Mental Health in Historical Perspective

Migration and Mental Health

Past and Present

Edited by
Marjory Harper

Mental Health in Historical Perspective

Series Editors

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Department of History
The University of Waikato
Hamilton, New Zealand

Matthew Smith
History of Psychiatry
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Marjory Harper
Editor

Migration and Mental Health

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Editor
Marjory Harper
School of Divinity, History and Philosophy
University of Aberdeen
Aberdeen, UK

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In memory of Dr Andrew McKie (1957–2013)
Lecturer in Mental Health, The Robert Gordon University, Aberdeen

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Notes on the Contributors

Arnar Árnason is Senior Lecturer in Social Anthropology at the University of Aberdeen.

Marilyn Barber is Adjunct Research Professor in the Department of History at Carleton University, Ottawa.

Juliet Cheetham is Professor and former Director of the Social Work Research Centre at the University of Stirling, and a former probation officer and later Social Work Commissioner with the Mental Welfare Commission for Scotland.

Lisa Chilton is Associate Professor of History at the University of Prince Edward Island.

Waltraud Ernst is Professor in the History of Medicine at Oxford Brookes University and Adjunct Professor at St John's National Academy of Health Sciences, Bangalore, India.

James Finlayson is a consultant psychiatrist and former general practitioner in the Hebrides, now working as a medico-legal specialist in psychiatry.

Marjory Harper is Professor of History at the University of Aberdeen and Honorary Professor at the University of the Highlands and Islands.

Will Jackson is Lecturer in Imperial History at the University of Leeds.

James Moran is Associate Professor of History at the University of Prince Edward Island.

Ellen Scheinberg is an Archivist, and President of Heritage Professionals, Toronto, a heritage consulting company that delivers archival, museum and information management services.

Sergei Shubin is Associate Professor in the Department of Geography, and Director of the Centre for Migration Policy Research at Swansea University.

John Swinton is Professor in Practical Theology and Pastoral Care at the University of Aberdeen. He previously worked as a nurse, initially within the field of mental health, and as a hospital chaplain, latterly as a community mental health chaplain.

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PART I

Conceptual Approaches

CHAPTER 1

Introduction

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Definitions of both mental health and migration are ambiguous and contested, and any attempt to integrate the two phenomena is fraught with the challenge of comprehending and interpreting such constantly moving targets. The difficulties are not confined to changes over time and space, but involve many different understandings of the criteria for 'normality' and multiple perceptions of migration. Nevertheless, there is sufficient evidence of a perceived link between migration and mental illness to warrant a multidisciplinary evaluation, blending conceptual and empirical models and covering a broad chronological, spatial and thematic spectrum.

The approach taken by this study has both pedagogical and practical merit, as academic analysis from the disciplines of social geography, theology, history, literature and anthropology is integrated with experience-based insights from practitioners in the fields of social work and psychiatry. By demonstrating difference and complementarity, such dialogue expands the boundaries of scholarship and allows diverse disciplines to evaluate—and sometimes apply—each other's insights. For instance, in scrutinizing similar triggers and outcomes, historians utilize reams of documentary evidence to investigate what happened—or did not happen; social policy tends to argue about what *ought* to happen following an analysis of the impact of policy and practice; and psychiatry addresses the aetiology and consequences of the problem from the standpoint of the clinician.

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Historiography and Terminology

Within the constraints imposed by privacy legislation, the following chapters deploy a range of sources to explore past and present understandings of migration and mental health. These include personal diaries and letters, novels, psychiatric hospital records, health policy documents, deportation legislation and social work files. We need to begin, however, by setting the historiographical compass, particularly in terms of recent academic scholarship that considers the relationship between the two phenomena. Since the 1970s books and articles on migration and diaspora have proliferated, thanks to a combination of scholarly debate and public fascination with genealogy, with the emergence of migration institutes and diaspora studies centres simultaneously reflecting and stimulating such sustained interest.[1] The adoption of an international comparative approach was spearheaded by demographic historians like Charlotte Erickson and Dudley Baines,[2] but the research field quickly expanded from quantitative evaluations of the migrants' economic background to include analyses of their personal testimonies, and investigations of individuals' strategies of removal and settlement, as a range of writers used the written and oral testimony of participants in a quest to inhabit the migrant mind.[3] Meanwhile the sociologist Robin Cohen has used the concept of diaspora as a tool to study transnational identities across a wide spatial, chronological and thematic tapestry that embraces trade, labour, colonization and involuntary exile.[4]

There is, however, no consensus about the definition of either diaspora or migration, the former being particularly controversial. Cohen's approach has been dismissed by the historian Donald Harman Akenson, as 'valueless' and riddled with 'palpably false historical assertions', particularly that 'diasporas of necessity are triggered by traumatic events' and that a 'return-to-the-homeland movement' is an integral trait of diasporic groups.[5] He also demonstrates the limitations of the argument that equates the Greek word *diaspora* with the Hebrew word *galut*, which signifies exile, and its claim that the term should therefore be applied exclusively to the enforced dispersions of the Jewish people. In the 1970s and 1980s the potent exilic motif was adopted by both the Black and Armenian Studies constituencies to describe their different experiences of traumatic banishment and longing for home.[6] By the 1990s, however, scholars were beginning to define diaspora in terms of its original Greek meaning of a dispersal of population through colonization, and used it to

refer to the uncontentious preservation of ethnic identities among voluntary migrants. It then became common currency in the wider study of demographic history, perhaps because of the pitfalls, bankruptcy and imprecision of terms such as 'push and pull' or 'migration'. Akenson had a different interpretation, however, contending that 'mushiness in meaning was a prerequisite for popularity'.[7] Current interpretations of diaspora tend to encompass both catastrophic dispersal and a positive, persistent interaction between migrants, their places of origin and their destinations.

A migrant's claim to be part of a diaspora involves an awareness of a group identity. Some migrants had a diasporic consciousness long before they packed their bags, and their wanderlust was perhaps galvanized by an awareness of their own scattered families and communities. Others waited until they had cut their moorings before they began to cultivate a self-conscious identity, possibly when the absence of their default culture in the new land made them more aware of its significance. Some migrants from peripheral economies or older age groups favoured the idea of a corporate ethnic identity, which might involve a semi-invented, or even spurious, world of collective memory and a passive culture of shared victimhood. In other cases, the production of memoirs by people who would never have applied pen to paper if they had stayed put reflects an awareness of the relationship between the individual and the community, particularly among women, who were more likely than male migrants to write reflectively and nostalgically.[8] Alternatively, diasporic identities were constructed retrospectively by subsequent generations, from letters, artefacts and memorials.

Such differences in the diasporic consciousness of migrants remind us of even deeper ambiguities in the definition of migration. These ambiguities are nothing new, for human migration has always incorporated a range of options: single and multiple relocations; short distance and intercontinental movement; lifetime, serial, step and boomerang migration; and permanent return. But perhaps the issues have become more explicit since the mid-twentieth century, as a result of an intangible shift in perceptions of migration as a public, corporate—and sometimes community—phenomenon to a more atomistic, isolated and private process.[9] Might the increased complexity of population movement in a globalized, hybridized world therefore be better conveyed by the more fluid and nuanced term 'migrancy'? For globalization is not just an impersonal economic process that affects business and investment markets and facilitates the navigation of international employment opportunities. More negatively, the

unprecedented potential for multiple and malleable identities opened up by ease of intercontinental travel and instantaneous communication means that rootlessness and instability have become the hallmarks of many of the 'transilients', rolling stones who are caught up in a lifelong saga of physical and psychological movement and are unsure of where to call 'home'.[10]

Debates about the definition and significance of terms such as migration and diaspora are clearly relevant to any evaluation of the wellbeing of migrants, not least to their mental health. The dislocation or isolation caused by the absence of networks, coupled with uncertainties about identity, could destabilize not just modern transilients but also those who simply migrated from A to B in much earlier eras. Miles Fairburn has claimed that early colonial society in New Zealand was 'gravely deficient' because 'community structures were few and weak and the forces of social isolation were many and powerful'. Adding that 'bondlessness was central to colonial life' and 'the typical colonist was a socially independent individual',[11] his controversial thesis raises questions about the degree to which migrants who could not cope with social independence were able to adjust to their new environment. Unprecedented isolation might well be combined with a determination to pretend to those at home that everything was going well and that the decision to migrate had been fully vindicated when, in fact, positive expectations had given way to negative and unsettling experiences.

The Antipodes have been the subject of the most up-to-date studies of the impact of migration on mental health. Angela McCarthy's monograph, *Migration, Ethnicity, and Madness: New Zealand, 1860–1910*, challenges Fairburn's colonial atomization theory by demonstrating the family environment in which insanity was often experienced and the diligence with which immediate family members visited their hospitalized relatives. Heavily rooted in institutional archives, her study is concerned with charting the way in which migration was perceived by patients and doctors, posing questions about issues of discrimination, marginalization and exclusion.[12] An earlier collection of 12 essays edited by McCarthy and Catharine Coleborne covers some of the same ground, but offers broader chronological coverage; expands the lens to incorporate Australia, North America, Fiji and Japan; and incorporates reflections on the migration of medical theories, attitudes and practices from Britain to the antipodean empire. Using a variety of case studies, it was one of the first publications to focus explicitly on the theme of migration as a factor in mental illness, a direction of travel that has been maintained by both McCarthy and

Coleborne, and is further expanded by all the contributors to this book.[13] Catharine Coleborne's recent monograph, *Insanity, Identity and Empire: Immigrants and Institutional Confinement in Australia and New Zealand, 1873–1910*, also adopts a helpful comparative approach by exploring in meticulous detail the formation of patients' identities through the lens of the colonial asylum, with particular reference to issues of gender, class and ethnicity.[14]

Two previous monographs by Coleborne scrutinize insanity in colonial Australia and New Zealand, while an interdisciplinary collection of 18 essays she co-edited with Dolly MacKinnon addresses Australian mental health issues in both the colonial period and the twentieth century.[15] Particularly useful in the transcolonial study, *Madness in the Family*, is Coleborne's integration of the history of insanity with family history and her deployment of letters as a key source. While her insights into the lives of patients are absent from Alison Bashford's evaluation of global population, hygiene, race and quarantine in the British empire, Bashford's approach offers helpful perspectives on insanity and immigration restriction legislation, demonstrating how 'the histories of the alien and the alienist are linked'.[16] The human element reappears in the individuals who feature in Philippa Martyr's short but engaging article on the deportation of lunatic migrants from Western Australia in the interwar decades.[17]

Bashford's study of the mental health criteria of immigration exclusion legislation is one of eight chapters in a recent collection of essays edited by Catherine Cox and Hilary Marland. Also included in *Migration, Health, and Ethnicity in the Modern World* is an insightful contribution by Letizia Gramaglia on migration and mental illness in the British West Indies, a location eighteenth- and nineteenth-century commentators frequently associated with mental and physical breakdown, or debauchery.[18] Probably best known in the Caribbean context is the literary allusion to hereditary insanity made in *Jane Eyre*, when Jane's wedding is stopped at the altar by the disclosure that the bridegroom was already married. Fifteen years earlier Edward Rochester had been sent to Jamaica to redeem the family fortunes by making a wealthy marriage, the result of which was a union with the 'mysterious lunatic' kept under lock and key at Thornfield Hall. 'Bertha Mason is mad', declares Rochester, 'and she came of a mad family; idiots and maniacs through three generations!'[19]

Equally revealing in a different way is the diary of Jonathan Troup, an Aberdeen-trained doctor who practised medicine in Dominica from 1788 to 1791. He commented on the susceptibility of young settlers, not only

to tropical pathogens but also to the mentally destabilizing consequences of licentious living, in which Troup himself also indulged. 'Mr Baie was dead', he wrote in his journal on 9 August 1789. 'He was at Culloden [and] obliged to fly after it to West Indies where he has … made a fortune but his own strong constitution torn to pieces by Debauchery & Med[icines] & a Drunken wife'.[20]

Insanity and its treatment in Britain's Indian and African empires have been addressed by two contributors to this book, Waltraud Ernst and Will Jackson.[21] Medical and social issues are skilfully integrated in Ernst's study of ideology, administration and therapy among the European insane in India; while Jackson's reconstruction of the life histories of European patients admitted to the Mathari Mental Hospital in Nairobi reminds us that settler colonialism in Kenya was a story of marginalization as well as of farming, game hunting and hedonism. The Canadian perspective has been studied by a third contributor, James Moran, in both a co-edited collection of essays and a monograph which, while focusing on the evolution of government-funded asylums in Quebec and Ontario, sets those developments in a comparative international context.[22] A few Canadian scholars have turned the spotlight directly on migration, mental illness and deportation,[23] but the most consistent interest in migration and mental breakdown has been in the plight of insane Irish migrants, particularly in England.[24] Yet there remains much scope for study. Migration is mentioned only in passing in *The Confinement of the Insane*, the international study of the history of asylums edited by Roy Porter and David Wright,[25] while *The History of Psychiatry*, the journal co-founded by Porter, includes only one article that deals specifically with migration.[26] Meanwhile, from a medico-legal perspective, the *International Journal of Law and Psychiatry* devoted a special issue in 2004 to the question of migration, mental health, and human rights, in an approach the guest editors acknowledged was an 'intuitively linked' but 'awkward amalgam' of interdisciplinarity.[27]

While scholarly scrutiny of the relationship between migration and mental health has often been undertaken from the historian's perspective, research—much of it collaborative—has also been undertaken in other disciplines. David Ingleby, Professor of Intercultural Psychology at Utrecht University, has edited *Forced Migration and Mental Health,* a review and critique of current mental health care provision for refugees, displaced persons and asylum seekers, relevant both to health and social work professionals and to policy makers;[28] and New York's Columbia

University offers a Graduate Program on Forced Migration and Health.[29] In the field of medical publications, *Migration and Mental Health*, edited by Dinesh Bhugra (past president of the Royal College of Psychiatrists and of the World Psychiatric Association) and Susham Gupta (consultant psychiatrist in East London) also includes a significant focus on refugees,[30] while articles in publications such as the *British Journal of Psychiatry*, *The International Journal of Migration, Health and Social Care*, *The Community Mental Health Journal*, *Transcultural Psychiatry*, and *The Canadian Journal of Psychiatry*, cover a range of current issues.[31]

Themes, Debates and Paradoxes

There is, of course, a huge general—and contentious—corpus of scholarship on madness, confinement and institutionalization, much of it stemming from Michel Foucault's pioneering study, *Madness and Civilization: A History of Insanity in the Age of Reason*, originally published in 1961.[32] The ambiguities, disputes, taboos and multiple understandings that surround definitions of 'madness', mental health and illness in different social, cultural and economic contexts are central to this book, and are addressed especially in the two chapters that constitute Part I: Conceptual Approaches. John Swinton provides the essential framework by posing the question, 'What exactly are we talking about?' when we try to unravel the entities that are now classified as mental illness. Historically the phenomenon we currently describe in those terms has taken various forms and even today diagnoses differ profoundly across cultures and contexts. Mental illness is clearly socially constructed and, while that does not mean it is not 'real', it is only relatively recently that *ill*ness has been the primary definitional language used to describe the phenomenon. But if we try to impose a one-dimensional—and socially powerful—medical perspective on an entity that also has complex political, social, cultural and spiritual components, we are in danger of ignoring the nuances of our subject matter and generating misleading or unconvincing hypotheses. Such a constricted lens is also likely to mar our understanding of migration, and undermine any attempt to evaluate the relationship between the two phenomena.

Swinton's plea for greater clarity and openness in defining mental health and illness is explicitly echoed in Sergei Shubin's chapter. He also emphasizes the contested and changing interpretations of both madness and migration, but reflects at greater length on their interrelationship, particularly the way in which madness was developed as a socio-cultural

construct to explain and justify problematic nomadism across the centuries. The chapter falls into two main parts. The first section, which draws particularly on Foucault, is a conceptual journey through the construction of the philosophical and social limits associated with madness and migration, from antiquity to the twentieth century. Migrants are portrayed as people who face simultaneously in different directions, inhabiting spaces in between different social norms. The second section explores the ways in which the lives of 'mad' migrants were interpreted within the pathologized institutional environments of the nineteenth and twentieth centuries. As their alternative visions and sensibilities were discredited by a preset grid of definitions and treatments of madness, they were 'caught up in the terror of placelessness'[33] because they did not conform to the measurable and objective space-time of the public world.

The chapters by Swinton and Shubin provide an essential contextual framework for understanding the empirically based studies in the rest of the book. In Part II, 'Historical Perspectives', the focus shifts from conceptual approaches to historical evaluations of migration and mental health and illness in a variety of locations and time periods. The six chapters in this section draw on memoirs, private and official correspondence, literary texts and institutional records. They view their subject matter through the analytical lenses of predisposing factors (including alien cultures and climates, ethnicity and gender) and outcomes (including denial of entry, detention and deportation). They also raise, implicitly, two contrasting questions. Might transient residence in 'alien' cultures (such as India) be more destabilizing than permanent settlement overseas because the migrants' gaze was always trained on the homeland to which they wished to return? Alternatively, did those who expected to put down permanent roots in North American or antipodean soil find themselves unexpectedly wrong-footed when their expectations of cultural assimilation were not fulfilled?

Chapters 4 and 5 take us to India and South Africa in turn. Waltraud Ernst's study of case histories from British India in the nineteenth century is concerned with migrants whose overseas experience was envisaged as a temporary episode in a military or administrative career. But these sojourners were no less vulnerable to health problems than permanent settlers, and Ernst utilizes diaries, autobiographies, letters and medical case reports to address questions such as: how was temporary residence in a climatically and culturally inhospitable country experienced by individuals whose experiences have been recorded by themselves or by medical authorities?

And to what extent was the alien culture they encountered a significant factor in triggering illness? She also raises a neglected counter question about the definitions and determinants of health and sickness, echoing the general warnings about ambiguous terminology articulated by Swinton and Shubin. While the narratives deployed in this chapter emphasize the hardships endured by an unquantified number of individuals who went to colonial India during the nineteenth and twentieth centuries, there were also those who settled down there happily once their military or administrative service was complete. Such unremarkable migrants—in India and elsewhere—also warrant our attention, for we need to understand those beneficial effects of migration that enabled successful settlement as well as those that triggered ill health and dysfunction.

Will Jackson likewise identifies the weaknesses of a one-dimensional approach to the study of migrants' health, but takes a different approach in his reflections on the boundary between sanity and its absence. Rather than highlighting the need to consider both success and failure, he trains the spotlight solely on struggling migrants, but points to the limitations of relying exclusively on psychiatric records when scrutinizing their mental health, and to the challenges of writing of illness without the language of its diagnosis and treatment. Echoing Swinton's warning that a purely medicalized interpretation of a range of conditions and experiences can be both misleading and unconvincing, he integrates psychiatric records with a range of non-psychiatric archival sources to construct a multitextured account of mental illness in a particularly challenging part of the British imperial world. Specifically, he seeks to marry the psychiatric records of patients confined in Cape Town's Valkenberg Asylum with petitions for help from failed British migrants to the office of the South African Governor General, and the case records of Cape Town's Society for the Protection of Child Life. In doing this he follows the figure of the dysfunctional British migrant not only on to the streets of that city, but also around southern Africa, back to Britain, and indeed across the British imperial world. His study challenges the positive stereotype of the 'isolated imperialist', whose adventures were celebrated in stories and statues, and echoes the findings of other contributors that the mobility of migrants could be both traumatic and resourceful.

Jackson's plea that historians who research dysfunctional migration should look beyond institutional perspectives is addressed to some extent in the next two chapters, which shift the focus to North America. Marjory Harper's study of contemporary views on the causes and consequences of

mental illness among Scottish and Scandinavian migrants in the nineteenth and early twentieth centuries draws on a blend of asylum records, migrant correspondence and memoirs, and fictional writings to tackle questions relating to the impact of environment, ethnicity and attitudes articulated by settlers, host communities, immigration officials and doctors. The chapter falls into two main sections, the first of which draws on historical and fictional literature to identify and evaluate general evidence of disappointment and despondency among migrants, particularly to the prairies, between about 1870 and 1914. Such literature either inferred—in coded language—some of the difficulties of adjustment to new surroundings, or articulated the dislocating experience much more explicitly through hand-wringing declamations. Echoing some of the themes addressed by Ernst and Jackson in respect of India and Africa, the emphasis is on how the environment, broadly defined, might be disconcerting or unnerving, particularly when the harsh realities of forging a settlement failed to match the expectations of betterment and the glowing rhetoric of recruitment agents. The second half of the chapter focuses specifically on Scottish and Scandinavian immigrants in North America who were portrayed in fiction, or (especially) diagnoses in asylum records, as suffering from mental illness. It draws heavily on case histories from the British Columbia Provincial Asylum to explore what happened when general despondency and alienation took on pathological clothing.

Marilyn Barber's chapter expands Harper's use of literary texts as a medium for analysing 'stories of immigrant isolation and despair' in Canada, and turns the spotlight more explicitly on the interaction of ethnicity and gender as definitional factors in contemporary perceptions of mental breakdown. Her main subjects are Irish and English migrants whose status within the dominant Anglo-Celtic culture in Canada did not shield them from experiences of dislocation and segregation. Using a selection of memoirs and novels from the 1850s to the late twentieth century, she explores the vulnerability of the migrant experience, highlighting how isolation and loneliness could lead to despair and dysfunction. Through the prism of Canadian literature, Barber touches on questions raised in Jackson's and Harper's chapters about the importance attached, directly or tangentially, to gender roles and to concepts of femininity and masculinity. She also considers whether literary texts reflected or helped to shape public opinion about the role of ethnicity, environment, religion and science in triggering or exacerbating mental ill health.

The chapter by Lisa Chilton and James Moran switches our attention from the territory of the asylum to consider wider legislative issues from an international historical perspective, as they consider the application of English lunacy investigation law in jurisdictions beyond England's borders. Their study reflects the intersection of a number of sub-disciplines in history and law—migration, mental health and illness, the history of empire and jurisprudence—and adds an important judicial dimension to the book's social, literary, cultural and clinical emphases. Referencing the philosopher Ian Hacking, whose work highlights divergent interpretations of normality and deviance, they reiterate the comments of other contributors about the complexities of defining mental illness. For Chilton and Moran, such complexities have particular relevance for the application of legal principles across international boundaries and continental divides, and also echo John Swinton's observation about the challenges of addressing variations in diagnosis across cultures. The point is further reinforced in the final chapter, when James Finlayson and Marjory Harper discuss the artificiality of psychiatric classification systems in different cultures.

The legislative focus, in a more recent context, is maintained in Ellen Scheinberg's analysis of the deportation of 'mentally and morally defective' female immigrants from Canada in the decade after 1946. She also revisits issues of class, gender and ethnicity scrutinized in other locations and periods by Ernst, Jackson, Harper and Barber, and one of the cases she cites—a doctor who attempted suicide because of 'disappointment for not being placed in her profession'—echoes Barber's literary reference to mental health problems among disappointed professional migrants in the same era.[34] In contrast to earlier Canadian studies that focus on government policy or on male deportees accused of political or economic crimes during the late nineteenth and early twentieth centuries, this chapter utilizes deportation case files produced by the federal government's Immigration Branch to examine the experiences of female immigrants who were targeted for mental health and related moral offences in the mid-twentieth century. Beneath the rhetoric of openness and acceptance towards immigrants, there emerged a fear of deranged and damaged refugees whom government officials and experts felt could pose a threat to the family and Canadian society. Many of the women in Scheinberg's survey carried emotional baggage from the Second World War and wanted to start anew in Canada, putting the past behind them. Yet immigration officials vigorously attempted to deport as many of these individuals as possible, labelling and expelling women who had a poor

prognosis for recovery, or who were adjudged incapable of rehabilitation or redemption. Those who were most susceptible appeared to be women who had violated the moral tenets of the day relating to their prescribed roles within the family and society, and 25 per cent of the 376 case files examined document female deportees accused of mental crimes.

Following these archive-rooted historical studies, the three shorter chapters which comprise the book's third and final part shift the discussion to anthropological and personal reflections. The general themes of rootlessness and loss of identity noted by Sergei Shubin emerge again in a specific location in Arnar Árnason's anthropological study of mental health, migration and melancholic nationalism in Iceland. Initially approaching the topic through the prism of a modern crime novel, Árnason integrates reflections from literature with ongoing ethnographic fieldwork, discourse analysis of public documents, archival research and interviews, to examine mental health in Iceland in the context of over a century of internal migration, the legacy of the Second World War and the effects of the country's economic collapse in 2008. Like Swinton and Shubin he suggests that medicalizing depression and anxiety may impede our understanding of a more nuanced and multifaceted phenomenon, and makes the case for a link between depression or anxiety and fundamental uncertainties about the nation's present and future ethos and identity. Echoing Shubin's point about the loss of identity associated with migration, he suggests that the dramatic rural to urban shift in Iceland which took place during the twentieth century was not simply a spatial movement, but embodied a much deeper, cultural dislocation. Specifically, Icelanders wrestled with the contradictory sentiments of simultaneously escaping from a life of drudgery and monotony and abandoning their heritage and birthright by severing their historic connections with the land. Such dilemmas are familiar motifs in narratives of migration, perhaps most notably in the development of an exilic consciousness among migrants from the Scottish Highlands who feature in passing in the final chapter. In traditional Highland culture the Gaelic word *duthchas* denoted a sense of mutual responsibility or trusteeship over the land, shared between chiefs and clansmen but which had been eroded from the late eighteenth century by the intrusion of commercial attitudes into estate management and the consequent unwilling exodus of clansmen to the Lowlands and overseas.[35] In Iceland rural depopulation arguably triggered a variation on that exilic consciousness, which was then reignited by the economic collapse of 2008.

Chapters 11 and 12 offer case-based insights from practitioners in social work and psychiatry. From 1998 to 2002 Juliet Cheetham was Social Work Commissioner with the Mental Welfare Commission for Scotland, having previously set up and directed the Social Work Research Centre at Stirling University. Alongside a career in academia, she has served on a wide range of public bodies, including the Commission for Racial Equality. Her chapter, like those by Harper, Barber and Árnason, draws on novels, but is rooted in her own experience, particularly as a social worker in Brixton in the 1960s. She points out that, traditionally, social policy in the UK has not included special services for immigrants, since the prevailing assumption is that, insofar as they need social support, their needs will be met by mainstream services. There has also been an expectation that a largely working-age group, with the ambition and resources to migrate, will be self-reliant and need little help. The lack of reliable data on the incidence of problems may indicate immigrants' determination to cope, or their ignorance or fear of available services, as well as the inertia or complacency of the host population. Yet, as other chapters demonstrate, the circumstances and demands of migration often have a negative impact on mental health. Cheetham's first case study reflects the problems that arose from misguided policies and unrealistic assumptions about immigrant resilience half a century ago, while the second illustration concerns debates about the extent to which a country can tolerate or encourage cultural diversity. Although in the last two decades there has been greater interest in promoting a more humane, rights-based approach in working with immigrants who confront personal and social problems, the contemporary furore about the consequences of the UK's membership of the European Union shows how the issues raised by the case studies illustrate enduring—and contentious—questions about the impact of immigrants on host societies.

The final contribution comes from James Finlayson, a consultant psychiatrist in the north of Scotland and former general practitioner in the Outer Hebrides, with historical context supplied by Marjory Harper. While endorsing the findings of other contributors about the potentially harmful effects of migration, the authors caution against claiming that migrants are more prone to psychiatric illness than those who do not move, and echo Ernst's observation that research tends to highlight only the negative effects of migration on health, rather than acknowledging that relocation is sometimes beneficial and restorative. Finlayson and Harper's concerns about untested generalizations that thwart attempts at a meaningful evaluation of the relationship between migration and mental

health also reiterate both John Swinton's opening question, 'What exactly are we talking about?', and Sergei Shubin's allusions to the ambiguous and contentious interpretations of both phenomena. The chapter reiterates and reinforces Swinton's comments about criticism of the most recent edition of *The Diagnostic and Statistical Manual of the American Psychiatric Association* for its harmful medicalization of challenges that are 'a normal part of being human'.[36] Like the chapters by Swinton and (to a lesser extent) Chilton and Moran, this final contribution also highlights the problems associated with applying psychiatric classification systems in different countries and cultures.

The warnings of a practising psychiatrist about the pitfalls of making simplistic generalizations are rooted in James Finlayson's own experiences among a range of migrants and non-migrants in the Scottish Highlands and Islands. His concerns echo the reminders of other contributors that we should be equally cautious in drawing definitive conclusions from the pronouncements of doctors, administrators and politicians in bygone eras. Indeed, one of the recurring themes of the entire collection is that the criteria used to define dysfunctional migrants were—and are—often inconsistent, both within host cultures and between those locations and the sending societies, and that different hierarchies operate in respect of the diagnosis and treatment of those whose rootlessness or alienation was pathologized within a variety of psychiatric categories.

The variety of approaches and experiences examined in this study demonstrates that every type of migration—physical and cerebral—could trigger or reflect both disconnection and dislocation and coherence and integration. Within the different contexts covered in these chapters we shall see contested definitions of success and failure, normality and deviance, as well as the short- and long-term consequences of living with a diagnosis of insanity in several eras and locations.

Notes

1. For details of the former, see the membership list of the Association of European Migration Institutions (http://aemi.eu/members/). Examples of the latter include the Centre for Migration and Diaspora Studies at SOAS (https://www.soas.ac.uk/migrationdiaspora/), the Scottish Centre for Diaspora Studies at the University of Edinburgh (http://www.ed.ac.uk/history-classics-archaeology/diaspora-studies) and the Centre for Diaspora and Transnational Studies at the University of Toronto (http://www.cdts.utoronto.ca/).

2. Charlotte Erickson, *Invisible Immigrants. The Adaptation of English and Scottish Immigrants in Nineteenth-Century America* (Ithaca and London: Cornell University Press, 1990, originally published 1972); Dudley Baines, *Emigration from Europe, 1815–1930* (Cambridge: Cambridge University Press, 1995, originally published 1991).
3. See, *inter alia*, David Fitzpatrick, *Oceans of Consolation: Personal Accounts of Irish Migration to Australia* (Melbourne: Melbourne University Press, 1995; A. James Hammerton and Alistair Thompson, '*Ten Pound Poms': Australia's Invisible Migrants: A Life History of British Postwar Emigration to Australia* (Manchester: Manchester University Press, 1995); Angela McCarthy, *Personal Narratives of Irish and Scottish Migration, 1921–65: 'For Spirit and Adventure'* (Manchester: Manchester University Press, 2007); Marilyn Barber and Murray Watson, *Invisible Immigrants: The English in Canada since 1945* (Winnipeg: University of Manitoba Press, 2015). There is also a considerable literature on migrants from Europe, which can be accessed through the websites of repositories such as the Balch Institute for Ethnic Studies (Philadelphia), the Multicultural History Society of Ontario (Toronto), the Norwegian Emigrant Museum (Ottestad) and the German Emigration Center (Bremerhaven). See also Jacqueline Templeton, edited by John Lack assisted by Gioconda Di Lorenzo, *From the Mountains to the Bush: Italian Migrants Write Home from Australia, 1860–1962* (Crawley, WA: University of Western Australia Press, 2003). The value of migrants' letters as a source is pondered most helpfully in two publications: David A. Gerber, *Authors of Their Lives. The Personal Correspondence of British Immigrants to North America in the Nineteenth Century* (New York and London: New York University Press, 2006); and Bruce S. Elliott, David A. Gerber and Suzanne M. Sinke (eds), *Letters Across Borders. The Epistolary Practices of International Migrants* (Basingstoke: Palgrave Macmillan, 2006).
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5. Donald Harman Akenson, 'Ever More Diaspora: Advances and Alarums', *Journal of Irish and Scottish Studies*, 4: 1 (Autumn 2010), 1–16. The quotes are on page 13.
6. Akenson, 'Ever More Diaspora'. See also Akenson, 'The Historiography of English-Speaking Canada and the Concept of Diaspora: A Sceptical Appreciation', *Canadian Historical Review*, 76 (September 1995), 377–409; and Akenson, 'A Midrash on "Galut", "Exile" and "Diaspora" Rhetoric' in Margaret Crawford (ed.), *The Hungry Stream: Essays on Migration and Famine* (Belfast: the Institute of Irish Studies at the Queen's University of Belfast and the Centre for Emigration Studies at the Ulster-American Folk Park, 1997), 5–16.

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8. Rosalind McClean, 'Reflections on Self and Nation: Scots in Diaspora return to the past', unpublished paper delivered at 'Nations, Diasporas, Identities' (conference of the Irish-Scottish Studies Programme at the Stout Research Centre for New Zealand Studies, Victoria University of Wellington, in association with the AHRC Centre of Irish and Scottish Studies, University of Aberdeen, March 2008).
9. Marjory Harper, *Scotland No More? The Scots who left Scotland in the Twentieth Century* (Edinburgh: Luath, 2012), 229.
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CHAPTER 2

Unravelling 'Mental Illness': What Exactly Are We Talking About?

John Swinton

Introduction

The issue of the rich and complex relationships between migration and mental health is both fascinating and enlightening, as the various chapters in this book highlight most effectively. Culture, context, trauma, social dissonance and dislocation all have important corollaries within the lives of those who, for whatever reason, find themselves transported from a place of homeliness and security to a space wherein home needs to be created and recreated rather than simply dwelt within. The rebuilding of our sense of home can be difficult and traumatic in terms of mental health and ill health. All of that is in some senses a given. What is less obvious however is precisely what is meant when we talk about 'mental illness'. The nature of mental illness is highly contested, so the suggestion that migrants can or will encounter it is also inevitably contested.

Within psychiatry there are ongoing discussions over what mental health problems are and how they should be approached. Historically there has been a confusing array of explanatory theories and paradigms: the movement of a woman's uterus (hysteria);[1] hidden subconscious processes (neurosis);[2] schizophrenogenic mothers, that is, forms of mothering that cause pathology (schizophrenia);[3] through to contemporary emphases on neurobiology and genetics (everything!). Each explanatory framework contains its own world view, anthropology and assumptions about what is normal and how that which is deemed abnormal should be dealt with.

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What is less clear are the reasons for medical descriptions and responses being given cultural priority over other explanatory frameworks. It is only relatively recently that 'illness' has been propounded as the primary definitional language used to describe those experiences some now call 'mental illness'. Previously people would talk of alternative realities (demons, visions, dreams and so on), thus offering a wide range of possible explanations for unusual behaviours. Now the tendency is to talk about diagnoses and symptoms *as if* they were nothing more than the 'side effects' of broken biology.

Criticisms of the DSM-5[4] criteria for mental disorders, which include phenomena like shyness, grief, internet use and mathematical ability, indicate, for some, psychiatry's tendency to transfer phenomena belonging to other fields such as education, law and religion into the realm of the medical.[5] Similar concerns have been raised by service users. The 'recovery movement' emphasizes recovery from mental distress as more personal and existential than medical. Recovery is measured in terms that have a wider reach than the simple reduction of symptoms or inpatient admissions. Success is also measured by how well people are able to pursue things that give their lives meaning.[6] Such an understanding of recovery converges with recent accounts of spirituality, personalism and existentialism while diverging from the dominant paradigm's stress on biological psychiatry. The Hearing Voices Network highlights that 'symptoms' have meaning.[7] Far from being meaningless manifestations of genetic or neurological defects, visions, hallucinations, delusions, deep sadness and manic highs are packed with meaning and are not as alien to our humanness as the medical model often infers. If something like 10–15 per cent of the non-psychiatric population hear voices,[8] and if it is assumed that the key is to effectively manage them, the experiences we have learned to describe as mental illness need not be understood as radically Other, but may be better understood as running along a continuum within which normal and abnormal experiences are perceived as quantitatively rather than qualitatively different.

The experience of mental ill health is thus seen to be much more open and flexible than some medical frameworks allow. Mental health problems are human experiences that are open to many interpretations, interpretations that vary greatly across cultures. Through such experiences people encounter the world in ways that are sometimes distressing but always personal, meaningful and often deeply spiritual. Whilst medicine has a place, issues of meaning and personhood are not epiphenomenal to treatment. If

recovery involves *persons*, and if mental health experiences are shaped by particular social contexts, circumstances, relationships and beliefs, looking at mental health problems from a variety of perspectives will inevitably educe important differences.

In this chapter I try to unpack some of the complexities of talking about mental health and illness as if they were fixed and obvious entities that reside in the world and which can be spoken about as if we are talking about the same things irrespective of culture and context. I want to offer some critical reflections on the nature of mental health problems and to offer some challenges and cautions that will have to be thought through in relation to the issues that underpin and drive this book. In essence I want to ask the question: *What do we mean when we talk about mental illness?* In offering some tentative answers and perspectives I hope to open up critical space for a deeper understanding of the complex content of the other chapters in this collection.

Mental Illness as a Thin and Vague Concept

St Augustine commented on the nature of time that he knew exactly what it was until someone asked him to describe it.[9] Mental illness runs along similar lines. 'Everyone knows' exactly what it is until they have to explain it. The concept of mental illness is thin and vague: it appears to tell us much more than it actually does. People provide elaborate explanations for what causes 'it'—neurobiology, genetics, social trauma—and talk about 'it' as if it was on par with a chair or an elephant. However, a deeper analysis reveals that the reductionism and reification implicit within many assumptions about mental illness are quite challenging. The suggestion that one knows what a phenomenon is because one discovers something about its origins is to assume that human beings live in only one domain, be that biological, social or spiritual. When human beings are reduced to a single domain, real dangers begin to emerge. Discovering that a particular set of experiences has a neurological root (and some would argue that no such discovery has been made),[10] does not tell us what 'it' is, but rather informs us about one dimension of what may have caused or impacted upon the experiences concerned. But cause does not determine outcome. It simply joins a set of possibilities for the future. The problem with accepting the terminology of mental *illness* and of acquiescing in the idea that perspectives on origins fully define the nature of human experience, is that it reduces significant types of human personal and social involvement in

the world to 'mere pathology'. The thick, multidimensional experiences of people with mental health problems are easily overpowered by thin reductionist assumptions of meaninglessness and an overdependency to prioritize medical explanation and intervention.

Such reductionism runs alongside an odd kind of reification. People often use the language of schizophrenia, depression, anxiety and so forth as if they are obvious concepts that are more or less settled in terms of form and interpretation. In fact, this is far from being the case. There is a huge diversity of content to such holding concepts. This is an important observation for the purposes of this book. There are dangers and pitfalls in reading back into history or across cultures, understandings, diagnoses and perspectives that may not accurately reflect the experiences of people at different times and in different contexts from our own. Indeed they may not express the experiences of people within our own cultures at any given moment in time.

The Somatization of Depression

An example of significant cross-cultural issues can be found in the anthropologist Arthur Kleinman's extensive study of depression in Taiwan. Kleinman observed that depression manifested itself in a quite different form within Taiwanese culture from standard Western understandings.[11] Because mental health problems are highly stigmatized within that culture, people's experiences of depression were not manifested via established Western symptoms, such as sadness, guilt, shame and so forth. Rather the experience of deep sadness was somaticized. It was taken into their bodies. People would complain of sore backs or vague pains in their abdomens. The feelings and experiences of what we in the West might call 'depression' were manifested in quite different ways due to the particularities of cultural assumptions and social expectations.

The implications of such an observation are obvious. If we are gauging levels of depression using standard Western criteria such as sadness, shame, and anxiety, we may well miss that which is culturally central to the experience and end up not seeing the ways in which people are managing their distress. As Westerners who are the inheritors of a hypercognitive worldview,[12] it is easy to become so focused on people's minds that we completely miss the voices of their bodies. Studying migration and mental illness cannot begin without serious reflection on what mental health problems are in all of their fullness, and why they may be manifested in particular and quite different ways according to culture and context.

Making Up People: Mental Illness as a Flexible Concept

In developing these provisional observations, it will be helpful to draw on the thinking of Canadian philosopher Ian Hacking. At first this may appear to be a rather unusual detour but, as will become clear, Hacking's thinking is central to the issues we are discussing here. Hacking opens his fascinating paper, titled 'Making up people', with a rather surprising assertion. *There were no perverts in the nineteenth century!*

> Were there any perverts before the latter part of the nineteenth century? According to Arnold Davidson, 'The answer is NO .... Perversion was not a disease that lurked about in nature, waiting for a psychiatrist with especially acute powers of observation to discover it hiding everywhere. It was a disease created by a new (functional) understanding of disease.'[13] Davidson is not denying that there have been odd people at all times. He is asserting that perversion, as a disease, and the pervert, as a diseased person, were created in the late nineteenth century.[14]

Hacking's interest is in the ways in which certain 'kinds of people' enter into and exit from society at particular moments in time. The idea of 'making up people' refers to this process of creating, sustaining and doing away with certain kinds of people through the process of describing and naming. Hacking's point is not that the actions we now name as perverted were not around before the nineteenth century. He asserts that it was not possible to describe a person as a pervert in the way we might do today, until the actions that form the medical category pervert were enshrined within medical diagnosis, social policy and the laws of the land. Once medicine and law decided to name a particular set of actions as perverted and the perpetrator of those actions a pervert, it was then possible for someone or a group of people to be named as perverts. Prior to that such types of people simply did not exist—or rather, they existed, but the category in which they might be placed and be understood had not yet come into being. Now it is possible to be this particular kind of person, a pervert, but it was not always so.

Philosophically Hacking describes this perspective as *dynamic nominalism*: a form of nominalism that examines the mutual interactions over time between the phenomena of the human world and our conceptions and classifications of them.[15] Central to this idea are the historical dynamics of the way in which naming something brings it into existence in a quite

particular way. Numerous kinds of people come into being (are 'made up') hand in hand with the invention of particular categories designed to label and rename them. Social change creates new kinds/categories/types of people. Perverts are one example of this idea of making up people. Another is the idea of homosexuality and heterosexuality. Hacking points to the ways in which homosexuality and heterosexuality came into existence towards the end of the nineteenth century. There had been plenty of same sex activity over time, but never same sex *people* and different sex *people*. It was only as, through social, medical and political pressure, these designators were brought into existence and enshrined in law that these sexual differences were brought into existence. Once homosexuality was enshrined in law and formally authenticated as being a recognized way of being in the world, it became possible to *be* a homosexual (or a heterosexual), in a way that one could not have been before these categories existed. Once things are named in this way we act upon them as if they were real in a way they were not previously deemed to be real.[16]

Naming and Acting

The idea of making up people or creating new dynamic kinds or categories of people is not mere semantics. Descriptions matter. Hacking notes that

> Except when we interfere, what things are doing … does not depend on how we describe them. But some of the things that we ourselves do are intimately connected to our descriptions.

Quoting the assertion of philosopher Elizabeth Anscombe that 'intentional human actions must be "actions under a description"', he goes on to argue that

> descriptions are embedded in our practices and lives. But if a description is not there, then intentional actions under that description cannot be there either … What is curious about human action is that by and large what I am deliberately doing depends on the possibilities of description … Hence if new modes of description come into being, new possibilities for action come into being as a consequence.[17]

New lenses bring new imperatives and new explanations demand different kinds of actions and facilities. Explanation and theory are always about action and power.

So how does all of this relate to migration and mental illness? Well, obviously, it raises some interesting questions with regard to what we mean when we use the term 'migrant'. What kind of person is a migrant? Is a migrant simply someone who migrates? Or does the term vary from culture to culture, society to society, politics to politics? Does it mean the same thing to be a migrant in Russia as it does in Somalia? What kind of people do historians 'make up' when they find themselves talking about migrants? So, while it is not my focus in this chapter, there is an interesting question around what kinds of people migrants are and why we choose to make them up in the ways we do.

For the purposes of this chapter, my main focus is on how Hacking's thinking can help us to understand usages of the variety of terms that comprise the category of mental illness. What kind of people are 'the mentally ill'? In other words, how do we make 'them' up and why do we make them up in the ways we do? Historically psychiatric terminology has been quite plastic in its meanings and the assumptions about the origins of the terms it uses. Words such as schizophrenia, depression, anxiety, bipolar disorder and so forth, are not 'natural kinds'. A tree might be considered a natural kind insofar as most people who look at a tree over time do not really question its existence as a tree. The names we give to the experiences deemed to form the concept of mental illness are different. They came into existence at particular moments in time and often go out of existence at particular moments in history. There was a time when schizophrenia did not exist and a time when it came into existence. Some argue that at this moment of time it is in the process of going out of existence.[18] Likewise, the idea of a 'mentally ill person' is a relatively recent way of describing people who encounter sadness, anxiety or alternative realities. That is not to say that the experiences some name 'mental illness' were not around prior to them being given the particular set of names we choose today: they just were not around in the ways we now assume them to be.

Categorizing Experience

The current understandings of mental health and illness, particularly in the West, have been deeply shaped by the psychiatric DSM criteria and coding, published by the American Psychiatric Association.[19] The DSM coding system is a manual which presents the various criteria for diagnosis and is the main source for the ordering and defining of mental illness. There are other systems, but the DSM system has been very influential

throughout the world. The DSM criteria are intended to enable psychiatrists to identify, describe and define precisely what constitutes each category of mental health problem. This is the legislative document that enables us to create particular kinds of 'mentally ill' people.

The problem with the DSM schemata is that they are constantly changing. They are put together by groups of psychiatrists who literally argue their way towards agreement as to what should sit within each diagnostic category. At the end of this process of arguing, psychiatrists present the 'scientific' basis for naming people as mentally ill and providing them with a particular diagnosis. Without this document, mental illness does not exist. This becomes particularly pertinent when, in the United States, the system of Managed Care requires a diagnosis before any payment can be made. Mental illness thus comes into existence with the construction of the DSM criteria. I will come back to the problems raised by the DSM approach as we move on. For now it will be enough to observe that this is not a purely descriptive document that reflects a fixed reality. It is a formative document which literally brings illnesses into existence or eradicates them.[20] The DSM criteria then are central to the ways in which we make up mentally ill people. This mode of categorization gives the impression that there is a consensus as to what constitutes mental illness, but it is really not the case, even with the most apparently obvious conditions. The case of depression is a good example of intrapsychiatric dispute.

The Case of Depression

Depression is a highly constructed and contentious term. Like homosexuality and perversion it is not a natural kind. While it is a word widely used within Western societies by lay people and professionals alike, a deeper reflection reveals that it is not at all clear what is meant by the term. It is not really a definable entity or 'thing' which we can look at, examine and use as an explanatory concept in the way we might a germ or a microbe. Indeed, as I have suggested, there is a real sense in which depression does not actually exist other than as a set of contested experiences people have a tendency to reify and consider to be a 'real thing'. As the psychiatrist Dan G. Blazer notes, when a diagnosis is reified,

> [t]he assumption seems to be that there is a 'real disease' called major depression and, by attaching the label, the psychiatrist pronounces that the patient has this disease. (This process of making an idea real has been

> labelled 'reification'.) Reification numbs us to the possibility that depression can be more a signal of the emotionally toxic society in which we live than a thing in and of itself. And if the effects of this toxicity are initially expressed through depression, then depression should signal a need to better understand and improve society.[21]

Blazer's point is interesting. By reifying depression we can be tempted to take our eye off the fact that it may be society that has the problem and that the individual may only be manifesting the symptoms of a sick society. That, I imagine, may be a useful insight for studying migration and mental illness. Is the psychological distress experienced by some migrants to do with the process of moving *per se*, or the process of moving into, or out of a particular context that may either be generally toxic, or specifically toxic to the particularities of the experience and context individuals, families and communities bring with them?

Blazer's observation also raises crucial questions as to exactly what depression is. Pilgrim and Bentall cast further doubt on whether there is a single, easily identifiable entity called 'depression' that can be recognized cross culturally or even intraculturally:

> there appears to be no consistent transcultural, transhistorical agreement about minimal necessary and sufficient pathognomic criteria for the phenomenon of interest. For this reason, depression, like other functional psychiatric diagnoses such as schizophrenia … is a disjunctive concept, potentially applicable to two or more patients with no symptoms in common.[22]

If Blazer, Pilgrim and Bentall are correct, then we have a problem. In what sense can we consider or assume that people are depressed when the very concept of depression is contentious, disputed and disjunctive? How can we be certain that our current understandings of what depression is actually relate to the experiences migrants had or are having within their own intercultural and intracultural experiences? Pilgrim and Bentall also point out that the description of depression and the symptomatic definitional criteria offered by people experiencing deep sadness often differ significantly from those offered by professionals and mental health 'experts'. That being so, can we be certain that what is reported in the documents recording or reflecting on the mental health of migrants actually takes seriously the lived experience of depression or any other form of mental health problem?

Exporting Madness

It will be helpful at this stage to return to the issue of the DSM criteria for mental illness,[23] and how they might impact upon the thinking offered within this book. Ethan Watters, in his book *Crazy Like Us: The Globalization of the American Psyche*, develops an interesting argument to suggest that the DSM criteria may well be a subtle mode of psychiatric colonization which exports not only particular diagnostic categories, but also Western definitions of how people should suffer. He summarizes his position in this way.

> Americans, particularly if they are of a certain leftward-leaning, college-educated type, worry about our country's blunders into other cultures. In some circles, it is easy to make friends with a rousing rant about the McDonald's near Tiananmen Square, the Nike factory in Malaysia or the latest blowback from our political or military interventions abroad. For all our self-recrimination, however, we may have yet to face one of the most remarkable effects of American-led globalization. We have for many years been busily engaged in a grand project of Americanizing the world's understanding of mental health and illness. We may indeed be far along in homogenizing the way the world goes mad.[24]

Watters' basic thesis is that American categorizations and understandings of mental illness are being exported in such a way as to occlude and overpower culturally conventional ways of understanding and responding to mental illness. What is developing is a kind of 'Maconaldization' of the world's mental health, within which other ways of understanding mental health and ill health are subsumed to a homogenized version of mental health and illness which sits well within Western cultures, but may actually be harmful for other cultures who do not go 'crazy like us'. Watters makes his case via some fascinating case studies focusing on depression, anorexia, schizophrenia and post-traumatic stress disorder (PTSD). He carefully lays out the uneasy influence of drug companies, the power of close communities for healing (as opposed to individual therapy) and the completely different worldviews that surround issues of trauma, illness and disability in different contexts and cultures. For current purposes Watters' reflections on PTSD will be illuminating.

Suffering Differently

PTSD is a diagnosis that has hit the headlines in significant ways recently, primarily due to the various wars in which America and the UK have engaged. Watters does not touch on the issue of war. Instead he highlights

the situation after the 2004 tsunami in Asia. Following that tragedy, mental health experts predicted a 'second tsunami' of mental illness in the light of the trauma people had experienced. In anticipation, droves of trauma researchers and counsellors rushed to the aid of the tsunami victims, hoping to pass on their knowledge and expertise around PTSD. Watters notes that a 'few years later, however, their efforts have raised a troublesome question: were they bringing the wrong treatment to the wrong people?'[25]

The problem was that the people experiencing the tsunami interpreted the event in completely different ways from the researchers and counsellors. Watters' point is not that trauma cannot induce mental health problems, or even that people did not experience something like PTSD. His point is the extent to which the survivors' cultural beliefs shaped their symptoms and the ways in which those potentially healing cultural resources were undermined by the introduction of alien forms of intervention: a new form of mental health imperialism.

The Problem with PTSD

Watters draws attention to the fact that over the last 25 years, PTSD has had a remarkable ascendancy in American psychiatry and in public consciousness.

> Proponents of the diagnosis assert that experiences of fear or horror often spark a cluster of 17 broad symptoms, including intrusive thoughts, memory avoidance and uncontrollable anxiety. The concept of PTSD also encompasses notions of how best to overcome the disorder, usually through measured re-exposure to the original trauma, supervised by a counselor. PTSD, many Americans assume, describes the way that *all* humans react to traumas.[26]

However, whilst Watters notes that researchers did find some signs of PTSD, it was clear that the wounds of the Sri Lankans who suffered in the tsunami were not simply manifestations of PTSD. Rather they related to the fact that one's role in one's group was lost or deeply disturbed. In other words the problem was conceived of in *communal* rather than individualistic terms. Likewise, whilst talking is central to the treatment of PTSD, the opposite was true within that culture. Similarly,

> Many East Africans, for instance, hold that the ability not to talk about distressing experiences is a sign of maturity. This runs counter to typical assumptions of trauma counsellors that a healing catharsis can be achieved

> through 'truth telling.' In Sri Lanka … the idea of splitting off from the group to heal psychic wounds through individual counseling can actually exacerbate the more salient fear of social isolation.[27]

What is not normally noticed is that the diagnosis of PTSD is actually a cultural explanation that may make sense in America, but may make little sense in other cultures. As psychology professor, Ken Miller, puts it: 'Imagine our reaction … if Mozambique flew here [to America] after 9/11 and began telling survivors to engage in a certain set of mourning rituals in order to sever their relationship with their deceased family members'.[28]

Naming Things Properly

So, what can we learn from Watters' observations that might relate to migration and mental health problems? Well, once again, we can see the dangers of not considering the cultural implications of any given diagnosis. Simply by naming the perceived psychological condition of migrants as, for example, depression, anxiety, trauma or whatever, we have already made some significant judgements with regard to how we intend to frame the issues, as well as importing a whole range of cultural assumptions. If we then try to use these judgements and assumptions to understand the impact of migration on the psychological condition of the particular groups we are scrutinizing, we will get into all sorts of bother. It may actually be a mistake simply to look at people's individual psychological states. The real issues may be somaticized or 'hidden' within the disconnection that people feel in relation to their communities. I do not mean that disconnection (a revised geographical and social state) leads to depression (an individual social condition). I mean that dislocation may be the key issue. It may be that the language of dislocation is preferable to the language of depression. In other words, it is not that dislocation leads to depression; the experience is appropriately named as dislocation. It may therefore be more accurate to use the language of dislocation, rather than the language of depression.

