to consider patterns of similarities and difference over time. It also extends the migration paradigm beyond patients to incorporate the international exchange of medical ideas and institutional practices, and the recruitment of a medical workforce. The volume's global focus also reflects the variety of destinations to which migrants, medical personnel, and ideas gravitated in the nineteenth and twentieth centuries. We suggest that this volume provides a set of rich findings which will also be available to other researchers in the global setting, and even pave the way for more international studies of migration, ethnicity, and insanity.

Certain gaps still exist. A sole focus on the United States is absent in this volume, but discussion of the Irish experience there appears in Malcolm's comparative examination of the Irish and mental health. Future research in the field should examine the experience in the United States which differed from many colonies with its longer history of settlement, greater degree of urbanisation, and more highly developed mental health care. In addition, we are conscious that many studies utilising patient records from asylums end around the turn of the century due to privacy restrictions imposed by legislation shaping the governance of state and national archives. Whether archival access in the future enables further contributions to the issues raised in this volume, or generates new areas of enquiry, remains to be seen. Acknowledging that ethnicity incorporates the multigenerational descent group, we are also conscious that the main focus of this volume is on the foreign-born generation of migrants. Whether the children of mixed parentage in many colonies were discriminated against and experienced increased admission to asylums as Eurasians did in India is as yet unknown. Alternatively, it may be that India's practice of repatriating insane Europeans explains this increase among those of mixed descent.[38]

In adopting a focus on migration and ethnicity, we are aware not to make exaggerated claims about these issues in connection with mental health. Similar concerns arose with a focus on women and mental health which overlooked the similar experiences men had in psychiatric care. Indeed, gender (and class) identities, or representations of these, have been singled

out by historians of the asylum for a number of reasons including the influence of Marxist histories and feminist histories from the 1970s and 1980s.[39] Crucially, patients were among those rescued by historians of medicine as part of this shift from the study of doctors to patients with asylum case books recording partial biographies of people otherwise hidden from history.[40] Similarly, the families of the insane have received new attention which to some extent obscures the nature of institutional power and the regime of the institution itself, as scholars have been quick to point out.[41] Nonetheless, all of these areas have opened the door to exciting ways of reading the vast archival sources in the field of the histories of psychiatry.

SOURCES AND METHODS

As numerous scholars indicate, the use of asylum case books has enriched studies of the asylum.[42] Many contributors to this volume analyse asylum case books and admission registers in both a qualitative and quantitative fashion. Wright and Themeles, for instance, draw on a database compiled from the admission registers of more than 12,000 patients admitted to four Canadian mental hospitals to show elevated rates of Irish admissions. McCarthy, meanwhile, makes quantitative and qualitative use of the case books compiled by medical officials at the Dunedin and Seacliff asylums in New Zealand, supplemented by case books from Scotland. These are used in conjunction with official immigration records and asylum reports. In tracing the earlier admissions of migrants and their family members, McCarthy points to the importance of considering prior experience as well as migration and settlement as factors for committal.

A reinterpretation of patient case records to locate different forms of the representation of ethnicity is advocated by Catharine Coleborne in her chapter. If patients, or 'those deemed to be "foreigners" in the world of reason', were also literally from elsewhere, their ethnicity compounded feelings of dislocation.[43] Extracts from patient case notes from the Yarra Bend Hospital for the Insane between 1873 and 1910 infuse Coleborne's reflections on understanding the institutional production of colonial identities, covering such themes as birthplace and origins, bodies and behaviours, sound, language, gestures and expressions. Drawing also on annual reports from the Immigrants Aid Society, Coleborne discusses those transferred to Yarra Bend from the Immigrants' Home in Melbourne. Colonial society was being shaped through understandings of class, gender, and ethnicity, and institutions like Yarra Bend helped to produce these categories in their records.

Patient records also feature in Leckie's study of colonial Fiji with a particular focus on *Girmitiyas* (Indian indentured workers). Like McCarthy she follows the *Girmitiyas*' journey to Fiji, as well as disembarkment and indenture to explore the link between migration, mental illness, and suicide. Akihito Suzuki, in his study of rural and urban systems of care in

Japan, similarly draws on case notes to examine in detail four individual experiences which reveal a mixed economy of psychiatric care encompassing urban and rural areas, and formal and informal care. Suzuki also examines in detail legislative requirements to reveal the development in Japan of two very distinct patterns of psychiatric care in urban and rural areas. The Confinement Act of 1900 in particular resulted in the creation of nine psychiatric hospitals between 1899 and 1910 (two had existed prior to the act).