Conclusion: Why We Might Want to Name Things a Little Differently

This chapter has attempted to show the deep complexities of the concept of mental illness and, by implication, how complicated it is to study and draw associations between mental illness and migration. That is not to

say that it cannot or should not be done. My point is that a critical eye needs to be kept on how and why understandings of mental illness are ascribed to migrants and what the implications of such ascriptions are for any conclusions drawn. So, in ending, I offer four questions I think it will be worth bearing in mind as we reflect on the issues raised in this book:

1. What exactly do we mean by 'a migrant'? If Hacking is correct, the category may well be flexible and open to various interpretations within and across cultures and nations.
2. If mental illness is a deeply contested category, what exactly do we mean when we talk about migrants having or experiencing mental illnesses?
3. Is the language of mental health and illness the most appropriate way to express the experiences of migrants, or do we require a broader, less therapeutic approach to understanding issues currently named as depression, anxiety, trauma and so forth?
4. Can we assume that the experience of the migrant's mental illness relates simply to the individual, or is it necessary to explore more carefully the sending and hosting cultures and their various ways of dealing, or not dealing, with trauma?

How we end up answering these questions will determine the trajectory of our thinking as we explore the interface between migration and mental health and ill health.

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that can be used in the research of mental disorders. It also provides a common language for researchers to study the criteria for potential future revisions and to aid in the development of medications and other interventions.' American Psychiatric Association: DSM-5 Development, http://www.dsm5.org/about/pages/faq.aspx (date accessed 15 November 2015).

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CHAPTER 3

Critical Perspectives on Histories of 'Madness' and Migration

Sergei Shubin

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Introduction

'For mortals, there is nothing worse than wandering'.[1] This passage from Homer's *Odyssey* draws our attention to the existence of the long-standing tradition of negative depiction of travel and its association with a deviation from the path of reason. In the Greek tragedy, Odysseus' wandering is often seen as a journey of 'madness' and alienation from oneself and society, since it is described as a voyage with no return, the process of driving him 'out' or 'aside' from his mind and making him express himself differently through movement.[2] Like Odysseus, Heracles' 'mad' wandering involved physical travels and mental displacement (metaphorical journeys in his mind), which helped him to return home only to be driven out again to find himself away, totally homeless and lost.[3] As Montiglio notes, in Greek literature 'madness, like exile, was wandering because it alienated the mad from self and society.'[4] In Homeric poems, such crazed travelling was often identified with *hubris*, the transgression of society's recognized moral barriers, a broader substitute for unreason.[5] Several characters in Greek tragedies (Io, Argus) expressed the cause for their mad wandering as *oistros*, a sort of terror or frenzy associated with insanity, which

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forced them to wander without purpose, transgress boundaries of 'sense' and pushed them into exile from settled society.[6] Here the links between madness and fear are established, and mad travellers are seen as consumed with *hubris*, shame and pride that make them tear themselves apart. Furthermore, mad wandering in Greek tragedy was associated with the human condition and the inner conflict of minds divided against themselves, where travelling offered paths to resolution or 'therapy' by allowing the insane to 'wander out' of society.

The stories from early Greek literature hint at three important matters this chapter will investigate further: firstly, the association of madness with abnormal behaviours developing in the process of physical and metaphorical limits; secondly, an expression of madness as a passage between reason and unreason, linked to the drawing of limits between normality and deviation; and thirdly, an opportunity to limit the movement of mad people and restore the insane to health through medical interventions. There is an often overlooked theme here of a complex relationship between geographical mobility, the ordering of madness and the experiences of itinerant individuals deemed insane,[7] which is at the heart of the following discussion. Historical analyses of madness (and its modern equivalent of mental illness) present it as a changeable and contested term, thus prompting its careful use within this chapter.[8] It traces the historical development of this theme in social and textual space and highlights the importance of madness as a sociocultural construct developed and used by society to sanction solutions for problematic mobile people.

Wandering Lunatics and Changing Spaces of Madness

Madness and Migration: Living in-Between

Since the time of the Greeks, medical and literary constructs in literature, and their deployment of the term *mad* in relation to living between the polarities of certainty and ambiguity, marked the beginning of the first important tradition in representing interconnections between insanity and migration. Understanding madness as the process of living in between the polarities of certainty and ambiguity and their correlates[9] closely relates to the understanding of migration as an ongoing struggle of living in between physical and metaphorical points of departure and arrival, which can leave migrants vulnerable to disorientations ascribed to mental illness.[10] From

descriptions of travel in antiquity, migration was often seen as a phenomenon marking outcasts, who struggled to deal with conditions of externality and internality and to find their place in the world. In Greek, one of the meanings of the verb wandering (*phoitaō*) defines 'the unconscious and painful wandering of the mad'.[11] In Greek literature mad wandering is portrayed as the result of individuals being torn between rival demands of duty and desire, love and honour (such is the case in Sophocles' *Ajax*), which leads to the sane majority distancing themselves both geographically (keeping physically away) and symbolically (highlighting the path away from 'good thinking') from the mad. World travellers appearing as madmen in Greek literature display the opposing conditions of certainty and uncertainty, knowing everything and nothing, which can lead to a bout of madness.[12]

Despite its provocative nature, however, travelling madness was not simply condemned as complete otherness, but as the dialogue existing between sanity (represented by the Greek *logos* or reason) and insanity (in the form of *hubris* or unreason). In other words, there was a certain acceptance that madness and its expression in travelling can illuminate new possibilities and new ways of knowing, and that writing from the point of view of the mad may say something important about the world, which effectively complements writing from the point of view of the sane. As a result, in pre-Socratic Greece travelling madness was rooted in the duality of reason and unreason—expressing a dialogue, which was going to be broken in the classical age, thus reducing madness to pathology or even muteness. Complementing literary traditions, Greek medicine developed a binary explanatory framework linking healthiness to equilibrium and madness to extremes of personal and psychological dispositions, as well as offering interventions (such as bloodletting or a change of diet), which enjoyed a long future in the policies of Europe's mental asylums.[13]

This tradition of identifying madness and mobility as living between the contradictory impulses of un/certainty continued in the Middle Ages and the Renaissance. Chris Philo[14] explores the historical construction of madness as a way of facing in different directions simultaneously and living with opposites, accepting paradoxes and contradictions—experiences which can be shared by many migrants caught between departure and arrival. He considers the fourteenth-century poem by William Langland that describes the lives of travelling 'lunatics' as influenced by the phases of the moon and explores opportunities for their inclusion in a settled society.

> But there are other beggars, healthy in appearance,
> Who want their wits—men and women also.
> They are the lunatic lollers and leapers about the country,
> And are mad as the moons grow more or less.
> They are careless of winter and careless of summer,
> They move with the moon, and are moneyless travellers,
> With a good will, but witless, through many wide countries.[15]

As this quote suggests, medieval 'lunatic lollers' were portrayed not only as troublemakers and beggars, but also as curious travellers following a path to spiritual enlightenment. However, such respect for people on a journey seeking closeness to God contrasted with the expulsions and negative reactions experienced by the majority of mad travellers. Medieval 'wandering lunatics' often lived on the threshold between externality and internality, acceptance and alienation, when mental eccentricity tended to be moralized and mental illness was considered as disease. During this period madness was located outside the boundaries of society ('out there') and the insane were condemned to move away from 'lawful' places and travel.[16] *The Book of Margery Kempe* from 1436, which describes her journeys across Europe while suffering from a 'hysterical' mental condition, provides several illustrations of the attitudes to medieval travel as a mentally unsettling activity needing to be tamed.[17] Margery's insistence 'on going everywhere' and her experiences of a psychological malady led to her travels between England, Rome and the Holy Land being portrayed loosely as madness by doctors and church leaders.[18] Her mad voyage was not only self-transforming, but also changed the definition of the limits between which mentally different people were permitted to function: she moved from separation from settled community (travel as a punishment for unconfessed and unrepented sin) to inclusion in a broader society. While in her earlier journeys Margery is described as a 'loller', an antisocial, crazed and mentally different woman, her ability to map her life story onto a religious context helped her to escape earlier accusations of heresy. By linking her travels to the narrative of pilgrimage, she became accepted as some sort of 'good' lunatic traveller with her insanity inspired by the love of God. Importantly, such portrayals of madness as essentially delusional, its increasing identification with erroneous thoughts and irrationality suggested future therapeutic opportunities to redraw the boundaries between the sane and insane and possibilities to retrain the mad to think correctly.

To recap, during classical times several themes of thinking about travelling mad people emerged, which continue to inform our understanding of madness and migration. First, both madness and migration were portrayed as existing between contradictions of externality and internality, certainty and uncertainty. Second, as well as fear and horror, there was a certain positivity attached to both madness and migration, which provoked not merely a condemnation, but also an ambivalent fascination and a belief in a possibility of transcendental movement and closeness to God. Third, due to their changeable character and ambivalent position in society, mad travellers and their portrayals not only invoked a dialogue between reason and unreason, but also prompted potential resolutions in the form of therapeutic interventions. Towards the end of the Middle Ages, this shift towards considering insanity as a treatable disease of the body led to the development of the second important theme linking madness and mobility, which locates both in the transitional spaces of a passage between the changing limits of deviation and normality.

Transitional Spaces of Madness and Migration

The Renaissance saw an increasing interest in madness and migration, each regarded as both the limiting and enabling factors for the avarice that makes wealth grow and for the curiosity that inspired men of learning. During this period madness and migration were considered as a 'passage' between reason and unreason, movement between the known and the unknown, as well as opening up the places and times in which problematic people find themselves.[19] In his book *Madness and Civilization* Michel Foucault describes medieval mad travellers as being caught in a passage between exclusion and inclusion, which signified the beginning of the development of the schism between 'reason' and 'unreason'.[20] He uses the mythical 'ship of fools' (*Stultifera Navis)* moving across the space of Renaissance Europe to illustrate an uncertain passage, a new mechanism of confinement and the expression of a symbolic difference between insanity and normality. Lunatics were put on boats to travel across major European rivers, expelled to wander and to live in transition, so that 'madmen led an easy wandering existence'.[21] Resonating with the earlier Greek literary descriptions, the mad were seen as returning from a voyage, from beyond the boundaries of the known, as bearers of an otherwise hidden truth. Representations of the mad in medieval times as caught between restfulness and restlessness, stillness and movement,

portray their passage as an 'easy' travelling existence, which makes their wandering appear smooth and effortless. Echoed in contemporary depictions of mobility, this approach aspires to make travel quicker and easier for some people within travel infrastructures by limiting unwelcome disruptions and resistances.[22] As a result, such ancient and contemporary visions of madness and mobility as contingent on 'ease' of passage assume the withdrawal of agency from the passenger, who is expected to submit to travelling control techniques (be it the medieval ship or modern engineered spaces of aeromobility) and to make the body amenable to effortless transient existence.

In medieval Europe, such being-in-passage also implied liminality and drew attention to the complex relationships mad travellers had with their surroundings. Symbolically, while travelling across medieval Europe mad people were confined to the prison space of the ship, not linked to its surroundings and existing 'in a liminal space of the passage'.[23] In this case, insanity was ordered not in a fixed space of modern asylum, but it was caught, metaphorically and geographically, in transit between two places.

> Confined on the ship, from which there is no escape, the madman is delivered to the river with its thousand arms, the sea with its thousand roads, to that great uncertainty external to everything. He is a prisoner in the midst of what is the freest, the openest of routes: bound fast at the infinite crossroads. He is the Passenger *par excellence*: that is, the prisoner of the passage.[24]

This quote describes mad people's transitional position in the medieval landscape, which translated into their changeable treatment. The land to which a mad person was travelling was unknown, but as soon as he reached it, the land from which he came became equally unknown.[25] Foucault's view of a madman as confined by the passage and manipulated by 'the infinite crossroads' of its watery surroundings compares to the contemporary understanding of mobility as a passage affected by the 'elementary geographies' of earth, water and air.[26] In this case, sea currents, atmospheric events and geological obstacles are understood to frame the ship's passage and the migrant's journey, with the physical qualities of texture, gravity, buoyancy of water and earth changing the migrant's friction and stability.

Like the changeable experience of madness described by Foucault, migration is often seen as 'the very fluid articulation of people and things'.[27] The figure of the passenger, be it a migrant or medieval madman, invites us to move away from the portrayal of a solitary travelling individual to

explore collections of technologies, imaginings, feelings, identities and objects within which mobile people are sustained. Furthermore, such being-in-passage of a traveller also suggests the unknown, the uncertain and the unidentifiable existences to which Foucault points in his formulation of madness. This uncertain and fluid notion of the mad passenger prompts a broader move away from stable and abstract subjectivities of migrants to 'subjects in transit', who develop 'identifications not identities, acts of relationship rather than pre-given forms'.[28]

Before the penal reforms of the eighteenth century and the reorganization of the space of insanity, madness and mad people continued their nomadic existence, constantly resisting fixity in specific guises and locations. As Philo explains, drawing on Michael Serres' analysis of Foucault's writings, wandering lunatics appeared outside the limits of the medieval social order, while their travels allowed them to exist within 'the original chaotic space in which madness had many points of contact with the world'.[29] Here Foucault stressed that the place of mad people in late medieval geographies was fluid; both exclusionary and inclusionary, yet restless and open to question. During this time, mad travellers were seen as a source of temptation and ambivalent fascination and as objects of disciplinary control. The erratic treatment of mobile mad people as confined to the exterior of settled society yet being allowed to move in and out of it, prompted a further redrawing of the boundaries between sane and insane, subject and object.

To summarize, three key points are found in the new understanding of madness and migration during this period. First, within the landscape of medieval Europe, both madness and migration emerged as shifting connotations, caught between changing symbolic and moral boundaries and prompting a variable treatment of mad travellers. Second, the changeable treatment of travelling lunatics highlighted uncertain and fluid notions of mad subjectivity, with fragmentary and contradictory aspects of identification later subdued in the process of objectifying madness (turning it into an object to be cured and policed). Third, the transient existence of mad people (as passengers) stressed the importance of both the metaphorical and the geographical space of the passage, which can smooth the transition or change expectations about travelling techniques and moving bodies. These developments entailed the emergence of a third tradition of representing itinerant madness in the classical age, which explicitly linked insanity to confinement and led to its repositioning within a specific system of geographic and moral coordinates.

Exclusion, Spatial Fixing and Classification of Mobility and Madness

By the end of the Middle Ages, the relative mobility of 'wandering lunatics' had been replaced with what Foucault terms the marginalization, spatial fixing and 'silencing' of the mad.[30] This attrition of the personal freedoms of travellers highlighted by Foucault resonates with the restructuring of the space of travel itself and the ensuing attempts to fix mobile people. With the start of the classical age, both mobility and madness began to be considered in relation to point-to-point dislocations within a system of orderable and calculable distances located in moral and geographical spaces. On the one hand, the power of confinement and restraint began to be applied to broader society through the mechanism of 'panopticism', a schema of discipline and generalized surveillance intended to make all bodies visible and amenable to self-discipline.[31] Emergent eighteenth-century modes of representation, such as novels, maps, newspapers and statistics, started to publicize otherwise unseen events to everyone and imposed a subtle discipline on all citizens. As a result, as not only mad people but also other travellers became aware that they were being watched by others, they started to internalize this public gaze and applied restraint to their behaviour. At the same time, the development of new travelling technologies[32] and the increasing importance of long-distance migrations led to a growing confinement and even incarceration of passengers, who submitted their mobile bodies to the regulations, trajectories and infrastructures of the emerging systems of travel.[33]

On the other hand, society also witnessed the development of 'sedentarist' thinking as a reaction to travelling people. This theory assumed the moral and logical primacy of fixity over mobility and justified the confinement of itinerants as potentially invasive and a challenge to the power of settled groups.[34] Such insistence upon stability and fixity in relation to mobile individuals started to be closely linked to the treatment of madness in an institutional context: both itinerant and insane people came to be 'treated with almost disdain' due to their limited social and moral roots.[35] From the mid-seventeenth century, mobility and madness started to be seen as a threat to the dominant sedentary society, being considered unproductive in economic terms and in need of isolation and confinement.[36] The development of institutional practices led to the presentation of mad people, paupers and vagabonds as inhuman and contributed to their marginalization in hospitals along with the denial of their own voices. Institutionalization moved madness away from its transitional location in the space of a passage and made it fixed and immobile.

During this period 'confinement replaces Embarkation' in the treatment of madness, and psychiatry was developed as a practice and science meant to restore the insane to health. In Foucault's terms,

> Madness … will never again be that fugitive and absolute limit. Behold it moored now, made fast among things and humans. Retained and maintained. No longer a ship but a hospital.[37]

Apart from the emphasis on isolating the mad, this quote reflects a changing thinking about the world which prioritizes bounded and rooted conceptions of identity for 'things and humans'. The development of confinement here is related to the exclusion of the mad from society and the allocation of a specific fixed place or 'natural abode'[38] for them—an attitude which significantly changed the lives of previously placeless and wandering lunatics. In many ways, confinement symbolically linked together beggars, layabouts, idle travellers and lunatics, who were considered different from normal citizens and identical to each other on the basis of their 'unreason'. The mad were not only denied thought, they were denied existence: 'Madness was excluded, leaving no trace, no scar on the surface of thought.'[39] Foucault suggests that this silencing of madness was linked to the redrawing of the line between reason and unreason and the associated ontological and social alienation of the mad in contemporary discourse on the basis of their inhumanity and idleness.

The classical age therefore saw the birth of an attitude towards the insane which implied a deliberate blurring of the difference between moral and mental problems. This new desire to exclude and confine madness led to a transformation of the link between insanity and migration and a fusion of symbolic and geographical spaces of madness. Once again, mad people were seen as having an 'errant existence'—now in relation to the symbolic space of moral values: 'They err … but it is no longer on the path of a strange pilgrimage: they disturb the ordering of social space'.[40] This representation of madness as moral error that can be redeemed led to the development of correctional mechanisms and moral therapies, which were later put into practice as the moral treatment of mentally ill migrants, a therapy driven by kindness and humanity.

A new distance established between the mad (as 'unreasonable') and therapists ('reasonable' people identifying madness) highlights a further movement in the eighteenth century towards the classification of madness and its consideration as pathology, with a similarity to the order of plants. The

parallel with biology helped to transfer the treatment of madness from an ethical domain dealing with the soul to the corporeal domain dealing with the body and led to the separation of the mad from other problematic people, such as the poor.[41] From the mid-eighteenth century lunatics in France were inspected and certified for confinement by medical officers, while vagabonds were simply signed off by the district prefects. The consequence of this process of pathologizing madness was the imposition of the power of confinement, the enclosed places of imprisonment, locale, over mind—which specifically affected travelling individuals expressing 'classifiable' conditions of violence and disruptive frenzy.[42] In the classifier's abstraction, madness as a problematic condition was 'circumscribed, medically invested, isolated, divided up into closed, privileged regions', such as hospitals.[43] Within the system of classification, the insanity of both itinerant and settled individuals breaking social and moral conventions was slowly mapped in relation to a specific definition of madness and a system of medical coordinates.

Against these frameworks, the mad traveller seemed to be portrayed as 'an abstract, anonymous figure that is an effect of mobility, rather than a self-subjecting identity-figure'.[44] This abstraction assumed mad subjects carried with them a very particular baggage that shaped the kind of understandings developed around madness. These descriptions assumed the existence of a specific 'mappable territory' or space of madness, which can be delineated and assigned specific characteristics.[45] As Philo notes, the abstract construction of a mad person led to an assumption about the existence of an 'ontologically and epistemologically coherent mode of being "out there" which *is* madness'.[46] In early nineteenth-century Europe, the medicalization of madness and its transformation into mental illness entailed the introduction of visual and surveillance technologies, which further contributed to a fixed spatial mapping of insanity in the imaginary classifications and space of social order. Foucault states:

> For the classifiers, the fundamental act of medical knowledge was the establishment of a location [*repérage*]: a symptom was situated within a disease, a disease in a specific *ensemble*, and this *ensemble* in a general plan of the pathological world.[47]

As this quote suggests, practices of classification and abstraction echoed Cartesian geometry. Madness, similar to movement, became framed as an object within the orderable frame of an accepted system of coordinates, medical or geographical systems of reference.

On the other hand, such abstraction and objectification of madness implied a limited articulation of the expressive life of mad travellers and neglected the fact that their individual identities were fragmentary, contradictory and impossible to fit within the presumed 'territory' of insanity. As Foucault stresses, the disciplinary power which functioned to individualize and classify an individual (mad traveller) also foregrounded the actual emergence of the subject and the variable processes of subjectivation.[48] As a result, such approaches often deprived mad itinerants of their material histories and presented them as clearly delimitable objects identified in relation to a fairly stable set of values and treatments.

To conclude, from the end of the Middle Ages interpretations of madness and migration witnessed three important changes. First, the 'great confinement' described by Foucault objectified madness and mobility, robbed them of their empowering features and relegated them to simple negations, absences of sanity and settled life. The interaction between reason and unreason was lost, replaced by a tyrannical, one-dimensional logic of reason. Second, the classification of madness and movement within the system of measurable medical and geographical coordinates reduced them to pathologies and presented them as an abstract system of signs (rather than modes of being) accessible for scientific enquiry. Third, the foreclosure of subjectivity in practices of classification and subtraction entailed a misunderstanding of the plural subject positions of mad travellers—for example, as both fearful and respected 'fools for God'. As a result, apparatuses of conventional psychiatry were deployed to compel the mad itinerants to re-present themselves as patients (as a stable subject) and madness was 'buried beneath the vocabularies of both psychiatric medicine and Freudian psychoanalysis'.[49]

Although this historical analysis of the development of attitudes to madness and migration may appear linear and straightforward, it only attempts to indicate key shifts in thinking that remained current in the West up until the nineteenth century and beyond. Despite attempts to capture and know insanity, it is still impossible for science to express it fully. Foucault himself insisted that everyday exchanges between the mentally normal and the mentally eccentric would inevitably produce more complex representations of insanity[50] and, it could be added, migration. The next section explores the complex lives of mentally ill migrants, of confused signals linked to bouts of craziness and disturbance and their interpretation within the institutional environments of the nineteenth and twentieth centuries.

Psychiatry and the Re-evaluation of Migration and Madness

International migration provides a critical lens through which to reimagine the role of earlier conceptualizations of madness and reactions to mad travellers in modern psychiatry. There are three important continuities between earlier interpretations of madness and understanding its more modern equivalents, such as mental illness, from 1800.

First, there is the continuing tendency, which we originally saw expressed in Greek literature, to link individual cases of insanity to mental disruption and inner conflict caused by migration. Psychiatric analysis of physical and psychological problems experienced by transnational migrants in the nineteenth and twentieth centuries firmly related the stress of actual dislocation to insanity, either immediately after migration or some time after moving to a new destination and failing to adapt to life in a new country.[51] Here migration, similar to its interpretation in Greek literature, is imbued with the horror of being out of place and is seen as the cause for transgressing boundaries of normality in a settled society. In line with the modernist discourse of Western psychiatry, a mad person was seen as lost in the increasingly mobile world of travel, caught up in the terror of placelessness, haunted by 'the horror of the absence of markings'.[52] The ambiguity created by migration, it was argued, could lead to an experience of madness as 'psychological placelessness, a horrifying experience of aloneness and disconnectedness'.[53]

Littlewood and Lipsedge[54] discuss this horror of being lost in relation to the case of Calvin Johnson, a twentieth-century Jamaican immigrant to the UK considered mentally ill by British psychiatrists due to his overzealous religious stance (his Rastafarian belief of being Godlike) and his disproportionate reactions to persecution (singing 'The Lord is My Shepherd' during his arrest). The psychiatric treatment of this individual as 'delusional' presents migration as a problem and represents his behaviour as an illness because of its removal from the 'right' context, which often happens with migrants. McCarthy provides further illustrations drawn from nineteenth-century Irish migration to New Zealand, where religious fervour was recorded as one of the major reasons for admitting migrants to asylums, with a special closeness to God considered abnormal and 'out of placeness' cast as an affront to public order.[55] Similarly, Harper explores the historical records of nineteenth-century British migrants to Canada certified as suffering from 'religious mania' (BC asylums) and 'religious excitement' (patients

in Ontario), attitudes which were seen as grounds for their social and political unacceptability.[56] Unlike medieval reactions to 'fools for God', modern accounts of madness witnessed medicalization and 'psychiatricization'[57] of migrant behaviours, increasingly linking insanity to abstinence from normal habits and considering mental illness as incompatible with rational norms of psychiatry due to its being controlled by some outside, otherworldly force.

Second, migration was also seen as a possible solution for the problems of individuals 'losing their geography' and sliding in and out of madness.[58] Many nineteenth- and twentieth-century migrants with mental health problems attempted to relocate themselves (at least in mind) to places of 'home' through objects, images and stories associated with their place of origin. These descriptions relate to late medieval conceptualizations of madness and migration as shifting processes that balanced externality and internality and reflected an individual's ability 'to live in … double bind without going crazy'.[59] Haarhus[60] analyses the migrant poetry of Janet Frame, her early twentieth-century travels between New Zealand and Britain and incarcerations in mental hospitals, to demonstrate the importance of movement, both physical and imaginary, in escaping the 'territory' of madness by 'connecting history, myth and the fragmented details on different sides of the world'. Frame considered the question of home as a constantly shifting horizon and migration as a movement transcending geographical places: 'How could you go home if you were already home? Or was home some place out of the world?'[61] In this case, migration offered an opportunity to develop new forms of belonging beyond her immediate context of the mental asylum and linked together dreams, memories and symbols of her origin. Similarly, madness expressed in the literary accounts of nineteenth-century migration in the Pacific was often presented as a process of moving between real and imaginary homelands, which 'symbolically challenged the limitations of rationality, bipolarity, hierarchy, authority, and the socially acceptable'.[62]

However, as these movements challenged the 'cartographic reason'[63] of settled societies, they also prompted attempts by psychiatrists to remap the existence of migrants within the preset grid of concepts using the facts of transgressions from the established visions of home. For example, the search for home and homesickness by twentieth-century British migrants in Australia was considered by doctors as the key factor contributing to mental breakdown.[64] Similarly, Harper notes that both the medical assessment and family correspondence relating to a Scottish migrant admitted to British Columbia's Provincial Asylum described homesickness as mental illness:

> It is very heart breaking, his constant desire to get home—'where there is no home.' If we could manage to pay his fare, would it be possible to get him transferred to any institution here [in Scotland]?[65]

Madness in this case appeared as a temporal problem to be solved, with the distant promise of resolution through migration. As a result, the emerging network of mental hospitals in the nineteenth-century British Empire dealt with the transient mad population by encouraging its mobility and 'keeping individuals moving through, rather than into, their institutions'.[66] These modern accounts of migrants kept in passage reflect Foucault's earlier observations about the medieval treatment of insanity within ships of fools, a symbolic practice of transportation involving the purifying power of water, the passage between the known and the unknown and the deliverance to 'home'. As Littlewood and Lipsedge illustrate in relation to British return migration in the nineteenth century, Canadian psychiatrists recommended the deportation of migrants with alleged mental defects and attempted to re-place them within their accepted home, believing that 'the patient will recover back in his original country'.[67]

Third, nineteenth- and twentieth-century psychiatric accounts objectified migration and insanity and presented them as pathologies that needed to be excluded and restrained. Similar to the narratives of Foucault's 'great confinement', disconnected and mentally unstable migrants in the British Empire were often marginalized and sent to mental asylums. There was a continuity between the deliberate blurring of moral and mental problems witnessed in the classical age and the modern treatment of mentally ill migrants. In nineteenth-century Canada and Australia migrant categorization of 'prisoners', 'patients', 'paupers' and 'lunatics' was riddled with ambiguity due to vague definitions of insanity (broadly linked to unproductiveness and social disorder), varied enforcement procedures across different sites and the slow establishment of the institutions of confinement.[68] Notably, itinerant gold prospectors were seen as predisposed to mental illness simply because of their wandering lifestyle, and their mobility was cast as a moral threat to the already chaotic social life of the gold rush. Echoing earlier positivist responses to madness as unreason and pathology, nineteenth-century psychiatrists often recommended the confinement of mentally unstable migrants 'deemed to be "foreigners" in the world of reason' and a potential threat to the social order of colonial life in New Zealand.[69]

However, increasing medicalization of madness led to the classifiers developing more complex meanings of confinement in consideration of the diversity of insane individuals. In particular, gender was used as one of the classificatory criteria of a migrant's insanity. The dominant psychiatric discourse in the nineteenth century considered women to be mentally unstable and more likely to be lost after migration due to 'the perceived weakness of the female body, and the dangerousness of the woman outside the family/community'.[70] The gendered dynamics of committal, diagnosis and treatment of madness in a colonial context also reflected the tendency to classify insane women migrants as more-or-less stable objects judged by the doctors against a set of fixed attributes of 'normal' femininity linked to respectability, social class, 'proper place and behavior'.[71] Borrowing from the treatment of mental patients as medicalizable objects in the classical age, modern psychiatrists also variably deployed the term mad in relation to different migrant ethnicities. In particular, physicians and local authorities dealing with Asian migrants to nineteenth-century Canada located madness within discourses of racial superiority and linked the confinement of insane non-white migrants to their potential threat to colonial order.[72] Similarly, Manderson discusses the example of the exclusionary classification of mentally ill Chinese migrants to Australia, which linked ethnicity to a set of objective judgements and a relatively stable set of values within a dominant racial discourse.[73] Psychiatric treatment of these individuals led to their 'two-fold dislocation': the isolation of mentally ill migrants as a matter of concern within the framework of mental health; and the confinement of the itinerant Chinese as a broader symbol of disease and a threat to white society within the assumed territory of insanity.

The examples in this section demonstrate that developments in psychiatry in the nineteenth and twentieth centuries led to further silencing of mad migrants within the territory of unreason. As a logical consequence of psychiatric rationality, doctors often turned away from listening to the mentally ill and regarded their concerns, histories and expressions of migration as meaningless and irrational cries of distress. Such use of medical metaphors and the pathologizing of migrant behaviour frequently aggravated their original malady and added layers of rejection, fear and exclusion. Through attempts to improve the moral management and diagnosis of mad travellers in relation to dominant orderings, psychiatry continued to develop regulatory environments in an attempt to capture the elusive object of insanity.

Conclusion

During the preceding analysis of variable categorizations and responses to insanity from the Greeks through the Middle Ages to the modern period, madness has emerged as a social construction linked to existing knowledge and used to demarcate troublesome and problematic individuals, such as migrants. On the one hand, both madness and mobility have appeared as active and changing concepts, although the structure of confinement and the exclusion of mad travellers were more or less continuous throughout the observed historical periods. Such categorizations relied on the development of associations between reason and normality, thus reducing the insanity of mobile individuals to otherness. There were noticeable tensions between the practices of containing and classifying mad migrants and the increasing fluidity of global movements, and between reason and unreason in relation to migration and difference. Institutions were forming and maintaining conceptions of madness and migration, but they tended largely to ignore their fluidity.[74] Knowledge and ambition in the process of migration, linked to detachment from practical situations and key factors in moving the world forward, were also framed as unreasonable due to their transgressing the limits of the social order. As a result, the Western tradition considered the 'limit-experiences' of mad travellers[75] merely as signs of transgression rather than as a different reality of stepping beyond the boundaries of a fixed and known world.

On the other hand, during the observed historical period madness and migration were often located within the individual, while the shifting systems of classification attempted to foreclose mad subjectivities. With the eighteenth-century shift in psychiatric practice to locating mental disorders in physical space, the madness of migrants was increasingly classified as a disease of the body rather than of the soul. Modernist approaches have largely rejected the Greek fascination with madness, which offered alternative ways of reasoning and seeing the world. As a result, powerful psychiatric currents have regarded mad migrants as losing their reason and ability to make sense rather than their bodily health. With each new edition of the classificatory systems attempting to impose a simple structure on the complexity of migrant mental states, the precariousness of constructions of the stable subject of mad traveller became more apparent. Despite admissions about different cultures exhibiting different manifestations of madness, continuous assumptions about static and clearly definable mental disorders offered contradictory interpretations of distance and strangeness in relation to continuously changing migration

and migrants. In particular, such stereotyping of mad patients ignored the migration experiences of individuals resisting the social order and attempting to retain their sense of uniqueness and belonging through physical or imaginary travel and oppositional interpretations of institutional structures. As a result, these constructions either overlooked the complex identities of mentally eccentric migrants or wrongly attributed madness to anxiety and fears associated with the development of alternative ways of being and cross-border movement.

There are two lessons that can be learned from this historical analysis of madness and migration. First, controversial and changeable categorizations of mad travellers point to the need to develop an openness to madness and its expressions. This implies the creation of opportunities to learn from the experiences of migrants who are mentally different and to consider their alternative approaches and understandings of travel and the world. As Philo suggests, such reorientation requires listening to 'mad voices [that can] be saying something genuinely different, other, important about the world'.[76] In resonance with the early Greeks' wonder at travelling madness, attention to the alternative visions and sensibilities of those considered mentally different can help to challenge classificatory criteria imposed on mad migrants and to avoid the limits of conformity. In terms of Deleuze and Guattari's 'schizoanalysis', madness can be seen as a set of different orientations in the world, more closely related to the fluidity of being on the move than to the fixed spaces of psychoanalysis. 'A schizophrenic out for a walk is a better model than a neurotic lying on the analyst's couch. A breath of fresh air, a relationship with the world.'[77]

This quote points towards mental difference and mobility as provoking anti-totalitarian, fluid engagement with the world and resisting the fixity of form and territory associated with madness and stability. Possibilities referred to by the term 'schizo' reveal different mad sensibilities and potentially new geographies of madness, which challenge closure and rigidity, and attend to the physical and emotional dislocation of migrants, their faith-based sensations and movements beyond rationality. As Olsson notes, 'even though the (post)modernist Deleuzian is a schizophrenic, he is not a crazy madman, but an outstanding cartographer, a person who has accepted the challenge of mapping the many connections that determine what it means to be human.'[78] Such openness to madness, of course, needs to avoid over-romanticizing insanity and the real terrors and agonies felt by troubled mobile individuals. The challenge is to learn from mentally different migrants in order to find alternatives beyond the constraints of the conventional language which describes madness in migration studies.

Second, the contradictions between the rigid mapping of migration and madness within medical and geographical 'territories' and the increasingly fluid transnational lives suggest the need to move beyond preset definitions of insanity. Both migration and madness are relational as they are constituted, moved and shifted through the movement of people and the cultures that define them.[79] Historical accounts of mad travellers, as discussed earlier, highlighted the importance of migrants belonging to cross-border communities, which is not limited to movement within a grid of geographical and medical coordinates. Even those mentally ill migrants confined within mental institutions were not detached from space since they maintained relationships with their families and engaged in imaginative travel between different homes. As a result, migrants' worldly experiences were not determined by geometry and measurable distance, but by the more prosaic notions of closeness and nearness.[80] Drawing on a broader understanding of migration as 'being on the move'[81] can therefore help to avoid automatically naming the difference exhibited by migrants as madness and thereby pathologizing it. The focus on being mobile can trouble conventional definitions of migration and madness predicated on binary categories of stability versus movement, permanence versus temporariness, home and homelessness, which proved problematic in giving adequate expression to the histories of transnational movements. This perspective can highlight a mobilized engagement of mentally ill migrants with the world, and their relations with other people and things, as well as provide a different approach for a sustained exploration of their transition, voyage and 'elementary' geographies of water, earth and air shaping their travel.[82]

By linking together social theory and migration histories, this chapter has challenged the objectified and purely medicalized treatment of migrants deemed insane and has attempted to reconnect mentally ill individuals with their material environment. By highlighting the elusive and contingent identities of mad travellers, and challenging the illusions of unity and consistency in their treatment, it has further complicated the analysis of mental health and mad subjectivities in research on migration histories.

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PART II

Historical Perspectives

CHAPTER 4

On Being Insane in Alien Places: Case Histories from British India, *c.* 1800–1930

Waltraud Ernst

'If sanity and insanity exist, how shall we know them?'[1]

The motivation for leaving one's homeland on a permanent or temporary basis has been identified in studies on migration as an important factor influencing migrants' physical and mental wellbeing. It has been argued that migrants might possess different characteristics from those inclined to stay behind and may be more, or less, prone to developing particular physical or mental conditions. Push and pull factors have been highlighted most commonly, with economic hardship being considered typical of the former and the expectation of rewarding career prospects or exciting adventures of the latter. Either way, disappointment, feelings of dislocation and utter despair may affect both permanent and temporary migrants. Conversely, migration may not always result in deteriorating mental and physical health: it can sometimes lead to better health and happiness following departure from adverse circumstances in the home country. Research tends to focus on the negative effects of migration on health and on the stresses and challenges migrants face, rather than any enabling and beneficial factors.

M. Harper (ed.), *Migration and Mental Health*,
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The stories highlighted in this chapter also accentuate the hardships, discontent and distress endured by an, as yet unidentified, number of people from the British Isles who went to colonial India during the nineteenth and early twentieth centuries. That there were also those who settled down happily in India once their term of duty was over is attested to, not least in petitions received by the colonial authorities to allow such men to stay on with their *de facto* Indian wives and the often numerous children they had acquired. A number of traders, merchants and planters, too, led a more or less comfortable life with their European or Indian wives. The factors that turn a migrant into a happily settled, reasonably healthy and mentally balanced settler—albeit subject to the usual economic, social and psychological vicissitudes of human life—would require as much attention as those circumstances and dynamics that lead to negative migration experiences. Relocation may not always mean dislocation; staying put 'at home' can involve distress, hardship and disorientation.

European colonial experiences in South Asia encapsulate migration trajectories of a very particular sort. First of all, the social demographics of migration changed considerably in line with the economically driven, evolving nature of British colonial engagements, fluctuating geopolitical strategies and shifting public attitudes and sentiments towards colonial rule among Europeans and Indians. During the East India Company era, from the late eighteenth to the mid nineteenth century, Irish and Scottish soldiers and sailors, and traders, merchants and planters, were over represented among those who sailed to the East. With the establishment of Crown rule following the Indian Rebellion of 1857, the 'jewel in the crown' of the British empire increasingly became a career outlet for Britain's middle classes and an alternative home for a multitude of 'poor whites' who tried to forge a living after being discharged from the military or having jumped ship.

During most of the nineteenth century migration to India and permanent settlement there did happen but were not encouraged. Both military and civil service personnel were supposed to return to 'Blighty' when their contracted time had expired. Poor expatriates found wandering at large in India faced repatriation whenever family connections or parishes that could be charged for their upkeep back home could be identified by the authorities. The British in India were supposed to be temporary migrants, unlike those who worked their passage, applied for subsidized or free transport, or paid their own way to settlements in New Zealand, for example, with a view to remaining there permanently. Even so, temporary

migrants' physical and mental health was no less pushed to the extreme, and in some cases beyond endurance, more than that of settlers, with favoured explanatory tropes for hardships focusing on the adverse effects of the new environments—the heat and dust of India rather than the prairie of Canada or the outback of Australia.

Another characteristic of British population movements within the context of colonial rule requires consideration. Military action was part and parcel of the might of the Raj, in particular during the early period, and the majority of Europeans in India were affiliated with the army or navy. We might ask if their woes could have been akin to the symptoms displayed by those suffering from what is nowadays conceived as post-traumatic stress disorder. There is some evidence for this in relation to soldiers and officers, as well as civilians. In regard to the latter, the circumstances of Joanna Kiernan who lost her children and husband during the Indian Rebellion of 1857, for example, could be considered as a case of war-related trauma.[2] On the whole however it seems that active combat was not a main cause of high morbidity and mortality rates among troops and their families. In any case, this chapter does not focus on any one psychological condition or medically constructed entity, such as 'nostalgia' or 'trauma', but intends to explore the experiences of Europeans during their stay in the tropics and their self ascription of symptoms and causes of ill health and discomfort, as reported by them and their doctors. Some of them were hospitalized in India, having gone 'doolally' (as mental breakdown was then popularly called locally). Others suffered more or less silently, expressing their anguish in letters to family members, without becoming institutionalized in one of the Indian 'lunatic asylums' dedicated to the reception of insane Europeans.

The sources used in this chapter have been selected with a view to elucidating migrants' varied experiences and perceptions, and of identifying different perspectives on migrants' psychological suffering, as expressed in diaries, letters and published autobiographies. Government and court proceedings help shed light on official responses to those seen to behave in unexpected and unruly ways, and medical case notes and certificates provide insights into doctors' explanations of the nature and causes of their patients' conditions. Of course, neither the records based on lunatic asylum reports, nor private correspondence and diaries, are necessarily representative of the fates and sentiments of those who were never institutionalized or whose views have remained undocumented and hence unavailable for posthumous analysis by researchers. They are

representations of some of the personal and structural issues that have been identified in literary accounts and historical writing on Europeans' lives in the East.[3]

Popular Views

> It really is a dreadfully difficult country to keep ones temper in—little difficulties grow simply enormous and every trial is a crisis. We have survived so far which is creditable I think for we've had plenty to contend with, but we've always managed to direct our anger on the outside world which doesn't care![4]

Perceptions of the European experience in India have been largely formed by late nineteenth and early twentieth-century literary representations of life during the Raj: the 'heat and dust' imagery of Forster's *Passage to India*; Paul Scott's *The Jewel in the Crown*; and Rudyard Kipling's stories of, for example, *Soldiers Three,* who suffered the trials and temptations of life under an alien sky. George Orwell's accounts of the isolation and despair of European colonial servants—based on his experience of Burma and his decision to quit the service and a steady career in the Indian Police to join, for a while, the down-and-outs in European capital cities—have shown that many a white man (and some women) suffered from and broke down under the burden they bore during their time in the colony. The literature on the Raj is full of glorifying stories of heroism and exotic splendour as well as tales of depression and mental and physical hardship. How does the popular imagery of British colonial endeavour and European lives in the East dovetail with the evidence we have in the shape of the diaries, autobiographies and letters from civilian expatriates and military personnel, and medical doctors' case notes?

How then was life in an alien country experienced by individuals for whom we have evidence in the shape of personal accounts and hospital records? And to what extent was the alien culture faced by migrants a factor in adverse health experiences? The above quote from a letter of Brigadier E. J. Montgomery's wife to a family member 'back home' in Britain gives some indication of how she coped with irritating aspects of daily life in India. For numerous people on duty, however, this response of 'directing anger on the outside world' would not be acceptable if superiors became the target, undermining discipline. For example, William Wooley, a private,

was finally declared to be of unsound mind after his having 'attempted to strike a Sergeant with a steel fork' when he had been ordered outside for exercise.[5] Open violence towards a superior had not been Wooley's first act of disobedience: he had previously been sent to prison after a court martial.[6]

However extreme Wooley's case might appear, it nevertheless shows how insubordination was handled in pursuit of discipline and obedience: imprisonment and flogging were frequent measures, while declaring people to be of 'unsound mind' was another, albeit less common. The contrasting examples of Mrs Montgomery's statement on the one hand and the consequences of William Wooley's behaviour on the other, show that people's freedom of action differed, depending on their respective social positions and specific roles. The agents of colonial rule were not a homogenous group.

Differences in the definitions of socially desirable and approved behaviour within specific contexts prevailed in the colony as much as they did in British society: social stratification and hierarchy are part and parcel of any military organization, not just in the Indian army and navy. However, according to Mrs Montgomery and many like her, both military and civil duty in the East were something special, to be differentiated from other services. The one-time civil servant and later historian Philip Mason even suggested that 'no one who wasn't there will ever really understand what it was like'.[7] What were those special features that might have contributed to the distinctive position ascribed to the Raj, apparently leading some to lose their temper and mental equilibrium?

Medical Views

> [i]t is necessary to bear in mind that the soldier's health in India, as elsewhere, is the product of all the conditions to which he is exposed. It is not solely the result of climate, nor of locality and dwelling place, nor of diet, habits, nor duties; it is the product of all of these.[8]

Dr W. Campbell, in charge of the lunatic asylum in Bombay (Mumbai) from 1849 to 1864, saw his objective to be 'to restore the habits of feeling, thought, and action, which will fit [the patients] for the business and duties of their various spheres in the social circle'.[9] Since he considered the 'position of the European soldier and sailor in India' as characterized by 'peculiar duties, trials and temptations', he argued that although 'it affords good ground … for a recommendation that [a patient] should not return

to duty, [it] must be admitted, that in no instance, after an attack of insanity should a man be permitted to remain in circumstances and relations which are obviously so likely to lead to a relapse'.[10]

One of the most difficult features of life in India was seen to be the climate. A grenadier who had left Cork in May 1846 noted in his diary that during a troop march 200 men were 'taken sick on the road' one morning and the temperature in the tents reached over 120 °F/49 °C.[11] He mused on another occasion:

> It was very hot the summer through, and we lost some of the finest looking men we had … Were it not for a future existence, and the fear of transgressing the Divine Will, who would not gladly escape from such a scene of torment as this sublunary life presents, by some placid manner of self destruction.[12]

An unlucky gunner by the name of John Luck implored his mother in his very first letter from 'Brompton Barex', before sailing to India in 1839, '& if for ever o adue … sell not my ole close'.[13] He described life during the April heat at Cawnpore (Kanpur) two years later:

> the torment of the moscatiors they are a kind of small fly and are very venisom there sting will often throw you into a fever as you cannot keep from scrating them … i have seen many Brave men who wold think nothing of the feild of Battle cry like children when they have not being able to sleep for the heat and the torment of the incets.[14]

Luck was well aware of the quite different conditions that prevailed for the officer class, telling his mother that 'the oficers have a pasage round there houses and mats hung around and water constantly thrown on them and inside a large number of fans are hung to the seiling and natives to pull them which keeps the rooms constantly cool'.[15]

From a nineteenth-century doctor's point of view the heat presented itself as a crucial factor that contributed to the onset of mental disorder, from which 'removal to a colder climate' was seen to 'afford the only hope for recovery'.[16] According to one of the prevalent medical doctrines, insanity was a disease of high vascular action. The Bengal Medical Board justified the costly repatriation of European military and civilian staff by pointing out to the authorities in England:

> having the brain for its principal seat, and being liable to sudden and violent exacerbations from every cause tending to derange the functions of that organ. Hence, even prior to experience, it might be predicted, that a climate

> like that of India, of which the atmospherical temperature is at all times higher than that to which the European constitution is naturally habituated, and during certain periods of the year sometimes even exceeds the warmth of the body in its healthy state would prove singularly prejudicial to mental disorders.[17]

Although 'exposure to Indian climate' appeared frequently in official statements and medical certificates as the 'exciting cause' throughout the nineteenth century, it was agreed that 'hard living and other irregularities' were also strongly related to attacks of madness. The nature of those 'very circumstances which first produced' the disease were not always identified, but doctors had an implicit understanding of them. Dr Campbell wrote in his report of 1853:

> The records of an asylum, if rightly read are fitted to teach us many touching, and instructive lessons. They tell us of disappointed love, blighted hope, and crushed ambition, of exhausting labour, distracting care, and corroding sorrow, of time mis-spent, and precious opportunities lost, or mis-applied, of unbridled passion, unresisted temptation; weakness, folly, dissipation, and crime.[18]

Despite his Dickensian tone, Campbell conceded that '[it is not our province to deal] with the lessons they inculcate … or the moral they point'. Because of the line he drew between his professional tasks and general moral reflection, there are not many details on the specific circumstances that had led to apparently insane behaviour of patients. Nevertheless, it is clear from the surviving records that patients under the care of Dr Campbell were treated comparatively kindly and humanely. He believed in the, then popular, medical model of 'environmental stress', which assumed that anyone could fall victim to insanity, given a particular combination of stress and predisposition. Like many of his colleagues in Britain, Campbell and some other doctors in India were attuned to the Tukes' dictum of 'moral therapy' and the kind treatment of patients, who were referred to as 'persons unhappily afflicted with insanity'.[19] Take the case of Lieutenant E. C. Zouch whose transfer to England was recommended by Campbell's predecessor, Dr D. Grierson, in 1844. 'Improvement', he explained, 'there is every reason to believe, will follow the sea voyage and no other treatment will be required than that kindness and attention to his personal comforts which his condition imperatively demands, of the impression of which he is very susceptible, and which he is fully able to appreciate'.[20]

From the late nineteenth century, ideas of 'degeneration' became widespread among medical practitioners. However, heat and dust, and a range of environmental stressors continued to be implicated in the onset of mental derangement among Europeans in India. Within the colonial context, characterized by assumptions of European racial superiority, the medical paradigm of degenerationism was better suited to typecast Indians. In contrast, a white person's condition could be improved, even cured, by removing him or her from adverse circumstances, with due attention being paid to their 'feelings and tastes', which were, in accordance with nineteenth- and early twentieth-century mores always seen as strongly linked with social position. Unlike Private William Wooley a few years earlier, Zouch sailed home in first-class as a patient.

Official Views

> 'disgraceful and highly irregular conduct and neglect of duty to the prejudice of good order and discipline...'

Some years prior to Zouch's admission to the lunatic asylum, he had been court-martialled in Bombay Harbour for 'most disgraceful and highly irregular conduct and neglect of duty to the prejudice of good order and naval discipline'.[21] In other words, his conduct was considered unacceptable and deviant. Midshipman Zouch had been ordered to assume temporary charge of the East India Company's steam vessel *Atalanta* moored in the harbour. The ship caught fire and superior officers rushed to the burning vessel, where they attempted to take command of the situation. An argument ensued regarding the line of command, during which Zouch was accused of being too drunk to perform his duty. The senior officers asserted that Zouch had looked agitated and unable to manage the confusion on the burning ship. A court martial was held and although he was found not guilty of drunkenness and only partially guilty of minor insubordination, both the commander of the local forces and the government were 'pleased to direct that Mr Midshipman Zouch be suspended from employment'.[22] Zouch was to be made an example of, in particular in the light of what was considered 'the insubordinate and unmilitary feeling which prevails among many of the junior members of the Indian Navy'.[23]

Zouch had appealed to the court in a moralistic vein, asking it 'to allow of a merciful construction being put on [his] actions and that the result of [his] verdict may not be to throw [him] in the world after ten years'

Service, with [his] prospects totally ruined and [his] character blasted and destroyed'.[24] Reprimand, rather than an understanding of the difficulties in coping calmly with stressful situations like a fire on board ship, was the typical response to events that involved insubordination towards seniors and was dealt with harshly, by flogging and execution.

Even before embarking for India in 1846 a British army private noted that after six weeks in Her Majesty's service, he had seen 'so many flogged that [he] was heartily tired of soldiering'.[25] Things were no better in India and he was soon to witness a soldier's execution. 'The prisoner's name was Richard Riley Atkins, his general Court Martial was read by the Brigadier in a loud impressive tone. Charging the prisoner with the crime of striking the Surgeon … with his shut fist … the Court, after what was called a due deliberation, sentenced the prisoner to be shot.'[26] During the following two weeks two more soldiers were executed: 'One of the Lancers, and one of the 23rd, the latter for striking a Sergeant.' 'Such scenes', the diarist noted, 'tend to make the soldier loathe instead of honouring his profession.'[27] In contrast to officers, soldiers were treated harshly for misdemeanours, with mitigating circumstances, such as environmental and personal stress, rarely being considered.

However, it also mattered whether disorderly and violent behaviour was aimed at Europeans or 'natives'. Frank Richards, who had worked in the pits of Blaina in Wales prior to and after his enlistment as a soldier, narrated an early twentieth-century episode from the place that, as a child, he had heard described as 'a land of milk and honey'.[28] A married sergeant of 13 or 14 years' service one day shot a *gharry-wallah* [cart driver]. He had never before threatened anyone or shown any murderous inclinations. Richards contended that, 'He was a reserved man and respected by all ranks'.[29] There was also no evidence that the heat, so often blamed for unexpected acts of violence and despair, 'had been causing him to behave queerly of late'.[30] Instead of initiating disciplinary procedures, the commanding officer 'allowed him the benefit of the doubt'; he had the sergeant confined in a small padded cell in hospital and told the victim's widow that the man 'who had shot her husband, was a madman and that nothing could be done'.[31] The woman was given ten Rupees and the sergeant sent home to England as an invalid, together with his wife and children. 'The truth', Richards concluded, 'never came out'.[32] Race and social standing intersected in complex ways in the punishment of violent actions.

From the nineteenth century, too, there are cases of officers, though few of NCOs, who had killed 'a native' and were sent back to England on

the grounds of a temporarily deranged mind. Some would return to India after a few years to continue their career.[33] There does not appear to be any evidence for similar circumstances in relation to soldiers, sailors or lower class civilians. It was generally agreed that furlough in England would contribute to a European's physical and psychological wellbeing: officers and civil servants tended to benefit from regular periods back home. Enlistment times for soldiers were long during the nineteenth century, lasting from seven to 21 years. This was a significant period for anybody who was unwell or felt profoundly homesick, like Gunner John Luck.

Military and civil authorities kept a keen eye on the paperwork pertaining to Europeans declared insane. They were not interested in the clinical details, as long as the required medical certificates were provided. The important issue was to identify details of a patient's family and parish to avoid financial liability for a former employee on the part of the East India Company or Her Majesty's military or civil services. Official records, hence, tend to be less illuminating on lower class migrants' personal circumstances and perceptions of migration, in particular, than the diaries and letters sent back to family members.

On Becoming Insane in Alien Places

The lack of information on migrants' environmental and personal circumstances prior to their mental breakdown is exemplified in the case of the trainee officer, Midshipman Zouch, who was certified insane five years after the fire on the *Atalanta*. Correspondence and minutes relating to the disciplinary punishment and financial arrangements fill more than 50 pages, whereas the medical statement of his case takes up only about three sides of paper. How then was Zouch's mental condition recorded? We learn that in 1844 'he attracted the notice of everyone on board of his ship'.[34] Not only did he walk the deck night and day, 'altho' it was no part of his duty', but he 'fancied [one morning] that he was to be hanged at eight o'clock: he attended punctually for the purpose and behaved in the most extravagant manner, when the hour passed and his anticipation had not been realized'. On another occasion on board ship he 'imagined himself transformed into a vegetable, an artichoke, and was in the habit of taking advantage of every shower that fell in order that he might be properly watered'.

Given these events it is hardly surprising that his superiors, charged with establishing and maintaining 'good order and naval discipline', had

no patience with a would-be artichoke, especially during a period when Scinde (Sindh) had just been annexed and the Punjab was about to be invaded by the British. Even the port surgeon, who was subsequently consulted, was helpless when his attempt to talk to Zouch was met by the seemingly incongruous response: 'you must just suffer as well as the rest'. There are no personal letters that could indicate what had led to Zouch's clearly strange, though perhaps shrewd, behaviour during his artichoke episode. The official records, though focused on administrative matters, provide some glimpses about his background.

Edward Charles Zouch was born in 1815 in Canada. At the age of 15 he enlisted as a volunteer for the Bombay Marine and sailed to India on the *Abercrombie Robinson*.[35] His eloquent defence speech on the occasion of the court martial and the fact that 'he spent some time daily in … reading' during his stay in the lunatic asylum at Bombay indicate that he had enjoyed some formal education prior to his nomination for service in the United Company of Merchants of England trading to the East Indies. After ten years of duty he was commissioned as Lieutenant in 1841.[36] During action in the Persian Gulf (Sindh) he suffered from impaired health and sunstroke several times, affecting his ability to discharge his duties.

There was not much else considered noteworthy by the authorities before Zouch's admission into the lunatic asylum apart from the earlier court martial, which was so common a procedure at the time as to not even affect Zouch's promotion prospects shortly afterwards. Doctors' observations following the artichoke episode are more intriguing though, not least because they differed considerably, depending on the patient's circumstances and the doctor's approach. The port surgeon described Zouch as a person 'fast falling into the state of confirmed idiocy' and 'walking about without his clothes and passing his urine and faeces wherever he happened to be at the moment'.[37] Assistant Surgeon Grierson at the lunatic asylum, by contrast, found Zouch to be 'taciturn and apparently indifferent to everything about him', but at the same time 'paying due attention to clothing and cleanliness'. While the port surgeon had commented on the patient's idiotic frame of mind, Grierson stressed indications of 'a degree of consciousness', as evidenced during Zouch's regular morning walks with the doctor, when he took 'great interest in the sea vessels and harbour'.

In an atmosphere of respectful appreciation by Grierson the 'artichoke' recovered quickly—without medical treatment. In keeping with the plant motif, Zouch even showed a 'diligent devotion to painting flowers'. He also engaged in reading and 'often expressed wonder that the day passed

so quickly away'. Echoing moral therapy precepts, Dr Grierson suggested that this improvement was 'effected by kind and encouraging intercourse, [and] the gratification of his feelings and tastes'. Finally, Grierson indicated what might have caused Zouch's bizarre behaviour: the mental derangement, he noted, 'seem[ed] to have supervened' from the disappointment suffered when Zouch was not sent to Europe following the bout of sunstroke in the Persian Gulf. Zouch had been desperate to get a break from duty in the East. Grierson empathized and recommended the patient's immediate transfer to England. Not surprisingly, Zouch recovered during the sea voyage and, being an officer, was sent back on duty and continued his career in the East after a three-year furlough in England.

Given the sequence of events reported in Zouch's medical reports, it seems likely that rather than being, as the formal diagnosis suggested, a 'maniac', with a 'melancholic general constitution', this obviously intelligent and sensitive man faked insanity. As his doctor suggested, he longed to take advantage of a long break in England after ten years of duty, the challenging and embarrassing affair of the *Atalanta* fire, the ensuing court martial, and the debilitating time in the Persian Gulf. Even if we lack detail on Zouch's personal thoughts and feelings, we can assume that the pressures on an individual must have been very severe to drive him to such an extreme means of gaining a release from duty in the East.

Feigning madness was referred to as 'working one's ticket' and was a well-known, though drastic, option chosen by those desperate enough to risk detection and, in the case of the lower ranks, flogging (officially until 1881) and even execution. Richards described several such instances during the 1930s, of men who 'did not take to Army life as easily as I myself … and were so fed up that they would do anything to get out of it'.[38] Some 'tried to get invalided out of the Army on grounds of ill-health, but it was difficult', he reasoned, 'to make oneself ill enough to do this without inflicting a permanent injury'.[39] A less dangerous path was to pretend, as Zouch seems to have done, to have 'lost one's mental balance'. The hope was 'to be sent to a military insane asylum. Once there, they reckoned on being discharged in a few months' time and certified sane enough to return to civil life.'[40] How frequently this happened is difficult to say. Richards provides one example that may not actually have occurred the way he describes it, but stands in for the experience of some of his comrades.

> His last words to the escort were: 'Well, so long, boys. I'll be thinking of you when I'm back in Blighty. I am supposed to be balmy [sic], and so I

> was to join the Army. But, one thing, I'm not half so balmy, and never have been, as those balmy bastards who still have to do six or seven years in this God-damned country. You'll be doing me a favour if you convey to them my deepest, heart felt sympathies'.[41]

John Luck, a century earlier, would have understood the despair and anxiety underlying the cruel bitter sarcasm of this message when he mused in a letter to his mother on his chances of dying from cholera at Cawnpore in June 1841:

> when you get this Complaint there is not time for wrighting for they seldom live more than 12 hours and they are not able to speak some times if every you shold be longer than 1 year or 18 months without hearing from me by going to the east india house in London or giting anyone to go you will get to know wether i ham living or not out of 40 men that joind this battalion with me there is not more than 13 left.[42]

In a postscript the next day he failed to finish on the more positive note he had intended:

> i feel quit strong to day and in good spirits i hope that we shal meet agane this side the grave the hopes of it makes me happy though there does not seem much Chance England home and beuty when i think of my own native land in a moment i seem to be there but relection at hand soon [hurries] me back to despair …[43]

The White Man's Burden

> THROWN AWAY
> And some are sulky, while some will plunge.
> [So ho! Steady! Stand still, you!] Some you must gentle, and some you must lunge.
> [There! There! Who wants to kill you?]
> Some—there are losses in every trade
> Will break their hearts ere bitted and made,
> Will fight like fiends as the rope cuts hard,
> And die dumb-mad in the breaking-yard.
>
> *Toolungala Stockyard Chorus.*[44]

Despite his laments, John Luck did not 'work his ticket'—his mother eventually managed to scrape together the sum required to buy her son's discharge. There was a fine line between the misery leading to feigned madness and actual mental disarray, as is evidenced in the case of gunner Francis Harvey who provided an autobiographical account of his sufferings while confined in the Bombay lunatic asylum under the supervision of Dr W. Campbell.

Harvey was admitted into the asylum in 1852 with the diagnosis of mania.[45] He was then 29 years old and had served eight years in the Company's army in India.[46] Prior to hospitalization he had been in the house of correction following a court martial on account of drunkenness and insubordination. Although prison staff reported that his 'former general character and conduct' were unknown, they concluded that he could 'hardly be considered of perfectly sound mind, previously'. After all, his comrades had described him as 'a gloomy unsocial man'. During his imprisonment he 'sprung upon one of the men who was upon watch … without any previous warning'. When being put under restraint 'by the exertion of several men', he fell into a state of sullenness. Medical treatment was considered called for. A 'blister applied to the head, the frequent use of tartarized antimony in nauseating doses and croton oil purgatives' seemed to 'have been beneficial', resulting in Harvey becoming 'more tractable'. Still, the prison surgeon noted that 'there can be no doubt of the necessity for his removal at once to the Lunatic Asylum'.

At the asylum the superintendent, William Campbell, provided a description of the patient's general appearance. Harvey was 'a square set well proportioned man, rather above the average height—General Appearance is singular …—he is deadly pale, … his expression of countenance is dreamy and absent, and he gazes fixedly on vacancy, as if contemplating things unseen by mortal eye'. His physical condition was described as poorly, as he was 'much reduced in flesh' and health was 'evidently broken'. The latter is not surprising, given the debilitating treatment regime imposed on Harvey in the prison, while on enlistment Harvey had been of 'fresh' complexion and nearly six feet tall.[47]

When asked by the doctor what his name was, Harvey apparently replied, 'Lord Byron. Lord Byron!', elaborating further in a tone and manner of 'great solemnity' on his conviction that he was 'the spirit of the immortal Byron, inhabiting the body of one Francis Harvey', and had spent the interval 'that had elapsed between his departure from the first and his occupation of the second tenement of clay … in the "Halls of

Destiny"'. By describing those 'Halls' as being located in 'vast adamantine plains … peopled with disembodied souls, and presided over by a Mighty Spirit', Harvey revealed good knowledge of his literary namesake, which was unusual for an ordinary soldier. He also seemed to have shared with the poet a special liking for the written word: four days after his admission he took 'the liberty to present [a] shadowy ill remembered outline of [his] former life' to Campbell's 'indulgent notice'. In fact Campbell deemed this to be 'of such interest and importance' that he—contrary to the usual recording practice—inserted it in the medical case description.

Harvey started his six page long autobiography with an expression of his feeling of 'gratitude for the kindly interest' which the superintendent evinced. At first sight this might read as a polite ritual, in accordance with the common conventions of social manners. Given the account of his life history, however, his introductory remark already touches, as we shall see, one of the central themes, the strained relationship between superiors and subalterns. Indeed he goes on, 'your interest becomes more affecting from the infrequency of the exhibition of such a feeling from a superior towards an inferior'.

Harvey opened the life story itself with a clarification of his personal identity, pointing out that, contrary to usual practice, he adopted his mother's family name (his paternal name being Warneford). It becomes evident from the way he described the different social and professional backgrounds of his mother's and father's family lines that he tended to sympathize with his mother's side, despite the fact that it had suffered a decline in wealth and social status. 'My grandfather Harvey about that period from the explosion of his mills [powder mills at Battle in Sussex, in 1798] and also of a banking firm at Hastings in whose affairs he was unfortunately involved, became an embarrassed man.' He was consequently unable to contribute significantly to his grandson's material wellbeing—although he was as supportive as his scarce financial means permitted.

The Warneford line on the other hand had possessed a respectable piece of property 'since the time of Richard 1st by whom it was granted to Robert de Wardenford'. This earlier Norman version of the family name itself indicates that the family had aristocratic antecedents. Moreover, Francis Harvey showed a 'wheat sheaf in blue ink on breast', according to the Register of Recruits and he himself pointed out that his family's 'crest is a wheat sheaf'.[48] Since that early period there appear to have been highly respected family members who continued the upward social mobility of the line. What seems to have irked Francis Harvey most was that, in

contrast to the unfortunate grandfather Harvey, his father's wealthy brother did not help to alleviate his nephew's circumstances. As Francis Harvey ironically put it: 'Dr. Warneford the "Munificent" has frequently permitted his name to be blazoned in the papers as the donor of hundreds, and even thousands of pounds to Hospitals and Colleges etc. but whether, from the above specimen of his ideas of private charity/when the right hand knoweth not the doings of the left/he would be inclined to assist me, I consider very doubtful.'

Francis's 'munificent' uncle was the well-known philanthropist Samuel Wilson Warneford (1763–1855), benefactor of numerous causes, including the Oxford lunatic asylum. Despite being the second son, he had been left a fortune by his mother and acquired further wealth by marriage. Francis was not the only one to detest his uncle, as other family sources reveal that Samuel did not allow himself 'to indulge in the exercise of private benevolence'—he did not leave anything in his will to his poor relations.[49] Francis's father, though educated at St John's College, Oxford, ended up with the respectable but poorly paid position of a village vicar. At his death there was little to pass on to his children, 'the calls upon his income had been so constant and that income comparatively so small that there was little or nothing left'. Keeping in character, his brother Samuel was not inclined to assist the bereaved, 'being applied to excuse himself on the plea that my father had been "an improvident man"'. Francis clearly found this judgement unfair, noting that Samuel and other relatives 'were unjust—particularly if his numerous family and the gentility of his connections be taken into account'.

What then did Francis Harvey contribute to this family history of social success and decline? Francis was born in 1823 at Bexhill, the fourth child and third son in a family of six boys and four girls. It seems plausible that Francis's sympathy, both for his father's position and his mother's declining family fortunes in the context of the history of both sides of the family, may have contributed to his perception of himself as an 'awkward solitary child, fearing even to engage in any but the simplest games or exercise, for fear [he] should excite ridicule in [his] endeavours'.

At the age of eight he was sent to London to be educated at the prestigious Christ's Hospital School. He characterized this period as one from which he 'profited comparatively little', due to his own 'dullness, timidity or diffidence'. It is in this context that he pointed out the connection between his fate in later life and his world view during childhood, 'I remember even at the early age of nine already feeling a settled dread

when I looked forward to the time when I should be constrained to face the world'. His method of coping with his dread of the future and the feeling of impotence and lack of self confidence was arguably the same as that which a decade later was to lead to imprisonment and finally confinement in the lunatic asylum: 'this feeling [of fear to excite ridicule] began to alternate with dreamy reveries of future greatness and attempts in my intercourse with my companions to assume a brusque[ness] and bravado as a cloak to my real diffidence and timidity'. As a result of this personal coping strategy he was expelled from school after five years because of his 'becoming a ring leader in an attempt to run away from the school and also in other acts of insubordination'. Apart from his time in a school at Poplar—where he stayed for two years, eagerly learning 'French, Navigation etc. and participating in lectures on different branches of Natural Philosophy'—his different stages in life were to be continually characterized by insubordination, more or less violent behaviour towards his superiors, and subsequent punishment and social failure.

The account of his professional career after he had left school reads: 'Having already two elder brothers at sea, partly in emulation of them … I determined to follow in the same line.' With some assistance from his grandfather Harvey he 'became what is by courtesy styled a Midshipman in the *Abercrombie Robinson*' and sailed to China in her. He returned in 1840 to find both father and mother deceased. There was insufficient of the family estate left for him to live on—after what little money there was had been earmarked for the education of his younger brothers and sisters—so he 'went on board the *Lady Flora* and sailed to Madras' in 1841. He was subsequently dismissed on account of a quarrel with both the chief mate and the captain during the voyage, and lost his pay of 100 rupees per month. He saw this incident as the 'first step in [his] downward career'.

Harvey then shipped to Malacca as second mate, worked his passage round to Calcutta, went to Moulmein and afterwards returned to England as an ordinary seaman. On arriving home he found his friends 'becoming embarrassed themselves and considered with justice that [he] had had [his] chance and that the younger members must have their turn'. From his appointment as a midshipman with good career prospects he had degenerated to casual employment as an ordinary seaman. For him this marked a further stage in his social decline. He again enlisted to sail to the African coast. There he contracted a serious bout of fever, 'which left [him] for months in a state approaching to imbecility'. On returning to England again he finally decided to enlist as a gunner in the Indian artillery of the East

India Company, 'being tired of the sea and fearing that [his] relatives might become tired of [him]'. His personal life history continued as hitherto—he spent two out of eight years' service in imprisonment on account of insubordination and finally ended up in one of the Company's asylums as 'the spirit of the immortal Byron, inhabiting the body of one Francis Harvey'.

When reading 'Lord Byron's' autobiography it is striking to what a great extent he was aware of the nature of his personal misfortune and the concomitant psychological mechanisms. For example, in reference to the cause of his 'first step in his downward career', he remarked: 'it was sufficient for any one to be nominated as my Superior or to have the power of controlling or injuring me to awaken a jealous distrust which sooner or later begot dislike'. Moreover, in full awareness of the hierarchical structure of army service he even related his psychological response to disciplinary demands. 'This is the feeling which has rendered me so unfit for the army. A sphere where there are so many circumstances to foster and sometimes even to apparently justify it.'

The strict hierarchical structure—one of the army's main features—itself encouraged Harvey's insubordinate tendencies. Nevertheless, this reaction could not easily be conceived of as a conscious rebellion against structural environmental constraints or even an act of individual revolt, or resistance in the Foucaultian sense, against the existing order or the politics of colonialism. Francis stressed that he would have preferred to have shown more obedient and thus more socially acceptable behaviour, 'I know that the feeling [i.e. jealous distrust, dislike] is wrong'. Harvey's experience of his family's misfortunes indicate that he yearned to gain social recognition, if not make his fortune, in the Company's service. In this attempt he was continually unsuccessful. What he actually achieved during his time in India is summarized in these words:

> two years of imprisonment, a considerable portion of which was solitary … This together with the effects of fever and general heat of the climate has by no means improved my idiosyncrasy, a constant and increasing melancholy, which has superseded my old passion—fits of distaste for society, unless when excited by artificial stimulus, and continual repining over the misused past, have rendered me what I am.[50]

What can Harvey's case tell us about migration and health and about insanity as manifested among colonial servants in the East? Both 'Lord Byron' and the 'Artichoke' had increasingly severe difficulties in coping with life within the constraints of the hierarchical structures of military

life. In Harvey's case the strong feelings of the importance of social position and material success, his resentment of the social hierarchy and distrust of superiors, and his lack of self confidence had from an early age engendered both retreat into fantasy and more or less violent responses when reality pressed in on his fantasy world. He had a clear understanding of the roots of his behaviour in his family history up to the failure of both his parents and the perceived inhumanity of his uncle. Taking up colonial service was a career choice for many from Harvey's and Zouch's background who hoped to achieve social recognition and material fortune. They shared this ambition with their lower-class brethren, like John Luck, who realized too late that 'this country would soon kill' him rather than enable him to make his fortune.[51]

But was it really India, the alien place, that had engendered the misery, breakdown and shrewd scheming of Luck, Harvey and Zouch? Judging from their own accounts, the tropical climate and disease clearly took their toll. But other factors seem to have had more substance. Luck's feelings of homesickness and a desperate unhappiness with military life started in the barracks at Gravesend, well before he reached India. Zouch had not fully recovered from the shame and humiliation of his court martial when the heat in the Persian Gulf made him desperate for a break from military service. And Harvey's flight into the fantasy world of Lord Byron was fuelled by his problems in accepting his subaltern position and lack of support from his family. The famous myth of the 'white man's burden' indeed encapsulates a crucial characteristic of these migrants' lives. These men suffered from their own social cultures and prejudices, and the oppressive and restrictive structures of British military and social life.

The white men carried with them not only barriers of social class and rank, but also ethnic, moral and religious stereotypes and prejudices against each other. David McPherson, a gunner enlisted with the East India Company, wrote a letter to his parents in Edinburgh while at sea during his return journey from India, being one of those certified as insane. He lamented about the 'many very many Enemies' he had made when 'striving to do good' by joining the Temperance Society. A conspiracy was instigated by Roman Catholic fellow soldiers, 'by name of Sullivan and Maloney', who were—as highlighted by McPherson, a Scottish merchant's son—'two Irishmen'. One day, while he had been at his post in Dum Dum, 'there was put under [his] pillow a white pocket handkerchief + thereon was written Sullivans name' and they 'reported the whole circumstances to the one authorities'. MacPherson attempted suicide 'shortly thereafter' and remained in such a bad mental state that

he was considered insane and a fit subject for repatriation.[52] In many other cases, the Irish bore the brunt of bullying and petty injustices, but they clearly also gave as good as they got.

Aliens and 'Natives'

Apart from the ubiquitous heat and dust, how did the alien culture figure in migrant experiences? It has been suggested that the personal expectations of wealth and the ensuing problems, such as those experienced by Luck, Zouch and Harvey, led to the attribution of misfortune and misery to the alien, 'outside world', as suggested by Mrs Montgomery, and to disinterest in, and even contempt for, the host population and its culture. Although this seems to have been so in the cases of Zouch and Harvey who were absorbed by their personal psychological needs, it was not always the case. In fact, even Zouch, once given the chance to recuperate from the stresses of military duty in the superior accommodation provided for officers in the Colaba lunatic asylum, enjoyed the exotic scenery afforded to him from the island across to the coast. Richard Compton, who had joined Her Majesty's 12th Royal Lancers in 1856, described military life in Bangalore in a letter a couple of months later to his brother Charles, a painter and civil servant in the War Office:

> my eyes often fill with tears when I think of the many many happy times that I have spent with all my dear friends and how different it is now.—It is not that I am exactly unhappy here, or that I dislike the Country far from it I think it a glorious Country—But I am so very very lonely.[53]

In his second letter he affirms that 'India (or any other foreign Country) is a fine place to see', even suggesting, 'I should much like you My dear Charly to see the Wonders of this place for I am sure with your artistic soul you would glory in them'.[54] Compton's problem was not lack of interest in India, but his painful experience of British military life: 'I like the Country amazingly + am heartily sick of the Army in fact I am sure I shall never do any good in it'.[55] Not surprisingly perhaps, just one year following his passage to India, he was admitted to hospital 'very depressed in Spirits + low in health'.[56]

Gunner John Luck's narrative also suggests a certain interest in Indian life, despite his despondent nostalgia. His sentiments about India and 'the natives' vacillate between curiosity or fascination and disapproval or abhorrence. On 29 May 1841 he described the scene he observed at the riverside in Cawnpore:

> i have stood by the river ganges and sean 7 or 8 bodies burning at one time and 12 floting down the river as they allways throw them in the river affter they are burnt as they call it holy watter and they crowd every morning to bathe in the river men and women all go in together i have seen 4 hundred men and women all in the river together.[57]

He went on to recite a poem that started with the line 'were sacred Ganges pours along the plane the indoo rols to swell the eastern main' and ends with 'the huge buffalo rents the creeking bows and stately Elephants untroubled brows'. Elephants that were 'as large againe as that in wombles Collection' [Wombell's Menagerie toured Britain during the early nineteenth century] exerted a particular fascination on Luck. Still, the wonders of India could not distract people like Harvey for long from a painful awareness of social decline, or Zouch from the desperate need for a break, or John Luck from his longing for home, as he put it, 'i ham so ancious to se my dear native home agane'.[58]

Conclusion

Ketaki Keshari Dyson aptly entitled her 1978 study of the journals and memoirs of European men and women in the Indian subcontinent *A Various Universe*.[59] The varied stories selected for this chapter also illustrate English, Welsh, Scottish and Irish experiences of the migratory process and temporary sojourn in colonial India. For some 'migration', used here in its widest sense as moving from one place to another, meant occasional hardship, misery and unsettling experiences, even insanity. Others coped with the passage to India and their temporary stay in the country just as they would have managed the ups and downs, challenges and threats of life back home where their families struggled to eke out a living, in the case of the lower classes; or strove to prosper during a time when the middle classes were emerging in Britain. Although for some migration led to medically certified, pathological conditions, the act of leaving the green and pleasant land and going East, for whatever reason, constituted a common phenomenon for generations of people from England, Wales, Scotland and Ireland, until decolonization occurred during the 1940s, 1950s and 1960s. Migration was, for a while, one of several default settings for impoverished and upwardly mobile Europeans alike. The pathologization of people movements in much of the extant migration literature, being arguably based on preconceptions that favour clear

national borders and 'authentic' or clearly circumscribed ethnic identities, may not adequately capture the full range of experiences of people who moved across the boundaries of established and emergent nation states. It also prevents us from normalizing migration as a process that may, at times, lead to a person's permanent, or fleeting, feelings of spatial and psychological dislocation, but may also harbour, as Foucault, Deleuze and Guattari have suggested, the possibility for decentred, multiple identities to emerge. This is not to suggest that the personal trajectories of Luck, Zouch and Harvey, for example, should or could be shoe-horned into the confines of postmodern or postcolonial theories. But the conceptual normalization of migration and the migration experience(s), and the investigation of people on the move and of successful relocation as part of the kaleidoscope of human life may help avoid a one-dimensional perspective that employs a single, pathologizing gaze. This may also help us deal with Rosenhan's question, which frames this chapter, about how to differentiate the sane from the insane in different places and what constitutes a 'normal' response in a particular situation.

Notes

1. David L. Rosenhan, 'On Being Sane in Insane Places', *Science*, 179 (1973), 250–8, 250.
2. Waltraud Ernst, 'European Madness and Gender in Nineteenth-century British India', *Social History of Medicine*, 9 (1996), 357–82.
3. The case studies discussed here constitute but a small sample of over 800 cases assessed by the author, and the usual methodological caveats concerning the scope and limitations of medical case reports, diaries and autobiographies prevail. For more details, see, for example, Waltraud Ernst, *Mad Tales from the Raj. Colonial Psychiatry in South Asia, 1800–58* (London and New York: Anthem, 2010), originally published as *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (London: Routledge, 1991); Waltraud Ernst, 'Asylum provision and the East India Company', *Medical History*, 42 (1998), 476–502; Waltraud Ernst 'Idioms of madness and colonial boundaries', *Comparative Studies in Society and History*, 39 (1997), 153–81; Waltraud Ernst, 'Institutions, People and Power', in Biswamoy Pati and Mark Harrison (eds), *The Social History of Health and Medicine in Colonial India* (London and New York: Routledge, 2009), 129–50.
4. Mrs R. Montgomery, Cawnpore [Kanpur], 7 June 1831. Centre of South Asian Studies Archive, Cambridge. [Brigadier E.J.] Montgomery Papers, 12.

5. British Library, London Records of Pembroke House and Ealing Lunatic Asylum, 1818–1892, Medical Certificates, 1843.
6. Waltraud Ernst and Detlef Kantowsky, 'Mad Tales from the Raj', *Society,* 22 (1985), 31–8.
7. Philip Mason, in Charles Allen (ed.), *Plain Tales from the Raj: Images of British India in the Twentieth Century* (London: Macdonald Futura, 1981, originally published 1975), 19.
8. *Royal Commission on the Sanitary State of the Army in India* (London: Eyre and Spottiswoode for HMSO, 1863), XXX.
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10. Pembroke House, Medical Certificates, 1852.
11. British Library, London, Manuscripts. A Grenadier's Diary, 1842–1856. 49.
12. A Grenadier's Diary, 37.
13. British Library, London. Manuscripts. 'My Dear Mother … if for ever o a due, sell not my ole close'. Gunner John Luck's Letters from India, 1839–1844. Letter 1.
14. Luck, Letter 6.
15. Luck, Letter 6.
16. Pembroke House, Medical Certificates, 1852.
17. British Library, London, Bengal Proceedings, 1818.
18. Report on the Lunatic Asylum Colaba, 31 March 1852.
19. Records of Pembroke House, Medical Certificates, 1852.
20. Records of Pembroke House, Medical Certificates, 1845.
21. British Library, London, Bombay Proceedings, 1840, E.C. Zouch.
22. Bombay Proceedings, Zouch.
23. Bombay Proceedings, Zouch.
24. Bombay Proceedings, Zouch.
25. Grenadier's Diary, 7.
26. Grenadier's Diary, 37.
27. Grenadier's Diary, 37.
28. Frank James Richards, *Old Soldier* Sahib (London: Faber, 1936), 14.
29. Richards, *Old Soldier*, 229.
30. Richards, *Old Soldier*, 229.
31. Richards, *Old Soldier*, 229, 230.
32. Richards, *Old Soldier*, 230.
33. Ernst, *Mad Tales.*
34. Records of Pembroke House, Medical Certificates, 1845.
35. British Library, London, Marine Miscellaneous Records, 1830.
36. Marine Miscellaneous Records, 1841.
37. Records of Pembroke House, Medical Certificates, 1845.
38. Richards, *Old Soldier*, 163.

39. Richards, *Old* Soldier, 164.
40. Richards, *Old Soldier*, 164.
41. Richards, *Old Soldier*, 169.
42. 'My Dear Mother'. Letter 8.
43. 'My Dear Mother', Letter 8.
44. Rudyard Kipling, *Plain Tales from the Hills* (Calcutta: Thacker, Spink and Company, 1888).
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47. British Library, London, Military Depots Register of Recruits: Artillery 1839–1840.
48. Military Depots Register of Recruits: Artillery, 1839–1840.
49. Mary Gibson, *Warneford. Being the Life and Times of Harriet Elizabeth Weatherell Warneford,* quoted in W.M. Priest, 'The Rev. Samuel Warneford, MA, LLD (1763–1855)', *British Medical Journal*, 6 September 1969, 587–90. The quotation is on page 589.
50. Records of Pembroke House, Medical Certificates, 1853.
51. 'My Dear Mother'. Letter 11.
52. Records of Pembroke House, Medical Certificates 1830–1842, letter by David MacPherson, August 1841.
53. British Library, London, Manuscripts, Letters of Richard Compton, 21 February 1857.
54. Letters of Compton, 22 June 1857
55. Letters of Compton, 22 June 1857.
56. Letters of Compton, 24 September 1857.
57. 'My Dear Mother'. Letter 7.
58. 'My Dear Mother', Letter 11.
59. Ketaki Dyson, *A Various Universe. A Study of the Journals and Memoirs of British Men and Women in the Indian Subcontinent, 1765–1856* (Delhi: Oxford University Press, 1978).

CHAPTER 5

Unsettled States: Madness and Migration in Cape Town, c. 1920

Will Jackson

Introduction

In the first two decades of the twentieth century, as many as half a million people sailed from the British Isles to southern Africa, a significant proportion of them with at least some idea in mind of permanent migration.[1] Almost all of these travellers spent time in Cape Town, the principal entry point to the subcontinent not only for migrants but also for assorted soldiers, speculators, missionaries and colonial officials and a miscellany of transients for whom Cape Town represented just one episode within much wider itinerations across Africa, the southern hemisphere and the so-called 'British world'.[2] This chapter takes Cape Town in the early twentieth century as its setting to investigate the confluence of migration and mental health through an integrated analysis of psychiatric and non-psychiatric archival sources. By looking at the case files of mental patients alongside case files relating to other kinds of distressed British migrants, its aim is to place mental health—and its failing—in a wider social and historical context than an exclusive focus on mental illness can allow.

It is, of course, impossible to talk of Cape Town at this time without also talking about settlers, race and empire. First settled by the Dutch in the seventeenth century, by the later 1800s South Africa represented a peculiar settler-colonial situation in which the struggle between English- and Afrikaans-speaking settlers was refracted through the wider imperial struggle for subcontinental control. The discovery of diamonds in the

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Cape in 1867 and gold in the Transvaal in 1886 precipitated war between the Afrikaners and the British, and the eventual unification of the Afrikaner republics (the Orange Free State and the Transvaal) and the British settler colonies (Natal and the Cape) under the Union of South Africa in 1910. The discovery of gold and diamonds also helps explain the dramatic increase in the number of Anglophone migrants to the region, while Britain's imperial wars of annexation, against the Xhosa, Sotho, Ndebele, Zulu and, most expensively, against the Afrikaners—the Boers—between 1899 and 1902, brought over 400,000 soldiers to the subcontinent, not only from Britain but also from Canada, Australia and New Zealand. In the 15 years after 1890, Cape Town's population more than doubled from 79,000 to 170,000, but the number of whites, in the Cape as across southern Africa, was dwarfed by the number of black Africans.[3] In 1921 there were 1.5 million 'Europeans' in the Union but almost 5.5 million Africans, Asians and Coloureds. This demographic minority status shaped decisively the lived experience of British expatriates and migrants. As representatives of a supposedly superior race, colonists lived with the often uncomfortable implications of the ideology from which their social privilege derived. They lived, too, in often deeply precarious circumstances. Lacking the social support networks they were accustomed to back home, migrants who lived with or befriended racial 'others' were liable to be shunned by respectable, 'white' society.

Any account of migration and mental health in Cape Town, therefore, must also be a story of racialized social life and colonial (mis)rule. The relevant scholarship, however, has tended to cleave between two quite separate bodies of work. The first, and more established, literature concerns the operation of psychiatry in colonial settings; the second, linking to the history of emotions and obtained—significantly—from non-psychiatric sources, addresses what might be termed the psychology of empire. What follows is a tentative attempt to speak to both fields by reading the records of mental patients together with those of failed British migrants who petitioned government for financial support or passage back to Britain, as well as magistrates' files pertaining to children thought to be living in undesirable circumstances.[4] Whilst it is true that in only a small number of cases is any particular individual traceable across all three of these archives, it is also true that the archives involve a remarkable degree of overlap in terms of the phenomena they describe. In form and content, these records have much in common: all contain migrants' own testimonies, whether in the form of letters, sworn affidavits or the transcriptions of interviews between

patient and doctor; all also contain the content of bureaucratic—that is to say, non-medical—discussion as to how particular individuals were to be dealt with, as immigration officials, police detectives, church leaders and welfare workers puzzled over the anomalous presence of failed white settlers in the infant white Dominion of South Africa; and all contain reconstructions of migrants' past lives, as if answers could be found for a colonist's distress in the backstories to their lives.

In other respects these bodies of sources differ considerably. Those writing to government for help did so freely and with more volition than psychiatric patients or the families of child welfare cases. In presenting themselves as worthy imperialists, however, their letters, more so than the other sources considered here, conform to discursive type. While only the hospital records are framed explicitly around mental illness, petitions from distressed migrants and the case histories divulged by the magistrates' files describe in no less detail the distress—social, economic and psychological—encountered by British migrants in the subcontinent. Indeed, it is precisely because these sources were *not* determined by psychiatric knowledge that they allow us to write of migration and mental illness outside a clinical, diagnostic frame. Above all, they get us out of the asylum, locating the lives of the mentally distressed at large and showing up the intimate relation between social structure, historical context and the entirely private human dramas of individual lives.

Thinking Outside the Asylum

While the history of mental illness has proved a rich vein in the story of European colonialism, by far the majority of this work has been sourced from psychiatric sources: that is to say, from asylum and hospital records, often supplemented with analyses of psychiatrists' published writings.[5] Of the lives of the mentally ill themselves, however, psychiatric records give only a partial view. Beginning with a patient's admission to a hospital or an asylum and ending with their discharge or death, patient records exist entirely within the institution—and within the discursive confines that the institution represents. While patients' hospital careers were exposed absolutely to the expert gaze, their experiences outside the asylum gates were only dimly understood. Indeed, it was precisely the limitations of psychiatric knowledge—and specifically its failure to see beyond its institutional bounds—that accounts for the exhaustive documentation of patients after they had been confined.

To be sure, a number of studies have signalled an intention to get outside the asylum walls. Despite their emphasis on the role of non-medical personnel in the apprehension of mental illness, the tendency to prioritize institutional records has remained. Bronwyn Labrum, in an essay pointedly entitled 'Looking Beyond the Asylum', stressed the importance of family, friends and neighbours in the construction of mental illness in New Zealand—yet she built her argument exclusively from patient case notes.[6] Julie Parle, also focusing on the role of the family in the committal process, nevertheless relied on the admission registers of South African institutions.[7] In documenting patients' 'paths to the asylum' many other historians have revealed what appeared—to neighbours, the police, family members, magistrates and others—as evidence that indicated a person was 'of unsound mind'.[8] The accent in much of this work is more on the social than the clinical history of mental illness but the overriding narrative remains the *construction* of particular individuals as insane.

What is often lost in this approach is an appreciation of the extent to which the experiences of those individuals who entered a psychiatric institution were shared by those who did not. It reinstates the boundary, in other words, between sanity and its absence. And the hospital remains foregrounded, as both the point of archival origin and the logical end point in narrative trails that culminate with a person's committal. Yet there does exist another branch of colonial history that, though it pays scant attention to mental illness as scientifically defined, is nonetheless attuned to the psychic instability of colonial communities and the deep, collectively felt anxieties that stemmed from their suppression of indigenous peoples.[9] As a number of historians have shown, across settler Africa colonial immigrants harboured an acute consciousness of their vulnerability amidst 'native' races. Here and elsewhere, colonists obsessed over the signs of imminent 'native' rebellion. Anxieties around the tenuousness of colonial rule also found expression in intermittent panics over the rape of European women, the disorderly conduct of 'poor whites' and the dangers of tropical disease.[10] While the best of this work has done much to reveal the emotional implications of colonial domination, it can sometimes nonetheless risk flattening out the colonial experience. If the colonial situation engendered particular species of fear and anxiety, it is worth considering how these might have varied according to the particular class position and social background of the afflicted individual. How might we read the intensity and texture of these emotions? And how did they combine with the concrete, material dimensions to any individual human life?

This account focuses on first generation Anglophone migrants with experience of passage from the British Isles to southern Africa. Their histories are compiled from the patient records of the Valkenberg Asylum, the petitions for help that were submitted to the office of the South African Governor General and the case records of Cape Town's Society for the Protection for Child Life.[11] Together, what these records reveal is the fundamentally unsettled nature of immigrant life for a significant proportion of those colonial migrants who entered southern Africa at this time. To settle, by definition, meant to put down roots, to stake belonging—and to remain. What emerges from these archives is the extent to which British migrants struggled in this task. These were people enfeebled by empire: men with broken bodies; women of doubtful or immoral character; children who suffered from their parents' lack of social standing. Imperial wars left veterans scattered across the subcontinent. Miners' phthisis, pneumonia and influenza brought an early death to many more.[12] In such stressful circumstances, the family—elsewhere the primary institution for emotional succour and material support—became stretched and embattled. Often, men and women fell to lives of itinerant and directionless travel, moving from town to town, institution to institution and colony to colony. Many of these, in their appeals to government and their testimony to doctors and welfare workers, described themselves as stranded, their presentation as such conveying their dilemma of being fundamentally 'not at home'.

The life of Jacob Brand dramatizes several of these themes.[13] Brand was 37 years old when he was admitted to the Valkenberg Asylum in November 1907, having been transferred from the prison at Kimberley where he had been held following his arrest for the theft of a chicken. 'He was found close to the Transvaal border', wrote the magistrate who despatched him to Valkenberg, 'and nobody seemed to know where he came from.' In fact, Brand had been picked up on the outskirts of Pudimo, an isolated railway station on the Kimberley to Mafeking line. Convicted for theft, court records identified him as 'Jacob Brand, European Adult Tramp'. In jail, Brand was observed to talk to himself, swear violently and tear his bedding; the warders' testimony was enough to warrant Brand's certification and his transfer under escort on the 600-mile journey south. Committal documents record that Brand had been born in England, had been seven years in the Cape and had been previously domiciled in Johannesburg. His occupation was stated as 'mechanical engineer', his religious persuasion 'Church of England'. As to the cause of his insanity,

whether it was hereditary and for how long Brand had been ill, doctors drew a blank. This was in large part because they could find no relatives or other intimates with knowledge of Brand's past life. As to who might pay for his maintenance costs, 'no friends or relatives [were] available to help him'. Only the name of a single relative, Robert Brand of Accrington, Lancashire, was supplied, to be notified in case of Jacob's death. Brand himself remained at Valkenberg for over 40 years. Collapsing suddenly on a winter's day in 1950 he died 'senile and demented' at 80 years old.

Jacob Brand personifies the figure of the isolated imperialist, the single male itinerant whose past life proved unknowable to those attempting to manage or assist him. In Africa, the character of the travelling white man is difficult to interpret. In colonial myth the explorer and the adventurer were much lionized figures, whose heroic statues derived to a great extent from their confident departure from 'civilisation'.[14] In letters to the Governor General, however, and in child welfare records, we see a different side to the picture. Specifically, we see the women and children whom British migrant men left behind. Empire, as John Tosh put it, served for men as a 'flight from domesticity'; in Cape Town evidence exists of thousands of British men who either used emigration to southern Africa as a way to disavow family responsibilities back in Britain or who left wives and children in South Africa before moving back, or on.[15] Many women wrote to government authorities asking for help in finding their husbands. In other instances, welfare officers found women struggling to keep households together after their husbands had departed. In the child welfare archives, the 'abandoned woman' was a recursive trope. While it is not the case that every man who left his wife did so to terminate his family ties—sometimes they moved in search of work and intended to return—women left alone found themselves under particular stress: first, because often shallow family support networks intensified women's dependence on male protector figures; and second, because in a colonial city such as Cape Town, female respectability carried racial value.

Morality, Migration and the Family

Mary Squire was born in London but migrated to South Africa with her parents in 1886 aged two. She married in 1904, aged 18, in Port Elizabeth in the Eastern Cape, but three years later her husband left for Australia.[16] After three or four letters from him, and one £3 remittance, he stopped writing. Both Squire's parents subsequently died. She then

lived, unmarried, in Cape Town with another man and—after he left her—with another (this man, it was noted, had left his own wife and children in England).[17] Because Squire had successive relationships with men, she was judged of dubious character. Women who lost their husbands, whether they deserted or died unexpectedly, posed a problem for colonial cultures that tied female morality to marriage. What was the honourable migrant wife supposed to do when she found herself without a husband? A respectability-saving return to Britain was perhaps the unstated but expected course of action. But women in that situation, especially those with children, very quickly found themselves in straitened circumstances, needing urgently to find additional sources of income to compensate for their inability simultaneously to seek paid employment and care for their children. One option was to take in lodgers; another was to gain housekeeping contributions from men with whom they had sexual or companionate relationships. Both carried very immediate dangers to reputation. Word from the Child Life Society's patrols was that Squire was 'quite shady'. 'She is a reputed loose character', one Society officer reported, and it was necessary that her children be removed to 'be saved from going the same way'.[18] Notably, Squire herself testified to the same effect. Interviewed by the Society she said that she was at 'her wits end'. She had discovered, she said, that her 14-year-old daughter, Amy, was going out with boys at night to De Waal Park, not returning until after 11 o'clock. 'It almost drove me mad', she said.[19]

Mary asked whether, were she were to go home to England, she would be able to take her children with her. As a temporary measure, she asked that they be taken into a 'safe home' while she 'got out of Cape Town to look for a situation'. Both children were judged to be 'in grave moral danger', however, despite also being noted to be 'in good health and well cared for in every way', and under the direction of the Society they were committed to the Industrial School at Paarl, to remain there until they reached the age of 18.[20] We do not know whether the children remained at the Industrial School or what happened to them after they were released.

The language of mental hygiene percolated the documentation generated by the Child Life Society and children, girls especially, thought to be exhibiting delinquent behaviours were commonly judged to be mentally remiss. In 1912 the British Consul at Elizabethville repatriated 14-year-old Juliet Keats to Cape Town.[21] Explaining why he booked her a second-class ticket (the conventional procedure was to book third-class accommodation, the cheapest transport available) the Consul wrote, 'I recognise that

in this I was acting beyond my instructions, but I took into consideration the fact that the child was travelling alone and is only just over fourteen years of age'. He went on:

> I have seen a good deal of her during the time she has been in my charge and [I] believe that there would have been some danger in sending her by third class … the child has no moral sense whatever. This may be due simply to faulty environment but I believe there must be also some hereditary degeneracy. There is no doubt whatever as to her immorality in the Katanga. This was fully proved in court where her foster mother and another were sentenced to six months imprisonment. I am strongly of the opinion that she needs some years in an institution where she could meet with discipline and kindness and be taught the elements of morality.[22]

Languages of mental illness were entwined with those of immorality. Their disciplinary force, however, was dissipated by migrants' own unruly movement. Moving on was both trauma and resource. By its nature, however, migration was inimical to family life. It was difficult—financially, logistically and emotionally—for a spousal couple, let alone a nuclear or extended unit, to move together. Josephine Hargraves was admitted to Valkenberg in 1926, aged 19. Her birthplace was unknown but her domicile was noted to be Wankie, the Rhodesian mining town close to the Victoria Falls.[23] Her father wrote concerned letters from the Wankie Hotel, explaining that she had 'developed mental trouble on her way out from home'.[24] Josephine, it seems, became 'excited' during the voyage from London to Cape Town. Her father, who travelled to the Cape from Rhodesia to meet her, had his daughter admitted to a private nursing home and returned to Wankie. When they could no longer afford the fees, Josephine's parents requested that she be transferred to Valkenberg. Plans were subsequently made for her to be transferred to the Ingutsheni hospital at Bulawayo, though it appears she may have been eventually released to her parents' care. Whether the family remained in Rhodesia and whether Josephine fully recovered her health is not indicated on her case file. It does appear, however, that her parents had migrated to Rhodesia before Josephine herself left London, where she had been working as a domestic servant. 'She is ignorant and appears to be defective', a psychiatrist at Valkenberg observed, '[she] admits she left school at fourteen and was only trained in the home craft'. If Josephine had found herself stranded, it was not in the colony, as the thinking behind imperial repatriation implied,

but in the metropole—although illness emerged in the act of migration, in the attempt to overcome distance and keep a family together.[25]

On other occasions British migrants found themselves unexpectedly isolated when the people whom they met and married in the colonies themselves migrated to Britain. Una Renwickon went to Cape Town from Dublin in 1912 and married a constable in the South African police. After he was dismissed from the service, however, Renwickon's husband sailed for England, dying in London in 1915. His wife and their adopted child remained in Cape Town where, sick and impoverished as Una was, they soon came to the attention of the authorities.[26] Other times British people married South Africans whom they had met in Britain. In March 1925, a society dedicated to the relief of distress amongst the European poor wrote to a Cape Town magistrate to notify him of Emily Sackville, 'a young English Woman',

> of good address, and apparently decent social standing, who was married in England to the man Sackville, a soldier from the Cape, coming out with him in due course. She is the mother of two children and is expecting her next confinement within ten days. Sackville has suddenly forsaken her, and cannot be traced; and the woman is left in the most alarming plight, penniless … and absolutely despairing, not knowing where to look for help and sustenance among strangers.[27]

Neither movement itself, however, nor the 'flight from domesticity' were the preserve of those who passed themselves as 'white'—or indeed of 'British' men. In 1921 the Secretary of the Child Life Society reported that the 'coloured' child Robert Dobbs had been abandoned by both his parents. His mother, it transpired, was in Cape Town but his father, Harry Dobbs (also stated to be 'coloured'), had worked his passage to England the previous year. He was last heard of performing in 'Allah's Garden' at Drury Lane in London. In a sworn statement to police, Dobbs's own mother, Eleanor (again, 'coloured') stated that she had received 'certain information' as to her son's whereabouts 'through a friend' but had heard nothing during the last six months prior to her interview by the Cape Town CID in February 1921.[28] The racial identity of Robert's mother, Catherine, notably is not indicated. 'I was born in Natal', she testified, 'but left there when a child.' That detail invokes another anterior generation of disrupted—and disruptive—family life. Why did Catherine leave Natal as a child? What had been her home life there? Who were *her* parents? And

who was that friend who passed news to Eleanor of her son's whereabouts in London? Does their presence suggest not only families but also larger networks of racially indeterminate South Africans in the British metropole and elsewhere across the British world?

Deviance and Distress

Case work carried the residue of the hinterland, the invasion of the past. Across all these archives, men chronicled the wars, and the campaigns of the wars, in which they had fought. They listed the diseases they had suffered, the injuries they had sustained, their periods of treatment and convalescence. Stephen Gallway, applying for a free passage 'home to England', introduced himself as 'an ex-Imperial soldier belonging to the South Stafford Regiment'. Gallway had been discharged in Pretoria in 1910 after 12 years' service 'in the Colours'.

> I went all through the Boer War and also in this late War. I am a married man, wife and one child. I have had a lot of ups and down in this country, making it worse. I am not a tradesman therefore it is very hard to get work. I have always worked in the coal mines at home which I am quite used to. All my relations are in England. I have not seen them since 1904 as I went out to India and then came to South Africa. All my discharges are all very good. I should very much like to get home again. I thought when I took my discharge in the country that I should better myself. I enlisted in Sheffield on May 31 1898.[29]

Fifty-two-year-old Joseph Groom gave the following statement to police after his children had been taken into custody.

> I was born in London, England. I am a miner by occupation. I joined the Pioneer Regiment in November 1916 and served in East Africa. In March 1919 I joined the Returned Soldier's [sic] Battalion and came to Cape Town. I left my wife and seven children in Johannesburg. My wife died in Johannesburg on the 31 May 1919. There are seven children of the marriage … I take a drink sometimes but I never get drunk.[30]

Others described disabilities incurred in war that prevented them from work. Matthew Foster was deaf, a condition caused, according to his wife, 'by exposure on the veld while on active service with the British South Africa Company Forces in 1890'.[31] Frank Barnes served in East Africa

during the First World War. 'I was in hospital with fever and poisoned legs', he wrote, '[and] am unable to follow my trade under present conditions as both of my legs have given in and the fever infection[s] are in my leg and breaking out and I am unable to walk.' Barnes claimed to have a four-acre farm somewhere. He could do well, he thought, with 'a little assistance, say 25 to 40 pounds'. While appealing to the fund on the grounds of rational financial investment—Barnes was a good man, went his argument, so financial support would bear fruit—he also invoked the language of mental illness. 'I would be quite satisfied to pull through', he wrote, 'but as it is at present it makes me depressed in my mind to make ends meet.'[32] The wife of Gabriel Whitney wrote that her husband was out of work, seemingly for good. Whitney was also a returned soldier, 'very much wounded in the arm, leg and back'. 'When the dull days come on', his wife wrote, 'he suffers very much.'[33]

The 'dull days' was an evocative intimation for Whitney's mental and physical distress. Applicants appealed to the empathy of their readers. They also raised the threat of social disorder. Tobias Goll, writing after learning that his application for assistance had been refused, stated that it was very hard for 'us men who got crippled in the war' to make a living in South Africa. 'When once we start on Relief Works, you get lower and lower in the gutter', he wrote, 'until serious things happen.'[34] Serious things involved violence, self harm—or 'coloured people'. Mrs Sackville, we recall, described herself as 'not knowing where to look for help and sustenance among strangers'. In Cape Town, British immigrants were socialized to regard people of variable phenotypical appearance as 'other'—as racial strangers. In South Africa, however (and in Cape Town in particular) deep histories of racial mixing meant that skin colour proved a highly unstable, unreliable marker of difference. Much of the case work of local welfare authorities was spent on constructing race: through their textual accounts of individual family lives and via constitutive referents of morality, character, cleanliness and respectability. Segregation, Saul Dubow argued, was a 'policy of social containment': in that light, the work of police detectives, welfare officers and psychiatrists can be understood as part of a shared endeavour to rectify social—that is to say, racial—disorder.[35] Distressed British migrants lived with the consequences of race, inasmuch as they were bound to in their positioning within a racialized society, but the instability of racial knowledge meant that they often failed to recognize racial difference, as did the arbiters of racial classification. Help and sustenance were found by

both British men and women with people classed as 'coloured'. Their doing so was itself liable to count as evidence of moral or mental failing, just as it could also indicate the unfortunate or degraded state of somebody judged to be deserving. Rhys Redwood, 20 years old and in the colony since he was a baby, had been a farmer in the northern Transvaal. His admission certificate states, 'he wandered about aimlessly and was twice put in jail. He preferred to live with natives … [and was] said to have had a disappointment in love and to have financial worries'.[36] Numerous British men passing through Cape Town at this time had children with women classed as 'coloured'. Their ability to parent successfully was hampered by the effects of prevailing racial feeling. When 28-year-old Kirsten Ward died of cancer in 1919, she left two daughters, aged nine and 13, who came to the attention of the Child Life Society after they stopped a passerby in the street one evening to ask for help. Their father, Garth Burroughs, had turned them out of home at six that morning. Enquiries revealed that Burroughs, a 50-year-old fitter from England, was frequently drunk. Further investigations revealed he had a wife and family in England whom he had deserted 13 years before. Both his 'off coloured' Cape Town daughters were taken into care.[37]

So long as men like Burroughs continued to think of themselves as British, as white, their children presented as objects of shame. This is not enough to explain the fact that Burroughs beat his daughters with a strap, but it does situate racial anomaly—the problem of the 'off coloured' daughters—and violence in close proximity. It raises also the question of the family—and of sexual relations between people deemed to be European and those deemed to be 'coloured'. In 1921 an 11-year-old girl, Sarah Chapman, was removed from her mother and placed in a children's home. She was being raised, it was said, in 'a corruptive environment'. It was a judgement that tallied with a particular sub clause of the 1913 Children's Welfare Act, but it emerged from a detailed investigation into Sarah's home. Crucially, a neighbour, Mrs Booyson, testified that while she believed Sarah was fond of her mother, that she was clean and had enough to eat, she was nevertheless at risk. 'I have often seen an off coloured man', she said in a sworn statement at the magistrate's court,

> lying on a couch in the bedroom. I have often seen this man and the girl Sarah playing together … I cannot say if she was ever interfered with in a bad way but there is no doubt that Mrs. [Chapman] is carrying on immoral

> relations with this coloured man. I consider she is a bad woman [and] certainly think she should be cautioned in regard to her immoral relations with this man.[38]

Mrs Booyson's statement was decisive. A police officer reported that Sarah appeared well behaved and fond of her mother. She is 'not neglected in any way', he surmised, and if taken from her mother 'would feel it very much'. Booyson, however, was noted to be 'a respectable European woman' whose statement was 'to be relied upon'.[39] Respect for racial boundaries, in other words, was not just internalized but forged by 'ordinary people'—in this case by a witness whose evidence of racial boundary crossing proved decisive in the separation of a mother from her daughter. In numerous other cases, racial mixing articulated both female immorality and mental illness. Enid Hollister came to South Africa in 1904, aged 17. Doctors described her, variously, as demented, depressed, indifferent, unreliable, imbecilic, irresponsible, unstable and 'a harlot without moral sense or sense of shame'. That she was living, unmarried, with a coloured man in a disreputable part of town was recorded as part of her psychiatric assessment.[40] Lawrence Seabrook, a 49-year-old shoemaker who came to South Africa in 1902, was admitted to Valkenberg in 1918. His case notes state, 'seems to be feeble-minded. Wife is a black woman of low type'. Seabrook, it was noted, had 'no relations available'. In his distressed state, Seabrook's racial transgression took on paranoid proportions. 'He states that his wife has been in league with coloured people in order to kill him', his doctor reported. Seabrook's delusions were symptoms of guilt. He died at Valkenberg in 1932, 14 years after his admission.[41]

Conclusion

Much of the recent work in emotions and empire has clustered, notably, around negative emotions—anxiety, fear and panic. The figure of the 'native rebel' was fixated upon by nervous colonialists who projected onto that figure their own guilty conscience. There is evidence of that fixation amongst psychiatric patients at the Cape, but more common across all three archives is what might be termed racial proximity. Children fathered by white men and coloured women troubled welfare workers, not merely because they were often raised in impoverished surroundings but also because their racial status was hard to define. While the language employed

by staff at the Child Life Society was a language of ill health, it frequently merged moral, mental and somatic components. Ideas of racial difference infused the construction of disorderly Europeans. In Cape Town, the presence of 'the soldier' or 'the sailor' loomed large in the case histories of women whose respectability was in doubt. Itinerant white men, it was well known, occupied southern Africa's violent, ramshackle spaces—the mining compounds, the native kraals, the ships, the docks, the roads—theirs was a form of 'native' contagion.