Comparing case notes with other sources is a feature of Dawson's examination of medical ideas at the Auckland Asylum. She uses key medical journals such as the *British Medical Journal* and the *New Zealand Medical Journal*, as well as the migration of medical personnel, to examine the flow of medical ideas about degeneracy and heredity from Britain to Auckland. By comparing the content of these medical journals with the case notes of patients at Auckland, Dawson shows that degeneration and 'family and vice' were commonly cited both in medical journals and case notes at Auckland.

The interaction between case notes and other sources continues with Knewstubb's exploration of medical doctors at Ashburn Hall in Dunedin. Taking a biographical approach, Knewstubb examines the ways in which medical education, travel, asylum employment, journal reading, and international networks all contributed to doctors' medical knowledge. She moves beyond these influences, though, to also consider the ways in which bourgeois cultural standards shaped doctors' judgements of patients with a particular focus on gender, ethnic, and religious differences apparent from case notes.

If most studies of nineteenth-century mental health rely on archival and documentary sources such as patient records, the exploration of such issues from the mid-twentieth century benefit from oral interviews. A somewhat under-utilised tool in histories of mental health, this is an approach showcased in Prebble and Fortune's study of British women who were recruited to New Zealand to work in mental hospitals after World War II. Interestingly, their interviews reveal a convergence with the examination of official documents and contemporary correspondence. Prebble and Fortune also situate their analysis within two main discourses: the professionalisation of psychiatric nursing, and the ideology of domesticity.

Interviews with refugee migrants experiencing mental health issues feature in Lynne Briggs's exploration of refugee settlement in New Zealand. All told, 100 interviews were conducted to explore the concept of 'demoralisation'. Briggs reveals that women were more likely than men to be depressed and feel hopeless and demoralised. Incorporating two case studies with female refugees, Briggs highlights the importance of incorporating pre-migration, migration, and post-migration experiences. Her contribution also highlights the policy implications of such research for providing clinical care to refugees.

An overarching synthetic approach drawing on statistics and secondary literature characterises Malcolm's survey of Irish institutionalisation, demonstrating their over-representation in asylums, both as a percentage among the foreign-born as well as among the total population. Although future work needs to adjust such statistics for age and gender variations, it is likely that the Irish-born will still be over-represented among asylum admissions as they were in Malzberg's study of New York State mental hospitals in the mid-twentieth century.[44] Malcolm advances beyond statistics, however, to reflect on the multitude of explanations put forward to explain Irish asylum admissions offered by lunacy inspectors in Ireland, historians, anthropologists, sociologists, and psychiatrists.

SIMILARITIES AND DIFFERENCES

Finally, read as a whole, this volume addresses questions of comparisons—across both time and place—and of contrasts between the various geographical and cultural sites of mental health treatment under examination. We began this introduction by asserting that most studies of mental health focus on institutional sites and records, and with some exceptions, this book is no different. However, the differences between institutional settings also remind us of psychiatry's own global histories, as well as the limits of its mobility. For example, modes of institutional care in Japan and those in the colonial settings here, including Fiji, Australia, New Zealand, and Ontario (Canada) differed in critical ways. Institutional care was privileged over familial care, despite attempts in colonial settings to modify this emphasis over time.[45]

The discussion of psychiatry's mobility as a discourse is raised in several chapters. Malcolm ranges over the Irish diasporic communities which extended to the United States, Australia, and beyond. Wright and Thelmes also challenge the tendency to focus on single sites through their analysis of four institutional sites in Ontario, deepening knowledge about the Irish and Scottish as populations supposedly more subject to institutional controls. McCarthy similarly finds evidence of a global history of insanity in her contribution to the discussion about how migration scholars might use asylums and patterns of mental illness over time to examine the wider world of migrations and the experiences of immigrants. In a different vein, Knewstubb and Dawson both explore the discourses of doctors and their own mobility through medical biographies and travelling ideas; the use of medical journals to investigate the global discourse of psychiatry is important to emerging studies which move between sites of institutions and medical personnel. Likewise, Prebble and Fortune show how in the twentieth century, personnel and ideas in this field of psychiatric practice kept travelling, part of global migration work patterns and trends which extended from old worlds to new.