Fergus Renwick had worked in the South African Constabulary, the Transvaal Town Police, as a labourer on railway construction works in Natal and the Cape and at an explosives factory near Durban. In December 1917 Renwick admitted to a Durban police inspector that 'for a number of years he [had] cohabited with native women'. From these women—again, recycling a classic imperial trope—Renwick believed he had contacted venereal disease, which, he stated, had 'somewhat affected him mentally'. Physically, the police inspector reported, 'he is a fine stamp of a man and shows no outward signs of any complaint, though after a few moments conversation with him, one cannot help noticing that he is suffering from some nervous breakdown'.[42] Renwick avoided confinement at a mental institution, largely because his father in England was willing to send him the £16 he needed for his passage 'home'.[43] In a letter he wrote to the Governor General requesting assistance in obtaining a passage (for a period all third-class accommodation was unavailable due to military requisition) Renwick made no mention of his relations with African women but offered an alternative view on his straitened condition.

> I cannot obtain employment in the country and moreover, rest, change and voyage are almost essential as a cure to my complaint, if such is possible, with residence for some time in a cooler climate. I have … defective eyesight, and bad teeth and as a matter of fact things have been going from bad to worse with me during the 12 years I have spent in South Africa, at the present moment I am in a state of destitution, apart from the £16 sent to me for my passage and rather than spend that here I will starve to death in this country which has spelt 'failure' for me from start to finish.[44]

Renwick's testimony emphasized the hardship of his immigrant life over his cohabitation with African women, but the dossier that contains his life history can be read both for one particular migrant's experience of South Africa's social margins and for the perceived deviance to which his hardship gave rise. Likewise, the appearance of other recurrent

phenomena— poverty, illness and the recourse to sexual and other forms of intimate bodily and affective contact with local people—yields insight into both the subjective reality of migrants' lives and the (only ever partially successful) attempts on the part of authorities to control and comprehend them. Alcohol, for example, features in a large proportion of the case files across all of these archives. While migrants themselves seldom referred to their drinking in their letters or in the statements they gave to authorities, officials wrote in great detail of what they regarded as excessive or problematic consumption. That simultaneity—of reticence on the part of migrants themselves and studied attention on the part of agencies allied to the state—typifies some of the methodological and historiographical challenges discussed at the start of this chapter.

In a study of the diagnostic tables of male and female patients admitted to the Valkenberg Asylum, Sally Swartz highlighted intemperance as one of the most common diagnoses. She linked this to colonial anxieties around the fragility of imperial authority and a prevailing concern with degeneration. Doing so revealed the ways in which the construction of mental illness reflected the intellectual climate of the times, but Swartz's focus on psychiatric knowledge nonetheless obscured the social and psychological reality that an individual's drinking entailed before they entered the asylum.[45] Such an approach stands in stark contrast to that adopted by the imperial historian Jonathan Hyslop who, in writing of British and Irish immigrants deported from South Africa during the interwar years, described alcoholism as 'both a symptom and a cause of the social dislocation among casualties of the imperial world'.[46] Alcohol, Hyslop writes, was not just a theme in deportee offences but also in their personal lives. There is a retrievable history to these people's lived experience, in other words, prior to their apprehension by state officials. It may even be the case that a study of migrant lives is particularly revealing of the social and experiential dimensions of ill health precisely because migrants tended to come to the attention of a range of bureaucratic agencies. Historians must continue, to be sure, to work to a large extent through authorities' own written sources—though as I have attempted to show here, working from multiple archival sites, each framed by its own institutional priorities and ideological concerns, can serve to deepen and nuance the empirical field of view.[47]

The evidence discussed here, it is worth emphasizing, illuminates just a fraction of far larger phenomena: within southern Africa, similar (and similarly copious) records can be found tracing the movement of British migrants through the port cities of Durban and Lourenco Marques;

Johannesburg, the city of gold, was where most optimistic migrants foundered. It was not only Anglophone migrants who encountered the kinds of challenges to mental wellbeing that are described in these kinds of records, however. Cape Town's child welfare archives are populated with the children of Afrikaners, coloureds and English-speaking South Africans, as well as those born to immigrants from Britain. Besides Britons stranded in South Africa, the Governor General's files also contain petitions from South Africans stranded overseas in Africa, Europe, North and South America and elsewhere. A significant minority of distressed migrants passing through Cape Town were continental Europeans. Until 1916 the Valkenberg Asylum admitted only European and coloured patients but black Africans were admitted to asylums across southern Africa. Migrant distress, one of the defining features of African life during the twentieth century, was of a very different order to that recounted here.

Sandra Maß has argued that across colonial Africa, 'it was doctors and psychiatrists who produced the frankest description of European fragility'.[48] In terms of simple volume, the view from Cape Town is different. In the asylum European fragility was effaced, transmuted from subjective distress to diagnostic phenomena, but European fragility in southern Africa is best thought of at large: on the street; on board ship; and loose on the African veld. To 'get outside of the asylum', as some historians have urged, scholars need to get out of the archive of the asylum as well—or, at the least, to read asylum archives together with non-psychiatric sources. In this case what emerges is a picture in which individual migrants struggled to establish viable social structures at the same time as they relied on family and other intimate relations to withstand the hardships of migration. At base, the distressed imperial migrant was a figure of anomaly, the unsettled settler, a character profoundly at odds with the guiding spirit of the settler colony. The fact that the histories of these failed white settlers were recorded in such considerable numbers points both to the closeness of the connection between colonial migration and mental ill-health and to the profound ideological puzzle which, for contemporaries, that connection entailed.

Notes

1. A precise figure is difficult to attain: this estimate is made from numbers supplied in James Belich, *Replenishing the Earth: The Settler Revolution and the Rise of the Anglo World* (Oxford: Oxford University Press, 2009); 379–82; Marjory Harper and Stephen Constantine, *Migration and Empire*

(Oxford: Oxford University Press, 2010), 122–36; and Andrew MacDonald, 'Colonial Trespassers in the Making of South Africa's International Borders, 1900 to c.1950', (unpublished PhD, University of Cambridge, 2012). The question of numbers confounds the problem of definitions: distinguishing settlers, migrants and expatriates from one another is made harder by the fact that many of those who entered South Africa at this time did not have a fixed idea as to whether they would remain in the colony temporarily or for the rest of their lives.

2. For the latest in a series of volumes framed by the concept of 'the British world', see Kent Fedorowich and Andrew S. Thompson (eds), *Empire, Migration and Identity in the British World* (Manchester: Manchester University Press, 2013).
3. Belich, *Replenishing the Earth*, 379, 381.
4. This essay forms part of a larger study into the history of migrant failure and the family in Australia and Southern Africa, enabled by an Arts and Humanities Research Council (AHRC) grant, AH/L004801/1.
5. Significant contributions include Waltraud Ernst, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800–58* (London and New York: Anthem, 2010), originally published as *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (London: Routledge, 1991); Jock McCulloch, *Colonial Psychiatry and the African Mind* (Cambridge: Cambridge University Press, 1995); Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria (*Berkeley, Ca: University of California Press, 1999); Lynette Jackson, *Surfacing Up: Psychiatry and Racial Order in Colonial Zimbabwe* (Ithaca: Cornell University Press, 2005); Sloan Mahone and Megan Vaughan (eds), *Psychiatry and Empire* (Basingstoke: Palgrave Macmillan, 2007); and Leonard Smith, *Insanity, Race and Colonialism: Managing Mental Disorder in the Post-Emancipation British Caribbean, 1838–1914* (Basingstoke: Palgrave Macmillan, 2014). On South Africa, see Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand* (Scottsville: University of KwaZulu-Natal Press, 2007); Tiffany F. Jones, *Psychiatry, Mental Institutions, and the Mad in Apartheid South Africa* (London: Routledge, 2012) and, most recently, Sally Swartz, *Homeless Wanderers: Movement and Mental Illness in the Cape Colony in the Late 19th Century* (Cape Town: University of Cape Town Press, 2015).
6. Bronwyn Labrum, 'Looking beyond the Asylum: Gender and the Process of Committal in Auckland, 1870-1910', *New Zealand Journal of History*, 26, 2 (1992), 125–44.
7. Julie Parle, 'Family Commitments, Economies of Emotions, and Negotiating Mental Illness in Late-Nineteenth to Mid-Twentieth-Century Natal, South Africa', *South African Historical Journal*, 66, 1 (2014), 1–21.

8. David Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 10 (1997), 137–55; Jonathan Ablard, *Madness in Buenos Aires: Patients, Psychiatrists and the Argentine State, 1880–1983* (Calgary: University of Calgary Press, 2008); Catherine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860–1914* (Basingstoke: Palgrave Macmillan: 2009); Roy Porter and David Wright (eds), *The Confinement of the Insane: International Perspectives, 1800–1965* (Cambridge: Cambridge University Press, 2011); Angela McCarthy, *Migration, Ethnicity, and Madness: New Zealand, 1860–1910* (Liverpool: Liverpool University Press, 2015).
9. Kim Wagner, '"Treading Upon Fires": The "Mutiny"-Motif and Colonial Anxieties in British India', *Past and Present*, 218, 1 (2013), 159–97; Maurus Reinowski and Gregor Thum (eds), *Helpless Imperialists: Imperial Failure, Fear and Radicalization* (Gottingen: Vandenhoeck and Ruprecht, 2013); Robert Peckham (ed.), *Empires of Panic: Epidemics and Colonial Anxieties* (Hong Kong: Hong Kong University Press, 2014).
10. Shula Marks, *Reluctant Rebellion: The 1906–1908 Disturbances in Natal* (Oxford: Clarendon Press, 1970), Chapter 6; Dane Kennedy, *Islands of White: Settler Society in Kenya and Southern Rhodesia, 1890–1939* (Durham, NC: Duke University Press, 1987), Chapters 6 and 7; Gareth Cornwell, 'George Webb Hardy's *the Black Peril* and the social meaning of 'Black Peril' in early twentieth-century South Africa', *Journal of Southern African Studies,* 22, 3 (1996), 441–53; Jock McCulloch, *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia, 1902–1935* (Bloomington: University of Indiana Press, 2000); Anna Crozier, 'Sensationalising Africa: British Medical Impressions of sub-Saharan Africa', *Journal of Imperial and Commonwealth History*, 35: 3 (2007), 393–415; Martin Thomas, 'Colonial Minds and Colonial Violence: The Sétif Uprising and the Savage Economics of Colonialism', in Martin Thomas (ed.), *The French Colonial Mind, volume 2: Violence, Military Encounters, and Colonialism* (Lincoln and London: University of Nebraska Press, 2011), 140–75; Brett Shadle, *Souls of White Folk: Settlers in Kenya, 1900–1920* (Manchester: Manchester University Press, 2015).
11. These are held in the special collections of the Jagger Library at the University of Cape Town and the Pretoria and Cape Town repositories of the South African National Archives, respectively.
12. Howard Phillips, 'Black October: the impact of the Spanish influenza epidemic of 1918 on South Africa', unpublished PhD, University of Cape Town, 1984; Harper and Constantine, *Migration and Empire*, 139–40.
13. All the names of individuals discussed in this paper have been changed for the sake of anonymity. This includes both people not treated as mentally ill and those who were.

14. The literature on explorers is considerable. For the most recent contributions see Edward Berenson, *Heroes of Empire: Five Charismatic Men and the Conquest of Africa* (Berkeley, Ca: University of California Press, 2011); Dane Kennedy, *The Last Blank Spaces: Exploring Africa and Australia* (Cambridge, Mass: Harvard University Press, 2013), and Berny Sèbe, *Heroic Imperialists in Africa: The Promotion of British and French Imperial Heroes, 1870–1939* (Manchester: Manchester University Press, 2013).
15. John Tosh, *A Man's Place: Masculinity and the Middle-Class Home in Victorian England* (New Haven, Conn: Yale University Press, 1999), 170–94.
16. National Archives of South Africa [hereafter NASA], Cape Town Records Centre, 1 (CT) 3, 105/19.
17. 1 (CT) 3, 105/19, A. V. Kidd, CID report, 25 March 1919; Mary Squire sworn statement, 21 April 1919.
18. 1 (CT) 3, 105/19: Mabel C. Smith, Secretary Society for Protection of Child Life, to Cape Town Resident Magistrate, 8 May 1919.
19. 1 (CT) 3, 105/19: A. W. Kidd, CID report, 3 June 1919; Mary Squire sworn statement, 21 April 1919.
20. 1 (CT) 3, 105/19: A. W. Kidd, CID report, 25 March 1919; Mabel C. Smith to Cape Town Resident Magistrate, 10 April 1919.
21. NASA, Pretoria, Governor General (GG), 1024, 41–104; 41–125.
22. GG 1024, 41–125, Arthur Pearson, Acting British Vice Consul, Katanga to Private Secretary, Governor General of South Africa, 2 December 1918.
23. Valkenberg archives, University of Cape Town Special Collections, BC 1043, F.E. 2099: Josephine Hargraves.
24. BC 1043, F.E. 2099: E. A. Hargraves to Superintendent, Valkenberg Mental Hospital, 27 May 1926; 19 July 1926; 2 August 1926; 8 August 1926; 15 August 1926; 30 August 1926.
25. Valkenberg, BC 1043, F.E. 2099, patient case notes, September 1926; E. A. Hargraves to Superintendent, Valkenberg Mental Hospital, 14 May 1926; Secretary for the Interior to Superintendent, Valkenberg Mental Hospital, 23 September 1926.
26. 1 (CT), 31, 114:24, M. T. McLouglin to The Magistrate, Cape Town, 30 July 1924; Edwin Davis, CID Police Report, 30 August 1924; M. T. McLouglin to The Magistrate, Cape Town, 30 July 1924.
27. 1 (CT) 12, 34/21, Mabel C. Smith to Resident Magistrate, Cape Town, 7 February 1921; Edwin Davis, CID Police Report, 16 February 1921.
28. 1 (CT) 12, 34/21, Eleanor Dobbs, sworn statement, 8 March 1921.
29. GG 1032, 41–125, Stephen Giles to Secretary, His Excellency the Governor General of South Africa, 18 April 1924.
30. 1 (CT), 13, 59:21, Joseph Groom, sworn statement, 15 March 1921.
31. GG, 1027, 41–333, Angela Foster to the Honourable Lord Buxton, 7 September 1916.

32. GG, 1032, 41–623, F. Barnes to His Excellency the Governor General, 20 April 1924.
33. GG, 1032, 31–619, Mrs Whitney to the Governor General of South Africa, 9 April 1924.
34. GG, 1030, 41–477, T. Goll to His Highness the Governor General, 22 January 1923.
35. Saul Dubow, *Racial Segregation and the Origins of Apartheid in South Africa, 1919–1936* (Basingstoke: MacMillan, 1989).
36. Valkenberg, BC 1043, M.E. 2156, First Periodical Report on a Mentally Disordered or Defective Patient, 16 May 1917.
37. 1 (CT), 2, 64:19, History Sheet; CID Police Report, 2 December 1918; Probation Officer to The Magistrate, Cape Town, 30 July 1920.
38. 1 (CT), 16, 208/21, Mrs Booyson, sworn statement (undated) appended to CID Police Report, 30 August 1921.
39. 1 (CT), 16, 208/21, H. Jones, Woodstock CID, to Sub-Inspector Spence, Woodstock Police, 30 August 1921.
40. Valkenberg, BC 1043, F.E. 2076, Superintendent, Valkenberg Mental Hospital to Attorney General, 20 September 1914; First Periodical Report on a Mentally Disordered or Defective Patient, December 1917.
41. Valkenberg, BC 1043, M.E. 1872, Case of Lawrence Seabrook, various documents.
42. GG, 1028, 41–350, A. W. Tuffs, Constable Durban CID, report, undated.
43. GG, 1028, 41–350, S. Grimaldi, Sub-Inspector Durban CID, to District Commandant, Pietermaritzburg, 5 December 1917.
44. GG, 1028, 41–350, F. Renwick to His Excellency the Governor General, 24 November 1917.
45. Sally Swartz, 'Changing diagnoses in Valkenberg Asylum, Cape Colony, 1891–1920: a longitudinal view', *History of Psychiatry*, 6 (1995), 431–51.
46. Jonathan Hyslop, '"Undesirable Inhabitant of the Union"… "Supplying Liquor to Natives": D. F. Malan and the Deportation of South Africa's British and Irish Lumpen Proletarians 1924-1933', *Kronos* 40 (2014), 178–97.
47. For a collection of essays that deliberately gets beyond authorities' writing, see Fiona Paisley and Kirsty Reid (eds), *Critical Perspectives on Colonialism: Writing the Empire from Below* (Abingdon: Routledge, 2014).
48. Sandra Maß, 'Welcome to the Jungle: Imperial Men, "Inner Africa" and Mental Disorder in Colonial Discourse', in Reinowski and Thum, *Helpless Imperialists*, 96.

CHAPTER 6

Ethnicities and Environments: Perceptions of Alienation and Mental Illness Among Scottish and Scandinavian Settlers in North America, c. 1870–c. 1914

Marjory Harper

'The history of migration is a history of alienation and its consequences'. That was the verdict of Oscar Handlin on the collective experience of 35 million immigrants in the United States in the century after 1820.[1] Migration has always been a contentious phenomenon, the controversy generally focusing on whether it was beneficial or detrimental to the security and prosperity of donor and recipient countries and communities. The recurring, and much debated, dilemma for politicians and employers in places of supply was whether to promote or discourage an outflow that might—depending on circumstances—be hailed as an escape route for the destitute and disaffected, or demonized as a debilitating loss of brain, brawn and capital. Meanwhile, host societies were equally ambivalent about whether new arrivals represented a welcome injection of cheap labour or an offloading of the unemployable.

Such depersonalized, policy-driven debates rarely considered the practical and psychological repercussions of migration for participants, although deterrent legislation and hostile public attitudes in the host lands had a significant impact on the settlement process. Oscar Handlin's assertion that migration involved an 'arduous transplantation' was swiftly countered by critics who, in the 1950s and 1960s, preferred to highlight

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integration, assimilation and cohesion, echoing the confident claims of earlier propagandists that migration was benign and beneficial.[2] It is only in recent years that researchers have begun to delve into the records of gatekeeping agencies, jails and asylums to address issues of distress, desolation and dysfunction in the collective and individual experience of migrants.[3] Drawing on a combination of personal testimony, fictional portrayals and historical documents, this chapter explores the causes and consequences of cultural alienation and mental illness among Scottish and Scandinavian settlers in North America between around 1870 and the First World War.

For much of the nineteenth century, Norway and Scotland followed hard on the heels of Ireland at the top of Europe's league of people-exporting countries.[4] The much-scrutinized Irish narrative was dominated by the catastrophe of the mid-nineteenth-century famine, with its emphasis on enforced exodus. The mental health implications of Irish mobility have been addressed fairly frequently in recent scholarship,[5] but Scottish and Norwegian migration, which was more commonly a quest for betterment based on a greater degree of choice, has not yet undergone detailed analysis from that perspective.[6] Although Sweden and Denmark supplied fewer participants, they have been included in the Scandinavian part of the study primarily because of the significant corpus of fictional writing that addresses the destabilizing impact of emigration from Scandinavia, particularly to the American midwest.

The study falls into two broad sections, the first of which identifies and evaluates general evidence of disillusionment among real and fictional immigrants. These individuals either inferred, in coded language, some of the difficulties of adjustment to new surroundings, or articulated the dislocating experience of intercontinental migration in outright warnings, angry outbursts and lamentations. Commentators and novelists often emphasized the role of environment, broadly defined, in triggering unsettlement, not least as inflated expectations of the new world were punctured by the harsh realities of transatlantic travel, extreme climate, dirt farming, exploitative workplaces or an alien culture. That broad context of settler alienation is then narrowed down to a medically rooted exploration of what happened to immigrants when disappointment and alienation took on pathological clothing, and considers whether environment was a key trigger for mental illness among migrants or whether factors such as ethnicity or heredity were seen as more significant.

Alien Environments: Disillusionment, Distress and Dislocation

The complexity of emotions and attitudes embodied in migration is captured in a bronze and marble monument unveiled in September 2013 on the quayside at Halifax, Nova Scotia. It is close to the site of Pier 21 where, between 1928 and 1971, one million new immigrants to Canada disembarked. The family separation depicted in the sculpture was, of course, only one thread in the tapestry of migrant emotions, but the very different body language of the man and woman demonstrate the gendered element to which frequent allusion was made in both documentary evidence and fiction.

Many emigrants set off for the New World with the optimism and determination suggested by the demeanour of the male figure in Armando Barbon's sculpture.[7] Their heads were filled with recruitment agents' honeyed assurances of fertile lands on which they could farm independently, good remuneration for wage labourers and an amenable society into which they could blend with effortless ease, jettisoning the evils of the old world while retaining its benefits. After Confederation in 1867 the Canadian government's promotional spotlight was trained increasingly on the prairie provinces, while south of the border the midwestern states were making an equally assiduous pitch for settlers.[8]

While some immigrants suffered in disillusioned or distraught silence, public complaints of misleading promises abounded. Four months after arriving in the Northwest Territories in 1903 a Scottish settler wrote back to the *Aberdeen Journal* that, far from achieving the success that fraudulent railway promoters had indicated was guaranteed to the industrious immigrant, the 400 new colonists who had travelled west on the train from Calgary were eking out a 'miserable existence' in and around Red Deer. 'I am very much discouraged', he wrote. 'My mind is so full that I can hardly write as I would like … everything is so different to how it is coloured and puffed up in their pamphlets.'[9]

To settlers from Europe and eastern Canada, the prairie was not only an empty and anonymous ocean-like wilderness devoid of trees, hills and hedgerows; it was also a 'half-made land' of unimaginable and unsettling psychological strangeness and a place where they feared losing their way in the featureless surroundings or being caught on the open plains during a fire or storm.[10] Even the quarter-section homesteads existed only on paper and bore no distinguishing feature from the surrounding land. Equally

unsettling were their earlier encounters with the towns where they alighted from the train before heading out to claim their homestead. These makeshift protrusions were, according to Edward McCourt, 'alien eruptions upon the face of nature', completely different from the long-established European towns and villages familiar to most of the new arrivals.[11]

The most frequent complaints concerned environmental hazards and loneliness. During Canada's intensified prairie recruitment campaign in the 1890s all references to inclement winter weather were replaced in official publications by euphemisms such as 'bracing' or 'invigorating', and snow-covered scenes were banned from promotional posters.[12] Yet no such window dressing could neutralize the unprecedented challenge of protracted winters with life-threatening sub-zero temperatures. Peter Wallace and his sons William (22) and Andrew (15) emigrated from Scotland to Manitoba in spring 1881, intending to establish a frontier farm. William's monthly letters home to his sister document the 'extraordinary precautions' that had to be taken in winter, especially when travelling, and the 'great many mishaps' suffered by neighbours who had died or lost limbs to frostbite.[13]

William Wallace, anticipating his first winter, was concerned that 'the long dark nights will be very monotonous'.[14] But monotony was not confined just to winter. The Countess of Aberdeen, visiting the two-year-old settlement of Hebridean Scots at Killarney in Manitoba in October 1890, found the prairie repellant:

> May Heaven preserve us from ever being fated to banishment to the far-famed wheatlands of Manitoba. Oh the inexpressible dreariness of these everlasting prairies, with their serpentine black trails winding through them—the struggle to live has swallowed up all the energy, and it has been quite the exception to see even any attempt after the commonest of tidiness, much less any effort to nurture a few flowers or plant a tree. One would not think that such a life could be helpful in fostering any higher tendencies.[15]

Ishbel Aberdeen's sentiments resonated with many settlers and commentators. Her claim that prairie settlers 'must realize what solitude means in a way which can scarcely be understood by those living in mountainous regions' was echoed by the Norwegian novelist Iver Bernhard when one of his characters asked rhetorically about Minnesota: 'How could people from beautiful enchanting mountains endure life on this flat moor without even a decent hill to look at? … On this great plain it seemed there could be nothing great to aspire toward or long for. All poetry and yearning were as though left out of life, or would be smothered if they appeared.'[16]

Environmental differences—which could be occupational and cultural as well as topographical—influenced the settlers' ability to adjust. Those who had come from close-knit communities were also unprepared for solitude. Archibald Docherty from North Uist recalled in old age 'the great loneliness of prairie life, after living in the islands where people were crowded together'.[17] He had arrived at Saltcoats in the Northwest Territories in 1889, along with 49 pioneer families, to the settlement which, along with Killarney, had been initiated by the British government a year earlier in an attempt to solve longstanding problems of land hunger and demographic pressure in the Outer Hebrides.

Pioneer wives in particular had little opportunity to retain or foster the higher aspirations whose absence was regretted by Lady Aberdeen and Iver Bernhard. Gendered problems of adjustment were often related to social and cultural background, especially for women who had been uprooted from an urban or urbane location, only to be replanted in the primitive squalor of a homesteader's sod house.[18] Climatic hazards, illness and death also played a part. William Wallace wrote of a neighbour whose shanty had burned down during the winter, and whose children had subsequently suffered frostbite. 'I pitied the sight his wife presented cowering and shivering at the stove. She was brought up in the West Indies … How they expect to get along I cannot imagine, as they are not worth a cent, and [have] only three acres broken. Such are some of the afflictions of pioneers.'[19] In the 1950s the Saskatchewan Archives Board circulated a series of questionnaires to elicit the recollections of pioneers about various aspects of settlement between 1878 and 1914. One respondent to the health questionnaire remembered 'a whole family of children contracting diphtheria, three of whom died. They were isolated because no one but the minister and doctor dared go near them. The mother had to wash and dress the little bodies and carry them down stairs in the burial box.'[20]

The particular loneliness and vulnerability of women is a theme that runs through two Scandinavian novels of pioneering on the US prairies. Vilhelm Moberg (1898–1973) was a Swedish journalist and author who, over a ten-year period from 1949, published a tetralogy of novels describing one family's migration from Smaland in southern Sweden to Chisago County, Minnesota, in the mid-nineteenth century.[21] The fiction draws on the real historical background: 1.2 million migrants left Sweden for America between 1824 and 1930, and more than 300,000 came from Smaland. Many of them, like the fictional party in the novel, were fleeing from rural poverty, famine, landlessness, social oppression and religious

persecution, and the story paralleled the experiences of many of Moberg's own family.[22] The central characters were Karl Oskar Nilsson and his wife Kristina. Karl and his brother Robert were convinced that America held out the promise of a better life, but Kristina did not want to leave her homeland, and only after the death of their oldest child did she accede to her husband's plans. But she never shook off her homesickness and when she died after a miscarriage Karl Oskar's increasing material success was marred by his personal loss and the negative impact of America's melting pot culture on his children.

Moberg is sometimes compared with Ole Edvart Rølvaag (1876–1931), whose novel about Norwegian settlers in Dakota Territory, *Giants in the Earth (Verdens Grøde*), centres on the anguish of the pioneer wife, Beret. Rølvaag (original name Ole Edvart Pedersen) was born on the island of Dønna, just south of the Arctic Circle, on Norway's north coast, and during his teens worked with his father and brothers at the fishing grounds off the Lofoten islands. At the age of 20 he emigrated to South Dakota, thanks to an uncle in the USA who sent him a ticket. For two years he worked as a farmhand before resuming his education and ultimately becoming a professor at St Olaf College in South Dakota.

Giants in the Earth centres on three Norwegian families who leave the Lofoten islands in 1873 to settle in Dakota Territory. Like Karl Oskar Nilsson, Per Hansa could see only the promise of the west, and the prospect of wealth and land ownership, but his wife, Beret, was consumed by loneliness and homesickness, intensified by the unsettling surroundings and her pregnancy.

> The formless prairie had no heart that beat, no waves that sang, no soul that could be touched … or cared … The infinitude surrounding her on every hand might not have been so oppressive, might even have brought her a measure of peace, if it had not been for the deep silence, which lay heavier here than in a church. Indeed, what was there to break it? She had passed beyond the outposts of civilization; the nearest dwelling places of men were far away. Here no warbling of birds rose on the air, no buzzing of insects sounded; even the wind had died away; the waving blades of grass that trembled to the faintest breath now stood erect and quiet, as if listening, in the great hush of the evening … All along the way, coming out, she had noticed this strange thing: the stillness had grown deeper, the silence more depressing, the farther west they journeyed; it must have been over two weeks now since she had heard a bird sing! Had they travelled into some nameless, abandoned region? Could no living thing exist out here, in the

> empty, desolate, endless wastes of green and blue? … How *could* existence go on, she thought desperately? If life is to thrive and endure, it must at least have something to hide behind![23]

Back in the realm of real migrants, the fact that promotional publicity was all targeted at men was a source of concern to Anne Macdonald, the Canadian federal government's recruitment agent for the Scottish Highlands in the 1920s. Part of her remit was to tour her area delivering public lectures and holding private interviews with interested families and individuals. During a visit to a crofting family near Bilbster in Caithness in 1924, she had plied the crofter with pamphlets, but in a memorandum to her superiors in Ottawa she expressed her frustration that because of the lack of written information specifically for women, she had been unable to give his anxious wife anything more than verbal reassurance.[24] Macdonald's claim was echoed by Janice Dickin McGinnis's subsequent assertion that Canadian recruitment propaganda in the early twentieth century was not only male dominated, but its misleading nature was 'particularly harmful to women'.[25]

Pathologies of Alienation

Misleading propaganda and environmental alienation undoubtedly contributed to the 'arduous transplantation' highlighted by Oscar Handlin, but did they actually trigger mental illness? Evidence tends to be anecdotal and impressionistic, even in medical records, which are characterized by inferences rather than explicit statements of causation. Vilhelm Moberg committed suicide in 1973, and while none of the emigrants in his tetralogy was explicitly affected by mental illness, both his central characters experienced depression. Even the optimistic Karl Oskar found the confinement of the transatlantic voyage 'depressing to his mind', while Kristina's recurring homesickness was expressed in terms of bewilderment at her alien surroundings, apprehension for the future and spiritual guilt at her actions. On the eve of departure, news of an emigrant shipwreck caused her to reflect on her ultimate accountability.

> The children were left in her care by God—wasn't she an irresponsible mother to take her helpless little ones out in a fragile ship to cross the forbidding ocean? She did not fear for her own life; but had she the right to endanger her children? If they went down with the ship, then it was she

> who drowned them, and God would ask accounting for them on the Day of Judgment.[26]

Ole Rølvaag more explicitly attributed mental illness to the 'strange spell of sadness' the 'unbroken solitude' of the prairie cast upon the minds of some settlers, claiming that 'Many took their own lives; asylum after asylum was filled with disordered beings who had once been human'.[27] In *Giants in the Earth* he charted the descent into depression of his central female character, Beret, who was unsettled by homesickness, thwarted expectations, an alien environment and childbirth. Even worse, she was consumed by a crippling guilt that, in defying her parents' wishes and abandoning her birthright by going to America, she had, not unlike Kristina Nilsson, also defied divine authority—in Beret's case God's commandment of filial obedience. In that way the author raised her anguish onto the plane of spiritual warfare.

> And she had done it gladly, even rejoicingly! … Was there ever a sin like hers? … Then she had arrived in America. The country did not at all come up to her expectations; here, too, she saw enough of poverty and grinding toil. What did it avail, that the rich soil lay in endless stretches? More than ever did she realize that 'man liveth not by bread alone!' … Even the bread was none too plentiful at times.[28]

In Beret's eyes, the stampede to the west had taken on a dangerously febrile form, as 'people drifted about in a sort of delirium'. She began to interpret every setback as a divine punishment for sin while every decision taken (such as the adoption of American names) was a further step away from their Norwegian heritage.

> But no sooner had they reached America than the west-fever had smitten the old settlements like a plague. Such a thing had never happened before in the history of mankind; people were intoxicated by bewildering visions; they spoke dazedly, as though under the force of a spell … 'Go west! … Go west, folks! … The farther west, the better the land!' … Men beheld in feverish dreams the endless plains, teeming with fruitfulness, glowing, out there where day sank into night—a Beulah Land of corn and wine! … She had never dreamed that the good Lord would let such folly loose among men.[29]

Beret's anguish was intensified by the way in which material ambition and the desolation of the prairie had dehumanized and even criminalized

her feckless and irresponsible husband, who staked his claim to the land by removing the landmarks placed by earlier Irish settlers and ran them off violently when they returned to challenge his claim. She was further unnerved by an encounter with a passing family of Norwegian land seekers whose loss of a baby—buried on the prairie—had led to the wife becoming 'insane from grief' and being tied up inside the wagon by her husband because she kept alighting and returning to the burial site.[30] In the end, however, in a strange twist of fate, Beret regained her sanity with the help of an itinerant minister who then stayed on in the community, and it was her husband, Per Hansa, who succumbed to the hostile prairie environment, dying alone in a blizzard.

Aksel Sandemose (1899–1965) was a Danish-Norwegian novelist who was one of the finalists for the Nobel Prize for literature in 1963, although he is not well known beyond Scandinavia. As a teenager he went to sea, but jumped ship in Newfoundland and worked in a lumber camp. Later, living back in Denmark and then in Norway, he wrote a series of partly autobiographical novels which reflected his interest in psychoanalysis and mental illness. One of those novels, *A fugitive crosses his tracks [En Flytning krysser sitt spor]*, concerns a Scandinavian who emigrated to Newfoundland as a response to having committed a murder, an act apparently caused by some kind of psychosis.[31]

Sandemose, like Moberg and Rølvaag, also highlighted the particular vulnerability of immigrant women, although he felt environmental alienation alone could not explain their predisposition to depression. He reflected on these issues, not in a novel, but in an article written following a trip to western Canada in 1927. His tour—during which he visited Danish settlements—was sponsored partly by the Canadian Pacific Railway in the expectation that he would use his findings to publicize the advantages of immigration, but his impressions were not favourable. Sandemose claimed the prairie, compared to Denmark, 'often resembles the Sahara Desert' with its emptiness and huge distances. Environmental solitude was compounded by cultural isolation, even within the confines of the family. Children soon abandoned—and then lost—their Danish language, even before going to school, where from the age of seven they were 'indoctrinated with a patriotic feeling for Canada', to the distress of their mothers.

> She feels she is standing in her children's way. Whatever they are happy about she doesn't understand. They quarrel with her, that strange creature who can't speak the only proper language. Soon they move about in what

> for her is a distant haze. She is a helpless, strange bird to her children. She cannot assist them and doesn't know whether what's happening to them is good or evil.
>
> It grows worse as the years pass. The children sit in the room with her and speak English if they don't want her to understand something. She thinks they're talking about her.
>
> The new land has robbed her of everything. The first year she complains and suffers openly. Then she becomes silent. But anyone who denies the tragedy of the first generation woman is quite simply blind.[32]

But it was not only women who succumbed. Nor was it only on the prairies that migrant anguish was associated with mental breakdown. For an analysis of the institutional, largely medicalized, response to these challenges, the focus shifts to the west coast, to evidence generated by the admission registers and case notes of patients in British Columbia's Provincial Asylum for the Insane.[33] The hospital was opened in 1872, initially in Victoria on Vancouver Island. Six years later it moved to the mainland location of New Westminster, where it operated for more than a century. Admissions in the 40 years after 1872 are contained in a single register with 3,525 entries, just over six per cent of which were readmissions. The following evaluation is based on the 1,210 admissions between 1872 and 1901 that have so far been transferred onto a database, along with 340 individual sets of case notes covering the four decades from 1872 to 1912.[34] While the quantitative sample taken from the admissions data is small (34.3 per cent of the entire register, but 100 per cent of those admitted during the asylum's first three decades of operation), the case notes draw on the entire period covered by the register. Cases were selected on the basis of Scottish or Scandinavian ethnicity identified by consulting the birthplace column in the admissions register, supplemented and contextualized by a random selection from other ethnic groups across the 40-year survey period.[35]

The proportion of immigrants in the asylum was greater than their presence in the provincial population as a whole; 67 per cent of asylum patients were immigrants compared with just over 42 per cent in the population as a whole. This is unsurprising, since recent arrivals often lacked the support systems and family networks of the native-born or longstanding resident, a feature noted in the institution's annual reports. In terms of birthplace, 404 were born in the British Isles and 322 in Canada. There were 80 Scots-born, along with 60 from Nordic nations (overwhelmingly Scandinavia), who constituted, respectively, 9.1 per cent and 6.6 per cent

of the hospital's foreign-born patients.[36] The asylum population was also overwhelmingly male: 78 per cent of the 1,210 patients sampled; 79.6 per cent of overseas-born patients; the vast majority in both cases being adults. In the province as a whole the 1891 census recorded that just over 64 per cent of BC's 98,173 inhabitants—but only 46.2 per cent of those aged over 20—were male.[37]

Statistics provide a skeleton, but what can the asylum's records tell us about contemporary perceptions of the causes, manifestations and consequences of immigrant insanity? Ethnic stereotyping was not explicit, although there was certainly sinophobia. In his annual report for 1886 the medical officer, Richard Bentley, in noting the admission of five Chinese patients, commented that 'it does seem a pity that this undesirable class should be such an expense to the country'.[38] His proposal to accommodate Chinese patients separately—implemented in 1889–90—was based partly on contemporary views about racial segregation, and partly on the argument that costs would be reduced by providing two tiers of facilities. Chinese patients, he claimed, 'do not appear to require the same amount of air space for the maintenance of health as white people'.[39] Bentley was subsequently discredited and resigned when a Royal Commission in 1894 uncovered evidence of mismanagement and abuse, including the suspicious demise of a Swedish patient, whose death by strangulation in 1892 had been attributed to suicide rather than mistreatment.[40]

Bentley's successor as medical superintendent, George Bodington, was himself an immigrant from England, but in his annual reports he repeatedly discouraged the 'shipping off either from the East or from Europe' of 'the wastrels of society' who demonstrated 'incipient or borderland insanity'. In a tangential reference to the challenges of a new environment, he warned:

> Useless and unmanageable as they may be at home, they become still more useless and unmanageable in the remote West, where the difficulties of life to be encountered are greater and the resources at command for their relief are less than those to be met with in older and more settled communities … It requires for success men not only stalwart in body, but healthy in mind.[41]

Yet, ethnically influenced evaluations of European immigrants are remarkably absent, especially in comparison with the records of antipodean institutions.[42] The relative silence on European ethnicity is surprising, because—particularly in the eugenics-dominated decade before the First

World War—Canada as a whole was preoccupied with the idea that weak-minded immigrants from Britain, especially England, were polluting their society and draining their economy.[43] Perhaps British Columbia's apparent disinterest in making ethnically based judgements about defects in its dominant immigrant group was attributable partly to the overriding political concern with Chinese immigration: by 1891 almost ten per cent of the province's population was Chinese-born, an influx that provoked discriminatory legislation.[44]

Of course, English speakers were at an advantage in terms of communication and this seems to have shaped value judgements. Norwegian-born M-M was probably suffering from postnatal depression when she was admitted to the BC Asylum in 1899 and where she died nine years later. In a revealing letter to her husband, the medical superintendent wrote in 1902: 'no one here speaks her language so we have to judge by her conduct. She seldom says anything.'[45] And when K., from Nelson in the Kootenays, was sent to the asylum in 1907 both the accompanying medical certificates testified to a linguistic nonconformity. One doctor reported that K. 'talks and shrieks in Gaelic continuously. Will not answer any questions, nor talk in English, merely yells in Gaelic.' His colleague confirmed that 'the patient was crying out in an *unintelligible* language'.[46]

Those are rare examples, which mention ethnicity tangentially as a manifestation of illness, rather than its trigger. Much more emphasis was put on a causal relationship between environment (broadly defined) and mental illness. For instance, 'indisposition and the long trip from Scotland to BC' were blamed for the attempted suicide of Mrs C. from Edinburgh in 1890.[47] Thirteen years later D., also from Scotland, 'became mentally unfit on his arrival in this country', when his inability to cope with his new surroundings—particularly the overland journey to the west—led to altercations with fellow train passengers and to temporary detention at Toronto before he was arrested at Mission in BC and taken to the New Westminster asylum.[48] E. was deported in 1911 after manifesting 'mental symptoms', including suicidal tendencies, three days after arriving at a construction camp in Golden in July 1911. These symptoms, according to one of the certifying doctors, 'must have been evident before patient left his home in Norway'.[49] Specific trauma during the journey to the new world probably contributed significantly to the plight of another Norwegian immigrant, M., who suffered a head injury in a train accident while travelling west, shortly after landing at Quebec in 1905. While recovering in hospital she contracted typhoid, which detained her for a further six months before she was able to continue

to British Columbia. Her head injury had, however, left her with a legacy of violent outbursts of temper, which led eventually to her admission to the asylum in 1911. With a secondary diagnosis of tuberculosis, she was discharged the following year, so that she could die at home with her brother.[50]

We have already noted that isolation was a dislocating phenomenon for prairie settlers. It was also frequently mentioned as a catalyst in the illnesses of several inmates of the BC Asylum. When a patient from Rhode Island was discharged in 1904, the medical superintendent, Charles Doherty, wrote explicitly to a relative in that state that he had advised the individual to avoid hot climates, adding that '[J] could have avoided all this by keeping out of isolated places'.[51] For gold prospectors, the physical hardships of their surroundings were often exacerbated by disappointed expectations of quick fortunes. Indeed, the need for a special facility for the insane had initially arisen in the late 1850s when the jail in Victoria had become overcrowded with casualties of the Cariboo gold rush, as 'many new-comers broke down under the strain and hardships endured, and had to be taken care of by the authorities'.[52] During the Klondike stampede four decades later, unsuccessful prospectors, brooding on their fate in the loneliness of their cabins in the Yukon, were similarly vulnerable to delusions and derangement as a consequence of the double experience of environmental alienation, and several were committed to the New Westminster Asylum.

Scots and Nordic settlers were represented among these individuals. When J. from Finland was admitted from Dawson City in September 1903, his case notes recorded that his insanity had been triggered by 'solitude' and 'onamism' (masturbation). The insanity of another Finnish miner, admitted a week earlier from the same location, was similarly attributed to 'solitude and hardship', as well as masturbation.[53] Their plight was similar to that of E. from Norway, who was admitted from the Yukon the following year after being found destitute, 'wandering over the hills in an aimless manner, without food or proper protection from the severity of a Klondike winter', and with delusions that he had made vast sums at the goldfields. His illness was attributed to 'solitude, worry, and insufficient food'.[54]

The curse of the Klondike was not confined to prospectors. 'Departure of husband for the Klondike' in 1898 was blamed for the mental collapse of Scots-born Mrs E.F., when she was left behind in Vancouver with a young child. She had been mentally ill on two previous occasions, once in Scotland and subsequently following the birth of her child, and her malady (diagnosed as 'acute mania') manifested itself in destructive, violent activity, 'excitement, shouting and screaming'.[55]

Value judgements were often embedded in diagnoses. 'A solitary life and bad habits' had allegedly triggered the delusional insanity of a 37-year-old bachelor from Dingwall in the Scottish Highlands, who was working as a mill hand in Port Moody, Vancouver Island, when he was admitted to the asylum in 1900.[56] Similar value judgements were evident in the case of J. from Shetland, whose entry in the admission register in 1899 stated that he was a man of 'no occupation' whose illness was attributable to 'inebriety'. But another source of information about this individual suggests his plight may have been rooted in disappointed expectations. Preserved in the Shetland Archives is a letter he wrote to his mother in 1891, a year after his arrival in Vancouver. He castigated misleading propaganda for luring him to a city characterized by high unemployment and living costs, coupled with low wages, and where, despite allegedly having some medical training, he had only been able to secure a succession of menial jobs. His last cent had been spent on mailing his tale of woe, but he urged his mother not to broadcast his fate. 'Had I better news to convey it would have been different', he wrote, 'but the outlook is so dark that it is better to keep it to yourselves.'[57] It is impossible to determine whether J.'s problems were a consequence of the alcoholism to which the medical authorities attributed his illness eight years later, or whether disappointment had driven him to drink.

The attribution of mental illness to intemperance sometimes invoked value judgements from families as well as medical professionals. When Edinburgh-born J. was admitted to the Asylum from Revelstoke in 1904, after trying to cut his throat, his father in Scotland denounced the 'unsettled, unsteady habits' that had caused the family 'much sorrow and vexation for many years' and agreed with Dr Manchester, the medical superintendent, that his son was a 'degenerate'.[58] His repeated emphasis that there was no history of insanity in the family reflects his determination to challenge a diagnosis that was much in vogue in mental health circles at the turn of the nineteenth century, and which fuelled Canadian allegations that European countries, especially Britain, were exporting their insane to the Dominion.[59] Newly admitted patients, or their relatives, were always asked if they, or any family members, had previously spent time in an asylum, but hereditary insanity was identified as the cause of illness in only three Scottish admissions, and in none of those from Nordic countries. This pattern differs from findings in other parts of the British Empire: perhaps the BC Asylum doctors were

influenced by a combination of relatives' protestations and a claim in the *Canadian Lancet* in 1895 that 'insanity as a disease is not transmissible by inheritance'.[60]

Glasgow-born C. had moved to British Columbia's Okanagan Valley after a brief and unsuccessful attempt to settle with his brother near Calgary, but was admitted to the New Westminster Asylum shortly afterwards. In correspondence with the medical superintendent, his mother (who also emphasized the absence of any family history of insanity) explained that he had been 'a very delicate and nervous boy from birth' and, although he had overcome the problem in his teens, it had returned in the form of recurring depression following a bicycle accident and two bouts of influenza. He had moved to Canada in 1910, 'thinking the open air life and climate would suit him better than the confinement of office work' but 'he did not like the isolation of the prairie', and environmental alienation had been compounded by unemployment when he moved to Calgary. After he had secured employment on a fruit farm at Penticton in the Okanagan, his brother initially wondered 'if the excitement of getting work had affected his mind' and was 'very much surprised and distressed' when C. was subsequently diagnosed with dementia praecox (schizophrenia), attributed to 'onamism', with 'complete recovery improbable'.[61]

Some individuals who had allegedly exhibited symptoms of mental illness before migrating were also characterized by a sustained itinerancy prior to their hospital admission. But even those without a personal or family history of insanity often displayed a chronic restlessness that had seen them lead peripatetic lives in numerous locations, either taking up a succession of jobs or resorting to vagrancy. That is not to argue that migration *per se* was a symptom and consequence of dysfunctionality, or that rootlessness caused insanity: on the contrary, geographical mobility was an essential attribute for those who wished to exploit the opportunities of an international labour market. But in some cases constant unsettlement may either have been a symptom of deeper problems or, more indirectly, may have predisposed the wanderers to mental illness, through the loneliness of ever-changing environments, often exacerbated by the absence or breakdown of family and community networks.

Several itinerant migrants who became patients in the BC Asylum had spent time in the USA as well as Canada. J. had emigrated from Aberdeen to Vermont to work in the stone quarries. Between arriving in New England in 1892 and his admission to the BC Asylum in December 1911, he 'has been wandering around various states, never remaining

in any one position for any length of time, and as he has not kept any account of his wanderings is unable to give any definite statement in this regard'.[62] Swedish-born S. was, like J., a vagrant, who had worked as a farm hand, logger and railroad labourer in Iowa, Minnesota, Washington, Montana, Alaska and various parts of British Columbia between landing in New York in 1893 and being admitted to the asylum 18 years later.[63] His fellow-countryman, F., had also undertaken short-term work on railroad construction, in mining, harvesting and surveying, and had spent seven years back on the family farm in Sweden before returning to Canada two years before his admission to the asylum in 1910.[64]

The 'religious excitement' that had characterized diagnoses in the mid-nineteenth century receded from asylum records after Dr Joseph Workman, the Irish-born 'father of Canadian psychiatry', had highlighted somatic factors while serving as medical superintendent of the Toronto Provincial Lunatic Asylum.[65] One rare exception to this silence in the BC records was rooted in a specific event when a female immigrant from Scotland was admitted in 1894 with a diagnosis of 'religious mania', triggered by a recent schism in the Free Church of Scotland, the so-called Second Disruption of 1893. According to her employer, 'her one topic of conversation was religion … The split in the Presbyterian Church has evidently worried her very much.'[66]

By contrast, the recurring emphasis on religious environment as a malign force in both Scandinavian and Scottish novels suggests that, in this respect, art did not mirror life. Perhaps the doom-laden connotations of Lutheran theology were in tune with the sort of Norse fatalism exemplified by Ole Rølvaag's character, Beret, just as Scotland's Calvinist identity generated numerous stereotypical fictional images of repressed, guilt-ridden Scots. In an example from the other side of Canada, it is a theme that is prominent in Hugh Maclennan's 1951 novel, *Each Man's Son*. Writing about a mining community of ethnic Scottish Highlanders in Cape Breton Island, this semi-autobiographical novel presents the Calvinist heritage of the characters as a curse which had made them 'ashamed of living', a bondage from which they made futile attempts to escape, either through drunkenness and dissipation or through an obsessive, and excessive, pursuit of knowledge.[67] 'You Scotchmen are all crazy, and the whole lot of you have corrupt consciences', was the conclusion of the novel's Acadian doctor, Fernand Doucette, in frustrated conversation with his friend, the work-obsessed Dr Daniel Ainslie.[68]

Conclusion

Environment was clearly an integral part of the positive rhetoric that fuelled settlement in North America in the nineteenth and early twentieth centuries. The frontier myth, on both sides of the border, drew many westwards, some in the hope of making a fortune and others to have illnesses cured or relieved. Conversely, the environment—both physical and cultural—could also exercise a malign influence on migrants' mental and physical health, a thread that is woven prominently into the negative, doom-laden narratives of many novelists. With the exception of the specific trigger of 'sunstroke', however, it rarely features explicitly in the medical records that have informed this study: doctors were much more preoccupied with heredity, or with lifestyle factors that demonstrated either misfortune or a lack of moral fibre among their patients. The list of vices and woes itemized in the records includes intemperance, onamism, venereal disease, infidelity, drug abuse, pecuniary loss, lawsuits, domestic troubles, physical illness and injury. Dr George Manchester, medical superintendent of the BC Provincial Hospital, noting in 1901 the 'startling' percentage of admissions who had been diagnosed with the syphilitic condition of 'general paresis', speculated about 'whether the climate has anything to do with the virulence displayed by this disease in this country', but was not prepared to venture an opinion, since it was so difficult to obtain reliable case histories from patients.[69]

Scottish and Scandinavian migrants were selected for scrutiny partly because of the high rates of emigration from Norway and Scotland, and partly because their different backgrounds might have offered an opportunity for ethnic and occupational comparisons. While ever-increasing numbers of Scots left urban environments, the pre-migration Scandinavian world was still that of the small farm. Yet neither novelists nor doctors singled out ethnicity or occupation for explicit comment, and the patient profiles within both groups are very similar, with the exception that it was more common for Scandinavian inmates of the BC Provincial Hospital to have spent time in the United States before coming to Canada.

The plight of disconsolate or dysfunctional migrants—raised by Oscar Handlin in the 1950s but largely ignored in succeeding decades—is beginning to emerge from scholarly obscurity. But much more research needs to be done, across both disciplines and destinations, to quantify and evaluate the experiences of a significant but neglected group whose stories are explored in this and other chapters.

Notes

1. Oscar Handlin, *The Uprooted* (Boston: Little, 1951, revised edition 1973), 3, 4.
2. Handlin, *Uprooted*, 3, 304–5.
3. See, for instance, Barbara Roberts, *Whence They Came: Deportation from Canada, 1900–1935* (Ottawa: University of Ottawa Press, 1988); Lorna R. McLean and Marilyn Barber, 'In search of comfort and independence: Irish immigrant domestic servants encounter the courts, jails, and asylums in nineteenth-century Ontario', in Marlene Epp, Franca Iacovetta and Frances Swyripa (eds), *Sisters or Strangers? Immigrant, Ethnic, and Racialized Women in Canadian History* (Toronto: University of Toronto Press, 2004); James E. Moran and David Wright (eds), *Mental Health and Canadian Society: Historical Perspectives (*Montreal, Ithaca: McGill-Queen's University Press, 2006); Angela McCarthy and Catharine Coleborne (eds), *Migration, Ethnicity, and Mental Health: International Perspectives, 1840–2010* (New York: Routledge, 2012). Anna Pratt's study, *Securing Borders: Detention and Deportation in Canada* (Vancouver: UBC Press, 2005), focuses on the second half of the twentieth century.
4. Thomas M. Devine, *To the Ends of the Earth: Scotland's Global Diaspora* (London: Allen Lane, 2011), 87.
5. See, *inter alia*, Elizabeth Malcolm, 'Mental Health and Migration: The Case of the Irish, 1850s-1990s'; and David Wright and Tom Themeles, 'Migration, Madness and the Celtic Fringe: A Comparison of Irish and Scottish Admissions to Four Canadian Mental Hospitals, c. 1841–91', both in McCarthy and Coleborne (eds), *Migration, Ethnicity and Mental Health*, 15–38 and 39–54; Elizabeth Malcolm, '"A Most Miserable Looking Object"; The Irish in English Asylums, 1850–1901', in John Belchem and Klaus Tenfelde (eds), *Irish and Polish Migration in Comparative Perspective* (Essen: Klartext Verlag, 2002); 121–32; Elizabeth Malcolm, 'Irish Immigrants in a Colonial Asylum during the Australian Gold Rushes, 1848–1869'; and Angela McCarthy, 'Transnational Ties to Home: Irish Migrants in New Zealand Asylums, 1860–1926', both in Pauline M. Prior (ed.), *Asylums, Mental Health Care and the Irish: Historical Studies, 1800–2010* (Dublin: Irish Academic Press, 2012), 119–48 and 149–66; Marjory Harper, 'Minds on the edge: immigration and insanity among Scots and Irish in Canada, 1867–1914' (forthcoming, *Journal of Irish and Scottish Studies*, 2016); McLean and Barber, 'In Search of Comfort and Independence' (above, note 3).
6. Exceptions are Ørnulv Ødegaard, *Emigration and Insanity. A Study of Mental Disease among the Norwegian-born Population of Minnesota* (Copenhagen: Levin and Munksgaards, 1932) and Marjory Harper, 'A dysfunctional diaspora? Causes of mental illness among Scottish migrants to

Canada, 1867–1914', *Neurosciences and History* (official journal of the Spanish Society of Neurology), 2014; 2 (1); 1–7.

7. The Halifax Port Authority commissioned 'The Emigrant' from Italian-born sculptor, Armando Barbon. It was unveiled in September 2013 at Pier 21, the Canadian Museum of Immigration.
8. See, for example, Lars Ljungmark, *For sale: Minnesota. Organized Promotion of Scandinavian Immigration, 1866–1873* (Gothenburg: Läromedelsförlagen, 1971).
9. Anon., '"Settlers" in Canada: Rough Experiences of Emigrants', *Aberdeen Journal,* 11 August 1903, p. 4, col. 8.
10. Ronald Rees, *New and Naked Land* (Saskatoon: Western Producer Prairie Books, 1988), 35. See also William F. Butler, *The Great Lone Land: A Narrative of Travel and Adventure in the North West of America* (London: S. Low, Marston, Low and Searle, 1872). Butler wrote of 'this utter negation of life, this complete absence of history … One saw here the world as it had taken shape and form from the hands of the Creator' (200).
11. Quoted in Rees, *New and Naked Land*, 42.
12. Rees, *New and Naked Land*, 14–15.
13. William Wallace to Maggie Wallace, 29 June 1881, 23 February 1883, in William Wallace, *My Dear Maggie: Letters from a Western Manitoba Pioneer*, edited by Kenneth Coates and William R. Morrison (Regina: Canadian Plains Research Center, 1991), 21, 118.
14. William to Maggie, 29 June 1881 in Wallace, *My Dear Maggie,* 21.
15. Library and Archives Canada [hereafter LAC], The Journal of Lady Aberdeen, MG 27, C-1352, 1L B5, 7 October 1890.
16. The Countess of Aberdeen, *Through Canada with a Kodak*, introduction by Marjory Harper (Toronto: University of Toronto Press, 1994), 121; Iver Bernhard, 'Nyveien til Fevatn', *Ved arnen* [*By the Fireside*], volume 59, no. 32 , 21 February 1933, p. 4, quoted in Dorothy Burton Skårdal, *The Divided Heart: Scandinavian Immigrant Experience through Literary Sources* (Oslo: Universitetsforlaget, 1974), 262.
17. Saskatchewan Archives Board, Saskatchewan Archives Questionnaire [hereafter SAB, SAQ], no. 2, Pioneer Experiences: A General Questionnaire, x2/2 (1889), Archibald Angus Docherty. See also Wayne R. Norton, *Help Us To A Better Land. Crofter Colonies in the Prairie West* (Regina: Canadian Plains Research Center, 1994).
18. See, for instance, Marjorie Wilkins Campbell, *The Silent Song of Mary Eleanor* (Saskatoon: Western Producer Prairie Books, 1983). In 1904 Campbell's parents emigrated from London to Saskatchewan, where her mother was dismayed when, after trekking over the prairie for days, the oxen pulling their wagon halted at the site of their quarter section, marked only by the land surveyor's four holes and marker.

19. William to Maggie, 8 June 1883, in *My Dear Maggie*, 135. For a comparable example from the 1920s, see Monica Storrs, *God's Galloping Girl: The Peace River Diaries of Monica Storrs, 1929–1931,* edited with an introduction by William L. Morton with the assistance of Vera K. Fast (Vancouver: University of British Columbia Press, 1984), 263.
20. SAB, SAQ, no. 8, Pioneer Health. S-X2, 2676, Diggle, Lottie Clarke, question 13. Thanks to Dr Elizabeth A. Scott for sampling the health questionnaire on my behalf. The general questionnaire is analysed in Marjory Harper, 'Probing the Pioneer Questionnaires: British Settlement in Saskatchewan, 1887–1914', *Saskatchewan History,* 52: 2 (Fall 2000), 28–46.
21. Vilhelm Moberg, *The Emigrants* (1951); *Unto a Good Land* (1954); *The Settlers* (1961); *The Last Letter Home* (1961), translated from Swedish by Gustaf Lannestock, with a new introduction by Roger McKnight (St Paul, Minn: Minnesota Historical Society Press, 1995).
22. Moberg, *The Last Letter Home*, x–xi.
23. O. E. Rølvaag, *Giants in the Earth. A Saga of the Prairie,* translated from the Norwegian by Lincoln Colcord and the author (New York, London: Harper and brothers, 1929, revised edition 1991), 37–8. Ellipses in original.
24. LAC, RG76, C-7396-7, vol. 248, file 179046, part 1, undated memorandum from Anne MacDonald to the Department of Immigration and Colonization, October or November 1924.
25. Mary Percy Jackson, *Suitable for the Wilds. Letters from Northern Alberta, 1929–1931,* edited with an introduction by Janice Dickin McGinnis (Toronto: University of Toronto Press, 1995), 145, 16.
26. Moberg, *The Emigrants,* 164–5.
27. Rølvaag, *Giants,* 424.
28. Rølvaag, *Giants,* 226.
29. Rølvaag, *Giants,* 227.
30. Rølvaag, *Giants,* 329.
31. Aksel Sandemose, *En Flytning krysser sitt spor* (1933), trans. A.A. Knopf, *A Fugitive Crosses His Tracks* (New York, A.A. Knopf, 1936).
32. *Aksel Sandemose and Canada: a Scandinavian Writer's Perception of the Canadian Prairies in the 1920s,* translated and edited with a critical introduction by Christopher S. Hale (Regina: Canadian Plains Research Center, 2005), 56.
33. The name was changed to The Provincial Hospital for the Insane in 1897.
34. Provincial Archives of British Columbia [hereafter PABC]. GR-1754, vol. 1, Provincial Mental Hospital, Essondale, Admissions Book, 12 October 1872 to 31 December 1912; GR-2880, Case Files, 1872–1912.
35. The admission register provides an index to patient files because the register number assigned to an individual at admission was also used as the patient file number. Case note files from the 1870s and 1880s contain minimal information, but become much more detailed by the end of the century.

36. PABC, GR-1754, vol. 1. Of the British-born, 60 per cent (242 individuals) were natives of England, 20 per cent (80 individuals) came from Scotland, 19 per cent (77 individuals) from Ireland and 1 per cent from Wales and the Channel Islands (5 and 2 individuals respectively). There were 29 Swedish patients, 15 Norwegians and 3 Danes, to whom have been added a further 13 from other Nordic countries, 11 Finns and 2 Icelanders. Using statistics from the 1891 Canadian census, the Scots accounted for 4.4 per cent of the provincial population, but 7 per cent of the asylum population in the sample. The comparative statistics for Scandinavian/Nordic immigrants in the provincial and hospital populations respectively are: 1.08 per cent and 4.87 per cent. Individual Scandinavian nationalities were not differentiated in the census statistics (*Census of Canada, 1891*, Place of Birth, Volume 1, Table D, p. 391).
37. *Census of Canada, 1891*, Ages of the People, Volume 2, Table I, pp. 3–5.
38. British Columbia Sessional Papers [hereafter BCSP], First Session, Fourth Parliament of the Province of British Columbia, *Annual Report of the Asylum for the Insane for the year 1886*, 441.
39. Mary-Ellen Kelm, 'Richard Irvine Bentley', in *Dictionary of Canadian Biography*, vol. 13 (Toronto and Quebec: University of Toronto and Université Laval, 2003–2015) http://www.biographi.ca/en/bio/bentley_richard_irvine_13E.html (date accessed 2 April 2014); letter from Bentley to the Provincial Secretary, 29 October 1894, quoted in Leslie Roman et al., 'No time for nostalgia!: asylum-making, medicalized colonialism in British Columbia 1859–1907 and artistic praxis for social transformation', *International Journal of Qualitative Studies in Education*, vol. 22, no. 1, Jan-Feb. 2009, 37–8.
40. BCSP, First Session, Seventh Parliament, 1894–5, *Report of the Royal Commission on the Asylum for the Insane*, 27 November 1894, 568–71. The patient had been found dead half an hour after being tightly laced into a strait jacket in contravention of the Medical Superintendent's own rules which 'strictly forbid the use of severe instruments of restraint'. See also Ninette Kelley and Michael Trebilcock, *The Making of the Mosaic: A History of Canadian Immigration Policy* (Toronto: University of Toronto Press, 1998), 95–8.
41. BCSP, *Report on the Hospital for the Insane,* 1897, p. 830. See also *Report*, 1896, pp. 845–6; 1898, p. 1304.
42. See, for instance, McCarthy and Coleborne, *Migration, Ethnicity and Mental Health.*
43. Marjory Harper, 'Rhetoric and Reality: British Migration to Canada, 1867–1967' in Phillip Buckner (ed.), *Canada and the British Empire* (Oxford: Oxford University Press, 2008), 163–4.
44. Robert A. Huttenback, *Racism and Empire. White Settlers and Colored Immigrants in the British Self-Governing Colonies 1830–1910* (Ithaca and London: Cornell University Press, 1976), 126; Marjory Harper and Stephen Constantine, *Migration and Empire* (Oxford: Oxford University Press, 2010), 173–5.

45. PABC, GR-2880, box 7, no. 949.
46. PABC, GR-2880, box 20, no. 2003. Author's italics.
47. PABC, GR-2880, box 3, no. 371.
48. PABC, GR-2880, box 13, no. 2680.
49. PABC, GR-2880, box 30, no. 2999.
50. PABC, GR-2880, box 30, no. 2981.
51. PABC, GR-2880, box 14, no. 1497.
52. BCSP, Third Session, Ninth Parliament of the Province of British Columbia, 1902, *Report on the Hospital for the Insane, New Westminster,* 1901, p. 464. In the 1850s the nearest asylum was in California, and patients were initially sent down to that State. See also Angela Hawk, 'Going Mad in Gold Country: Migrant Populations and the Problem of Containment', *Pacific Historical Review*, 80: 1 (February 2011), 64–96; and Hawk, 'Madness, Mining, and Migration in the Pacific World, 1848–1900', unpublished PhD, University of California, Irvine, 2011.
53. PABC, GR-2880, box 13, nos 1432, 1431. Both men had relatives in the United States, in North Dakota and Wyoming respectively. While Finland is not a Scandinavian country, it shares a boundary with Sweden, and has some topographical and cultural similarities to its two western neighbours.
54. PABC, GR-2880, box 14, no. 1497. E. had emigrated to the United States in 1875.
55. PABC, GR-2880, box 5, no. 819.
56. PABC, GR-2880, box 7, no. 1024.
57. Shetland Archives, SC. 12/6/1915, J. to his mother, 9 June 1891.
58. PABC, GR-2880, box 13, no. 1488.
59. C. K. Clarke, 'The Defective and Insane Immigrant', *University Monthly* (University of Toronto), 8 (1907–8), 273–8.
60. J. L. Davison and Charles Sheard (eds), *Canadian Lancet: A Monthly Journal of Medical and Surgical Science, Criticism and News*, XXVII (Toronto: Dudley and Burns, 1895), republished by Forgotten Books, 2013), 268–9. The quote is on page 270. In the database sample as a whole, heredity was given as a cause of illness in 72 of the 1,210 entries. For discussion of the significance of heredity in other locations, in both contemporary accounts and recent scholarship, see Orson S. Fowler, *Hereditary Descent: Its Laws and Facts Applied to Human Improvement* (New York: Fowler and Wells, 1847), 101–24; R. L. Macdonnell and A. H. David (eds), *Canada Medical Journal and Monthly Record of Medical and Surgical Science, vol. I* (Montreal: John Lovell, 1852), 640; Catharine Coleborne, *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860–1914* (Basingstoke: Palgrave Macmillan, 2009), 54–8; Angela McCarthy, 'A Difficult Voyage', *History Scotland*, 10:4 (July 2010), 26–31; Maree Dawson, 'Halting the "Sad Degenerationist Parade": Medical Concerns about

Heredity and Racial Degeneracy in New Zealand Psychiatry, 1853–99', *Health and History*, 14: 1 (2012), 38–55; and Catherine Cox, *Negotiating Insanity in the Southeast of Ireland, 1820–1900* (Manchester: Manchester University Press, 2012), Chapter 2, 'Expansion and Demand'.

61. PABC, GR-2880, box 30, no. 3019, mother to Dr Charles E. Doherty, Medical Superintendent, 12 September 1911; brother to Dr Doherty, 31 August, 16 September 1911; PABC, GR-1754, vol. 1.
62. PABC, GR-2880, box 31, no. 3129.
63. PABC, GR-2880, box 31, no. 3111.
64. PABC, GR-2880, box 25, no. 2585.
65. Thomas E. Brown, 'Workman, Joseph, in *Dictionary of Canadian Biography*, vol. 12, http://www.biographi.ca/en/bio/workman_joseph_12E.html (date accessed 4 August 2014).
66. PABC, GR-2880, box 4, no. 569. For details of the 1893 split, see James Lachlan MacLeod, *The Second Disruption: The Free Church in Victorian Scotland and the Origins of the Free Presbyterian Church* (East Linton: Tuckwell Press, 2000). PABC, GR-2880, box 30, no. 3005 gives the case of a Finnish immigrant who had 'received a visitation from God' after going up to the Yukon in 1911.
67. Hugh Maclennan, *Each Man's Son* (Toronto: McClelland and Stewart, 2009, first published 1951), 66.
68. Maclennan, *Each Man's Son*, 129.
69. BCSP, 1902, *Report on the Hospital for the Insane, New Westminster,* 1901, 472.

CHAPTER 7

Stories of Immigrant Isolation and Despair: Canadian Novels and Memoirs Since the 1850s

Marilyn Barber

In *The Female Malady* published in 1985, Elaine Showalter notes that representations of madness in literary texts are not simply reflections of medical and scientific knowledge, but are part of the fundamental cultural framework in which ideas about insanity are constructed. Writing from a feminist perspective on women, madness and English culture, Showalter draws extensively upon women's diaries, memoirs, and novels in order to include women's voices as well as the male views set out in medical literature. One of her first examples is Bertha Mason, the madwoman in the attic in Charlotte Brontë's well-known novel, *Jane Eyre*. While Showalter describes Bertha's violence, sequestration, and regression to an inhuman condition as a powerful model of female insanity for Victorian readers, she never mentions Bertha's Jamaican immigrant background.[1] Yet ethnic identity, or the immigrant experience, is a vital aspect of the cultural framework that literary texts both reflect and help to shape and is thus significant in an understanding of ideas about insanity.

In multicultural Canada, publicity recently given to two contemporary books, a memoir and a novel, has helped to highlight a cultural link between immigration and mental health problems. In her memoir, *My Journey*, published in January 2014, Olivia Chow, a Chinese immigrant and former Toronto MP, reveals how her father suffered mental breakdown after migrating to Toronto in 1970. He came to Canada with expectations of a

M. Harper (ed.), *Migration and Mental Health*,
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'wonderful new life', having been a school superintendent in Hong Kong, but he could not adapt to a Canadian classroom even though he spoke English well. Like many other immigrants, he was reduced to working as a taxi driver or occasional labourer. His resulting frustration and shame led to an escalation of his domestic violence and paranoia, which had been better controlled in Hong Kong, and eventually to the psychiatric ward of a Toronto hospital. Underlining the inadequacy of mental health support for immigrants, Chow notes that 'the isolation that we felt as a family is something I have never forgotten'.[2] The message that immigrant isolation and despair could lead to mental breakdown was reinforced a few weeks later when, in March 2014, the annual CBC program, *Canada Reads,* looking for a novel that could change Canada, selected *Cockroach* as the runner up for the year. Written by Rawi Hage, an immigrant from Beirut, *Cockroach* depicts the dark side of life in Montreal's immigrant community through the character of a self-described thief who, having failed in a suicide attempt, has to attend therapy sessions.

Taking an historical perspective and drawing upon selected memoirs and novels from the 1850s to the post World War II era, this chapter examines how literary texts have contributed to the portrayal of immigrant mental breakdown in Canada. While novels and memoirs are different literary genres, both explore the coming together of individual memory and experience with collective memory and experience.[3] The boundary between autobiography and historical fiction is porous, with both reflecting the selectivity of memory, the influence of the time of writing, and the desire to tell a story. The main focus here is on Irish and English migrants who could undergo serious problems of adaptation even though they formed part of a dominant Anglo-Celtic culture in Canada. The Irish were particularly important in mid-nineteenth century migration to Canada, whereas English migrants formed a significant proportion of the large waves of arrivals in the early twentieth century and the period after World War II. The selection of literature for examination reflects these social and temporal considerations. The intersecting significance of ethnicity, gender, and class is central to the analysis. Do the literary texts reflect or help shape contemporary perceptions of the immigrant experience as a contributing factor in mental breakdown? Similarly, what importance is attached, implicitly or explicitly, to gender roles and to concepts of femininity and masculinity? In addition, the chapter explores the challenges attributed to the new environment and the changing place given to religion versus science in the understanding of mental breakdown.

The Case of Grace Marks

Among the thousands of Irish migrants to Canada in the mid-nineteenth century, Grace Marks acquired widespread notoriety for her involvement with a sensational murder that led to her incarceration in prison and asylum. Other Irish immigrants who were committed to such institutions after succumbing to isolation, poverty, or disease generally faded into shadows hidden in institutional records.[4] By contrast, Grace Marks stood out boldly because of the melodramatic nature of her crime combined with her youth and sex. Nonetheless, the details of her migration experience remain sketchy. In 1839, Grace, age 12, arrived in Toronto with her Irish Protestant father, a stonemason by trade. Grace first worked for various employers in Toronto as a domestic servant, a typical occupation for Irish female immigrants, including those as young as Grace, while she thought her father settled west of the city. Four years later, in July 1843, Grace was hired by Nancy Montgomery, housekeeper to Thomas Kinnear, a bachelor gentleman of Scottish background living north of Toronto. Within a month of taking up this new position, Grace Marks, at the young age of 16, along with her fellow servant, James McDermott, an Irish Catholic immigrant, was accused of the murder of their employer and his housekeeper. This sensational crime, involving violence, sex, and the ultimate insubordination, made Grace Marks a very public figure. James McDermott was hanged but Grace had her sentence commuted to life imprisonment because of her 'feeble sex', 'extreme youth', and supposed witlessness.[5] At the trial Alderman Dixon, the only employer to testify, characterized Grace as 'soft' or of 'weak intellect'.[6] Contemporary newspapers actively debated Grace's guilt but literary texts have been most influential in perpetuating the memory of Grace and presenting her insanity.

Susanna Moodie, well known for her writing on pioneer life in Upper Canada (now Ontario) is the author initially most influential in transmitting the story of Grace Marks across space and time. The youngest daughter of the literary Strickland family, Susanna grew up as part of the gentility in rural Suffolk, England. In 1832, at age 28, she emigrated with her half-pay officer husband, John Dunbar Moodie, and their first child in search of a better life for the family in Canada.[7] In *Roughing It in the Bush*, Susanna Moodie describes her own hardships, trials, frustrations, and fears as a settler in the backwoods of Upper Canada. The experience certainly challenged some of her class assumptions and perhaps explains the sympathy she expresses for the plight of Grace Marks.

In *Life in the Clearings*, first published in England in 1853, Moodie vividly reports her observations of Grace Marks, first in the Kingston Penitentiary, and then in the Toronto Lunatic Asylum to which Grace was transferred for a brief period in 1852–3. After moving to Belleville in 1840 when her husband was appointed sheriff of Victoria District, Moodie wrote *Life in the Clearings* as a sequel to *Roughing It in the Bush* to convey her views of the longer-established Canadian society along the front of Lake Ontario, where she felt more at home. State institutions, such as penitentiaries and asylums, were considered an important part of establishing civilization as Ontario emerged from the raw pioneer years. They were open to visitors who wished to view the inmates—rather like a zoo, as was later remarked—and Susanna, as an author and wife of a sheriff, was both eager and able to take advantage of the opportunity. Her chief interest in visiting the small women's section of the Kingston Penitentiary was to look at the 'celebrated murderess', Grace Marks, whom she described as having a 'slight graceful figure' but 'an air of hopeless melancholy in her face'.[8] Writing from memory, as she told her readers, Moodie could not remember exact dates regarding the murder that took place eight or nine years earlier and identified Grace, especially for English readers 'who may never have heard even the name', simply as 'a young Irish emigrant girl hired into the service of Captain Kinnaird, an officer on half-pay'.[9] Moodie explained Grace's crime by quoting at length from McDermott's final confession, obviously a biased source because McDermott wanted to condemn Grace as the instigator of the murders. His description of Grace as very pretty but 'insolent' and 'saucy' towards the housekeeper, whom she despised for her airs of superiority, resonated with some of the common negative stereotypes of the Irish domestic servant. When Susanna Moodie visited the penitentiary some years after the murder, however, she had already learnt from Grace's attorney that Grace was greatly changed. In the most evocative prose of the chapter, Moodie paints the visions that Grace claimed left her no peace. As Grace supposedly told her lawyer, awake or asleep she could not escape the 'terrible face' and 'horrible bloodshot eyes' of Nancy Montgomery.[10] Even at night, in the silence and loneliness of her cell, those blazing eyes made her prison as light as day. Thus she was suffering 'the torments of the damned'. Viewing a 'furtive' woman unwilling to make eye contact, Moodie felt pity for 'this unhappy victim of remorse'. Because Grace was transferred to the Toronto Lunatic Asylum shortly before Moodie wrote about her penitentiary encounter,[11] the chapter on Grace Marks concludes with the author's hope that

Grace's guilt might be attributed to the 'incipient workings of this frightful malady', that is the 'fearful hauntings of her brain' that terminated in madness.[12]

With her description of the visions, Moodie prepared the way for her next viewing of Grace Marks a short time later in the Toronto Lunatic Asylum. Visiting Toronto for the first time, Susanna was impressed by the new asylum, with its white brick structure and spacious grounds. On her tour of the institution, she viewed through glass some of the women in the violent ward who were dancing and shouting and displaying a diabolical mirth with their hands secured in mufflers. Among these 'raving maniacs', as she described them, she recognized the face of Grace Marks, 'no longer sad and despairing, but lighted up with the fire of insanity, and glowing with a hideous and fiend-like merriment'. She did not know that Grace would soon be returned to the penitentiary as supposedly cured, and would spend the next two decades there until granted a pardon in a general review of long-term prisoners in 1872.[13] Therefore, Moodie expressed a heartfelt wish for an ultimate divine resolution to Grace's misery. In her words:

> Unhappy girl! When will the long horror of her punishment and remorse be over? When will she sit at the feet of Jesus, clothed with the unsullied garments of his righteousness, the stain of blood washed from her hand, and her soul redeemed, and pardoned, and in her right mind?[14]

For Moodie, Grace's salvation was not to be obtained through science or the new moral treatment being introduced at the Toronto Lunatic Asylum, but through religious faith. The redemption of the soul was not only desirable but possible because 'even in the extinction of reason, we acknowledge the eternal presence of God, and perceive flashes of his Spirit breaking through the dark material cloud that shades, but cannot wholly annihilate the light of the soul, the immortality within'.[15]

Moodie did not explicitly link Grace's ethnicity or her immigrant experience with her subsequent fate but nonetheless she depicted the transformation of a young Irish emigrant girl into a 'mad' woman wracked by lurid visions in the penitentiary and shrieking like a phantom in the asylum. The timing of Moodie's two viewings of Grace meant that her character sketch highlighted manifestations of insanity that usually received far less attention than the crime for which Grace was committed. Moodie responded with genuine human sympathy to a woman in such distress who, being safely within the walls of an institution, was no threat. It is also

possible that she was being cautious in reference to Irish ethnicity because she had been criticized for what was perceived as a derogatory description of the Irish in *Roughing It in the Bush*.[16]

Reading Moodie's account of Grace Marks more than a century later inspired Margaret Atwood to write her historical novel, *Alias Grace*. Atwood notes that the decade of the 1990s, during which she published *Alias Grace*, saw a spate of historical novels produced in Canada, perhaps because Canadian culture was sufficiently mature to want to incorporate more knowledge of the past.[17] In her 550-page novel, Atwood had more space to develop the character and circumstances of Grace Marks than did Moodie in her two chapters. In addition, Atwood could draw upon concepts of memory and analyses of gender, class, and ethnicity that were not available to Moodie. Atwood stated that in writing fiction, even though it was based on real events, she did not change any known facts but felt free to invent where there were gaps in the historical record. Although the blending of fact and invention can be frustrating for historians, it gives Atwood flexibility in developing the social context of Grace's life.

While Moodie simply mentions that Grace is an Irish immigrant, Atwood adds plausible details, many of which are not in the historical record, to develop the sense of isolation that Grace felt as a result of her family's immigration in 1840. In Atwood's version, Grace's mother died in the filthy conditions of the ship's hold during the long eight-week voyage to Canada, and was buried at sea with the family's second-best sheet as her shroud. It was a matter of pride for men to provide for their family but Grace's father did not fulfil this duty. Although he was a skilled stonemason, his earnings were all spent on drink, in Canada as in Ireland. In his drunken rages, he also began beating Grace as he had previously beaten her mother. As the oldest daughter with eight younger siblings, Grace escaped from the abusive family environment when she obtained a position as a scullery maid with a wealthy Toronto family. Here she was briefly happy because she developed a close friendship with Mary Whitney, the native-born Canadian servant with whom she shared an attic room. Tragically, Mary died shortly after a botched abortion when her employer's son refused to accept any responsibility for her pregnancy. It was during this trauma that Grace first experienced temporary memory loss and saw visions. By the time she arrived at her final domestic position, three years later after a series of short employments, Grace had lost all contact with her family, who had vanished. As she reflected on her sixteenth birthday, 'I was indeed alone in the world with no prospects

ahead of me except the drudgery I'd been doing'.[18] Even the birds were strangers as she did not know their names.

Atwood highlights the vulnerability of Grace, alone in a new world and forced to survive without the support of extended family, close friends, or even a familiar natural environment. Throughout she implicitly emphasizes the significance of gender: women, not men, experience unwanted pregnancies and are the main victims of domestic violence. She gives less attention to the specific importance of Grace's Irish origins, although she does recognize that the Irish in Canada were often the subject of prejudice and suspicion. Grace, however, came from Northern Ireland and was Protestant rather than Roman Catholic at a time when the religious distinction was very important in Canada. She was also a member of a shopkeeping and artisanal family, which usually conveyed respectable social status. Atwood allows Grace to explain in her own words.

> What I say at the beginning of my Confession is true enough. I did indeed come from the North of Ireland though I thought it very unjust when they wrote down that *both of the accused were from Ireland by their own admission*. They made it sound like a crime, and I don't know that being from Ireland is a crime although I have often seen it treated as such. But of course our family were Protestants and that is different.[19]

Thus Grace believes she may have been victimized because of being Irish, but resists such victimization in her own self-identity. In the novel, Grace's experiences as an immigrant and a young woman, more than her Irish identity, are linked to her possible mental breakdown.

Writing in the nineteenth century, Moodie turned to religion to find hope for Grace's soul and portrayed madness as the work of the devil. Writing in the twentieth century, Atwood explores the efforts of the medical community to treat Grace's mind and body. Most of the novel consists of Grace recounting her life to a fictional Dr Simon Jordan, an American alienist with European training who is brought to Kingston in 1859 to try to restore Grace's memory and thereby secure her release from the penitentiary. Atwood empowers Grace by making her the main narrator of her story, as opposed to using the views of male journalists, or the interpretations of the male medical community found in most institutional records. At the same time, Grace's story becomes highly nuanced and ambiguous, with issues of memory acquiring a central importance. The silences are as significant as the words. Does Grace not remember, or simply claim not to

remember? Is she insane, or feigning insanity to obtain better treatment? Did she become temporarily insane as a result of being confined in the penitentiary, or did her mental instability have earlier origins, as her visions might indicate? Whatever the answers, it becomes clear that Dr Jordan is not going to obtain them through either talk therapy or the analysis of dreams, considered to be the manifestation of subconscious memory. His repeated presentation of various vegetables to Grace in an attempt to restore her memory of bodies in the root cellar is useless. Another doctor tries neuro-hypnotism, reputedly more scientific than the mesmerism or séances that were rapidly gaining popularity in the mid-nineteenth century.[20] Readers, however, know that this supposed doctor is actually Grace's friend, an itinerant peddler who is an accomplished ventriloquist and who has practised his art at fairs. The voice heard during the hypnotic session is his own. In the end Grace is granted a pardon and released from prison, but, in Atwood's version at least, not because of any success achieved by the medical community in treating her. As Atwood notes, 'the true character of the historical Grace Marks remains an enigma'.[21]

One aspect of the enigma of Grace Marks is partially explained by historical research regarding state asylums in Ontario. The brief period that Grace spent in the Provincial Lunatic Asylum in Toronto coincided with an intense conflict within the Ontario medical community concerning the proper treatment of the criminally insane. In 1850 the surgeon at the Kingston penitentiary was alarmed by the increase in insanity cases, almost an epidemic that he believed could not be adequately treated by a reformatory regime that still included considerable physical punishment. When legislation in 1851 authorized the removal of insane persons from any prison to the public lunatic asylum, he immediately began transferring inmates considered insane to the new Toronto asylum where they could receive proper therapeutic treatment. The asylum superintendents, by contrast, were outraged by the influx of criminally insane patients who, they argued, did not belong with the ordinary insane. Joseph Workman, appointed superintendent in 1853, regarded the penitentiary transfers as either imposters seeking better conditions or 'moral monsters' who would destroy the moral management therapy that he wanted to prevail at the asylum. He solved the problem by quickly declaring the unwanted patients to be cured and sending them back to the penitentiary.[22] Grace Marks was deemed cured shortly after Workman's arrival at the asylum.

Grace Marks attracted literary attention because she was an exceptional woman, a convicted murderess. Nonetheless, the telling of her story reflects problems experienced by other immigrant Irish women in the mid-nineteenth century who, similarly, were poor and without support in Ontario. Nor was Grace unique among Irish immigrants in being confined to prison and asylum, or in having visions, especially since spirits, fairies, witches, and devils were central to Irish folk belief.[23]

Western Perspectives

By the early twentieth century the flow of immigration to Canada had shifted westward. The Last Best West with its promise of opportunity, independence, and adventure captured both the immigrant imagination and the interest of many authors. One of the most popular and prolific of the western Canadian authors was Nellie McClung. A leader in the western Canadian women's movement, she used her writing to portray social problems and show how reform could be achieved. Responding in her autobiography to criticisms of her didactic enthusiasm, she wrote, 'I hope I have been a crusader … and if some of my stories are sermons in disguise, my earnest hope is that the disguise did not obscure the sermon'.[24] The sometimes overwhelming isolation of pioneer life in western Canada that could lead to emotional breakdown and 'prairie madness' is one important social issue she addresses in her fiction.

In 1880, at age six, McClung migrated with her family from the rocky soil of Grey County, Ontario, to the more fertile land in Manitoba just opening for European settlement. Growing up in Manitoba as a second-generation Canadian, McClung strongly identified with western Canada as home. At the same time, she knew the sorrows her parents had suffered as immigrants. Her Tipperary Irish father, John Mooney, as a young man of 18 migrated to the Ottawa area in 1830 with his two brothers. In a short time both brothers had died of typhoid and her father was alone. He also lost his first wife after only one year of marriage. McClung was told she was Irish like her father, that she derived her outgoing personality, her wit, humour, and storytelling ability from him. Only later in life did she recollect with regret how her father was bitterly homesick for his Irish glens.

> He often told me there was music in the very air of Ireland, crickets in the grass, the whirring of wings at nightfall, and more than that, a gentle soft piping that is both merry and sad, and can turn the very heart in you. I asked

> him if this was the music of the little people who dance on the leaves and he said he was not rightly sure.[25]

McClung's mother, Letitia McCurdy, was a practical Presbyterian Scot from Dundee who did not believe in ghosts or fairies. Letitia migrated to relatives in Canada with her mother and sister when her father died in the Dundee cholera outbreak of 1856. Nellie, who was the youngest of six surviving children, recorded how her mother showed strength and ingenuity in caring for her family but was, nonetheless, depressed by prairie isolation. McClung remembered 'she would fall into low spirits the first few years we were in the country and sit drooping and sad under the pall of loneliness that wrapped us around for many months in the year'.[26]

Although McClung's parents did not succumb to the homesickness and loneliness they suffered, not all migrants to the prairies were so fortunate. In her fiction, McClung captured the impact of the prairie environment and the difficulties in human relations that contributed to mental and physical breakdown. The land itself was a harsh protagonist, wearing down the human spirit. The vast expanse of the prairie and the long distances between homesteads created a profound sense of isolation. Often the wind too seemed an enemy. It was not a gentle soothing breeze but a powerful force that howled and shrieked, bringing blizzards in winter and swirling dust in summer. The extremes of the climate, not only the intense cold of winter but also summer heat and droughts, challenged human survival. Men and women could both be adversely affected by the prairie environment, but in McClung's fiction women had the greater psychological struggle. While men's work required they travel in sometimes dangerous conditions, women were confined to the homestead by their family responsibilities and often deprived of female companionship for long periods of time. In her speeches as a political activist McClung frequently told the anecdote of the man who brought his wife to an insane asylum, saying 'I don't see how she can be crazy … Where would she get it? She hasn't been off the farm for twelve years!'[27]

In her short story, 'The Neutral Fuse', McClung describes the mental breakdown of an English bride who settled with her husband in the drought area of the west. Her choice of an English migrant identity for the bride was undoubtedly not accidental: middle-class English immigrants from a more urban society were often considered unprepared for rural homestead life. When Sadie Benton first arrived with her London clothes, her foolish little hats, and her sweet, soft voice, she seemed much too dainty for life on the prairie. Appearances were deceptive, however, because Sadie quickly adapted

and won acceptance with the help she gave to the school, the church, and her neighbours. Fifteen years passed, some good, but the last seven were successive years of drought, crop failure, and disappointment. Sadie maintained a cheerful exterior but she wrote her inner thoughts at night in her little red book, wondering why God would send such destruction to hard-working people, and decrying the screaming winds that shook the house.

> I hate the wind with its evil spite,
> And it hates me with a hate as deep,
> And hisses and jeers when I try to sleep.[28]

Trying to maintain her spirits, Sadie had planted flowers on the sheltered side of the house and she thrilled with the anticipation of having a spot of beauty in her drab world. Then, one night, as the buds were about to burst into bloom, and coincidentally while her husband was away in town to earn money, the wind attacked and destroyed all her hope, along with her flowers. In the last entry in her book she wrote,

> 'I know it isn't the flowers alone / That the wind has murdered in roaring glee; / It isn't the flowers that are lying dead / With blackened body and bleeding head — / It's me!'[29]

When a neighbour came to visit the next morning, she found Sadie 'serene and calm, but queer'. Prairie madness had invaded her brain although, it is important to note, only because extremely difficult conditions challenged her former successful adaptation. McClung attached blame to the environment and not to any innate ethnic characteristics.

Sadie's mental breakdown in the cruel natural environment is only half the story McClung tells. In the important second half, McClung explains how Sadie is restored to health not through confinement in an asylum but by a supportive women's network. On learning that she was definitely 'queer', the Daughters of the Empire, a women's organization to which Sadie belonged, unanimously agreed to provide funds to send her to a city convention so she could have a rest from her constant chores and a much-needed change of scene. Sadie's condition, however, worsened in the city; in a trance-like state she was arrested for shoplifting colourful paper flowers in the Fifteen-cent Store. The woman judge did not sentence Sadie to jail but instead sent her to a woman doctor to recover. As was explained, her court was more like a mental hospital than a place of punishment. They tried to find out what was wrong with people and how to prevent

recurrences. The doctor with whom Sadie spent a few days investigated her situation and told her that her temporary breakdown was a danger signal. She must not place such heavy burdens on herself by always hiding her own disappointments and becoming exhausted with the work she undertook. McClung also used the story to challenge the stigma attached to mental illness. The Crown Prosecutor at the court tried to reassure Sadie, telling her, 'We feel sure you are honest. Just something slipped in your brain. Brains are queer things—they can go out of order just like stomachs, or livers, or gasoline engines.'[30] And in case readers missed the message the first time, the doctor later repeated it, with a key addition.

> It's no disgrace to have a brain go out of order; you would not feel disgraced if your liver went on strike or your stomach refused to function. It is quite aristocratic to have a heart that misses a beat, so why should anyone feel so disgraced to have a brain that falters in its work? Indeed, it is a wonder that women on the farm do not all develop mental trouble, they work so hard, and have had, in the last few years particularly, so many disappointments.[31]

While 'The Neutral Fuse' is the main story in which mental breakdown forms the central plot, McClung conveyed similar messages regarding challenges to women's mental health in a number of her other books about early twentieth-century life in western Canada. The women succumb to their fears and depression when they feel isolated and alone in an alien environment. Most, like Sadie, are English immigrants, or at least of undefined Anglo background. In her first novel, *Sowing Seeds in Danny*, published in 1908, McClung includes a poignant portrait of Polly, an English domestic servant on a Manitoba farm who dies of typhoid. She notes that she based the character of Polly on an actual case reported in a Manitoba newspaper. Although she gives willing service and is very anxious to please, Polly never receives any kindness from her employer and sleeps in a spartan attic room. Consumed by homesickness and by worry for her widowed mother in England, who depends on Polly's wages to stay out of the workhouse, Polly does not have the strength to fight the fever. As the nurse in the hospital observes, 'she is dying of homesickness as well as typhoid'.[32] In the end Polly is able to die more contented because she receives a token of home, a bouquet of handsome red poppies that grew from seed she brought from England. The poppies were sent to the hospital not by her employer but by Pearlie Watson, the heroine of the novel, who has taken Polly's place as domestic help in the farm household. Being mistakenly thanked for this act of human kindness, however, does

lead the employer to regret her unsympathetic treatment of Polly and to send the needed money to Polly's mother. McClung's message is clear, earlier human kindness would have mitigated Polly's homesickness and might even have prevented her death.

McClung as a reformer wanted to give western Canadian farm women hope, not lead them into despair. Hence, as in the case of Sadie, women's emotional or mental breakdown in her fiction is usually temporary, a warning sign, rather than a continuing impairment or a fatal collapse of mind and body. Because the cause is external, recovery can occur through the support of other women without medical intervention. Nonetheless, as is indicated by the humorous anecdote which introduces this section, McClung was also aware of more serious cases of mental breakdown that she did not incorporate into her fiction writing. In *The Black Creek Stopping-House*, Evelyn Bryden and her husband Fred were enticed to migrate to Manitoba by eloquent, if quite misleading, letters from Fred's ne'er-do-well twin brothers who were seeking help so they could avoid doing farm work. The twins, a version of the despised remittance men, had emigrated to Manitoba because their wealthy English aunt indicated she would leave them money if they went to Canada. Fred, unlike his brothers, applied himself successfully to farming, but Evelyn had difficulty adapting to the change in her life. She arrived with clothes even more inappropriate than Sadie's—an opera cloak, a dress of green silk, embroidered stockings, and beaded slippers. After a few months she was tired and depressed by the continuing failures in her cooking, and the rough chapped condition of her formerly white hands. She also felt threatened by the alien prairie environment. In McClung's words, 'the utter loneliness of the prairie, with its monotonous sweep of frost-killed grass, the deadly sameness, and the perpetual silence of the house, had so worked upon her mind that it required but a tiny spark to cause an explosion'.[33] In such a state of mind Evelyn, like Sadie, found herself alone at night because Fred was away helping neighbours with threshing. The twins, thinking only of their own pleasure, likewise had departed for duck hunting. Soon Evelyn began to hear voices, strange, whispering voices, then mocking, gibbering voices growing louder. Along with the voices, she glimpsed ominous black shadows, even though she drew down the blind to block outside faces staring at her. The temporary terror and madness vanished when a very human knock sounded at the door, but Evelyn was vulnerable to the person knocking, an ill-intentioned man who wanted to steal Evelyn away from her husband. McClung, however, maintained moral proprieties by

having Evelyn restored to her husband through the intervention of the resourceful Irish woman proprietor of the Black Creek Stopping House, a former officer in the Salvation Army. In another article, first published in *Saturday Night*, McClung includes an almost identical account of the breakdown of a lonely prairie woman who, fearing her environment, continually hears whispering plotting voices and sees terrible black shadows. In this story the woman is rescued less dramatically by a new neighbour who brings human companionship and thus drives the mocking voices away forever.[34]

Drawing on her religious faith, McClung believed that cooperation and active care for others must be the foundation of Canadian society. Helmi, the Finnish immigrant heroine of *Painted Fires* and an exception to McClung's usual concentration on British and Irish settlers, provides an example of the emotional support to be derived from religion. In her difficult journey from immigrant domestic servant to Canadian wife and mother, Helmi is sustained by memories of the welcoming friendship she had received on becoming a member of the Canadian Girls in Training (CGIT), a Methodist youth organization. Through all her trials, she holds fast to her CGIT covenant with God, 'Cherish health; seek truth; know God; serve others'.[35] Only once does she briefly falter and consider suicide. Having lost contact with her husband, who went prospecting and then left for the war, Helmi must survive alone with a new baby but no money. Although an excellent worker, she knows that no one wants a woman with a baby. In her depression, Helmi berates God for making life so difficult for women. Sinking into another world, Helmi's 'soul wandered lonesomely, torn with the old problem of whether to go on or to stay'.[36] Then the baby's cry reaches out to Helmi and restores her strong defiant spirit. As is most usual in McClung's fiction, there is a happy ending.

McClung's optimism contrasts with the darker outcomes in some other prairie fiction. For example, Sinclair Ross, writing about the devastating impact of the 1930s depression in western Canada, also describes how hardship and loneliness can lead to madness. In *The Lamp at Noon*, he evokes the emotional and physical threat of the natural environment, especially the constant screaming wind that spreads the dust filled air. His story, however, has a deeper psychological dimension that ends in tragedy. The young couple, Paul and Ellen, are not only isolated on their homestead but each locked within themselves, unable to communicate their feelings adequately. In an ultimate madness of concern for their child, Ellen runs out into the windstorm clutching the baby, who is smothered

by the dust. Ross, like McClung, develops the significance of gender but gives more attention to the problems of masculinity and, arguably, is less sympathetic to the plight of women. Worn out by the struggle to make a living on the farm, Paul has acquired a 'haggard strength', a 'harsh and clenched virility'; his self respect and manhood depended on maintaining the farm and not acknowledging any vulnerability. Therefore, he rejects Ellen's entreaties to leave the farm as the 'fretful weakness of a woman'. For her part, Ellen feels caged, she broods and worries when left alone in the house. While emphasizing Ellen's isolation, Ross nonetheless portrays her feminine nature as lacking in strength and more prone to breakdown. She displayed a 'plaintive indignation, a nervous dread'; she still longed for pretty things and had 'the face of a woman that had aged without maturing'.[37] Writing in the 1940s from a male perspective, Ross takes for granted Ellen's subordinate place in the farm household. From a more modern feminist perspective, Ellen's breakdown could be linked to her inability to share in the farm decision-making, as much as her physical isolation.

Having masculine identity bound up with the breadwinner role and successful achievement in work could also lead to mental breakdown. I conclude with a brief examination of a post World War II novel set in urban rather than rural western Canada that illustrates such breakdown. The title of Denis Godfrey's novel, *No Englishman Need Apply,* published in 1965, evokes the long-standing Canadian resentment of those English immigrants who assumed they were far superior to mere colonials. The subject of the novel reflects the increasing dominance of educated professionals among the postwar wave of English migrants fleeing austerity in Britain. An aspiring young English academic, Philip Brent, reluctantly accepts a position at what he considers to be a remote western Canadian university because he has no other offer. Denis Godfrey, himself a postwar English migrant who became a professor in the English department at the University of Alberta, is thus addressing both a community and questions of exile and belonging with which he was well acquainted.[38] In the novel, Philip Brent finds himself at the centre of a bitter struggle for control of the university English department between the head of the department, an earlier English immigrant who wants to reinforce British culture at the university, and his arch-rival, a Canadian educated in the USA, who has American sympathies. From the perspective of his wife, who more readily accepts life in Canada, Philip only slowly reconciles himself to his new situation, but nonetheless is not as resistant to change as their neighbours,

the 'ultra-English' Somervilles. She recognizes the 'old colonial attitude' in the Somervilles who 'acted, spoke, dressed, ate, and thought as if in England' and fined their children for any 'Canadianism' they might utter.[39] At the university, Philip acquires a reputation as a good lecturer but nonetheless, like Olivia Chow's father, has some difficulties adapting to the more democratic Canadian classroom. Returning after the summer break, Philip is shocked to discover that he has been fired and a new American recruit has taken possession of his office. Philip is allowed to remain until spring at an inferior rank and lower salary, but the humiliation of the rejection leads to his increasing isolation and depression. His wife anxiously observes Philip becoming 'unnervingly withdrawn', worse than a previous time in London when job rejections had accumulated.[40] Although he pretends to go through the motions, Philip no longer performs his teaching obligations. His deepening dreamlike abstraction leads to a suicide attempt, a criminal act that his wife manages to keep secret, although doctors are suspicious. Having acquired pneumonia as a result of hypothermia combined with a drug overdose, Philip makes the long journey back to life in a regular hospital bed, not a psychiatric ward. Nonetheless, his story resonates with that of Olivia Chow's father. Although from very different ethnic backgrounds, both men are educators who suffer mental breakdown because of rejection in Canada, and there are indications that both had suffered less severe instability before their emigration. In spite of cultural differences, their masculine identity is closely associated in both cases with professional achievement. Interestingly, Chow's mother also suffered downward mobility in status and income in Canada. A former teacher in Hong Kong, the only employment that she could find in Toronto was as a seamstress in a sweatshop, as a maid, and then as a laundry worker in the noisy damp basement of the Delta Chelsea Hotel, an environment that left her with arthritis. Her mother, however, persevered and not only cared for her family but bore the brunt of her husband's anger in the home.[41]

This chapter has not attempted a survey of literary texts dealing with Irish and English immigrants who experienced emotional and mental breakdown. Instead it has selected certain authors, albeit well-known ones, for more detailed examination. Therefore caution must be exercised in any generalizations. Nonetheless, certain concluding remarks can be made. These literary texts, whether memoir or fiction, reflect the vulnerability of the immigrant experience. Although chain migration could be important in promoting movement to Canada, the Irish and English migrants depicted in the literature tended to come to Canada as individuals or members of

nuclear families, and so, often lacked familiar community support at times of crisis. Particular ethnic attributes reinforced their immigrant status and possibly predisposed them to problems. The Irish with their folk belief in the little people were prone to see visions, and Canadian prejudice against the Irish condemned them as drunken or demented. English women, especially of the middle or upper social orders, were depicted as arriving inadequately prepared, in both knowledge and clothing, for life on the prairies, and Englishmen might bring an attitude of superiority that fostered rejection. Gender issues cut across these ethnic differences. Regardless of background, women tended to be more isolated in the home, whether as domestic servant or wife. Indeed, the major theme that emerges in all the literary texts is how isolation and loneliness lead to despair and mental breakdown. The alien prairie environment imposes a particularly threatening physical isolation for women alone on scattered homesteads. Loneliness and isolation, however, are also felt by those surrounded by other people: Grace Marks in the penitentiary and asylum; Polly shown no kindness by a harsh mistress; Helmi with no money among crowds in a large city; or Philip Brent suffering rejection by colleagues at the university.

The literature seldom deals with medical scientific solutions to mental breakdown, and when it does in *Alias Grace*, the doctors are conspicuously unsuccessful. Nellie McClung is the author who is most anxious to promote reform. Drawing upon her religious faith and her commitment to the women's movement, she describes the importance of the healing power of friendship, neighbourliness, and community support in overcoming isolation and the consequent breakdown. Interestingly, recent research at the University of Chicago Centre for Cognitive and Social Neuroscience provides scientific backing for McClung's religious principles, even in cases where there may be both a genetic and an environmental component.[42]

Notes

1. Elaine Showalter, *The Female Malady: Women, Madness, and English Culture, 1830–1980* (New York: Penguin, 1985), 61–8.
2. Olivia Chow, *My Journey* (Toronto: Harper Collins, 2014), 23–7.
3. There is an extensive international literature on the significance and interpretation of memory in history. For this study I am also drawing in particular on Margaret Atwood, *In Search of Alias Grace: On Writing Canadian Historical Fiction*, Charles R. Bronfman Lecture in Canadian Studies, University of Ottawa, 21 November 1996 (Ottawa: University of Ottawa Press, nd).

4. See Lorna R. McLean and Marilyn Barber, '"In Search of Comfort and Independence": Irish Immigrant Domestic Servants Encounter the Courts, Jails, and Asylums in Nineteenth-Century Ontario', in Marlene Epp et al., eds., *Sisters or Strangers?* (Toronto: University of Toronto Press, 2004), 148–151 for examples of Irish women in the Rockwood Asylum for the criminally insane opened in Kingston in 1856.
5. McLean and Barber, 'In Search of Comfort and Independence', 134; Margaret Atwood, *Alias Grace* (Toronto: University of Toronto Press, 1996), 525–6.
6. Susan E. Houston, 'The Role of the Criminal Law in Redefining "Youth" in Mid-Nineteenth-Century Upper Canada', *Historical Studies in Education/ Revue d'Histoire de l'Éducation*, 6: 3 (1994), 39–55, cites collected archival and newspaper evidence regarding Grace Marks.
7. Charlotte Gray, *Sisters in the Wilderness: The Lives of Susanna Moodie and Catharine Parr Traill* (Toronto: Viking, 1999) explains the background and immigrant experiences of the Strickland sisters.
8. Susanna Moodie, *Life in the Clearings* (Toronto: Macmillan, 1959) 157, 169.
9. Moodie, *Life in the Clearings,* 158.
10. Atwood notes that the influence of Dickens' *Oliver Twist*—a favourite of Moodie's—is evident in the tale of the bloodshot eyes. *Alias Grace,* 556.
11. Grace Marks was admitted by warrant to the asylum in May 1852. Archives of Ontario, RG10-20-B-1, Admission Orders Nos. 1182 and 1183, Grace Marks and Bridget Maloney.
12. Moodie, *Life in the Clearings*, 170.
13. Canada, *Sessional Papers,* 1873, No. 75, 'Return of Pardons for 1872'.
14. Moodie, *Life in the Clearings*, 224.
15. Moodie, *Life in the Clearings*, 226.
16. Towards the end of *Life in the Clearings*, Moodie wrote, 'It was likewise very cruelly and falsely asserted, that I had spoken ill of the *Irish people* because I described the revolting scene we witnessed at Grosse Isle, the actors in which were principally Irish emigrants of the *very lowest class* … The few Irish characters that occur in my narrative have been drawn with an *affectionate*, not a malignant hand.' (*Life in the Clearings*, 277).
17. Atwood, *In Search of Alias Grace,* 23–6.
18. Margaret Atwood, *Alias Grace* (Toronto: McClelland-Bantam, 1996), 308.
19. Atwood, *Alias Grace*, 116.
20. In her 'Author's Afterword' in *Alias Grace,* 558–9, Atwood states: 'The Spiritualist craze in North America began in upper New York State at the end of the 1840s with the "rappings" of the Fox sisters, who were originally from Belleville—where Susanna Moodie was by then resident, and where she became a convert to Spiritualism … the movement spread rapidly and was at its height in the late 1850s, being especially strong in upstate

New York and in the Kingston-Belleville area'. See also Joseph McCabe, *Spiritualism: A Popular History from 1847* (London: Unwin, 1920) and Alex Owen, *The Darkened Room: Women, Power, and Spiritualism in Late Nineteenth-Century England* (London: Virago, 1989).

21. Atwood, *Alias Grace,* 558.
22. James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (McGill-Queen's University Press, 2000), Chapter 5, 'Criminal Insanity: The Creation and Dissolution of a Psychiatric Disorder', 141–51.
23. See McLean and Barber, 'In Search of Comfort and Independence' for other examples.
24. Nellie McClung, *The Stream Runs Fast: My Own Story* (Toronto: Thomas Allen and Son, 1965), 69.
25. Nellie McClung, *Clearing In The West: An Autobiography* (Toronto: Thomas Allen and Son, 1976), 181–2.
26. McClung, *Clearing in the West*, 172.
27. Mary Hallett and Marilyn Davis, *Firing the Heather: The Life and Times of Nellie McClung* (Saskatoon: Fifth House, 1993), 103.
28. Nellie McClung, 'The Neutral Fuse', in *All We Like Sheep* (Toronto: Thomas Allen, 1926), 106.
29. 'The Neutral Fuse', 113.
30. 'The Neutral Fuse', 121–2.
31. 'The Neutral Fuse', 126.
32. Nellie McClung, *Sowing Seeds in Danny* (Toronto: Thomas Allen, seventeenth edition, 1947), 176.
33. Nellie McClung, *The Black Creek Stopping-House and Other Stories* (Toronto: William Briggs, 1919), 62.
34. Nellie McClung, 'You Never Can Tell', in *The Black Creek Stopping-House*, 167–8.
35. Nellie McClung, *Painted Fires* (Toronto: Thomas Allen, 1925), 59.
36. *Painted Fires*, 222–3.
37. Sinclair Ross, *The Lamp at Noon and Other Stories* (Toronto: McClelland and Stewart, 1968), 13–23.
38. Hallvart Dahlie, *Varieties of Exile, The Canadian Experience* (Vancouver: University of British Columbia Press, 1986), Chapter 8 'Emigrés and Academics', 192–4.
39. Denis Godfrey, *No Englishman Need Apply* (Toronto: Macmillan, 1965), 71–2. See also George Melnyk, *The Literary History of Alberta, Volume Two: From The End of the War to the End of the Century* (Edmonton: University of Alberta Press, 1999), 24.
40. Godfrey, *No Englishman Need Apply*, 219.
41. Chow, *My Journey*, 23–5.
42. John Cacioppo and William Patrick, *Loneliness, Human Nature and the Need for Social Connection* (New York: Norton, 2008).

CHAPTER 8

Mad Migrants and the Reach of English Civil Law

James Moran and Lisa Chilton

How did English lawmakers and legal experts understand the legal situations of people who were considered to be mentally unwell but whose circumstances had them moving around, sometimes over considerable distances beyond England's political boundaries? In an age of extensive population movement, throughout the British Empire and beyond, to what extent did a person's location affect English courts' findings? The subject of migration and madness has captured the interest of historians who have arrived at the subject by following a wide range of historical threads. Thus, an exploration of migration and mental health brings us to the intersections of several historical sub disciplines: migration history, mental health/illness history, legal history, and not least, the history of empire.

The historiography relating to the management of people who were mentally unwell was dominated for much of the latter part of the twentieth century by studies of asylums. A logical intersection between asylum-based histories and the history of migration has produced a wide range of social historical studies. Using the records produced by asylum managers and doctors, historians have been able to reconstruct elements of ordinary people's migratory paths into and between institutions for the mad. For example, Hilary Marland, Catherine Cox, and Sarah York have done extensive work on Irish-born migrants who spent time in English asylums during the course of the nineteenth century.[1] Their findings overlap in significant ways with those of historians who have studied asylum records in colonial contexts. In colonial settings there were demonstrably higher

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rates of immigrants, and especially Irish immigrants, committed to state-run asylums.[2] These studies highlight the mental wear and tear that came with dislocation, the challenges that resulted from lost community-based structures of care, and the politics involved in managing mentally unwell migrants *en masse* during the nineteenth century.

Historians who have explored the intersections of mental health and migration history have focused upon the ways in which nation-building agendas of the late nineteenth and early twentieth centuries resulted in the expulsion of newcomers who were found to be mentally unhealthy. In the Canadian context, for example, historians have produced works that explore in detail the politics and mechanisms (legal and extra-legal) by which Canadian officials organized the deportation of recent arrivals who were determined by experts to be either in a state of feeble mindedness or of insanity.[3] As such studies show, in Canada and elsewhere laws linking mental ill health with the loss of rights to citizenship could be as much about state regulation within the nation as they were blunt tools of expulsion.

Historians have also pointed to the cultural implications of insanity in an imperial context. For example, Richard Keller argues that immigration from former colonies like those in French North Africa to France were (and still are) informed by the 'vocabulary of pathological maladaptation and the tensions between Islam, republicanism, and global modernity'.[4] For Keller, migration and post colonialism are enmeshed in discussions about mental wellbeing, creating 'a lexicon of psychological normality and pathology'.[5] In *Mad Tales from the Raj: The European Insane in British India, 1800–1858*, Waltraud Ernst explains that Europeans who lost their minds in colonial India, and who did not recover quickly from their mental malaise, were sent back by the East India Company to 'Pembroke House, the Company's lunatic asylum near London'.[6] This 'passage from India'[7] mobilized those who had moved great distances to the colony in the first place back to England—a process that was designed, at least in part, to preserve 'the prestige of the ruling race through institutionalization and repatriation of the European mentally ill'.[8] In his work on the history of fugue, Ian Hacking demonstrates that mobility and madness were understood in fundamentally different ways in and out of the British Empire.[9]

This chapter contributes to the historiography relating to mental health, migration, law, and British imperialism through an exploration of a handful of eighteenth- and nineteenth-century cases relating to individuals whose geographical mobility and madness drew the attention of developing lunacy

investigation law in England. As a part of the English civil legal response to those who were considered *non compos mentis*, and who had considerable property at stake, lunacy investigation law developed from its origins in the fourteenth century into an increasingly sophisticated response to madness in England. However, those responsible for the development and implementation of this law were challenged by the jurisdictional uncertainties of mad individuals who did not reside in England, who wandered in and out of the country, or whose English citizenship was under question. An assessment of disputes over the jurisdictional boundaries of English lunacy investigation law in places like France, Russia, Germany, the United States, Jamaica, and India highlights the ways in which England tested its legal powers against the jurisdictional uncertainties and challenges of other nations, and of the colonies within its imperial orbit.

A review of these legal cases indicates that in grappling with migration and madness, English lawmakers exerted England's superiority in its response to lunacy in the expanding British Empire. This included vesting colonial officials with the legal powers of lunacy investigation while at the same time reserving the right to exert ultimate control of the procedure from England. In jurisdictions that were not a part of the empire the situation was more complicated. In dealing with mad individuals who were understood to be English subjects living in other countries, English legal authorities assumed full authority over these expatriates. Remarkably, there is also evidence to suggest that the architects of the laws of lunacy investigation extended their authority over those who were not clearly subjects of the British Crown. In its response to these individual cases English legal experts developed legal understandings of what madness was and how it ought to be addressed. At a broader remove they also attempted to prove the superiority of a rational English approach to migration and madness.

British Subjects

The Trustee Act of 1850 technically addressed questions of jurisdiction over the mad in various parts of the United Kingdom of Great Britain and Ireland. But, as the following cases involving England and Ireland demonstrate, there was still considerable confusion and sometimes tension over the legal management of migration and madness across this multifaceted political space. The case of John Davies pivoted around interpretations of the Trustee Act. Davies was appointed as a member of a group of three trustees to the will of Sir G. Parker. In Parker's will was a provision that

allowed for the appointment of new trustees should one of them 'die, or decline, or [become] incapable of acting'. It appears that this provision was ready-made for Davies who had been 'a person of unsound mind' for some years prior to an 1851 petition to the Chancery Court by his two fellow trustees for permission to follow the will's provision to replace Davies with another trustee. In their view 'a conveyance from the lunatic trustee was … necessary' along with the appointment of a new trustee, and this could only be done with the 'aid of the Court'.[10]

This all seemed rather straightforward except that the trustees were asking the Chancery Court of England for permission to replace Davies—the mad trustee—as a guardian for property that was situated for the most part in Ireland. A legal expert acting on behalf of the two trustees made his case by referring to the 54th section of the 1850 Trustee Act, noting that

> the powers and authorities of the Court of Chancery in England under the Act were expressly made to extend to all lands and personal estate within the dominions, plantations and colonies belonging to Her Majesty except Scotland, and that therefore, the Lord Chancellor of Great Britain had a concurrent jurisdiction with the Irish Court over lands in Ireland.[11]

While Lord Chancellor Truro (Thomas Wilde) agreed with this reading of the law he nevertheless concluded that, with a full consideration of the act in mind, 'it was not intended … to give the Lord Chancellor of Great Britain sitting in lunacy a concurrent jurisdiction over lands in Ireland; and that, therefore, as to those the Lord Chancellor in Ireland must be applied to'.[12] The outcome of this case was that Truro did appoint a new trustee to replace Davies, but with the provision that the new trusteeship powers would not apply to any property that Sir G. Parker owned in Ireland. Presumably a separate case had to be made for the new trustee's powers that would apply to the bulk of Parker's Irish property.

Debates concerning the case of Herbert Graydon suggest more jurisdictional jostling over the 1850 Trustee Act. Graydon was found to be *non compos mentis* in Ireland through a lunacy commission that was initiated and carried out in Ireland. In 1850 his daughter (and only child) petitioned to change the terms of her father's guardianship arrangement, which, if successful, would technically have excluded Graydon's brother from Graydon's wealth, to the benefit of the daughter's husband and children. Like the previous case, despite the fact that Graydon's property was located in Ireland, the petition was to the Lord Chancellor

of England. The Lord Chancellor's initial response was blunt in its reminder of jurisdictions:

> The lunatic living in Ireland, why do you come here? Why not apply to the Lord Chancellor of Ireland? He is intrusted with the care of this lunatic, and the power to act as protector is given, by the 33rd section of the Act, to the person who has the protection of the particular lunatic. Suppose a person to have been found lunatic here, it would be a very inconvenient proceeding to go to the Lord Chancellor of Ireland.[13]

This initial statement was explained in the English Report, which noted that the Act of 1850 was really passed to simplify the alienation of estates in England. For example, the Report noted:

> it would be a great inconvenience to have to apply to a particular Court where the lunatic happened to be—India, for instance, or Holland—for consent to effect estates in England. This Act is confined to estates in England, and the Irish Act to estates in Ireland.

Despite this feedback, Graydon's daughter (and her husband) still tried their luck with the English courts: 'the parties are quite willing to take the risk of this proceeding being inoperative', they wrote.[14] The political and economic joining of Ireland and Great Britain by the Act of Union in 1801, together with the extensive multifaceted takeover through force and more subtle forms of coercion dating back to the time of Cromwell and beyond, likely encouraged English citizens to consider English-Irish boundaries to be loosely fixed at best. The technical boundaries of legal jurisdiction were not compelling enough to dissuade interested parties from testing their luck with Irish property.

The issues raised in the two cases reviewed above, where the property under consideration was located in Ireland and in England, concerned legal jurisdiction *within* the United Kingdom. In both cases, legal authorities were loath to assert control over land or person situated beyond Welsh and English borders. In the case that follows, questions of jurisdiction were clearly less fraught with political tension, even though the person in question had lived in Europe for about 18 years by the time of the investigation.

According to the legal testimony of his brother, in about 1733 Thomas Southcote was considered by his family to be sufficiently disordered in mind to be sent from Essex across the English Channel to a 'religious

house' in Ghent. By 1743 Southcote's father was convinced that his son was not receiving adequate care at the Ghent institution, so he had him moved to an asylum at St Venant, France.[15] Thomas Southcote had an estate in England that was worth £600 per year and, on the death of his father, Southcote's brother Philip petitioned for a *writ de lunitico inquirendo* to inquire into the mental state of his sibling, presumably to deal with the property inheritance their father's death had brought into effect. As the notes taken for the English Reports state, although there was ample evidence of Southcote's madness to warrant a lunacy investigation, this case posed several challenges. The first difficult question was 'whether a subject, who is abroad, can have a commission issued against him in England'. The second question was how to 'prove the lunacy of one, who cannot be brought before a jury for inspection, if the commission is opposed … [by] the least contrariety of evidence'.[16] Inconveniently, Southcote was not a resident of England. His medical attendants in St Venant advised that he was too frail physically to make the trip back to England to stand the civil trial in lunacy launched against him. This posed a third question to the Lord Chancellor involved in the case, which was how it was possible to determine the identity of an English subject who had for so many years been out of the country.

The Lord Chancellor considered the jurisdictional and juridical dilemma presented by the case of Thomas Southcote in the following way:

> it would be unreasonable, that the King's subject, being abroad, and a lunatic, should lose his protection. The commissioners cannot execute the commission beyond sea, as in the case of a commission to appoint a guardian, because the authority is not in them alone, but in the jury too. But if a commission were not to be granted, what situation would the subject be in with respect to his safety and protection from the King?[17]

Part of the concern here was that, from a legal perspective, the law of lunacy investigation was seen primarily as a form of protection of the person and property of those deemed *non compos mentis*. With a history dating back to the second half of the thirteenth century, lunacy investigation law had, by the time of Southcote's lunacy, developed into a sophisticated legal mechanism by which to determine cases of madness, and to respond with a guardianship arrangement to care for the mad and his/her property (especially those with relatively large amounts of property). This included a petition for a lunacy commission, a trial with a full jury and witnesses' testimonies, and

the appointment of guardians for the person and property of the individual deemed to be mad. The lunatic's property was, in principle, to be carefully managed, some of it for the care of the person determined to be mad and his/her relations, but the rest to be held until such time that the lunatic was sufficiently rational to supersede the earlier verdict of *non compos mentis*. But it was designed with the assumption that its subjects would be, literally, within reach of the law. Those who migrated abroad posed a challenge to the practice and principle of lunacy investigation law.

Colonial Matters

In this case the resolution was to allow for the commission to be granted. Despite the fact that 'the commissioners and jury have a right to inspect the person of the lunatic, and examine him before them', the Lord Chancellor concluded that, as no one contested Southcote's insanity, and as the caregivers in France were loath to let him travel on account of his fragile mental state, an exception could be made in this case.[18] In reference to colonial cases that might parallel that which has just been examined, the Lord Chancellor noted that 'in the *Plantations* indeed the governors will have a power to take care of the person and estate there by virtue of the king's commission appointing them governors: but not farther'.[19] However, these colonial legal authorities 'cannot take care of a lunatic's estate in *England*; for that', the Lord Chancellor noted, 'there must be a commission under the great seal of *England* appointing a committee of the estate'.[20] Although the spirit of the lunacy investigation law had both the welfare of the mad and the protection of their property in mind, in cases of mad migrants the two would, in all likelihood, need to be viewed more as separate parts of a greater whole. As Lord Hardwicke explained:

> The law gives this inquiry [into lunacy] with two distinct views; for [the] sake of the lunatic or idiot himself, and for the sake of the crown's right. The first is, that the party may not do himself a mischief, may be taken proper care of, and put into proper hands; which inquisition, when the person is beyond sea, would seem fruitless, as it could not have effect: but in the other view it is absolutely necessary to have such inquiry relating to the prerogative of the crown as to these lands in *England*: of which right by the common law and declared by the statute *de Prerog Regis*, the crown cannot be deprived by the person's being beyond sea.[21]

Noting that a *writ de lunatico inquirendo*, grounded in common law, could be used with some flexibility and discretion to suit the circumstances of the case, Hardwicke nevertheless fleshed out a response to Thomas Southcote that tried to accommodate the dilemma posed by the movement of mad English subjects. Though admitting that it would be hard to prosecute the law of lunacy investigation in this case in the precise way that it had been designed and implemented over the centuries in England, the Lord Chancellor nevertheless made it clear that the English Crown would not be abandoning its subjects—or letting them slip from its legal grip—despite their distant proximity to English shores.

As Lord Hardwicke intimated in his deliberations over the case of Thomas Southcote, for colonial subjects of the British Crown authority had been vested in colonial governors to issue commissions in lunacy cases. This power was recognized officially on 29 July 1772 with the circulation of a draft clause 'to be inserted in the instructions to Governors in America giving them, as Chancellors, the power to issue commissions for the care and custody of idiots and lunatics'.[22] This draft document, addressing the colony of Nova Scotia, but circulated amongst all of England's North American possessions, reiterated the 'Royal Prerogative' in matters of idiocy and lunacy, in England and in 'our Provinces in America', and also noted that 'great trouble and charges may arise' for colonial officials who 'shall have occasion to resort unto Us for directions'.[23] With this in mind, the colonial governors were informed that they had 'full Power and Authority without expecting any further special Warrant from Us … to give Order and Warrant for the preparing of Grants of the Custodies of such Ideots and Lunaticks and their estates as are or shall be found by Inquisitions'. The governors were further encouraged to follow the legal process of lunacy investigation law 'as nearly as may be as hath been heretofore used and accustomed in making the same under the Great Seal of Great Britain'.[24]

Presumably new migrants to the colonies of North America would be subject to the extension of this law if a portion of their wealth to be placed under guardianship were held in the colony of their residence. These powers over the trial and guardianship process of mad colonists were taken up readily in the colonies of East and West Jersey, and they appear to precede the abovementioned official clause by decades. As early as 1692, Governor Andrew Hamilton was exercising this authority to provide guardianship for the insane in East and West Jersey. For example, Hamilton appointed the wife of Samuel Hooten of Shrewsbury, his daughter, and her husband

as Hooten's guardians as he was 'rendered uncapable [sic] to act through a distemper of lunacy'.[25]

We can see the articulation of this perspective on the reach of lunacy investigation law into the colonies in two cases involving Jamaica. In the first case, John Houstoun, a plantation owner in the Trelawney township of Jamaica, had a commission of lunacy issued against him in Jamaica and was found to be *non compos mentis*.[26] The usual process ensued, with three guardians appointed to oversee his personal care and the protection of his property, which included a plantation and several slaves. At this point, the logic of the colonial powers of lunacy investigation seems to have been realized. However, at some point Houstoun's guardians decided to bring him to England, to the Staffordshire city of Lichfield, hoping that his bodily and mental health would improve there. One of the guardians accompanied Houstoun to Lichfield 'in order to take care of his welfare and comfort'.[27] Although Houstoun's guardians from Jamaica did not think it was necessary to repeat the process of lunacy investigation in England, Lord Chancellor Eldon disagreed. His reasoning was thus:

> The commission now existing in *Jamaica* is no reason why a commission should not issue here. On the contrary, it is evidence of the absolute necessity that there should be somebody authorised to deal with the person and estate of this lunatic. While the lunatic is here, no Court will have any authority over him or his property, unless a commission is taken out.[28]

One reason for the Jamaican committee's reluctance to enter into a new commission of lunacy was undoubtedly the appreciable expense associated with the proceedings. Another was the fact that Houstoun's half sister Elizabeth Ann Flowers and her husband were pursuing the new commission and would thereby likely complicate the issue of who had control over Houstoun's person and perhaps also his property. What little evidence we have of this case seems to make it clear that Houstoun's property was held in Jamaica in its entirety. On one level, this makes the Lord Chancellor's insistence on another lunacy investigation irrelevant as Houstoun's property in Jamaica could be perfectly well overseen by the guardians empowered by Great Britain's extension of its lunacy laws to the colonies under precisely these circumstances. Either something about his return to England changed Lord Eldon's outlook, or the desire to ensure England's hold on the process overrode the logic of the law in this case.

In another case involving an estate in Jamaica, the person whose mental health was in question, Thomas Richard Halse (or Hals), was not actually a resident in the colony. Halse, legally an infant at the time of his first trial, had a lunacy commission launched against him in 1743 by Francis Sadler, his half brother, who was concerned that a property Halse stood to inherit in Jamaica worth £1,500 per year would be improperly managed if left in the hands of his sibling. At this point of his career Sadler was already well known in Jamaica because he had been an influential army lieutenant in the 1739 settlement with the Maroons. By 1742 he had established the Montpelier plantation in St James parish. For reasons that are unclear, Halse's mother refused to present Thomas at the lunacy hearing at Hertfordshire where she and her son were residing, but the proceedings went ahead nonetheless, with the verdict that 'he was not a lunatic, but judged … not proper to take care of his affairs during his fits'.[29] The Lord Chancellor considered this trial and its outcome as unacceptable. He thus superseded the Hertfordshire proceedings and ordered a new commission to be held at Middlesex, where Halse was thought to have been seen last. But the law's preference to make available for inspection those who were not clearly insane was once more thwarted in this case. Just before the trial, Halse and his mother relocated to Antwerp. The second trial went ahead but this time Halse was declared a lunatic and custody of his person and of the estate in Jamaica was granted to Sadler.

Whatever motivated Halse's mother (and perhaps Halse) to evade the proceedings in lunacy by moving across the English Channel, the result was that Halse's half brother gained control over his Jamaican property. The English Report of the case alludes to this legal dilemma (and confusion) in stating that:

> the crown has a right to its subject, wherever he is; can send for him over; and then the committee of the crown may take his person. That is the proper method, by giving authority in an amicable way to bring the person over, though it cannot be done by force. So the court has granted the guardianship of an [insane] infant though beyond sea.

In this case the geographical realities were even more challenging since the guardian's residence was in Jamaica and, at least as of 1744, the mad person's residence was in Belgium.[30] The movement of Halse out of England to Antwerp and the residence of Sadler in Jamaica made the prosecution of English lunacy investigation law difficult. Yet it is clear that English

legal authorities tried to fit the case within the principles of English justice concerning those considered mentally incapable of managing themselves or their property.[31]

Contests with Foreign States

Lunacy investigation law and its intersections with broader laws governing guardianship and property attempted, through statute and interpretation, to exercise control over British subjects in the face of the twin challenges of madness and varying forms of geographical mobility. As we have seen, this included mad English subjects who resided in colonial settings, who lived in England with property in colonial settings, who relocated to Europe with land holdings in Great Britain, and whose movements and wealth fell across an English-Irish geographical divide. The challenges to English law in these cases were readily apparent. So too were the efforts of Lord Chancellors to maintain the rational conformity of individual cases to laws that were created to maintain a measure of imperial order. But what did the English gatekeepers of lunacy investigation law have to say about mentally alienated migrants whose national identities were less clearly British? Were mad people with more ambiguous connections to the British Crown also considered to be fit subjects for English intervention? The answer, it would seem, was yes.

For example, Princess Bariatinski (Elizabeth Catherine Louisa Maria Frances Bariatinski) was born in Russia in 1807. Her father was a 'Russian nobleman' and her mother, who died while giving birth to the princess, was born into a wealthy English family. As a very young infant Bariatinski was sent to England to be brought up by her maternal grandmother, Lady Sherborne, and her aunt, the honourable Anne Dutton. In 1829, at the age of 22, Bariatinski began showing signs of mental aberration, but like many mentally alienated people of the mid-nineteenth century and earlier, she continued to be managed by her mother's family despite her worsening mental state. What eventually prompted her maternal family to launch a legal investigation into her mental state late in the year of 1843 was the arrival of her half brother Prince Bariatinski, who 'claimed the custody and management of her person and property, insisting that by the laws of Russia he was entitled to it as the head of his family'.[32] This threat to the princess's person and property (which was estimated to be roughly £30,000 in British funds along with properties in Russia) prompted an initial struggle between the prince and the princess' aunt. The aunt filed a

petition for a lunacy commission to ensure control over her niece's person and property; the prince protested the petition and, failing this, requested that he be in charge of any lunacy commission that might be filed against her in England.

This set off a battle between legal experts on behalf of the prince and those acting in the interests of the princess' aunt, Anne Dutton, that highlighted the dilemmas of mobility, jurisdiction, madness, and imperial reach. Although admitting that they could not find any prior case 'in which an alien had been the subject of [an English] commission of lunacy', Dutton's counsel argued nevertheless that 'there was no reason for confining the benefits arising from the exercise of this branch of the Royal prerogative to the Queen's subjects'.[33] Besides, they argued, it was standard for the Lord Chancellor to grant a lunacy commission 'where either the person of the party or any of [the lunatic's] property was within the local limits of the jurisdiction'.[34] Despite acknowledging that the princess was not technically a British subject by birth, she was, they argued, very much in need of protection by British law. In pursuit of their argument, Chancery Court clerks were tasked with making a list of cases 'in which commissions had issued against parties having foreign names'.[35] The clerks complied, but they could not guarantee that any of them were bona fide foreigners![36]

In a spirited counter argument the prince's counsel argued that, according to Russian law, 'the Prince was entitled to the custody of his sister' and that the Lord Chancellor 'had no right to interfere with a party on whom a foreign jurisdiction had already attached'.[37] To add legal legitimacy to this argument, the prince and his legal experts quoted from Emerich de Vattel's authoritative *Law of Nations*, which stated that,

> the State, which ought to respect the rights of other nations, and in general those of all mankind, cannot arrogate to herself any power over the person of a foreigner, who, though he has entered her territory, has not become her subject.[38]

On the face of it, this was compelling logic. But, as the legal deliberations proceeded, it became clear that the lunacy investigation jury would rule in favour of keeping Princess Bariatinski and her property within the jurisdiction of English law.

Lord Chancellor Lyndhurst concluded that the prince had got the spirit of the English lunacy investigation wrong. This was not, he pointed

out, a 'proceeding … directed *against* the party' but it was 'all for [her] benefit'. He further justified the jury's decision this way:

> I am satisfied, unless some authority can be cited to the contrary, that the Court has jurisdiction, and that it is its duty to throw protection around the person and property of an individual in this situation … The Crown does not take possession of the lunatic's property for its own benefit; but it takes it by its officers, for the purpose of applying the income to the party's maintenance and accumulating the surplus for him in case he recovers, or applying it according to the directions of this will, if he happen to have made it before he became insane.[39]

With this reiteration of the spirit of lunacy investigation law, Lord Lyndhurst ordered that the lunacy investigation should proceed in favour of Anne Dutton. After all, he concluded, 'what can be more proper, what more humane, what more consistent with the general character of the law of England, than such a course?' The trial, held in July 1844 at London's Canonbury Tavern, confirmed that Princess Bariatinski was *non compos mentis* and had been in that state since 1830. With the evidence at hand from the English Reports it is hard not to agree with the Lord Chancellor that this was the best of the unpleasant options for Princess Bariatinski.[40] In this case English lunacy investigation law was considered applicable to those whose birth in a foreign country made their status as subjects of the Crown questionable. It also constituted a direct challenge by the English Chancery Court to the powers of international law and the laws of foreign countries in matters of migration and lunacy.

An interesting twist on the intersections of madness, migration, empire, and English civil law can be found in the case of David Ochter-Lony Dyce Sombre. In this instance English legal authority was mustered to deny the legitimacy of legal and medical determinations about Dyce Sombre's mental state in several jurisdictions, including France, Russia, and Belgium. Further adding to the intrigue of this case were Dyce Sombre's hybrid origins, and the impressive geographical breadth of his travels over the course of his adult life. The extent of trial detail (including a summary of Dyce Sombre's life history) is partly the result of a fierce legal battle contesting his mental state when he made his will. Dyce Sombre wrote a rebuttal, almost 600 pages in length, of the English courts' decision finding him insane.[41] His storied life has also been the subject of historical biographies.[42]

David Ochter-Lony Dyce was born in 1808 in Sirdhana, Bengal. His lineage included a fascinating variety of ethnic backgrounds (German Catholic, French Catholic, Scottish Presbyterian, Indian Muslim, and Hindu).[43] As a child Dyce was adopted as the heir apparent of Zerbonissa Sombre, one of the wives of Dyce's grandfather (Walter Reinhardt 'Sombre'), who became ruler of the principality of Sirdhana upon her husband's death.[44] Dyce added the name Sombre to reflect his new status. Dyce Sombre received his earliest religious education under the tutelage of a Church of England chaplain, but later, like Zerbonissa, converted to Catholicism.

When Zerbonissa Sombre died in 1836 she left about £500,000 to Dyce Sombre. The money was essentially a British payout for territory they had annexed towards the end of Zerbonissa's life.[45] At this point Dyce Sombre became stateless. Between 1837 and 1838 he made a trip to China and then moved to Calcutta. In August 1838 Sombre moved to England, taking his considerable personal fortune with him. Within three years he had married Mary Anne Jervis (daughter of Edward Jervis, Viscount St Vincent) and was elected as a Liberal MP for Sudbury. Despite this seemingly hopeful start to a wealthy and respectable life in England, by 1841 he had been ousted from government for bribery, and by 1843 was separated from his wife. What had happened?

According to the extensive English Reports of Sombre's lunacy investigation he had developed a growing delusion that his wife was adulterous. His declining mental state reached the point where medical attendants were required to put him under physical restraint. Sombre was taken to Hanover Lodge in Regent's Park, where he remained under psychiatric care for a few months. At this point Sombre had a lunacy investigation launched against him that found him to be *non compos mentis* since the autumn of 1842. The trial revealed, among other things, that as early as 1840 Sombre had consulted with Dr Monro about his health. Although Monro did not seem to think that Sombre was especially unwell at that time, by the time of the trial both Monro and Dr Conolly were of the opinion that Sombre had delusions that his wife was unfaithful to him and that he was being poisoned. In the autumn of 1843 Sombre was given leave to travel under the professional care of Dr James Martin and a medical attendant, John Grant, in the hope it might improve his health. He escaped his attendant at Liverpool. By the end of September he was in Paris.

Sombre lived in Paris for seven years. At the beginning of his stay someone acting on behalf of the guardianship committee in charge of his person tried to get him back to London but, according to the English Report, the

'French government' refused to let 'the solicitor of the committees of the person' bring him back; at least not until an inquiry into Sombre's state of mental health, conducted by 'French authorities', found him insane.[46] In October 1843 Sombre was examined by French authorities, including M. Delesert, the 'Prefect of Police', Dr Ollife, who would become his medical attendant during his stay in Paris, Dr Béhier, and Dr McCarthy. The French investigation concluded that he was no longer insane and thus Sombre 'remained his own master in France'.[47] Shortly thereafter, and armed with evidence from the verdict in Paris, Sombre was back in England petitioning for a supersedeas of the earlier verdict of insanity. Lord Chancellor Lyndhurst refused to supersede the lunacy commission.

Sombre then went on an extensive tour of Europe and Egypt. The timing of his travels is not clear, but in both St Petersburg and Brussels, Sombre launched medical inquiries into his mental health and in both places he was reported to be of sound mind. Armed with this further evidence of his mental recovery, Sombre returned once more to London in 1847 for another attempt at the supersedeas of the lunacy finding against him. This time, Drs Henry Southey and John Bright, the physicians most often relied upon by the Chancery Court in lunacy investigations at that time, had a more qualified assessment of Sombre's mental state. Dr Bright noted that 'the power of the delusion as to Mrs Dyce Sombre's infidelity was less manifest but he was not free from it'. Nevertheless, both doctors agreed that 'so far as regards the engagement of property, they entertain no doubt of his competency to take care of it'.[48] This more ambiguous conclusion led the Chancery Court to a hybrid kind of verdict whereby Sombre was 'entrusted with the surplus of his unappropriated income'. This, they argued, 'would remove one source of great irritation tending to retard a recovery towards which he seems already to have made some advance'.[49] Sombre was back in England twice in 1848 and once in 1849 to muster yet more evidence as to the complete recovery of his mental state. In all three cases the Lord Chancellor concluded that the evidence pointed to a mind that was still in need of the guardianship protection of the English Court. In 1851 he once more returned from Europe to try his luck in superseding the Chancery Court decision, but he died in London before the new investigation began.[50]

The Chancery Court evidence drew on three principal arguments in its repeated refusal to grant Sombre a clean bill of mental health. The first was that a grand deception was at play at the hands of a physician, Dr Anthony

Mahon, who was hired by Sombre to help him to shed his status as a lunatic in the eyes of the English Chancery Court. The English Reports of Sombre's case claimed that in 1845 Sombre had agreed to pay Mahon £10,000 if he could arrange for the lunacy commission to be superseded.[51] This involved Dr Mahon and others 'exerting all their influence with Dyce Sombre, to induce him to conceal from his medical advisers, and, indeed, from all whose duty it was to discover the truth those feelings and those convictions which had been deemed insane delusions'.[52] In this deception, 'no effort was left untried to induce Dyce Sombre to represent himself, not that he really was, but as it was deemed most expedient that he should appear to be, to obtain a given end—the superseding the Commission'.[53] Moneyed interests trying to deceive the Chancery Court in its pursuit of the truth were thus considered one major impediment to justice that those upholding the English law had to overcome in Sombre's case.

The second major argument of the English Court for continuously denying Sombre a verdict of sanity was that the foreign physicians were not as capable of expert judgment as were the medical experts in England. This can be seen, for example, in the way that the sanity verdict of the physicians in Paris is dismissed in the English Reports. Being careful not to criticize them, Judge Lushington noted:

> Whatever means were possessed to enable the examiners to arrive at a just conclusion were most carefully employed; but a knowledge of [Sombre] and his habits was necessarily wanting, and especially Dyce Sombre's ignorance, at the time, of the French language; and the examination being carried on by interpretation, probably led them to conclusions different from those arrived at in England.[54]

As if the point had not been made clearly enough, he continued: 'If this [French] examination failed, conducted as it was with so extraordinary a care, it may furnish some reason why greater weight should not be attributed to the reports of other physicians abroad'.[55] Ignoring the fact that some of the physicians in Paris and in other places were English and that others would surely have had some facility with the English language, these medical experts were deemed less capable of prying out Sombre's symptoms of lunacy than their counterparts connected to the English Chancery Court.

The third argument related to what was described frequently in the English Reports as Sombre's 'Asiatic qualities'. Noting that 'Asiatic blood did … probably to a considerable extent, flow in the veins of Dyce Sombre',[56] the trick was to determine the extent to which his emotional

preoccupation with the idea of his wife's infidelity was due to the Indian side of his mixed race background. 'We think', the Report said, 'that we may safely conclude that … [his] Asiatic origins and habits … would probably render him more prone to jealousy and suspicion than would be the case with respect to Englishmen'.[57] In the stated opinion of the Chancery Court, Sombre's Asiatic temperament might help to explain his 'jealousy' and 'suspicion' of his wife, yet it was also clear that these attributes of origin could not account for the insane quality of his behaviour. The fact that these opinions were stated in the official record says much about imperial attitudes towards colonized subjects.[58]

The official English Reports of this trial amounted to a resounding affirmation of the power of English law in matters of lunacy on international and imperial levels. Sombre's foreignness was duly noted in order to differentiate his mercuric behaviour from that of a true Englishman. Nevertheless, his madness, though difficult to separate from his Asiatic constitution, deserved the protection (and control) of English lunacy investigation law. Indeed, it could only be detected by English legal and medical expertise in the face of misrepresentations of Sombre's mental state by several legal and medical officials in many foreign jurisdictions. In the opinion of the English legal system, the more Sombre had migrated from England to prove his sanity, the more insane he became.

Conclusion

The reports reviewed in this chapter about England's consideration of issues relating to mad migrants speak volumes about the broader purview of English law in the service of domestic and imperial power. Because these cases required legal officials to consider how to apply lunacy investigation law to those whose madness went hand in hand with considerable geographical mobility, they were certain to encourage these officials (especially Lord Chancellors) to think about the broader powers of the English state in an international context. As Christopher Tomlins has argued, 'geography and law' were mobilized as much as was pure force to 'explain and justify' English colonial rule.[59] In the English colonies the legal inheritance of the law of *non compos mentis* would safeguard the immediate economic and social concerns of settlers whose relatives had gone mad, while at the same time preserving the integrity of property and inheritance. Yet, despite this encouragement for the colonies to employ the English law of lunacy investigation to resolve the problems posed by

mad migrants, English legal officials also tried to ensure that they maintained ultimate control and power over the legal process from the centre of empire. This use of lunacy investigation law as part of the reach of empire was not necessarily limited to colonial settings. For mad English subjects who ended up in places outside the empire, and for those whose English identity was not clear cut, the same body of law was used to demonstrate the superiority of English legal and medical expertise in lunacy over experts in other countries. It was also used to punish those who, in various ways, challenged English legal authority.

Notes

1. Catherine Cox, Hilary Marland and Sarah York, 'Emaciated, Exhausted, and Excited: The Bodies and Minds of the Irish in Late Nineteenth-Century Lancashire Asylums', *Journal of Social History*, 46:2 (2012), 500–24; Catherine Cox, Hilary Marland and Sarah York, 'Itineraries and Experiences of Insanity: Irish Migration and the Management of Mental Illness in Nineteenth-Century Lancashire', in Catherine Cox and Hilary Marland (eds), *Migration, Health and Ethnicity in the Modern World* (London: Palgrave Macmillan, 2013), 36–60. See also Elizabeth Malcolm, '"A Most Miserable Looking Object"—The Irish in English Asylums, 1851–1901: Migration, Poverty and Prejudice', in John Belchem and Klaus Tenfelde (eds), *Irish and Polish Migration in Comparative Perspective* (Essen: Klartext Verlag, 2003), 115–26; and John Walton, 'Casting Out and Bringing Back in Victorian England: Pauper Lunatics, 1840–70', in William F. Bynum, Roy Porter, and Michael Shepherd (eds), *The Anatomy of Madness: Essays in the History of Psychiatry*, *volume 2* (London and New York: Tavistock Publications, 1985), 137–41.
2. See for example: David Wright, James Moran and Sean Gouglas, 'The Confinement of the Mad in Victorian Canada', in Roy Porter and David Wright (eds), *The Confinement of the Insane, 1800–1965: International Perspectives* (Cambridge: Cambridge University Press, 2003), 100–28; and the articles by David Wright and Tom Themeles, Elizabeth Malcolm, Angela McCarthy, and Catharine Coleborne, in Angela McCarthy and Catharine Coleborne (eds), *Migration, Ethnicity, and Mental Health. International Perspectives, 1840–2010* (Routledge: New York and London, 2012).
3. Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880–1940* (Ithaca: Cornell University Press, 1997); Robert Menzies, 'Governing Mentalities: The Deportation of 'Insane' and 'Feebleminded' Immigrants out of British Columbia from Confederation to World War II', *Canadian Journal of Law and Society*, 13:

2 (Fall 1998), 135–73; Fiona Alice Miller, 'Making Citizens, Banishing Immigrants: The Discipline of Deportation Investigations, 1908–1913', *Left History,* 7:1 (2000): 62–88; Barbara Roberts, *Whence They Came: Deportation from Canada, 1900–1935* (Ottawa: University of Ottawa Press, 1988).

4. See Keller's aptly entitled Chapter 6, 'Underdevelopment, Migration and Dislocations: Postcolonial Histories of Colonial Psychiatry', in Richard Keller (eds), *Colonial Madness: Psychiatry in French North Africa* (Chicago: University of Chicago Press, 2007), 191.
5. Keller, 'Underdevelopment'.
6. Waltraud Ernst, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800–58* (London and New York: Anthem, 2010), 27. Originally published as *Mad Tales from the Raj: The European Insane in British India, 1800–1858* (London: Routledge, 1991).
7. Ernst, *Mad Tales.*
8. Ernst, *Mad Tales*, xv.
9. Ian Hacking, 'Les Aliénés Voyageurs: how Fugue became a medical entity', *History of Psychiatry*, vii (1996), 425–49.
10. Case of John Davies, 1851, English Reports, 42 E.R. 268.
11. Case of John Davies.
12. Case of John Davies.
13. Case of Richard Herbert Graydon, 1850, English Reports, 47 E.R. 1648.
14. Richard Graydon.
15. Details of this case can be found in: Case of Thomas Southcote, 1751, English Reports, 47 E.R. 1105; and 27 E.R., 71.
16. Case of Thomas Southcote, 1751, English Reports, 47 E.R. 1105.
17. Case of Thomas Southcote.
18. Case of Thomas Southcote.
19. Case of Thomas Southcote.
20. Case of Thomas Southcote.
21. Case of Thomas Southcote.
22. Draft of a Clause to be inserted in the instructions to Governors in America, 29 July 1772, in Archives of the State of New Jersey, First Series, volume X, *Documents Relating to the Colonial History of the State of New Jersey*, Frederick Ricord and William Nelson (eds), *volume X, Administration of Governor William Franklin, 1767–1776* (Newark: Daily Advertiser Printing House, 1886), 382–3.
23. *Draft of a Clause to be inserted in the instructions to Governers in America.*
24. *Draft of a Clause to be inserted in the instructions to Governers in America.*
25. See *Documents Relating to the Colonial History of the State of New Jersey, volume 21, Calendar of the Records in the Office of the Secretary of State, 1664–1703*, edited by William Nelson (Paterson, NJ: The Press Printing and

Publishing Company, 1899), 193–4. See also *Documents Relating to the Colonial History of the State of New Jersey, volume 23, Calendar of New Jersey Wills, volume 1, 1670–1730*, edited with an Introductory Note on the Testamentary Laws and Customs of New Jersey by William Nelson (Paterson, NJ: The Press Printing and Publishing Company, 1901), XXXVIII. In this series, editor, William Nelson notes that 'the authority to take proofs of wills and inventories and appraisements was usually exercised by someone designated for the purpose by the Governor. In some cases, however, original jurisdiction was exercised by the Governor and Council, as the following extracts from their records will show'. Included in this list was the abovementioned example of madness. Further research has demonstrated that as these two colonies consolidated and, after the American Revolution, became the State of New Jersey, the use of lunacy investigation law not only weathered the storm of American independence, but also thrived as a principal mechanism for dealing with the mad.

26. Case of John Houstoun, 1826, English Reports, 38 E.R. 121. This narrative was also partly reconstructed with the help of the John Houstoun entry of University College London's *Legacies of British Slave-Ownership* website. See: http://www.ucl.ac.uk/lbs/person/view/2146633522 (date accessed 28 August 2015).
27. Case of John Houstoun, 1826, English Reports, 38 E. R. 121.
28. Case of John Houstoun.
29. Case of John Houstoun.
30. Although the intervening fate of Thomas Richard Halse is uncertain, upon his death, Halse Hall and Mountain sugar plantations were left by his will to Francis Sadler. As Higman, Aarons, Karklins and Reitz note, by the 1750s Sadler had become a major player in the economic and political life of the colony. See Barry W. Higman, George A. Aarons, Karlis Karklins, and Elizabeth Jean Reitz, *Montpelier, Jamaica: A Plantation Community in Slavery and Freedom, 1739–1912* (Mona, Jamaica: The University of the West Indies Press, 1998).
31. In the case of John Webb, one can see this same desire to exert the legal control beyond English borders, this time with an outcome more satisfying to English jurisprudence. Case of John Webb, 1826, English Reports, 47 E.R. 1095.
32. Case of Princess Bariatinski, 1843, English Reports, 41 E. R. 674.
33. Case of Princess Bariatinski.
34. Case of Princess Bariatinski.
35. Case of Princess Bariatinski.
36. Undaunted, the Chancellor stated that 'The list of foreign which I have been furnished is not quite conclusive of the jurisdiction to grant a commission against an alien; but it is very improbable that all those parties should have been subjects of this country'. Princess Bariatinski.

37. Case of Princess Bariatinski.
38. Case of Princess Bariatinski.
39. Case of Princess Bariatinski.
40. This option was likely more unpleasant than it was represented to be in the English Report. One aspect of the trial not highlighted in the English Report was the Lord Chancellor's repeated criticism of the domestic conditions in which Bariatinski was being kept, and the lack of opportunity for her to get out into the fresh air and to be in the company of others. Several months after the verdict of insanity, and after his recommendation about her care, the Lord Chancellor discovered that her guardians were asking her Russian relatives to use equity from her property there to pay for improved conditions for the princess. This nickel and diming over the establishment of proper conditions for Bariatinski's care did not please the Lord Chancellor. See 'The Reports. Equity Courts. Lord Chancellor's Court. 30 May and 2 December 1844; 18 April and 24 July 1845, Re. Bariatinski, a Lunatic', in the *Law Times, and Journal of Property, from October 1845 to March 1846, volume VI* (London: Office of the Law Times, 1846), 17–18.
41. Dyce Sombre, *Mr. Dyce Sombre's Refutation of the Charges of Lunacy Brought Against Him in the Court of Chancery* (Paris: Dyce Sombre, 1849).
42. See for example, Michael Fisher, *The Inordinately Strange Life of Dyce Sombre: Victorian Anglo-Indian MP and Chancery 'Lunatic'* (New York: Columbia University Press, 2010); Michael Fisher, *Counterflows to Colonialism: Indian Travellers and Settlers in Britain, 1600–1857* (Delhi: Permanent Black, 2004). For a radical neurological explanation of Sombre's odd behaviour see Ronald Pies, Michael H. Fisher and C. V. Haldipur, 'The Mysterious Illness of Dyce Sombre', *Innovations in Clinical Neuroscience*, 9: 3 (March 2012), 10–12.
43. Fisher, *The Inordinately Strange Life,* 2.
44. Case of David Ochterlony Dyce Sombre, English Reports, E. R. 1419. Zerbonissa Sombre is named differently in the various primary and secondary sources that include information about her life. In Fisher's book on Dyce Sombre she is named Farzana.
45. Details concerning this history may be found in Fisher, *The Inordinately Strange Life,* 71–7.
46. Case of David Ochterlony Dyce Sombre, 1856, English Reports, 14, E. R. 480.
47. Case of Dyce Sombre.
48. Case of Dyce Sombre.
49. Case of Dyce Sombre.
50. Fisher, *The Inordinately Strange Life*, 316.
51. Case of Dyce Sombre. See also Fisher, *The Inordinately Strange Life*, 263.
52. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life.*

53. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life*.
54. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life*.
55. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life*.
56. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life*.
57. Case of Dyce Sombre. Fisher, *The Inordinately Strange Life*.
58. There is a substantial body of literature that deals with this subject, especially as it relates to gender relations that diverged from those considered typically 'British'. For a summary of the key themes in this literature, see Philippa Levine, 'Sexuality, Gender, and Empire', in Philippa Levine (ed.), *Gender and Empire* (New York: Oxford University Press, 2004).
59. Christopher Tomlins, 'Law's Empire: Chartering English Colonies on the American Mainland in the Seventeenth Century', in Diane Kirby and Catharine Coleborne (eds), *Law, History, Colonialism: The Reach of Empire* (Manchester: Manchester University Press, 2001), 28, 27.

CHAPTER 9

Canada's Deportation of 'Mentally and Morally Defective' Female Immigrants After the Second World War

Ellen Scheinberg

Introduction

This study investigates female immigrants who were targeted for mental health and moral infractions under the *Immigration Act* from 1946 to 1956. Most of these women were admitted as war brides, single displaced persons brought in through the domestic employment scheme, or as the wives of male Displaced Persons (DPs) who were selected as labourers through the International Relief Organization. There was also a small number of non-immigrants who came to Canada as visitors, students or temporary workers. It was a period of expansive growth in regard to the economy as well as immigration admissions. This decade was also marked by radical changes *vis-à-vis* the immigration programme and legislation. Some scholars reveal that beneath the rhetoric of openness and acceptance towards these newcomers there was a pervasive fear of deranged and damaged immigrants posing a threat to the wellbeing of Canadian society.[1] While the focus during the mid to late 1950s was on violent male DPs, female immigrants were actually far more likely to be committed to an asylum and issued with a deportation notice by the federal immigration programme than their male counterparts. This chapter provides some insight into the lives and experiences of postwar female deportees who were targeted under the mental

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DOI 10.1057/978-1-137-52968-8_9

health clause. It describes the department's stance and actions in regard to this process, identifies the specific qualities and conditions that rendered these women vulnerable, and finally, recounts how they responded to the department's efforts to deport them from Canada.

The early Canadian literature pertaining to the history of deportation is quite rich and was produced during the 1970s and 1980s by Barbara Roberts, Henry Drystek, and Eric Lyle Dick. These scholars situated their studies in the early twentieth century, relied primarily on government policy files, and focused their attention on male deportees accused of political or economic related offences under the *Immigration Act*.[2] Subsequent scholars, like Fiona Miller, moved their studies to other levels of government, incorporated more diverse sources like case files, and addressed the role that gender, class, and ethnicity played in regard to deportation policies during the early twentieth century.[3] There has also been significant work undertaken in the areas of immigration, mental health, and the eugenics movement for the same period by Barbara Roberts, Ian Dowbiggin, and Robert Menzies.[4] Within the last two decades, impressive works have been produced by US scholars such as Deirdre Maloney and Eithne Luibheid, both of whom tapped into INS[5] case files and court records, and incorporated gender, class, race, ethnicity, and sexuality into their analyses, moving their investigations into the second half of the twentieth century and telling the diverse deportation narratives from the perspective of the immigrants.[6]

While Canada's immigration policies and legislation were in many respects modelled on those of the USA, one cannot look to American works to draw an understanding of the Canadian context, since the Canadian system was characterized by some major differences, primarily the denial of access to the courts to immigrants challenging deportation orders.[7] This chapter examines female deportees from different countries and backgrounds, and their interactions with the Canadian state during a period that has not received much attention by Canadian deportation experts. It also relies on an untapped source—Immigration HQ case files[8]—and focuses on those women who were targeted for mental health infractions under the *Immigration Act*, demonstrating how those policies shaped the experiences of these vulnerable non-citizens.

Methodology

In addition to delving into a wide array of secondary and primary sources—such as published government reports, House of Commons Debates, and policy files—this study relies on deportation or HQ case files created by

the Immigration Branch to document individual female deportees. These case files range in size from eight to 400 pages and contain a broad array of documents, including correspondence and transcripts from inquiries. They document the deportees' interactions with the Immigration Branch, from the time they received the deportation notice to the point where they were either removed from Canada or the order was officially rescinded. Many of the case files cover a lengthy period of time—some as long as 15–20 years—in instances where the case was stayed,[9] since that action triggered a lengthy investigation of the immigrant and her family, which was used to ensure the individual was recovering from her illness and adapting well to Canadian life. Consequently, these files offer rich qualitative evidence, opening up a rare window on some of the voices and an understanding of the diverse experiences of this heterogeneous group of women.

A Microsoft Access database comprising 21 fields and two tables was developed: the first table captures data relating to the 376 deportation cases that represent the full female population of deportees for the period under investigation; and the second relies on data extracted from the 94 case files from the subgroup of women who were targeted for mental health offences under the Act. The database was used to generate statistics and charts, and to draw comparisons between the mental health deportees and the total female population, and with male deportees, using government generated statistics from this period. Since the immigration programme's statistics were not consistently broken down by gender, did not include the number of appeals, and have been criticized by scholars for inaccuracy, the Access database has been employed both to address these gaps and omissions, and to verify the department's often flawed figures.[10]

The Postwar Years

During the period under investigation, the Immigration Branch admitted 1,387,176 immigrants into Canada, making this the largest influx of immigrants since the years preceding the First World War.[11] While Prime Minister King was willing to open the country's doors to welcome some of Europe's refugees, he promulgated an immigration policy that focused on the careful selection of immigrants (along with their dependents) who satisfied the economic needs of the country. King's vision was articulated in an address he delivered in the House of Commons in 1947, stating 'the government will seek by legislation, regulation and vigorous administration, to ensure the careful selection and permanent settlement of such number of immigrants as can be advantageously absorbed in our national economy'.[12]

In essence, the government's objectives, according to Canadian immigration historian Donald Avery, were to focus on the country's economic needs and reinforce Canada's Eurocentric immigration policy, in order to preserve the existing character of the Canadian population.[13]

The immigrants who were admitted came from many different countries and experienced different plights during the war. The first to arrive, between 1944 and January 1947, were the approximately 61,000 war brides and their dependents.[14] They were predominantly from Britain, but a small number came from countries like Holland, Belgium, and France. These women had been subjected to German bombing raids during the war and, despite speaking the language, were forced to leave everything familiar to them when they came to Canada and adapt to a different culture and climate. Also admitted were over 300,000 refugees who had survived as Nazi slave labour and/or in concentration camps, only to find themselves subjected to DP camps for many additional months after the war.[15] In turn, 10,499 carefully selected single female domestics were brought in under one-year contracts.[16] A significant percentage of these women had lost their families, were stateless, and had no other place to call home. They all came to Canada in search of security, new opportunities, and the chance to rebuild their lives.

Due to the heightened role and prominence the immigration programme assumed after the war, on 18 January 1950 the government decided to unite the immigration and citizenship functions under a new ministry called the Department of Citizenship and Immigration.[17] Immigrants at this time were carefully scrutinized, screened, and selected for specific occupations such as agriculture, mining, forestry, and domestic work. The screening was particularly rigorous for domestic servants, who had to be single, between 18 and 40 years of age, from the right ethnic background,[18] and successful in passing examinations that evaluated their health, moral conduct, previous relationships, and sexual experiences. As well as being given X-Rays to check for tuberculosis, they were subjected to a Wasserman test for VD and a pregnancy test, since as Christine Harzig states, 'one would only want the most healthy and morally impeccable person working around husband and children'.[19]

Most of the female refugees were severely scarred by their experiences during the war—both physically and emotionally. These experiences often included the murder of family members, being interned and used as slave labour in Nazi concentration and war camps, periods of severe deprivation and malnutrition, and rape.[20] Consequently, Mark Wyman remarks that many of them were desperate to leave the DP camps, and those who escaped Soviet-ruled countries were terrified of being sent back to their

homelands.[21] The Canadian government was concerned about the DPs' war experiences, consequently they tried to cherrypick those women whom they felt were the best fit for domestic work and most likely to adapt well to Canadian life.[22] To bolster their chances of being selected some female DPs felt compelled to lie about their experiences during the war, as well as their backgrounds, skills, and education.[23]

The Immigration Legislation and Process

According to the 1952 *Immigration Act*, any immigrant who was diagnosed with a mental illness was subject to deportation. That legislation did not dramatically change the immigration system or policy, however it added ten new categories of immigrants barred from entering the country. These included: idiots, imbeciles, morons, those who were insane, constitutionally psychopathic personalities, and those suffering from epilepsy.[24] Although epilepsy today is viewed as a medical condition, at the time it was considered a psychiatric disorder. Homosexuality, which was also added to the list within this legislation, shifted from an immoral offence to one that was pathologized during this period.[25]

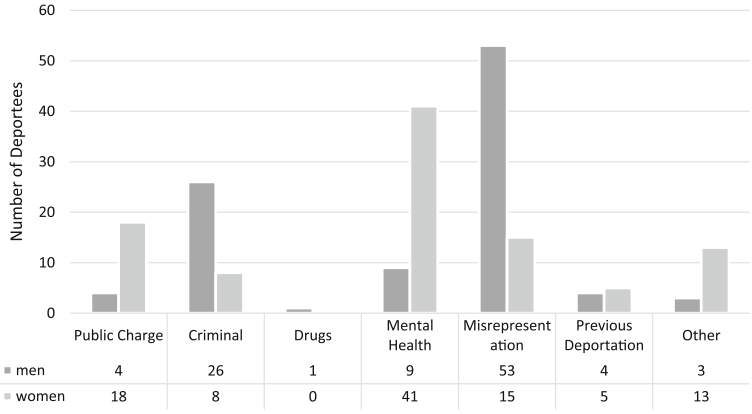
Under the old system, all appeals were directed to the General Board of Immigration Appeals, but typically were forwarded to the Minister before a final judgement was rendered. Under the 1952 Act, appeals were now directed to the Immigration Appeal Board (IAB), which was structurally somewhat independent from the Department, but was composed of individuals nominated by the Minister. Despite its façade of power and autonomy as a tribunal, the IAB did not achieve that type of separation and status until 1967.

In cases involving mentally ill immigrants, the senior immigration officer was supposed to assume that the case would be appealed for individuals who were unable to express themselves. The hearings were held in camera, and although deportees had the right of counsel, few immigrants could afford this luxury. The burden of proof during the appeal rested on the immigrant. Unlike in the USA, under Section 24 of the 1952 Act there was no recourse for the immigrant if the appeal was rejected, since it stipulated that 'no court, judge or officer has jurisdiction to review, quash, reverse, restrain or otherwise interfere with any proceeding, decision or order of the Minister or any Board of Inquiry … unless the person is a Canadian citizen or has domicile'. The new Act also vested greater powers in the Minister and his officials over selection, admissions, and deportation. In the end, the Minister could quash or stay any decision, prompting

Canadian immigration historian Reg Whitaker to refer to the legislation as essentially 'a prohibition act with exemptions'.[26]

Statistical Profile of the Female Mental Health Deportees

The Immigration Branch issued deportation orders to 5,253 immigrants from 1946 to 1956. Women represented anywhere from a low of three per cent in 1946 to a high of 11 per cent in 1949 of the deportees during this period.[27] Men were therefore far more likely to violate the Immigration Act and be targeted for deportation. Another area that truly distinguished the male and female deportees was the nature of their transgressions. Whereas men were predominantly targeted for misrepresentation or criminal offences, women were more likely to be charged under the mental health clause. In 1949, the department's statistics reveal that mental health cases among female deportees were as high as 41 per cent compared to nine per cent for their male counterparts.[28] For the decade under analysis, 25 per cent of the women who were issued with deportation notices were charged with this offence.[29] The breakdown of offences for the remaining female deportees include: 18 per cent for public charge offences, 15 per cent for misrepresentation, eight per cent for criminality and 13 per cent for other offences. While the numbers fluctuated from year to year, the insanity clause was consistently the most commonly used offence to deport female immigrants (Table 9.1).



	Public Charge	Criminal	Drugs	Mental Health	Misrepresentation	Previous Deportation	Other
men	4	26	1	9	53	4	3
women	18	8	0	41	15	5	13

Table 9.1 Deportation offence by gender (1949)

The women in this group were relatively young—mostly ranging in age from 25 to 39 years—and overwhelmingly white.[30] In regard to their citizenship, the data reveal that 23 per cent of the women were from the UK, three per cent from Ireland, 17 per cent from Central Europe (mainly Germany), 15 per cent from Eastern Europe (mainly Poland), 14 per cent from Northern Europe, seven per cent from Southern Europe, and 12 per cent from the USA, while the rest were either stateless or from other parts of the world such as the Caribbean and Australia Table 9.2.[31] In terms of their marital status, slightly more than half (52 per cent) were single, 33 per cent were married, and the remaining women were divorced, separated, or widowed.[32] Since the total population of female deportees was evenly split between single and married individuals,[33] and a significant majority of female immigrants admitted to Canada during this period—66 per cent—was married,[34] it is apparent that single or separated female immigrants were far more vulnerable to being targeted for deportation than their married counterparts, particularly under the mental health clause.

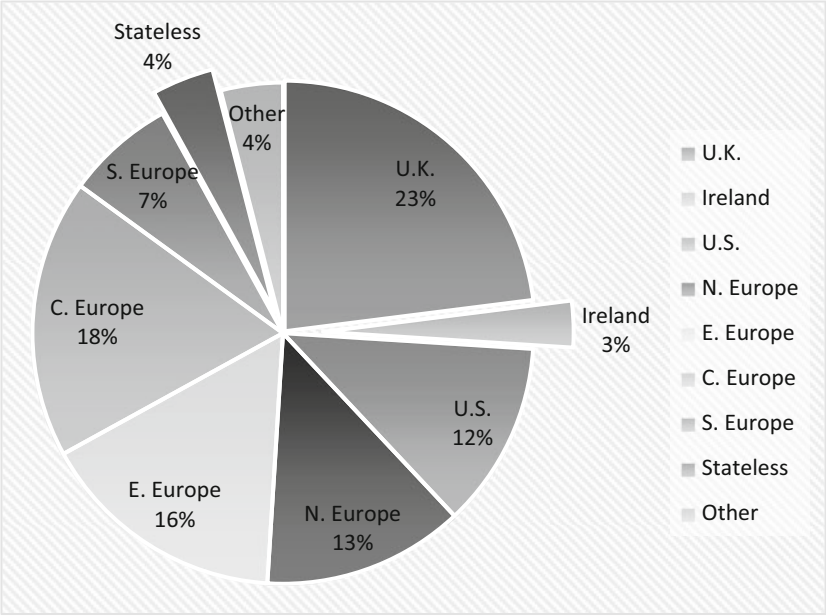


Table 9.2 Country of citizenship

Finally, in regard to their stated occupations, 47 per cent of the women from this category were employed as domestics and 18 per cent found work in other occupations such as office work, waitressing, nursing, or factory work. Only 21 per cent of the women self-identified as housewives, which meant that approximately 12 per cent of the married women were engaged in paid labour.[35] Evidently then, single domestics and other working women were far more likely either to succumb to mental health breakdowns or to be targeted by the Immigration Branch for mental health offences under the Act than their counterparts who were married housewives (Table 9.3).

Experiences of Mental Health Deportees

For many of these women, the transition to Canadian life was not easy. For instance, Ella was a war bride who followed her new Canadian husband Conrad to Canada and ultimately ended up parenting her three children on her own at the Canadian Airborne Regiment military base in Petawawa while her husband was stationed overseas. She was diagnosed with schizophrenia and placed in an asylum in 1953. Her children were boarded out while she was ill, which must have contributed to her anxiety. In her interview she attributed her condition to the isolation and poor living conditions in Petawawa, which had a population of around 1,000 in 1951 and was a two- to three-hour drive away from the nearest city—the nation's capital—Ottawa.[36]

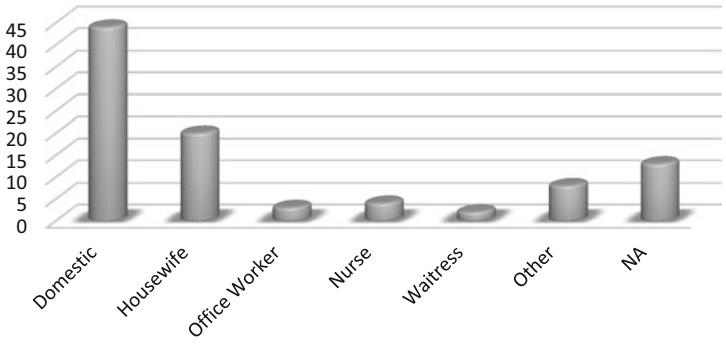


Table 9.3 Vocations of female deportees

Unlike war brides such as Ella, a sizeable number of the women from central, northern, and southern Europe did not speak one of Canada's two languages and, in many cases, lacked family support or immigrant network connections. Moreover, despite the department's efforts to weed them out during the selection process, a fair percentage of the refugees who came in as domestics were trained professionals who were forced to take on degrading, and in some instances, oppressive employment to gain admission and remain in Canada. Some of the women in this category were artists, nurses, teachers, and two had practised medicine in their homelands.

Monika, a 39-year-old Polish woman, was one of the two doctors in this group. She practised medicine as an eye specialist in Graz, Austria, before being admitted to Canada in May 1951. She had a sister in the USA and a nephew in Toronto and came to Canada as a domestic. After working for a family in Niagara Falls for several months, Monika attempted suicide by cutting her wrists with a surgical knife. She was subsequently hospitalized and diagnosed with manic depressive psychosis. The doctors at the Toronto Psychiatric Hospital attributed her condition to 'disappointment for not being placed in her profession'. Her case file also revealed two other major factors that must have contributed to her condition: an employer who threatened to deport her to Russia if she did not work harder; and an extreme fear on her part of returning behind the Iron Curtain.[37]

There were also several cases of women who were hospitalized after either losing a baby or giving birth to a child. For instance Matilda, who was of Norwegian extraction but a resident of the UK based on marriage, was institutionalized in Toronto in 1955 after the birth of her third child. Her husband had been working in Winnipeg—thousands of miles away—for an extended period, leaving her alone to care for their children in an unfamiliar community with little support.[38] She likely had post-partum depression, which was further exacerbated by the stress of taking care of her family alone.

One German national named Marie struggled with very different issues. While most of the female refugees who were part of this group would be categorized as victims of the war, Marie would be considered a collaborator, since she had been a member of the Nazi party. After her arrival, she tried to make amends and start anew by applying herself as a domestic, joining church groups in her community of Kitchener, Ontario, improving her English, and leading a good Christian life. Unfortunately, she became pregnant from a beau who had promised marriage, but abandoned her after he was informed of her condition. Six months after the birth of her

son in 1953, she became mentally ill and was diagnosed by her doctor with paranoid schizophrenia with 'delusions of persecution'. In a letter to the department after her inquiry, her lawyer attributed her health problems both to German guilt relating to crimes against humanity and to guilt and shame about her status as an unwed mother.[39]

The Scientific Planning Council of the Canadian Mental Health Association discussed the problem of mental illness experienced by new immigrants at a meeting held in Toronto in August 1954. They attributed these health problems to new immigrants' 'fear of authorities, new surroundings, and freedoms if refugees'. But they also felt that the attitudes of Canadians towards newcomers had a significant impact on the mental state of immigrants. The individual who was particularly at risk, they asserted, was 'the mother who is left at home all day and who doesn't have the same chance to become assimilated or hear one of our languages'.[40] For the Association and the Immigration Branch officials who deferred to these experts in the area of mental health, the only solution for refugees and immigrants who were 'damaged' by the war, isolated, and unable to speak the language was assimilation, which ultimately was the surest route to avoid institutionalization and deportation. Historian Franca Iacovetta in her article 'Making "New Canadians"', contends that experts during the postwar years were intent on 'Canadianization', which involved identifying 'deviant' immigrants and helping the women conform to Canadian standards of domestic life, which were predicated on strict gender roles.[41]

Rather than providing women with counselling and helping them adapt to their new country, psychiatrists at the time tried to label them with a pathology, typically schizophrenia,[42] and relied on treatments such as electroshock therapy (EST), insulin injections that induced comas, cold baths, pills, lobotomies, and other tools of the trade popular with the psychiatric profession at the time.[43] Adele, for instance, a single German woman who entered the country as a domestic, was hospitalized in British Columbia, diagnosed with manic depressive psychosis, and subjected to six treatments of EST.[44] Christa, a single mother from Denmark, was placed in the Ponoka Hospital in Alberta and, during her stay, was also treated with EST, hydrotherapy, and occupational therapy. Despite all these treatments the doctors reported little improvement.[45] Another deportee, Stella, was administered long baths and doses of alcohol during her six-week stay at a hospital. During that time she complained to the immigration authorities stating 'they put me in a bath for eight hours and forcibly fed me alcohol, to which I objected very much'.[46]

After the war, a certain anxiety arose within the country over appropriate gender roles. The experts—social workers, psychologists, doctors, and teachers—tended to label anyone who failed to conform to prevailing gender norms as abnormal or even as insane. These norms were based on white, middle-class, Anglo-Celtic models of ideal women and families. As Mona Gleason explains, 'the normal family constructed through psychological discourse had full-time mothers, well-adjusted, bright, industrious children, and attentive fathers'.[47] Hence, women who did not conform to the norms, for example, by rejecting domesticity, proper feminine behaviour, or heterosexual norms, could be condemned, labelled as insane, and relegated to an asylum, which essentially served as a place of 'gender regulation' argues Joan Busfield, or 'moral quarantine' according to Dorothy Chunn and Robert Menzies.[48]

Although mental illness was experienced by both sexes, women tended to be committed more often and for different reasons than men. Some scholars contend that women during the postwar years, particularly the 1950s, were committed to asylums at a far higher rate than men. For instance, Chunn and Menzies discovered that 82 per cent of inmates in British Columbia's asylums during the 1950s were women. While behaviours such as violence and promiscuity were tolerated for men, women who exhibited those tendencies risked being pathologized and institutionalized. In many instances the threat of deportation brought on additional stress and led to a further deterioration in the health of these women. Many of them had lost family members during the war and had little or nothing to return to. Furthermore, the prospect of returning to Europe was likely perceived by many of these women as inconceivable and unbearable, since their homelands conjured up traumatic memories of the conflict. Dorothy, a British woman who had served as a sergeant major instructor in the RAF during the war, expressed great fear of being sent back to London and to the scene of the bombings.[49] Monika, the Polish physician (mentioned earlier) who was working as a domestic, expressed severe anxiety about being shipped to Russia. Her doctor indicated to the department that the deportation order was undermining her condition, despite his attempts to console her by saying that deportation might not actually transpire.[50] One extreme response was displayed by Margareta, a single Hungarian immigrant who came over as a domestic in 1950. She revealed in her testimony that during the war she had been arrested by the Nazis and placed in a concentration camp after helping a Jewish family in Budapest by giving them money. She had killed a Russian soldier after her release from the

camp to protect herself from his advances. Her lawyer submitted a writ of *habeas corpus* to the department, arguing that his client's life would be in danger if she was returned to her homeland. Margareta ended up engaging in two hunger strikes and threatened suicide after receiving the deportation order.[51]

Despite the fact that the vast majority of these women demonstrated a great determination to remain in Canada, there was a small number who expressed a desire to return to their homelands. They included Adele, who told her doctors that she wanted to return to Germany since the people there had lived through the same experiences as she had, which would enable her to fit in better there.[52] Such requests for deportation were extremely rare, illustrating how difficult Adele's transition to Canadian life must have been, particularly with Canadians' lack of understanding and empathy for what she had endured during the war. Another example was a single woman named Elizabeth, a citizen of Wales. She came to Canada on her own, worked at several different jobs, gave birth to a son in Toronto in 1950 and ended up relinquishing him for adoption, and was hospitalized in 1951. She had no relatives in Canada and felt she could not stay. She revealed to the immigration authorities: 'I am not very popular here now, that is for sure', adding, 'since the child was born and since I gave it up I don't seem to have friends'. Hence, Elizabeth likely assumed that she could avoid the stigma of having a child out of wedlock by returning to the UK.[53]

Cooperation Between Physicians and the State

While some scholars have emphasized the type of collusion that typically existed between the Federal Immigration Branch, the provinces, and psychiatric experts,[54] which was evident in many instances, according to the records and data reviewed pertaining to this group, it was not always the rule when it came to the physicians involved. Indeed, during this period there was a significant amount of pressure exerted by the Immigration Branch on hospitals to report immigrants who had been admitted to asylums, so that they could be deported. This was particularly true for those immigrants committed to asylums who had been in Canada for less than five years and had suffered from mental illness before being admitted, since they were the easiest to deport and the costs incurred could be passed on to shipping companies.[55] They argued that their actions were prompted by pressure from the provinces to help them free up hospital

beds for Canadian citizens who were ill, and ultimately deport individuals who would pose a long-term economic burden, based on the state of their health. In actuality, it was the federal government that prodded provincial officials to cooperate more fully with the deportation process.[56]

While many physicians complied, there were numerous instances where doctors refused to capitulate, choosing instead to protect their patients by challenging attempts by the Immigration Branch to interrogate and deport them.[57] For instance, after trying to deport a Scottish domestic who was being cared for at the Allan Memorial, and later the Verdun Protestant Hospital for the Insane, the superintendent of the latter institution, Dr George E. Reed, refused to let her be sworn in or give testimony under oath during a deportation proceeding, claiming that it would be 'worthless from a legal standpoint and forbidden'.[58] He revealed that her husband and parents were dead and that she was displaying some progress since receiving treatment. She had also expressed severe anxiety about being sent home.[59] In response, the departmental official attempted to go over Dr Reed's head and secure the hospital's cooperation.[60] In the end, this was unsuccessful and the department conceded that Reed's concerns were valid. The department also promised that in the future it would allow the superintendent of the hospital to decide whether the mental health of the patient would permit her to give testimony and, if not, the patient's physician would be interviewed in her stead.[61]

Another similar complaint was issued by the Director of Psychiatric Services for the Branch of the Saskatchewan Department of Public Health. He wrote a scathing letter to the Deputy Minister, Laval Fortier, after a patient being treated in one of his hospitals was kept there long after her discharge date, due to delays the department was experiencing arranging her deportation. The Director of Psychiatric Services objected vehemently, stating:

> a mental hospital is not a prison and is not operated as such and indeed, in an increasing number of wards, the doors are not locked. While many of the patients in mental hospitals are detained against their will, the essential feature of the administration of a mental hospital is treatment of the patient and it is therefore not possible to ensure the continued detention of a person in a hospital to the same extent as if he were incarcerated in a prison … It would seem to be entirely wrong in principle to attempt to use a mental hospital as a prison or place of detention for a person who is no longer mentally ill.[62]

As such, although the hospitals and department often worked in tandem to deport long-term immigrant patients whom they felt had a poor prognosis—particularly those who were unable to pay their bills—some physicians fought to ensure that these women were given adequate care and treated like patients rather than prisoners.[63]

Deportation Results

When assessing the statements and statistics generated by the Department of Citizenship and Immigration, one would assume during this period that while many immigrants were issued with deportation notices, very few were deported back to their country of origin. Mental health deportations for men and women, they indicated, stood at around 600 between 1946 and 1956. This would have represented approximately 11 per cent of all immigrants who were targeted. And if first-time admissions to hospitals for immigrants stood at 29,373 for that period as they state, only two per cent from that category were being deported.[64] What one discovers when examining the case file data is that 84 per cent of the female mental health deportees appealed their deportation orders. In the end, all but one of the women who did not appeal[65] and 53 of those who did were deported, which represents 71 per cent of the mental health deportees.[66] (Table 9.4).

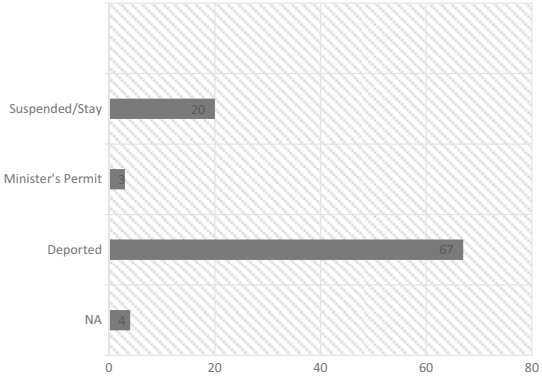


Table 9.4 Deportation results for female deportees charged with mental health offences (1946–1956)

Unless the department focused most of its efforts on expelling female rather than male deportees—particularly those charged under the mental health clauses—which was not the case, their figures really do not jibe with the data extracted from the case files and information gleaned from the policy files. In her book *Whence They Came*, Barbara Roberts describes the Immigration Branch's use of extremely low, fictitious deportation figures within its annual reports in order to obfuscate its efforts to deport as many 'defective' immigrants as possible during the first third of the twentieth century. She referred to this as 'a classic example of lying with statistics'.[67] Evidently, this trend continued during the postwar years.

To personalize these statistics we should examine what really transpired in terms of the fate of the women from the mental health group. It is quite evident that immigration officials were intent on ridding Canada of as many mentally ill immigrants as possible, but which ones were spared and why? Women who were given an encouraging prognosis during their stay in hospital, and those who had a family prepared to pay the bills that accrued, could secure a reprieve. Single women who returned to work and had some type of support network were also given preference and, finally, married women with supportive husbands and family who could provide care and financial support after their release typically had favourable outcomes.[68]

Support from politicians, religious leaders, and community organizations could also be beneficial. For instance, Hannah, who survived the Holocaust but was stateless and lost her husband and parents during the war, was given a poor prognosis from her doctors, but the support she received from her MP, Dr John Kucherepa, and funding from the Jewish Family and Child Services, succeeded in convincing officials she would be a good risk.[69] For married couples it was very important for the woman to have a strong marriage with a hardworking and loyal husband to recover and remain in Canada. Some of the women had husbands who visited them on a regular basis, worked hard to pay the hospital bills and the mortgage, and made arrangements to ensure the children were well cared for and safe. One deportee named Anita had a husband who paid all her hospital bills and even saved $2000 along the way. He acted as her counsel during the inquiry and made a plea for her at the hearing. The Latvian Federation of Canada also supported her case.[70]

In some instances departmental officials attempted to manipulate the situation by taking husbands aside to inquire whether they would be open to having their spouse deported on her own. This was more common in cases where the prognosis was poor or the wife had committed an

unpardonable moral crime, according to the state. One female patient, Brenda, had been hospitalized in St Thomas, Ontario, for five years when she received a deportation order in 1951. The officer asked her husband if he would be willing to allow his wife to be deported back to the United States. Brenda had contracted syphilis[71] after being gang raped earlier in her life in the USA.[72] Her husband informed the officer in charge, H. A. Vince, that he wanted her to remain in Canada. The department had little option but to monitor the family's situation on a regular basis until 1955, when the Minister declared that 'her husband is Canadian, they have two Canadian children and the hospital authorities are apparently quite satisfied with her husband's payments to them'.[73] Ultimately, the husband's emotional and financial commitment to her, and her family's Canadian citizenship, went a long way in convincing the department to postpone and finally cancel the deportation order.

Several women, however, were abandoned by their husbands during their time of need. Ona's husband disappeared after she took ill: when he finally turned up he asked the department for a certificate stating that his wife would be confined permanently, in order to secure a divorce.[74] When informed that his wife would be sick for the rest of her life, Aniela's husband abandoned her in hospital and left for Reno to obtain a quick divorce. He, in fact, was probably responsible for her illness, having mistreated her during their marriage by attempting to get her to kill herself by using the gas stove in their apartment. This prompted the immigration official responsible for her case to refer to him as a 'sick man'. After he failed in his attempt to secure a Reno divorce, he asked the Polish Consulate to send his wife back to Poland and tried to get an annulment instead.[75]

Cases involving women with VD, such as Brenda's, or morality infractions such as prostitution, promiscuity, or homosexuality, were also typically placed on the department's deportation fast track. Roza, a young domestic from Poland, had been found working as a prostitute in Montreal, and was discovered by the doctors to be suffering from syphilis.[76] She had lost her first husband in a concentration camp and her family was presumed dead. Her new spouse, who resided in Sudbury, supported her and wanted the department to let her stay and recuperate at the Toronto hospital where she was being treated. The department, however, felt that she would probably return to prostitution once she was discharged.[77] Despite their serious misgivings, they monitored her for a considerable time and allowed her to remain in the country, likely because deportation was not, in their words, 'practicable', due to her statelessness. During and after

the war the Canadian state spent considerable resources trying to identify and eradicate VD. Women—who were viewed as the 'carriers'—served as scapegoats for the VD scare, becoming the symbol for the country's anxiety over changing sex and gender relations.[78] The department was thus heavily involved in the state's plan to rid Canada of these women.

Lesbians were another group of women who were extremely vulnerable and viewed as unlikely to be rehabilitated. While lesbian and gay immigrants were typically arrested and treated as criminals before the war, during the postwar years, the state and experts began to medicalize homosexuality and segregate gay men and lesbians by placing them in asylums.[79] There were two women in this group who were committed to asylums and treated for their homosexual proclivities: Margareta, the Hungarian refugee mentioned earlier; and Gytha from Denmark. Margareta was diagnosed as a pathological personality and sexual deviant with a poor prognosis. Her clinical report indicated that she had 'informed the hospital authorities she had difficulty adjusting to the Canadian way of life which she attributes, in part, to her practice of homosexuality, which is not accepted in this country'.[80] Despite feeling like an outsider, she was extremely fearful of returning to her Communist-led homeland. Gytha, the Danish woman, was described by the medical supervisor as having 'expressed strong sexual urges towards persons of her own sex', which he and his staff felt she had exhibited in the ward.[81] While Margareta was a DP and Gytha had an affluent father living in the same province who ran a large hotel in British Columbia, both women were viewed as incapable of rehabilitation and were deported. Clearly, the department went out of its way to expel lesbians from Canada, departing from its normal policy of allowing DPs and immigrants with successful and supportive families to remain in the country.

Although the department worked like a well-oiled machine when it came to deporting 'undesirables' back to their homelands, it faced certain difficulties transporting mentally ill patients, particularly during the postwar years. The two main challenges involved securing transportation and negotiating with countries that would have to provide long-term care for these patients, particularly those in central and eastern Europe that were ill-equipped to take back mentally ill refugees.

Firstly, shipping companies had problems transporting large numbers of mentally ill patients. In 1951, the main shipping company on which the department relied for this purpose, Cunard Donaldson Ltd., delayed the transportation of 'mental patients' for many months, due to the need to

update and repair the SS *Samaria*. The three- to five-month delay created a huge backlog, which resulted in severe logistical problems and added expenses for the department.[82] There were also instances where deportees ended up being stranded in transit due to technical problems with the ship.[83]

Another concern about transportation was the treatment of deportees by the escorts who were assigned to look after them *en route*. Common practice at the time was to send at least one or two female escorts, along with male officers in some instances, to accompany female deportees during transportation, particularly those who were potentially violent. There were many incidents during which these deportees had become either self-destructive or violent on the ship. An Italian woman was actually rejected by the ship's surgeon as a passenger in December 1955, after threatening to go on a hunger strike and subsequently attempting to escape by jumping out of the hatch.[84]

Secondly, it was a major challenge to convince other nations to accept these 'damaged' deportees who required a great deal of care after their arrival. All the countries involved required sufficient advance warning to make arrangements for the patients once they arrived. Canada signed an agreement with the USA in 1953,[85] which greatly facilitated and expedited transactions between these neighbours. The UK simply asked that a report be sent to the National Assistance Board ahead of time, to avoid 'people wandering around who should be receiving care and attention, which might be the basis of some criticism'.[86] The German government, however, required six months' notice before it admitted patients who were mentally ill.[87] Transportation to eastern European countries, as one would imagine, was practically impossible.

Unfortunately, the Canadian authorities did not always handle these cases properly or abide by the agreements, which led to criticism and bad publicity. In its haste to expel mentally ill immigrants, the department occasionally left them stranded overseas with no funds and no one to welcome or care for them. In 1949, this prompted the District Superintendent to send out a memorandum to the Immigration Inspector-in-Charge in Toronto, in which he reported: 'This is a situation which has arisen before and caused the department considerable embarrassment, it appears that some of your officers are still dealing too casually with the deportations of persons suffering from mental trouble'.[88] Their overzealous commitment to rid Canada of some of these immigrants knew no bounds. For instance, despite the barriers to deporting immigrants back to Iron Curtain countries, the department would seek out creative alternatives to serve its pur-

pose. For instance, when handling a female refugee from Yugoslavia, it tried to deport her to the British-occupied zone of Germany. This not only violated the Act in regard to returning immigrants 'Whence they Came', but also their right to be sent to a place where they spoke the language and had family members to receive and support them. In the case of this Yugoslavian deportee, not only was she transported to a foreign land, she was also stopped upon her arrival and rejected by authorities because she was missing the necessary travel documents.[89]

About 12 per cent of mental health deportees left voluntarily, of their own accord.[90] A number of them wanted to bypass the stress of being formally deported by leaving on their own. Delma, an Irish mother of two children, chose voluntary deportation, leaving her ex-husband and one of her offspring behind as he insisted, to avoid the disgrace of deportation.[91] Unfortunately, a number of the women, like Delma, made this choice with the misconception that they would be permitted to return to Canada at a later date. Marie selected the same option several years after her case was suspended. She later wrote numerous letters to the department pleading to be readmitted with her young Canadian-born son. The official who responded indicated that she was prohibited from entering the country because of her status, but conceded that the department was willing to allow her son to live in Canada if he so desired.[92]

The remaining women fought vigorously to stay in Canada. Despite their lack of power and resources, a fair number attempted to fend off the department's efforts to deport them after losing their appeals. One non-immigrant, who was born in Canada but had become a US citizen and wanted to return to her home, refused to sign the deportation order sent to her on the grounds that they had not proven she had been in a mental hospital in the past.[93] Some took matters into their own hands and disappeared. One of them bought herself seven extra years in Canada, returning to Germany voluntarily in 1962.[94] Dorothy, the former RAF officer, disappeared in 1952 when her appeal was dismissed and remained in hiding until 1956, when she was deported back to England. She justified her actions, stating in a letter to the department that it gave her too little time to prepare for her trip and treated her 'like a piece of city garbage awaiting transportation to another bin'.[95] And when Grace, an American woman, physically lashed out at officials when they tried to transport her south of the border, she was placed in an ambulance with three escorts, rather than the traditional method of using public transportation.[96] Finally, there were also several cases where the women tried

to commit suicide while in detention or in transit.[97] Clearly then, despite being ill, vulnerable, and in many cases stateless, a number of these female deportees displayed tremendous determination in fending off the department's efforts to deport them.

Conclusion

While the department displayed considerable zeal in removing as many mentally ill female immigrants from Canada as possible, the numbers began to fall considerably after 1953. This sharp decline during the early to mid-1950s can be attributed to a number of factors: logistical and political difficulties involved in expelling refugees back to their homelands; a response to the backlash that emerged around 1954 from the Canadian Bar Association;[98] and MPs from the opposition parties—particularly the Conservative Party—against the new Immigration Act and the department's harsh treatment of immigrants.[99] A successful Supreme Court case in 1956 by female deportee Shirley Brent[100] posed the final blow, effectively putting the department on the defensive and leading to the revamping of the deportation system with the introduction of a slightly more transparent process and an independent Immigration Appeal Board.

When it came to mental illness, it is apparent that Canadians and experts perceived immigrants to be more vulnerable than other groups. Female immigrants, particularly those who did not conform to conventional gender norms, had a greater likelihood of being institutionalized and targeted for deportation. Those who were given a good prognosis and had the support of family, their physician or psychiatrist, a religious leader, local politicians, and their community, were more likely to be allowed to remain. The department, however, appeared to be particularly unyielding when it came to those afflicted with VD, those who had engaged in prostitution, and notably women accused of being 'sexual deviants', like the two lesbian immigrants described earlier. In the end, the federal immigration programme relentlessly laboured to expel as many individuals as possible from this group before the five-year deadline ended, for parsimonious reasons as well as to protect Canadians from 'defective' and 'deviant' women whom they felt could pose a threat to the Canadian family and to society. While these women often had no recourse but to comply with the department's efforts to return them to their homelands, some tried to escape, engaged in letter-writing campaigns, fought back *en route*, or attempted to commit suicide, which was the ultimate form of resistance. Despite

their vulnerable status as non-citizens, they often displayed considerable resourcefulness, perspicacity, and fortitude when combatting efforts by the state to have them expelled from the country they viewed as refuge and home.

Notes

1. In her article, 'The Sexual Politics of Moral Citizenship and Containing "Dangerous" Foreign Men in Cold War Canada, 1950s–1960s', Franca Iacovetta argues that there was a pervasive fear during this period of mental illness among refugees and DPs, due to their experiences during the war along with the patriarchal cultural traditions they imported from the old country. The women, she contends, were viewed as damaged victims and the men as sexually aggressive and potentially violent individuals. *Histoire Sociale/Social History*, 33 (November 2000), 377.
2. See Barbara Roberts, *Whence They Came: Deportation from Canada, 1900–1935* (Ottawa: University of Ottawa Press, 1988); Henry Drystek, '"The Simplest and Cheapest Mode of Dealing with Them": Deportation from Canada before World War II', *Histoire Sociale/Social History,* 15:30 (November 1982); Eric Lyle Dick, 'Deportation Under the Immigration Act and the Criminal Code, 1919–1936' (unpublished MA, University of Manitoba, 1978). For a legal analysis of the early deportation process, see Shin Imai, 'Canadian Immigration Law and Policy: 1867–1935', (unpublished LLM, York University, 1983).
3. Fiona Alice Miller's article, 'Making Citizens, Banishing Immigrants: The Discipline of Deportation Investigations, 1908–1913', examines female deportees before the First World War, using a sample of 51 case files created by the Ontario Bureau of Colonization. *Left History,* 7:1 (2000), 64.
4. See Ian Dowbiggin, '"Keeping This Young Country Sane": C. K. Clarke, Immigration Restriction, and Canadian Psychiatry, 1890–1925', *Canadian Historical Review,* 76:4 (1995); Barbara Roberts, 'Doctors and Deports: The Role of the Medical Profession in Canadian Deportation, 1900–1920', *Canadian Ethnic Studies,* 18:3 (1986); and Robert Menzies, 'Governing Mentalities: The Deportation of "Insane" "Feebleminded" Immigrants Out of BC from Confederation to WWII', *Canadian Journal of Law and Society,* 13:2 (Fall 1998).
5. Immigration and Naturalization Service (USA).
6. Deirdre Maloney, *National Insecurities: Immigrants and US Deportation Policy Since 1882* (Chapel Hill: University of North Carolina Press, 2012) and Eithne Luibheid, *Entry Denied: Controlling Sexuality at the Border* (Minneapolis: University of Minnesota Press, 2002).
7. See Section 24 of the 1952 *Immigration Act.*

8. These files were reviewed and cleared by Library and Archives of Canada's Access to Information staff in 2000. They should represent the full population of female deportees from 1946 to 1956. Since the names were redacted, fictitious names have been used for some of the women for identification purposes, as well as to humanize these once voiceless and nameless women. For more details, see Ellen Scheinberg, 'Two Perspectives on the Same Source: An Examination of Federal Deportation Case Files', *Archivaria* 57 (Spring 2004), 51–67.
9. Within the appeal process for deportations, some immigrants were granted a stay or suspension of the deportation order. This ruling deferred deportation temporarily to provide the immigrant with time to heal and prove her worth as a potential Canadian citizen.
10. Ninette Kelley and Michael Trebilcock note in their comprehensive work on Canadian immigration that there are no published figures revealing the number of appeals granted by the IAB or minister during this period. See Kelley and Trebilcock, *The Making of the Mosaic: A History of Canadian Immigration Policy* (Toronto: University of Toronto Press, 1998), 344.
11. Valerie Knowles, *Strangers at Our Gates: Canadian Immigration and Immigration Policy, 1540–1990* (Toronto: Dundurn Press, 1992), 190.
12. Freda Hawkins, *Canada and Immigration: Public Policy and Public Concern* (Montreal: McGill-Queen's University Press, 1972), 91.
13. Donald Avery, *Reluctant Host: Canada's Response to Immigrant Workers, 1896–1994* (Toronto: McClelland and Stewart, 1995), 173.
14. See Charles P. Stacey and Barbara M. Wilson, *The Half Million: The Canadians in Britain, 1939–1946* (Toronto: University of Toronto Press, 1987), 141.
15. Hawkins, *Canada and Immigration*, 17.
16. Avery, *Reluctant Host*, 165.
17. Department of Citizenship and Immigration, *Annual Report*, 1951.
18. Gerald Dirks notes that Prime Minister Mackenzie King was open to accepting refugees, but only those likely to make good citizens. In *None Is Too Many*, Irving Abella and Harold Troper indicate that Baltic and Estonian refugees were at the top of the ethnic hierarchy, since they were viewed as clean, hardworking, and resourceful. Both were also perceived as most likely to adapt and assimilate. In contrast, Jews were placed at the bottom of the ladder. See Gerald Dirks, *Canada's Refugee Policy: Indifference or Opportunism?* (Montreal: McGill-Queen's University Press, 1977), 148 and *None Is Too Many: Canada and the Jews of Europe, 1933–1948* (Toronto: Lester and Orpen Dennys Ltd., 1983), 225.
19. Christine Harzig, 'MacNamara's DP Domestics: Immigration Policy Makers Negotiate Class, Race and Gender in the Aftermath of World War II', *Social Politics,* 10:1 (2003), 33.

20. Marlene Epp estimates that as many as 20,000–2,000,000 German women were raped during the war. Some were forced to comply in exchange for food, protection of themselves or their family members, or to avoid repatriation. Marlene Epp, *Women Without Men: Mennonite Refugees of the Second World War* (Toronto: University of Toronto Press, 2000), 58, 62.
21. Wyman notes that the fate for returning DPs was forced labour, the Gulag, or death. As a result, some DPs were so desperate to avoid repatriation that they lied about their nationality, went into hiding, resorted to hunger strikes, and in a small number of cases, attempted suicide. Mark Wyman, *DPs: Europe's Displaced Persons, 1945–1951* (Ithaca: Cornell University Press, 1998), 64–7, 81.
22. Milda Danys, *DP: Lithuanian Immigration to Canada After the Second World War* (Toronto: Multicultural Historical Society of Ontario, 1986), 132 and Harzig, 'MacNamara's DP Domestics', 33–4.
23. The Department of Labour sent officials to the DP camps to assess and select female refugees they deemed suitable for domestic service work in Canada. Mark Wyman reveals that the officials were wary of highly educated women, since they felt they were unsuited for this type of work. See Wyman, *DPs*, 193.
24. *Immigration Act*, 1952, ch. 325, ss. 5 (a).
25. Homosexuality fell under Section 5(e) of the 1952 Act. Only two women out of the 94 case files that I examined identified themselves as lesbians. Both were diagnosed with a pathology and placed in an asylum. It is quite possible there were others who escaped detection. Those who were caught had to undergo treatment aimed at rehabilitating them to conform to societal standards of feminine, heterosexual behaviour. Gary Kinsman makes this assertion, stating 'The inclusion of homosexuals and "homosexualism" in the immigration act, however, was symbolic of the Cold War hostility to homosexuality that extends into the 1970s'. See Gary Kinsman, *The Regulation of Desire: Sexuality in Canada* (Montreal: Black Rose Books, 1987), 124.
26. Reg Whitaker, *Canadian Immigration Policy Since Confederation* (Ottawa: Canadian Historical Association, Booklet #15, 1991), 18.
27. These figures are derived from department statistics for the period 1946–1949, which reveal a growing number of women who were issued with deportation notices as time went on. Unfortunately, similar statistics are unavailable after 1949. See 'Statement of Deportations'. Library and Archives Canada [hereafter LAC], RG 26, Vol. 23.
28. LAC, RG 26, Vol. 23, 'Statement of Deportations', 30.
29. This figure is derived from Table 2 of the Access database, which includes data for the 94 women who were targeted for mental health issues.
30. The data reveal that 78 per cent of the women fell into this age category. In regard to race, 93 per cent self-identified as white, two as black or biracial, and three as Jewish. Access database, Table 2, gender and race fields.

31. Access database, Table 2, citizenship field.
32. Access database, Table 2, marital status field.
33. The data for the full female population of deportees reveal that 38 per cent of the total group of female deportees was single and the same percentage was married. Access database, Table 1, marital status.
34. This includes the marital status of all female immigrants over 19 years of age who came to Canada between 1946 and 1956. Statistics Canada Historical Data (CANSIM), Table 075-00007.
35. This figure represents the number of married women from this group (31 or 33 per cent) minus those who labelled themselves as housewives (20 or 21 per cent). Since three of the 13 women who did not provide information about their occupations (captured under the NA category) were married, this figure has an accuracy level of ±3 per cent CANSIM, Table 075-00007.
36. Petawawa is a military base situated in eastern Ontario near the Ottawa River. See LAC, RG 76, Accession 91-92/011, Box 74, File E29638.
37. LAC, RG 76, Accession 91-92/011, Box 34, File D49070.
38. LAC, RG 76, Accession 91-92/011, Box 65, File E17329.
39. LAC, RG 76, Accession 91-92/011, Box 63, File E13523.
40. 'Research Activities in the Field of Psychiatry', Appendix J, Digest of Discussions of the Scientific Planning Council of the Canadian Mental Health Association, August 1954, Toronto. LAC, RG 26, Vol. 80.
41. Franca Iacovetta, 'Making "New Canadians": Social Workers, Women and the Reshaping of Immigrant Families' in Franca Iacovetta and Mariana Valverde (eds), *Gender Conflicts: New Essays in Women's History* (Toronto: University of Toronto Press, 1992), 274.
42. Carol Warren argues that madness was defined differently according to time and place. She defines schizophrenia as 'a group of psychotic reactions characterized by fundamental disturbances in reality relationships and concept formations, with affective, behavioral and intellectual disturbances in various degrees and mixtures'. See Warren, *Madwives: Schizophrenic Women in the 1950s* (New Jersey: Rutgers University Press, 1991), 20, 22.
43. In her work, *The Female Malady*, Elaine Showalter contends that female patients in the United States were subjected to EST at a rate of 3 to 1 compared to their male counterparts. See Showalter, *The Female Malady, 1830–1980* (New York: Pantheon Books, 1985), 205.
44. LAC, RG 76, Accession 91-92/011, Box 70, File E22285.
45. Memo to file, from Dr T. C. Michie, Medical Superintendent, Provincial Mental Hospital, Ponoka, Alberta, July 24, 1952. LAC, RG 76, Accession 91-92/011, Box 43, File D82422.
46. Minutes of the Board of Inquiry, Toronto, 26 October 1948, p. 2. LAC, RG 76, Accession 91-92/011, Box 43, File D82422.

47. Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999), 5.
48. Joan Busfield, *Men, Women and Madness: Understanding Gender and Mental Disorder* (New York: New York University Press, 1996), 101, and Dorothy Chunn and Robert Menzies, 'The Gender Politics of Criminal Insanity: Order-in-Council Women in BC, 1888–1950', *Social History/ Histoire Sociale*, 31:62 (November 1998), 277.
49. LAC, RG 76, Accession 91-92/011, Box 32, File D41492.
50. LAC, RG 76, Accession 91-92/011, Box 34, File D49070.
51. LAC, RG 76, Accession 91-92/011, Box 29, File E25494.
52. LAC, RG 76, Accession 91-92/011, File E22285.
53. LAC, RG 76, Accession 91-92/011, Box 29, File D24599.
54. Some scholars, like Carol Warren and Mona Gleason, argue that State officials and psychiatrists relied on legislation and psychiatric labels, in the words of Gleason to 'normalize the ideals of the dominant white, Anglo-Celtic, patriarchal vision of life'. See Gleason, *Normalizing the Ideal*, 4.
55. Section 40 of the Act outlined this financial arrangement the department had with the shipping companies regarding the deportation of immigrants. It stipulated that the transportation company that brought the immigrant to Canada would be held responsible for transporting the individual back to their home, free of charge, if the immigrant had not yet achieved residence and had been afflicted by health problems, or committed other offences under the Act, before embarkation to Canada.
56. After a large number of immigrants who were being treated for mental health issues were going unreported, Dr G. D. W. Cameron, Deputy Minister of National Health, sent a letter to the heads of provincial departments of health on 21 September 1953, asking for their cooperation in securing support from physicians working in mental institutions to submit reports for all immigrants who had been in Canada less than five years. These were to be sent to the Director of Immigration in compliance with Section 19 of the Act. LAC, RG 29, Vol. 3091, File 854-4-300.
57. When reviewing the case files of the mental health deportees along with the related policy files, I came across at least half a dozen instances in which the doctors involved vigorously fended off attempts by the department to deport their patients.
58. The controversy that arose is documented in a memo from Mr Baldwin, Chief of the Admissions Division, to the Director of Immigration, on 10 January 1953. LAC, RG 76, Vol. 752, File 514-20, pt. 2.
59. LAC, RG 76, Accession 91-92/011, Box 60, File E9691.
60. LAC, RG 76, Accession 91-92/011, Box 60, File E9691.
61. Memo from L. A. Couture, Departmental Legal Advisor to C. E. S. Smith, Director, 23 January 1953, p. 3. LAC, RG 76, Accession 91-92/011, Box 60, File E9691.

62. Memo to Mr Fortier, 1 May 1956. LAC, RG 76, Accession 91-92/011, Box 84, File E46434.
63. In one memo to the Director of Immigration, the Chief of Admissions indicated that it cost the mental institution $5 a day to care for a patient. The department therefore embraced expedience when it came to deporting individuals whom it felt would remain in hospital indefinitely and could not pay their bills, feeling it had a responsibility to protect the provinces from these exorbitant expenses. Memo from the Chief of Admission to the Director of Immigration, 12 March 1951. LAC, RG 76, Vol. 752, File 514-20, pt. 1.
64. Memo from Mrs Nancy Elgie, Research Division, to the Director of Canadian Citizenship Branch, 4 January 1958, p. 5. LAC, RG 26, Box 80, File 10-2-19.
65. One of the women who did not appeal received a Minister's Permit and was able to remain in Canada. These permits had to be reviewed on an annual basis and approved by the Minister. RG 76, Accession 91–92/011, Box 67, File E19034.
66. These figures are from Table 2 of the Access Case File Database. Since four cases did not include documentation identifying what transpired with the deportees at the end of the process, it is possible that the deportation rate could be slightly higher.
67. Barbara Roberts, *Whence They Came*, 47.
68. The department's stance was properly articulated by J. W. Dobson, in a memo to the Chief of the Administration Division in the following statement: 'If the prognosis is favourable and opportunities exist for re-establishment, then it is not likely that deportation would be effected. Also, even though chances of recovery were slight, if the individual's immediate family was resident in Canada and prepared to look after him, the person would probably be allowed to stay in this country'. Although this memo was written on 24 April 1958, it reflected the position adopted by the department during the earlier years as well. LAC, RG 76, Vol. 752, File 514-20, pt. 2.
69. LAC, RG 76, Accession 91-92/011, Box 73, File E27366.
70. LAC, RG 76, Accession 91-92/011, Box 22, File C96180.
71. Syphilis can cause mental changes, including gradual deterioration of personality, impaired concentration and judgement, delusions, loss of memory, disorientation, and apathy or violent rages. This disease can result in the widespread destruction of brain tissue in some cases during the late stages. If untreated, it can prove to be fatal. *Encyclopaedia Britannica* Online, www.britannica.com.
72. This patient had been subjected to 150 intravenous injections of Thio-Bismol, 80 hours of fever therapy, and 12 injections of Mepharsen. Clinical Record, Ontario Hospital, St Thomas, Case Book 392, April 8, 1946, p. 3. LAC, Accession 91-92/011, Box 4, File A75218.

73. Annotation by the Minister on a memo produced by A. C. Aldridge, Central District Superintendent to the Director or Admissions, 19 January 1955. LAC, Accession 91-92/011, Box 4, File A75218.
74. LAC, RG 76, Accession 91-92/011, Box 49, File D93397.
75. LAC, RG 76, Accession 91-92/011, Box 26, File D11112.
76. Memo from A. C. Aldridge, District Superintendent, to Director of the Admissions Division, 6 May 1954. LAC, RG 76, Accession 91-92/011, Box 65, File E17357.
77. The memo from the Appeal Sub-Committee dated 1 June 1954 stated that 'he has promised that he will do everything in his power to make her rehabilitation a success and he was intending to proceed to the Ontario Hospital, Toronto, to see whether he could complete arrangements for her discharge'. LAC, RG 76, Accession 91-92/011, Box 65, File E17357.
78. Kinsman, *The Regulation of Desire*, 110.
79. See Luibheid, *Entry Denied,* 86.
80. Memo, 9 March 1951. LAC, RG 76, Accession 91-92/011, Box 29, File D25494.
81. Appeal Memo, 26 March 1953. LAC, RG 76, Accession 91-92/011, Box 51, File D96343.
82. Letter from Laval Fortier to Arthur Randles, Esq., Director, Cunard Donaldson Ltd., 17 March 1951. LAC, RG 76, Vol. 752, File 514-20, pt. 1.
83. In one case, when a Scottish domestic was being returned to her homeland, the ship transporting her lost its rudder during the voyage. She was detained in Montreal until the repair work could be completed. A second Scottish deportee who was transported at a different time was held in a Halifax hospital for five weeks for the same reason. See files D92955 and D86189.
84. Memo from P. R. Coyne to the Central District Superintendent, 5 December 1955. LAC, RG 76, Accession 91-92/011, Box 65, File E16220.
85. This agreement was called the Repatriation of Certain Insane American Citizens Act (24 USC 196a). It authorized the transportation of Americans in Canada who were in asylums to their place of residence, a hearing in a US district court, and treatment at Saint Elizabeth Hospital in Washington DC. Memo from Legal Division to Director of Immigration, 27 October 1955, LAC, RG 76, File 416-20.
86. Memo from the Superintendent of Canadian Immigration Services, London, to the Chief of Operations, 8 July 1952. LAC, RG 76, Vol. 750, File 514-15, pt. 1.
87. Letter from the Under Secretary of State, External Affairs, to the Director of Immigration, 14 September 1955. LAC, RG 76, Vol. 752, File 514-20, pt. 2.
88. Memo from the District Superintendent to the Inspector-in-Charge, Toronto, 31 August 1949. LAC, RG 76, Vol. 752, File 514-20, pt. 2.

89. LAC, RG 76, Accession 91-92/011, Box 8, File B91446.
90. This figure was extracted from Table 2 of the Access database. Some women who chose this option wrote letters to the department after they were deported, pleading to be readmitted to Canada. After being deported, it was impossible to enter the country without the formal consent of the Minister of Immigration.
91. LAC, RG 76, Accession 91-92/011, Box 45, File D86240.
92. LAC, RG 76, Accession 91-92/011, Box 45, File E13523.
93. LAC, RG 76, Accession 91-92/011, Box 72, File E25560.
94. LAC, RG 76, Accession 91-92/011, Box 69, File E21780.
95. LAC, RG 76, Accession 91-92/011, Box 32, File D41492.
96. LAC, RG 76, Accession 91-92/011, Box 85, File E48606.
97. See cases D66030, D25494 and E16220.
98. The Canadian Bar Association produced a scathing report that was sent to the Minister of Immigration in June 1954. It called for a number of reforms: the codification of the immigration regulations by the department; the publication of the intra-departmental directives; implementation of the proper and legal appeal procedures as contemplated in the Act; examining the possibility of making departmental files available to applicants and their attorneys; recognition of barristers and solicitors regarding immigration laws; and the establishment of procedures setting forth reasons for each rejection. It also recommended the creation of an immigration appeal board that could follow proper judicial and legal practices. Canada, House of Commons *Debates*, Session 1955, Vol. 3 (Ottawa: Queen's Printer, 1954), 1166.
99. The strongest criticism of the government's handling of deportations came from Conservative Party members Davie Fulton and John Diefenbaker. They brought forward a motion for censure in February 1955 that was ultimately defeated, but continued to challenge the department's actions. The motion of censure stated that 'in the opinion of the House, the immigration policy of the Government is not clear, consistent or co-ordinated; it is not in conformity with the needs or responsibilities of Canada; and in its administration denies simple justice to Canadians and non-Canadians alike'. Kelley and Trebilcock, *The Making of the Mosaic*, 326–7 and Hawkins, *Canada and Immigration*, 108.
100. Canada (Attorney General) v. Brent (SCC-9 February 1956).

PART III

Anthropological and Personal Reflections

CHAPTER 10

Between the Past and the Future: Migration and Melancholic Nationalism in Iceland

Arnar Árnason

Introduction

> Erlendur drove into the oldest part of town, down by the harbour … thinking about Reykjavík. He had been born elsewhere and considered himself an outsider even though he had lived in the city for most of his life and had seen it spread across the bays and hills as the rural communities depopulated. A modern city swollen with people who did not want to live in the countryside or fishing villages any more, or could not live there, and came to the city to build new lives for themselves, but lost their roots and were left with no past and an uncertain future. He had never felt comfortable in the city. Felt like a stranger.[1]

Erlendur is the fictional detective at the centre of Icelandic author Arnaldur Indriðason's series of murder mysteries. In his personal journey, Erlendur embodies the story of migration in Iceland in the latter half of the twentieth century, the depopulation of the rural areas and the spectacular growth of the city of Reykjavík and its adjacent towns. It is the same journey as that taken by the author's own father, the writer Indriði G. Porsteinsson, who narrated the uprooting on which Erlendur muses in many of his novels. One of Indriði G. Porsteinsson's books tells of Ragnar who has just left the countryside for 'the gravel', *mölina*, as the urban areas in Iceland came to be known, and his attempts to set down roots there.[2] A taxi driver, he becomes involved with a young woman whom he

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picks up at the American army base that was established in the country just after the Second World War. The young woman, clearly standing in for the nation as whole, has had troubled dealings with the American army, a situation from which Ragnar seeks to rescue her. That mission involves an attempted return to the countryside from where Ragnar hails, a journey that brings the novel to its dramatic conclusion.

This story of migration, as told by Indriði G. Þorsteinsson and as Erlendur reflects on it, is not simply a spatial movement, not simply a migration from countryside to urban area. It speaks simultaneously to an understanding of a particular direction and movement of history, of a particular temporal movement. In other words, the story is clearly tied to a particular appropriation of time. It tells of a temporal migration that moves people from one particular place and time to another and more uncertain place and time. As such the story speaks of a temporal disjuncture, a temporal dislocation. The migration leaves people, Erlendur suggests, without a past they had before and facing an uncertain future.

The story in which Erlendur offers these musings is called *The Silence of the Grave*. The murder that provides the mystery turns out to have been committed during the Second World War. In Iceland the Second World War—which eventually brought the American army that features in Indriði G. Þorsteinsson's novel mentioned above—is portrayed as an important historical turning point, but one that points to a turning quite different from the one experienced by the countries that participated more fully in the war's traumas. The war is seen in Iceland as having brought with it much closer and more frequent contact with the outside world, modernity, progress and urbanization, ethnographically understood. As such the conflict is clearly linked in local conceptions with the processes that took people from the countryside, the farms and the fishing villages, to the Reykjavík area. This contact with the outside world, specifically, took place in the form of and association with foreign occupation, soldiers, machinery and commodities. It brought desired goods that made life easier, but at the same it uprooted people and left them in the position articulated by Erlendur.

It was during the war that Iceland achieved full political independence after a century of ceaseless bloodless struggle. While independence was clearly on its way, the war, specifically the occupation of Denmark by the German army, was the context that allowed for independence to arrive when it did. While the war thus has many positive connotations in Icelandic historical consciousness, at the same time the presence of a foreign army, and indeed the greater contact with the outside world that this brought,

was and is seen as undermining national identity and culture—the very features that in the Icelandic case were seen to justify political independence in the first place.[3] There is acute ambivalence here, one that is reflected in the story. The murder victim, the reader is given to believe, suffered physical and possibly sexual abuse as a child, having been placed in a vulnerable position because of the poverty endemic in the Iceland he grew up in before the war. He, in turn, visits violence upon his wife and children. Their escape from his tyranny is made possible by the war and the presence of foreign soldiers, in a similar way to how Icelandic society is often portrayed as having begun its escape from poverty when the war visited the country. The victim's body is only unearthed because of building work taking place as Reykjavík spreads even further 'across the bays and hills'.[4] His fate, his identity and that of his killers, are only unearthed because of the depopulation of the rural areas and the expansion of the city, processes that have their crucial turning point in the effects of the war effort on Iceland.

I have dwelt on this story of migration in Iceland as locally it is frequently tied to a certain sense of a lack of roots and associated social and medical problems. Erlendur's musings are, for example, offered as he is frantically, desperately searching for his drug-addicted daughter, her problems quite clearly related to the lack of roots her father articulates. It is widely recognized that the rate of depression and anxiety disorders in Iceland is very high.[5] Drawing on ongoing ethnographic fieldwork, interviews carried out in the course of fieldwork and an analysis of public documents, in this chapter I examine local discourses on the prevalence of mental illness in Iceland. This earlier story of migration is important as I focus on the recent economic collapse in Iceland and links that are made between the consequences of this collapse and mental health. Employing contemporary readings of Sigmund Freud's *Mourning and Melancholia*,[6] I suggest that the links people draw here re-dramatize key understandings of Icelandic history, understandings that were initially dramatized in the context of rural to urban migration. I conclude by linking depression and anxiety disorders in Iceland with a particular form of melancholic nationalism that has also manifested itself in recent political developments in Scotland.

Gerben van den Abbeele speaks of the importance of the journey as a metaphor in Western ideas. He suggests that attached to the idea of the journey is a return to the home, but home as it was when the journey began.[7] When Iceland celebrated full political independence from Denmark in 1944 the event was spoken of as a homecoming. The then prime minister, Ólafur Thors, addressed his nation by saying: 'Icelanders,

we have arrived home. We are a free nation.' As historian Guðmundur Hálfdanarson notes, the imagery evoked here suggests that the independent nation-state is 'not primarily a political form but a home where the nation can find peace in its own country'.[8] I suggest it is the impossibility of this fantasy that fuels melancholic nationalism in Iceland.

Depression and Anxiety Disorders in Contemporary Iceland: A Few Numbers and Some Local Discourses

It is by now well established that the prevalence of mental health problems in Iceland and the number of people on long term medication for mental illness are both substantial.[9] Iceland appears particularly badly on lists comparing mental health in different countries. For example, the OECD, Health at a Glance report from 2013 reveals the following regarding mental health and medication in Iceland.[10]

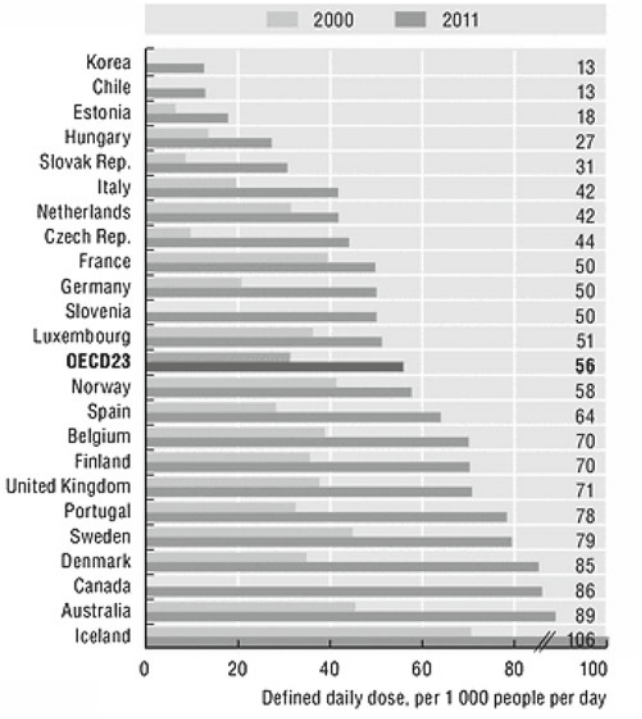

Table 10.1 etc.

According to this 71 DDD (defined daily doses) were prescribed for every 1,000 people in Iceland in 2000. By the year 2011 this had reached 106 DDDs. The average for OECD countries was 31 in 2000 and 56 in 2011. Iceland is almost twice the average. The Directorate of Health in Iceland estimates that at any given time between 12,000 and 15,000 people will suffer from depression in the country.[11] Even so these numbers are difficult to ascertain. The gap between suffering and diagnosis is notoriously both wide and complex to assess. What might be the reasons for this prevalence of depression and anxiety in contemporary Iceland? How could the country score so highly on these lists, given how well it scores simultaneously in rankings of the happiest countries in the world and in rankings on living standards? It is well established in the anthropological literature on health in general and mental health in particular that cultural factors impact heavily on the prevalence, experience and responses to matters of health.[12] I am of course not suggesting that depression and anxiety are culture-bound syndromes in Iceland. However, understanding depression and anxiety as medical problems rather than say spiritual ones, as is now the case in the country, clearly has implications for how these are then addressed. It is one of the complaints in Iceland that mental health problems are treated with medication and that alternative treatments, talking therapies specifically, are not readily available.[13] While matters of available services are of course important here, some would suggest that this practice is not unrelated to an understanding of depression and anxiety as primarily medical problems.

The position articulated here is barely more than a truism in medical anthropology, and perhaps only by now the starting point to ask more searching questions about the precise implication of culture in illness. In asking about the impact of culture—left deliberately broad and vague here for now—on mental health, Ian Hacking's notion of interactive kinds is useful.[14] Hacking writes on interactive kinds in a discussion on the theory of social construction. Substituting his questions with ones more closely related to the topic here, we might ask: what is involved in claiming that depression is a cultural phenomenon that is socially constructed rather than a biologically based natural phenomenon? Hacking notes the proliferation of claims that various phenomena are socially constructed. He adds that such proliferation is in danger of making the very notion of social construction meaningless. His key point is that the effect of social construction is importantly tied to the 'kind' that is its subject. So the chemical composition of the moon, for example, is presumably unaltered

irrespective of how the moon might be socially constructed in different cultures, in some cases as a divine being with considerable influence on human affairs, or in other cases as an insignificant rock being hurled through space by forces beyond its control. The moon is unaltered by these different constructions because the moon is not an interactive kind and does not respond to how it is socially constructed. Human beings, by contrast, are, according to Hacking, interactive kinds. That is to say, they interact with the social constructions imposed upon or made available to them—depending on where you want to place the agency. It matters whether you understand yourself or the people around you, or indeed if others understand you as suffering from the medical problem of depression as opposed to the spiritual malaise of melancholia. The different understandings are very likely, to say the least, to be tied into different ways of dealing with the problem, different authorities and individuals with different expertise who are trusted to speak on it, and intervene in it and so on. How people understand the origin of mental health problems is surely important here too.

The prevalence of mental health problems, depression in particular, has not escaped the attention of people in Iceland and has become a topic of considerable discussion. In the discussions that I have witnessed and participated in during fieldwork, a few key themes appear frequently. Some people suggest a certain depressive disposition is common in the country, which is in keeping with ideas about Nordic, or Scandinavian melancholy often associated with the imagery of the north more generally.[15] In a well-established and a well-known move, this particular form of emotionality is often linked to artistic disposition and creativity. There is obviously considerable romanticism here attached to depression, one that sits badly with the prevalent use of medication.

In local discussions this image of the depressed inhabitant of the north is sometimes linked to weather conditions in Iceland in general and the long and dark winters in particular. In fact the lack of light also emerges in local discourses as an independent cause of depression. These factors are in turn sometimes associated with romantic sensibilities and artistic dispositions—the weather and the light are seen to combine with the landscape to inspire a particular kind of artistic output.

Other discourses exist and in some the rapid urbanization and, understood here in local terms, the ‘modernization’ of the country are implicated in matters of mental health. The twentieth century in Iceland was marked by a population explosion and dramatic internal migration. In 1880

there were 72,455 people living in Iceland. Today that number is around 330,000. In 1890 around 12 per cent of Icelanders lived in settlements of more than 200 inhabitants, in 1990 that was 89 per cent. Of the 330,000 or so people living in Iceland at the moment around 230,000 live in the capital, Reykjavík, and the muncipalities adjacent to Reykjavík, together known as the capital area, *höfuðborgarsvæðið*.[16] This is a fundamental transformation in the settlement of the island. The twentieth century thus saw the birth and the shaping of Iceland as an urban society as a result of massive internal migration. Locally this migration is most fundmentally understood in terms of a movement to Reykjavík and the capital area more generally and in some formulations it is very clearly associated with a lack of roots and consequent social and mental health problems, drinking and drug taking.

Importantly and interestingly, at times this process of migration is spoken of as an escape, *flótti*, from the rural areas, *landsbyggðin*, to the Reykjavík area, the 'gravel'. The term escape, *flótti*, hides an acute ambivalence. There is no denying that in many cases people understood themselves to be escaping the hard work and arduous life of fishing and farming in rural areas. They understood themselves, also, to be escaping, as they saw it, the relative monotony of life there, the limited opportunities on offer. This is a theme in many memoirs published in Iceland in the last decades of the twentieth century, not least the celebrated work of Tryggvi Emilsson. This is certainly partly the experience that Erlendur narrates, it is an important feature in Icelandic literature more generally in the latter half of the twentieth century and it remains a characteristic of life in Iceland where many of the rural areas struggle to retain their population. At the same time though, there is, as Erlendur again attests to, a sense of loss accompanying this escape. It is a loss of connection with the land, with history and, at times, with direction and purpose as articulated in a number of Icelandic novels, as mentioned at the start of this chapter. In some local discourses such loss is again tied to the prevalance of depression.

Möl, gravel, is, as noted already, a reference to urban areas in general in Iceland. The word is not neutral but often carries connotations of moral and spiritual degradation and poverty. This is understood to be the consequence of a lack of contact with the heart of Icelandic identity, which, as the anthropologist Kirsten Hastrup points out, is the independent farmer and his—the gender is deliberate—farmstead.[17] It is the loss of connection with this identity that is sometimes evoked in discussions around depression in Iceland. It is relevant that it has been the practice of parents in the urban areas of Iceland to send their children for summer stays on farms.

Of course the motivations for this, and the benefits sought, were variable but the idea that children who otherwise spent their time 'on the gravel' could in this way come to know the real Iceland, was clearly important.

In discussions people locally recognize that the factors cited above—in particular those of national character, light and weather—would suggest a relatively stable level of depression in the country, but this does not match their experience. On the contrary, they suggest the prevalence of depression seems to be rising instead of remaining constant and, even more importantly, anxiety disorders rather than depression as such seem to be the mental health problem most strikingly on the increase over the last few years.[18] This, local discourse recognizes, requires an explanation that must be located outside the relatively fixed points of national character, the weather or the light.

The economic collapse in Iceland in the autumn of 2008 features heavily, almost exclusively, as an explanation. Having enjoyed a remarkably rapid expansion in its economy, specifically its financial sector, over a few years, people in Iceland were caught more or less entirely by surprise by the sudden collapse of its banking system in October 2008. What followed was a period of considerable economic hardship for many and profound uncertainty for all. There is evidence to suggest that the experience has had a significant impact on people's health[19] and in local discourses this link is quickly and often forcefully drawn. While the economic collapse is thus seen as having had an adverse effect on people's health in general, its impact on mental health in particular is often singled out. Indeed, it would seem reasonable to assume that a sharp downturn in people's economic situation coupled with an intense uncertainty about the future might lead to problems with depression and anxiety. While in no way do I seek to diminish this impact of the economic collapse, I think that its connection with mental health is perhaps more complex. The explanations suggested in local discourses here point to links with the consequences of the rapid internal migration of the twentieth century and recall the issues evoked through the figure of Erlendur at the start of this chapter. To trace the connection and its complexities it is necessary to discuss further the reaction to the collapse in Iceland.

Collapse: Past, Present, Future

When the Icelandic financial system collapsed in 2008, a short period of somewhat panicked bewilderment was swiftly followed by intense efforts to account for and make sense of what had happened,[20] and the recent

history of the country quickly became subject to extensive scrutiny. The years of spectacular economic expansion leading to the collapse had generally been depicted in dominant public discourses as a period of economic and social progress.[21] It is significant that this progress was understood to have been achieved because of the peculiarly Icelandic qualities of the country's businessmen: quick thinking, bravery, decisiveness—qualities that were constructed as having been part of the national character since the time of the Vikings, who allegedly settled the country.[22] This period of spectacular growth had not only clearly come to an abrupt end with the collapse but an end that went against what might be called here the national ideological fantasy. Kirsten Hastrup has observed how Icelandic history is, in dominant local discourses, constructed as consisting of three distinct phases.[23] The last of these is the period following full independence in 1944 when political sovereignty was to ensure cultural restoration and economic progress after the degradation and humiliation of foreign rule. This period has been understood as the age of the bright future, 'a period of progress', to quote Hastrup, 'of increasing technological sophistication and wealth'.[24] Never had this promise 'of increasing technological sophistication and wealth' appeared to have been realized so spectacularly as in the years leading to the collapse. And while the 'bright future', to which the post-Independence period had pointed was, of course, interrupted by economic downturns, they were dwarfed in comparison to the collapse of 2008.

These events put contemporary Icelanders in an unusual but by no means unique position. Anthropologist Michael Carrithers has in recent years explored the theme of problematic national histories in particular with reference to post-war and then post-unification Germany.[25] Carrithers discusses specifically the importance of overcoming the past, *Vergangenheitsbewältigung* is the German word, 'as a new item of rhetoric' that appeared first in West Germany in the 1950s.[26] This, he adds, is in a global perspective an 'unusual understanding of nationalist history' which is more usually celebratory. Something similar, it might be argued, happened in Iceland in the aftermath of the collapse. A historical trajectory that was enshrined in broader national fantasy and taken for granted as obvious, was suddenly cast in doubt. Such were the temporal effects of the collapse that, for many, Iceland seemed to go back in time and in development by a couple of decades at least. For example, measures such as strict control over the flow of currency, abandoned 25 years earlier because of increasingly progressive openness towards global markets, had

to be readopted. For others still the very future of the 'nation' appeared to be in doubt as thousands of people, young people in particular, left the country for a better future elsewhere. It is of some importance that the most popular destination turned out to be Norway, the land from where, as the Sagas relate, Iceland was settled and Icelandic society established.

What is being suggested here is the possibility that, apart from any impact the economic downturn might have had on individuals and their families through financial hardship and uncertainty, there were also major effects on the imagining of the 'nation' and its future. More specifically, it is possible that this latter effect may also have been implicated in people's mental health following the economic collapse. In Iceland there was a plethora of attempts immediately following the collapse to read its effect on the nation as a whole. Thus, it was quite often remarked that the Icelandic nation had, some would say again, shown itself to be like an alcoholic. The years leading to the collapse were the lengthy drunken bender when people threw money about recklessly in a binge of consumption. The year after the collapse saw the inevitable hangover that would always follow. Others said the nation had suffered a terrible loss and had to undergo a process of mourning following the collapse. They pointed out that Iceland, in the midst of widespread political protests after the collapse, was a society consumed by anger. Some therapists warned of the dire consequences this might have for the general population and for children, 'the future of the nation', in particular.[27] The period immediately following the collapse, they observed, had been characterized by shock as people and politicians failed to make sense of what had befallen them. For some time the nation was in a phase of anger. It needed to be helped to move beyond this state and eventually towards an acceptance, a resolution and a view to the future, or the consequences for both individuals and the nation as a whole might be serious.

As an anthropologist trained mainly in the British tradition of social anthropology, I am conditioned to be sceptical of moves that seek to read the state of such a collectivity as 'society' or 'the nation' in terms of ideas developed to understand individual psychology.[28] Even so I want to engage with the analyses of the therapists here, taking them as further examples of local discourses on mental health. I do so not to analyze the state of the 'nation' or society, entities I think are best understood as always in the process of becoming and never quite being, but rather because I think they can help us understand how the collapse and, before that, migration might be seen as implicated in mental health in Iceland. I am going

to entertain the therapists' assertion that people in Iceland have, since the collapse, been engaged in a process of mourning. What they have mourned though, I want to suggest, is not so much the economic losses they have suffered, as the therapists seemed to imply, but something else. However, before going there it is necessary to discuss Freud, mourning and melancholia.

Mourning and Melancholia: The Play of Identification

In his seminal paper in 1917 Sigmund Freud sought to draw a distinction between mourning and melancholia. Mourning, he writes, 'is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, an ideal, and so on'.[29] In the circumstances of loss 'we expect the temporary condition Freud calls "the normal affect (sic) of mourning": the experience of a "painful frame of mind," a loss of interest in the outside world, in other people, in activity, and in love'.[30] Thus mourning is characterized by painful dejection and reduced activity. Its hallmarks are, in fact, many of the factors we still recognize rather easily, I would suggest, as accompanying grief. Melancholia, on the other hand, involves, according to Freud, intense feelings of guilt, self reproach and a lack of self-esteem.[31]

What underlies both mourning and melancholia is the survivor's withdrawal of what Freud calls libido, or sexual energy, from the loved one. Freud argues that no one would willingly let go of a loved object and withdraw libido from the loved one. Rather, the person in mourning will frequently hang on to the loved one in a 'hallucinatory wish psychosis'. That is, the bereaved person may not be willing or able to accept the reality of their loss, as bereavement workers might be more likely to put it now. To escape from this state of hallucination, Freud continues, the bereaved person needs to 'bring up' and—to use modern terminology—work through the memories that bind them to the loved one. It is only once that work has been completed that the bereaved person is again 'free and uninhibited'.[32]

It is important to note that, according to Freud, mourning is normal and healthy. Melancholia, on the other hand, is not. Indeed, he contends that it is the consequence of unsuccessful mourning, when the bereaved person fails to work through the memories and the emotions that bind them to the deceased. Until that has been accomplished, the bereaved

person is not free but tied to the deceased and thus inhibited.[33] This of course invites the questions: why is mourning not always successful? And, what leads to melancholia?

Freud attributes melancholia fundamentally to the ambivalence of the bereaved person (or, in his words, the 'ego') towards the lost person.[34] He notes that ambivalence is not uncommon in relationships, adding that it is more possible to manage the ambivalence while both parties to the relationship are alive. Freud points out, very perceptively, that melancholic patients describe themselves in words that always fit the deceased loved one better than the patient themselves. The bereaved person identifies with the deceased and through that identification retains the connection despite the loss of the loved one. Here, quite clearly, the memories that bind the two together are not brought up and worked through. According to Freud, melancholia is the result of the bereaved person hanging on to a relationship that, in reality, is over because of the death of the other party. Consequently melancholia is unhealthy.

This discussion of mourning and melancholia refers most directly to the individual psychological processes Freud sought to understand. In attempting to change the focus of the discussion so that it can inform a social analysis more clearly I have been inspired by the work of Judith Butler and Diana Fuss.[35] They both look to Freud to understand the processes whereby individuals accept and invest in the subjectivities and identities made available to them by structures of power, even as that acceptance subjects the individuals to the power of those structures. They both see loss, mourning and identification as important in that process. Here, however, I draw most directly and immediately on the work of Jonathan Flatley to establish my particular position. He stresses that '[i]nstead of mourning, which Freud saw as a kind of libidinal decathection from the lost object, the melancholic internalizes the lost object into his or her very subjectivity as a way of refusing to let the loss go'.[36] Flatley then argues that by this 'Freud is not so much correcting or improving (as he supposed) our view of melancholia as giving us in his theory of melancholia an allegory for the experience of modernity, an experience … that is constitutively linked to loss'.[37] Here 'melancholia is no longer a personal problem requiring cure or catharsis, but is evidence of the historicity of one's subjectivity, indeed the very substance of that historicity'.[38]

In the case of Iceland this historicity not only speaks of the advantages 'modernity' brings but it also speaks of the possible losses that may be attached to the arrival of those advantages. What may be lost is the

connection with the past, the roots, the core of the identity and the future that such an identity is seen to secure—a loss made all the more problematic because of the national fantasy of a return journey to the origin.

How exactly might this process of mourning happen? Crucial to Freud's articulation of the process is the notion of identification hinted at above. For Freud, mourning involves identification with the lost love object: in his words, 'If one has lost a love-object, the most obvious reaction is to identify oneself with it, to replace it from within, as it were, by identification'.[39] 'By incorporating the spectral remains of the dearly departed love-object', as Diane Fuss puts it, 'the subject vampiristically comes to life.'[40] But identification is not simply a mechanism for coping with loss. Rather, Freud suggests that the '"character of the ego" is constituted by these losses as a kind of "precipitate of abandoned object cathexes." This means, furthermore, that the ego thus contains, like an archive or an archaeological site, "the history of those object choices."'[41] Freud in effect 'is suggesting, our losses become us. Thus, Freud … is placing the melancholic mechanism at the very origin of subject formation'.[42] Identification is 'the psychical mechanism that produces self-recognition. Identification inhabits, organizes, instantiates identity'.[43] That is, identification with the other precedes identity: identity is 'the self that identifies itself', to use Jean-Luc Nancy's formulation. 'Identification is the detour through the other that defines a self.'[44]

These ideas of mourning, melancholia and identification are useful, I suggest, in understanding depression and anxiety in contemporary Iceland. The collapse in Iceland in the autumn of 2008 was accompanied by losses and if these losses were mourned, then what was involved were certain processes of identification. These ideas will thus help to clarify what exactly was mourned following the collapse, what connection that has to migration in the history of Iceland and how depression might be linked to melancholia.

Mourning the 'Icelandic' Thing

I return now to the suggestion that depression and anxiety in contemporary Iceland may be linked to processes of mourning following the economic collapse in 2008 and that these may be linked to the country's history of migration. While thus entertaining the suggestions made by therapists in Iceland, I would like to suggest first that what people in Iceland mourned was not simply the material losses they suffered in the aftermath of the collapse but something more.

I suggest, first of all, that what was mourned in Iceland following the collapse was a future. I have already mentioned how the construction of history in Iceland suggests that political sovereignty early in the twentieth century was to be followed by progression towards a glorious future.[45] The post-independence era in Iceland has been marked by efforts to widen and enhance the country's economy to move it beyond its early reliance on fishing and farming. The widespread support in the country both amongst politicians and the general public for the biotechnology company DeCode is a case in point.[46] The years before the economic collapse seemed to fulfil this promise wonderfully with the exponential growth of the financial sector and its reach beyond the country's borders. In overtaking foreign businesses, furthermore, Icelandic entrepreneurs could appear to be reversing, or even revenging, the history of the country's exploitation by its Danish rulers. With the collapse in 2008 both the present and the future were severely compromised, apparently even entirely lost. Not only did the collapse serve to undermine the positive direction of Icelandic history, which for long had been taken for granted. It also served as an unwelcome reminder of more distant historical upheavals. The isolation immediately after the collapse, brought about by a lack of foreign currency, evoked the events leading up to the submission to the Norwegian King in the thirteenth century, while the escape from the country to Norway in particular, evoked recollections of the people who had left for America in the nineteenth century and raised the spectre of the disappearance of the nation, a powerful historical trope.

While it is important not to diminish the importance of this loss described above, I think what people mourned more than the bright future was the past, or perhaps more accurately that which is assumed to exist outside of time, or, to offer a slightly different formulation and adapt Marilyn Ivy's phrase, 'the Icelandic Thing'.[47] Ivy reminds us first of all how the establishment of modern nation states, like Iceland, rested upon the 'repression of internal differences in the service of what Slavoj Žižek has called the "national thing," one that could stand apart from' external powers. Žižek draws here on the work of Jacques Lacan on desire as emerging 'from an irrevocable lack within human subjects'.[48] For Žižek, the national thing is 'the particular nexus of national identification that is organized around what he calls "enjoyment"'.[49] Žižek is trying to understand what cements a political community. He says:

> What holds together a given community can never be reduced simply to the point of symbolic national identification: A shared relationship with *the others* enjoyment is always implied. Structured by means of fantasies, this thing—enjoyment—is what is at stake when we speak of the menace to our 'way of life' presented by the other … National and racial identities are determined by a series of contradictory properties. They appear to us as 'our thing' … as something accessible only to us, as something 'they', the others, cannot grasp; nonetheless, 'our thing' is something constantly menaced by 'them'.[50]

Not only is the 'thing' simultaneously beyond the others' grasp while always under threat from them: if we try to specify the 'thing' we end up with tautologies or empty lists[51]—the Icelandic 'thing' is Icelandic culture or it is the Sagas, the history, the landscape, the language and so on. The limitation of the list is that it does not specify the thing it seeks to specify; the Sagas, Icelandic history, the landscape and the language all imply the other in various forms. And thus the 'thing' cannot be 'reduced to those details themselves; there is something more that causes them to cohere into a nexus of identification and belief, into "our" national thing as a fantasy of shared enjoyment'.[52]

There is no question of the huge importance of the 'nexus of identification and belief' that is the Icelandic thing in holding that given community together. The distinctiveness of Icelandic—I will refrain from calling it a thing here—culture, language and identity was evidenced repeatedly in calls for the country's independence. Furthermore, as anthropologist Inga Dóra Björnsdóttir has argued, this distinctiveness was frequently seen as being under threat from 'others', not least foreign occupying armies, at risk in the country's participation in international processes, even as this participation was seen as necessary for the economic development and the future of the country.[53] But that is also precisely the moment when the 'thing' appears as such, in the engagement with 'the other', and appears as always at risk—as Ivy speaks of with reference to Japan.[54]

What might this have to do with mental health in Iceland, with the current prevalence of depression and anxiety? The collapse in Iceland in 2008 has been considered so far as an economic collapse. This was indeed how it was initially represented in the country, as an economic catastrophe that had its origin in the international money markets outside Iceland itself. However, as the proverbial dust started to settle the claim became ever louder, and more convincing, that preceding the financial crisis in Iceland, there had been an even more profound moral, social and political collapse.

Many argued that Icelanders had often before faced economic uncertainty because of the harsh environment in which they live and the vagaries of the international markets where they sell their produce. Hardship like that, observers would add, was nothing new, but had been instrumental in making Icelanders who they are.[55] However, what the banking crisis and the wider economic collapse that followed revealed was a far more troubling sundering of the moral, social and political fabric of the country. The call became ever louder that the collapse of the political and moral order of society was the ultimate cause of the economic crisis: that its origins were, in other words, internal to Iceland. This call became ever more persistent as research and then prosecutions unveiled unsavoury and often illegal practices and collusion between business, politics and bureaucracy.

At the height of the economic boom in Iceland, in the years leading to the collapse, there were times when Icelandic entrepreneurs appeared to be ready to take over the world. At that time powerful discourses constructed their success as having been achieved through their special Icelandic qualities, including quick thinking, decisiveness, bravery and a never-say-die attitude. These were depicted as qualities shared by the nation since the time of the Viking settlers, or characteristics forged through centuries of struggle for survival in a harsh if beautiful environment. What these discourses effected was the suggestion that, somehow, the whole nation was implicated and that everyone participated in the success of the entrepreneurs. More important, however, was the simultaneous implication and defence of the 'Icelandic thing' in the process. While Icelandic national fantasy has long understood the economic prosperity of the country to be dependent upon participation in international processes, these have been understood as a threat to the 'national thing'. Yet here, on the other hand, were entrepreneurs able to do the business for Iceland precisely *because* of their Icelandic qualities. As the collapse and its aftermath then revealed that the bright present and future had not been built on any special qualities other than financial speculation and mismanagement, the Icelandic thing was severely risked. The successes that had been portrayed as having been achieved through specifically Icelandic qualities, now turned out not to be successes but deceptions and fraud. This was a double slap in the face of celebratory national history, national fantasy.

So, what people mourned, perhaps, was Icelandic society as they had understood it to be, or hoped it was, one based on trust and honesty. It is instructive that following the collapse people sought to engage in

and champion the 'traditional' economic activities of fishing and farming. Traditional wool jumpers, socks and hats became popular. Knitting and the growing of beards became more fashionable than the sharp suits and dresses associated with an Iceland awash in money, an entity which had just disappeared, at least for some. So what people identified with in their 'mourning' was not the Iceland of the entrepreneurs, the Iceland lost in the collapse itself. Rather, what they identified with, what they sought to keep alive while mourning it, was the Iceland that had existed before the economic expansion, the Iceland of farming and fishing. At the same time though, surely, there was a recognition that this was an Iceland effectively long since gone, if it had not always been a fantasy, a 'thing'. This then is a process of mourning that will not and cannot bring a resolution. And, as such, perhaps it is a process of mourning that will always lead to melancholia, and in turn feed depression and anxiety.

Conclusion

The prevalence of depression and anxiety in contemporary Iceland is a matter of some concern locally. Numerous discourses exist that seek to account for this prevalence. This chapter has focused in particular on discourses that link depression and anxiety to the 2008 economic collapse in Iceland and its aftermath. It has argued that themes that have come to the fore around the collapse and mental health are linked to matters raised around migration in mid-twentieth-century Iceland and mental health at that time. Key here, it has been contended, is that migration in this context is not simply a spatial movement but a phenomenon that involves temporal dislocation at the same time.[56] As such, it is a movement in which loss plays a constitutive role so that we might view it in terms of mourning, melancholia and identification.

Gerry Simpson, Professor of Law at Melbourne University, wrote in anticipation of the Scottish independence referendum in 2014 that 'melancholy nationalism' is

> a political and cultural nationalism that both revels in and rebels against national sentiment. It is a nationalism that understands itself as a yearning for something that has never existed, a nationalism that allows itself to suspend that knowingness every so often in order to be moved by quixotic tribal gestures, a nationalism that feels the threat from global sameness, yet escapes regularly into cosmopolitan plural identity.[57]

This is not to argue that such a formulation fits exactly with the Icelandic case. It is, however, to suggest that Icelandic nationalism 'understands itself as a yearning for something that has never existed', that it is 'a nationalism that allows itself to suspend that knowingness every so often'. Or rather, it is to suggest that Icelandic nationalism is one that yearns for something that it believes existed while at the same time it knows it never did and cannot exist again. This is the fantasy of the journey of a return to the origin. This then is a loss that cannot be resolved, cannot be recovered. Its mourning will always lead to melancholia, always lead to depression, while being constitutive of subjectivity.

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CHAPTER 11

Doing Harm or Doing Good? Some Reflections on the Impact of Social Work and Social Policy on the Mental Health of Commonwealth Immigrants to the UK in the Twentieth Century

Juliet Cheetham

Earlier chapters have described some remarkable attempts to respond to the personal and social dilemmas presented by immigrants who became mentally ill. The illnesses they experienced would now probably be described as pychoses. Diagnoses were made, albeit at times in vague terms; some sufferers were placed in institutions and some were repatriated. There are examples of thoughtful and compassionate care as well as of harsh treatment. There is also evidence that some civil authorities gave thought to the appropriate response to immigrants who were found to be mentally ill.

This chapter describes different circumstances. Its focus is on a broader concept of mental health and illness, namely the stress, anxiety and depression which are common experiences amongst migrants. These are also recurring problems in the general population, often attracting little or no formal intervention. What treatments and responses there are take place largely unobserved in the community and there is an absence of good systematic empirical data. We rely on a handful of studies. Roland Littlewood and Maurice Lipsedge, who have published comprehensive evaluations of transcultural psychiatry since 1962, use case studies to examine the link between racism, psychological ill health and the inadequate treatment of

M. Harper (ed.), *Migration and Mental Health*,
DOI 10.1057/978-1-137-52968-8_11

ethnic minorities. They analyse the comparative incidence of mental illness amongst different ethnic groups but acknowledge the limitations of data based only on hospital admissions. They also explore the possible impact of the stresses of migration on mental health. The 2005 edition of their book brings together material from a variety of sources to illuminate current knowledge about the incidence of mental illness amongst different ethnic groups.[1] In 2011, a wide-ranging collaborative study brought together guidance on the mental health of migrants in different nations, including the UK, in order 'to present advice to clinicians and policy makers on how to provide migrants with appropriate and accessible mental health services'.[2] Three years later, however, research at the University of Oxford's Migration Observatory demonstrated that evidence about the mental health of immigrants in the UK still remains limited.[3]

Littlewood and Lipsedge's concerns about the shortcomings of hospital admissions data are well founded. We know that the numbers of people experiencing mental distress are far, far greater than those who receive treatment in psychiatric hospitals or clinics.[4] We also know, from observed experience, that immigrants are extraordinarily resilient. Their ambition, determination, and sometimes their desperation, provide some protection in dealing with the extraordinary stresses of migration, which commonly include loss of family, friends and cultural links, economic hardship, loneliness and discrimination. While policy makers might give some passing recognition to these dislocating experiences they have assumed they are part of the price migrants are, or should be, prepared to pay. They have also assumed that if migrants do need some help then assistance can be found in the mainstream health and welfare services.[5] There are few organizations which cater specifically for the welfare of immigrants, and those that exist work largely with refugees. Although from the late 1970s there was increasing awareness that public services were not adequately responding to the needs of Black and Asian people,[6] the remedies proposed focused largely on the need to combat the racial discrimination and poverty which were damaging their life chances. Mainstream services were also encouraged to adopt culturally sensitive approaches but the emphasis was on the citizenship of service and not on their immigration status.[7] In the twenty-first century, with significant immigration to Britain from the European Union, there have been growing allegations in the press and from some political parties about the pressure immigrants place on health and welfare services. These alleged demands have not been documented in any systematic way, and the essential contribution of immigrants to the staffing of Britain's health and welfare services is not acknowledged.

This chapter uses case studies, based on the author's experience as a social worker in London in the 1960s, to raise questions about responses to common migrant experiences which might be expected to promote or threaten mental health. Social work experience can be a valuable source of information about what is not working well in social policy. It can illustrate inherent tensions and conflicting objectives, particularly for vulnerable populations, people at the sharp end. It thus acts as a kind of litmus paper of the consequences of social policies for less successful citizens. Case studies can also demonstrate migrants' essential resilience and their capacity to cope and make the most of what help may be on offer: 'if you have to survive, you do'.

A West Indian Mother's Search for Day Care

The first study, describing a situation which took place in 1967, shows how the prevailing social policies of the day inflicted serious harm on a family. A single working mother was seeking day care for her child from the social services. Her request was robustly refused and she therefore turned to the then unregulated private market. Such experiences were commonplace.

In the 1960s and 1970s there was large-scale migration to the UK from the countries of the New Commonwealth: the West Indies, India and Pakistan. In substantial part this migration was a response to labour shortages in the UK, with some industries, such as London Transport and the National Health Service recruiting people in the New Commonwealth for work, particularly in London and the Midlands. Working men also came to take jobs in industries, such as textiles, where wages and conditions of work could no longer attract native-born British workers. Many women from the Caribbean came to work in hospitals as nurses and auxiliaries. Some had children whom they left at home with family members until they were in a position, as they saw it, to bring those children to the UK and establish a life for them there.[8]

Euphemia Blair (a pseudonym), a qualified nurse, was such a woman. Her circumstances, and those of her daughter, were not uncommon. Social work agencies at that time received many similar requests. Mrs Blair approached her local children's services office in 1967, soon after her three-year-old daughter, Bella, had arrived to live with her after having stayed with her grandmother in Jamaica for two years. Bella's father, who remained in Jamaica, occasionally contributed money for her upkeep but played no active part in her life. Mrs Blair now had a contract with a

nearby hospital and a modest flat. She had achieved her great ambition to give her daughter a good life in Britain. Bella's mother had two matters to resolve. She needed full-time day care for her daughter while she was at work. She was also concerned that Bella was not the happy responsive child she remembered but was withdrawn and disobedient. Sadly Mrs Blair was faced with a huge shock. She had already learnt that there were no workplace nurseries. I now told her that the local authority only provided day care for children in the most exceptional circumstances, for example when parents had a long-term illness. I also told her that this was because it was believed that it was not in the interests of children under five to be separated for long periods from their mothers or mother substitutes. This policy was strongly influenced by the research of John Bowlby[9] and, at the time, somewhat uncritically absorbed by many social workers, including myself and my superiors. The upshot was that the local authority could provide no care for Bella, nor could we point her mother to any alternative source of help. However, we could offer her some assistance in understanding and coping with her daughter's sad and difficult behaviour. So I encouraged Mrs Blair to think about its likely causes: the recent loss of her grandmother; living in cramped and cold conditions after the freedom of her yard in Jamaica; reunion with a person she could not remember.

Mrs Blair was baffled. She had been recruited to work in a hospital for old people where it was difficult to obtain any qualified staff. She was here not only to contribute but also to make a better life for herself and her child. Grannies had always looked after the children of working mothers in Jamaica and returned them to their parents as circumstances permitted. 'What was the government going to do about it?' The social services'—or rather my—response was outrageous. The tragic answer was 'nothing', until things went very wrong.

Mrs Blair had no option but to find her own solution: she had a contract with her employer; she had borrowed a huge sum for her own and her child's fares, and this loan had to be repaid. She was also committed to a life in Britain which she still thought promised so much for herself and Bella. Mrs Blair therefore placed her daughter with a minder who cared for about eight children at any one time in a dark, damp and malodorous basement. This minder, who wanted to oblige parents, allowed children to stay in the evenings and overnight in totally unsatisfactory conditions. She was thus a godsend for parents, and she was not overtly cruel to their children. But they simply could not thrive in such circumstances. Health and safety criteria—little thought of then—were disregarded, and so was

the emotional and intellectual welfare of the children. How could it be otherwise with one person caring for eight children aged from a few weeks to nearly five?

How did I learn about what happened to Bella after her mother left my office empty handed and disillusioned? A few months later I was part of a social work team that made an unannounced visit on this basement one evening. In those days such visits were called raids. There was no established system for regulation, registration or inspection of private child-care 'facilities', although it was widely known that there was some dreadful private care of babies and infants. It was clear that the children in this basement 'resource' could not continue in such conditions. They were removed to temporary emergency overnight care. Their parents were contacted and asked to provide better alternative care, and they were told if this could not be done their children would be taken into care and placed with foster parents or in children's homes. These resources were in very short supply in London and so Bella was sent to Devon, at a distance where it was almost impossible for her mother to visit.

There is no doubt that harm was done here. Although Bella did receive care that allowed her mother to work this outcome was achieved in circumstances in which Mrs Blair felt blamed as a failing mother, and indeed was seen as such in some quarters. She almost lost touch with Bella who had more traumatic loss and change to deal with. Although she and her mother were reunited when she was seven their relationship remained difficult. As a teenager Bella ran away from home, rebelling against her mother's increasingly desperate attempts to control her. She was again taken into care. She did not achieve well at school and eventually found only temporary and menial work. She disappointed her mother and herself.

Cases like Bella's were not rare tragedies in that era. They were experienced in varying degrees by many parents from the West Indies for whom preschool care was virtually unobtainable for many years. Some were driven to place their children in unregistered, unregulated private foster care, often with damaging, albeit unintended, consequences.[10] Although parents from the West Indies were eagerly recruited to work in Britain no thought was given to the consequences for their children. In part this was because of public service workers' general lack of knowledge about the processes of migration (which only affected a small part of the UK) and about immigrants' countries of origin. It was a product too of the belief, still prevailing, that no special provision should be made for migrants,

who—it was argued—can and should fend for themselves. Indeed, in contemporary politics there are strong beliefs that immigrants to the UK should now be, in large part, excluded from social benefits until they have worked in Britain for some years.

However, immigrants were not alone in these struggles to obtain child care while parents worked. Increasingly in the late 1960s and 1970s single and married mothers sought work, by choice or necessity. They too faced the dilemma of finding affordable, adequate care, and they too often had to resort to unsatisfactory child minding or day nurseries, which appeared in response to public demand. Numerous studies revealed the vicissitudes faced by parents looking for child care, its frequently poor quality, and the special problems confronting black parents and their children.[11] As so often, immigrants had highlighted more general problems in society. And slowly the government responded.

Does any of this have resonance today? In many ways, 50 or 60 years on, Britain is a different country. Increasingly, over three or four decades, there has been growing child-care provision, coupled with funding, to meet the needs of working parents and preschool children. In 2015 the situation is unrecognizable from the one which confronted Euphemia Blair half a century earlier. Parents are expected and encouraged to work and can receive funds to assist with child-care costs. This is especially so for parents who are on benefits but expected to return to work.

Resources for child care are subject to tight registration, inspection and regulation, and standards of care have improved beyond recognition. Early years education is firmly on the agenda. Educational authorities in large urban areas are constantly monitoring the performance of children to take account of their ethnicity. Anxiety about the underachievement of certain groups remains—particularly now the attainments of white boys of working class parents—but current educational policies both encourage and require additional attention and resources to raise standards, with mixed success. Legislation to outlaw race and sex discrimination and promote equality has greatly reduced the gross disadvantages suffered by Mrs Blair and her generation. All this will benefit the children of immigrants and their parents. The argument that the needs of immigrants and their families should be catered for through mainstream services has therefore been vindicated in part. Nevertheless, many immigrant parents and their children suffered huge problems, and no doubt damage, until their plight was recognized as being shared by many native-born Britons, with the ensuing social policies.

That is not the end of the story. At the beginning of the twenty-first century immigration to the UK remains highly contentious, as is clear from the emergence of the United Kingdom Independence Party. Issues of British identity were frequently raised during the 2015 General Election campaign, and debates continue over whether or not the UK should be a multicultural melting pot. In addition, the increasingly desperate efforts of refugees from war and political and religious persecution to reach Europe, and of tens of thousands of people from Africa and the Middle East seeking work, have all reinforced the resistance in Britain to any further immigration. Strong arguments are now put forward, by all major political parties, to deny immigrants access to some or all social benefits. Such exclusive policies are extended, in substantial part, to immigrants from the European Union, who are free to work and live within Britain's borders. These plans include proposals to prevent workers in Britain sending Child Benefit back home to support children there. The unintended consequence of this might well be children being brought to live in the UK. Although there is recognition in Britain that it is critical—for individuals and the economy—for all children to achieve their potential, and there is extra support in schools to promote this, outside educational policy there is growing hostility to provision for immigrants, especially in housing and health. It is likely, therefore, that if these policies are enacted, the children of some immigrant parents will experience additional poverty.

Conflict Within an Asian Family

The second case study illustrates an enduring issue for migrants and their families, and for the societies to which they have moved: how far can and should traditional cultural values be maintained?

Shama and Mohammed (pseudonyms), a sister and brother aged 15 and 13, were born in Britain. Both their parents had migrated there from the Indian subcontinent in the 1970s. Their mother stayed at home to care for the family, which included two younger children. Their father was a semi-skilled worker in the motor industry. They were a close knit family with a number of relatives who lived nearby. The children performed quite well at school and their parents encouraged this, although they had little contact with teachers. The family attended the local mosque and valued both its religious and social support. However, they faced increasing tensions.

Shama wanted to attend social clubs, which had boy and girl members. She had school friends who were boys and, her parents suspected, a white

boyfriend. She scoffed at her parents' talk of her marriage 'at about 18'; she wanted to go to college and to have a career. Mohammed also had white friends and wanted to spend more time with them, going to sporting events and the cinema. He was allowed more freedom to do this than his sister, a disparity which was an increasing source of tension.

Shama complained to her school about her parents' attitudes. Teachers and counsellors saw what she was experiencing as familiar culture conflict. They tried to encourage Shama to understand her parents' point of view, and they attempted unsuccessfully to talk with her father and mother. The situation deteriorated. Mohammed started to truant from school and reported to his teachers that his parents had chastised him when they heard about this. Shama started to stay out late with her boyfriend and to spend time with him at the weekend when she should have been helping in a relative's restaurant. Her parents resorted to locking her in a room and threatened her with a return to Pakistan. She began to do less well at school and to lose weight. Her teachers also thought there were some signs of self harm. They were unsure how to respond, recognizing what was happening as 'a clash of cultures' but having no confidence in their ability to tackle this situation effectively.

The parents became more and more panic stricken at the apparent disintegration of their happy and successful family. They did not know where to turn for help. To discuss this at the mosque might incur shame. Contacts with the school seemed to result in mutual incomprehension. Although the father had some standing outside the home through his work, which he found supportive, the mother was very isolated and became increasingly depressed. This was noticed by her general practitioner when she was treating her for an infection. She prescribed anti-depressants but the reasons for the depression were not explored. It was attributed to loneliness, which was, of course, only part of the story.

Such situations remain common in all countries where migrant families face standards of conduct and lifestyles which challenge their own values. These situations attract mixed and paradoxical responses from public agencies. It can be, and in this case was, variously argued: that this situation constituted a clash of cultures which would resolve itself; that there were problems here but we should tread cautiously because we do not want to make matters worse in a family which had obvious strengths; that this young girl's human rights were being threatened—she might end up in a forced marriage—and so she deserved strong protection; similarly, chastisement of a child is a form of abuse which must be fully investigated

and stopped; however, if parents lose all trust in educational and welfare agencies then this will be to the detriment of the family.

Such prevarication, while perhaps understandable, seemed to paralyse the teachers and social workers and so there was no positive intervention for Shama and Mohammed or their parents. Eventually the school's hand was forced when both Shama and Mohammed appeared with visible bruising—the result, they said, of being beaten by their father. Child protection procedures were initiated, to the huge distress, and some bafflement, of the parents; and there was uneasiness amongst all the parties about the way forward. There was no real future for Shama and Mohammed outside their family, since foster or residential care would have been inappropriate. Although they were angry with their parents, and at times bitter about their treatment, neither young person wanted separation. Implicitly they seemed to recognize that to break out of the arm lock you have to cast off the embrace. They wanted 'a fairer deal; to be more like our friends; to have more freedom; for mum and dad not always to think we are hopeless'.

Fortunately for this family, and for the public agencies, there was a local community organization attached to the mosque. It had not been involved before because of the parents' anxieties about sharing their problems and public agencies' suspicions about resources they thought would have a strong religious orientation. A new social work manager decided that the possibility of a link between her department and the community organization should be explored.

In a series of meetings it emerged that there was much common ground in the two groups' approach to the dilemmas posed by Shama and Mohammed and their family. Importantly there was agreement that some compromise should be possible in a family where there were such obvious strengths. There was also exploration of the dangers inherent in turning a blind eye to, or failing to challenge, serious risks or problems for fear of intruding, inappropriately, on cultural values. For example, some enquiries into the deaths of children, which might have been prevented by public agencies, have shown that social workers, who were ill informed about the values of the families with whom they were working, ignored serious instances of physical punishment of children on the grounds that such behaviour 'was part of their culture'. Other examples include failures by schools to take seriously young Asian girls' statements that their parents were going to send them home for a marriage they did not want.[12] Although such behaviour may seem both bizarre and outrageous it has occurred at times when public agencies and individuals were being strongly

criticized for both their institutional and individual racial discrimination. This can deter necessary intervention for fear of accusation of racial discrimination. Strong leadership and some cultural confidence are needed to avoid such situations. This was achieved through the relationship between the social work department and the community organization.

Shama, Mohammed and their parents agreed to a series of meetings with workers from the community organization and the social work department; some of these were group meetings and some were individual. There was much support for the achievements of both parents and children. Workers from the mosque organization were able to reassure the parents that there were many families who faced similar problems, and that they could be resolved. They were praised for what they had achieved and for the aspirations they had for their children. There were also contracts drawn up to deal with the management of tricky situations, which included rules and expectations for the children's behaviour and which were a compromise between the wishes of children and parents, and a ban on physical punishment and restraint.

Over six months the family recovered its equilibrium. Shama and Mohammed achieved well at school, and although they remained critical of their parents' perceived unfairness they mostly kept to the agreed contracts about behaviour. The parents were pleased with their children's progress at school; they were delighted to learn from Shama's teachers that she had the ability to go to university and accepted the plan for her to pursue this goal. There was no more talk about a planned marriage at 18, but there was continued resentment about the intervention of social workers and their perceived overreaction. The community worker had several meetings with the parents and, with their permission, told teachers and social workers about: their moving accounts of their hopes for and fears of life in Britain; their bafflement at what they and their friends saw as the low standards of so many young people's behaviour in the UK; their fears of 'free choice' for girls' friendships; and their concerns for boys' associations with friends, most of whom drank alcohol and some of whom used drugs. Sadly, such thoughtful, fearful reflections were not at that time part of the everyday discourse with teachers and social workers. Nor was this part of their professional training. Only novels or rare personal accounts provided some glimpses of these experiences and of the strains of migration which can exact a great personal toll. Some examples are offered here because they illustrate well the personal experiences of immigrants that are not easily accessible except by those who work closely with them and who are privileged to hear their stories.

Perspectives from Literature

In 1971 Ursula Sharma, a sociologist with a deep knowledge of Punjabi communities in India and Britain, published a perceptive and sympathetic account of an immigrant family. This was based on her close relationship with them and innumerable tape-recorded conversations about their reasons for emigration, their experiences in Britain and their resigned but uneasy accommodation to features of life in their new country. They were shocked at what they saw as a threatened disintegration of family life and the endless pursuit of material gain. They also feared their children would become alienated from them and absorbed into a culture they saw as having many flaws. Cultural dislocation is a recurring theme.

> If I say this over and over again it is because what I feel most about this country—that here there is no room for affection in people's lives. This is true both of the English and the Indians who come to live here—the Indians become like the English because they are working under the same conditions. Here no one takes thought for the other … People are too busy making money for themselves over here to find time to love each other.[13]

These parents realize they must stick together.

> Now that we live in England we always have to remember that we are in a foreign country. If I alienate my wife or leave her, where shall I turn? Or if she is irritated with me, where can she go? If we were in India she could always take the children to her parents' house for a little rest. But we have no family here and if we start arguing and split up, what would become of our children?[14]

They also see that they must accept a degree of accommodation to the culture that will absorb their children.

> Sometimes I curse this television and wonder why I even bought it. I say to myself that it would be a good thing if it broke down, because then my children might study in the evenings. But here everyone keeps a television—what would my children say if we did not also keep one? We have a problem here because children cannot help doing as they see others do … We cannot force them to conform to our ways … If my daughters want to go to dances and meet English boys when they grow older, how will we be able to stop them? Suppose Asha [his daughter] were to get mixed up with a boy here, we could do nothing unless we were to rush her off to India and get her married immediately over there … I would be helpless … If they [his

> children] had become so English as to want to arrange their own marriages, then it would already be too late for me to object. I do not want them to be unhappy and so this is a serious problem for me. I cannot make my children do as I say; I can only explain to them what I think is right and just hope that they will follow those customs that I look upon as best.[15]

This family's sentiments echo the hopes and fears of Shama and Mohammed's family and provide an insight into how they negotiated the tensions, sadnesses and conflicts of their life in Britain. It is an insight that would have greatly helped the teachers and social workers who were unsure how to respond to a family they found so hard to understand.

It can also be challenging for those who have no experience of migration to understand the huge stress it can create for indviduals. Samuel Selvon came to England from Trinidad in 1950. In a novel first published in 1956 he describes the high hopes and excitement—but also the fear—of West Indian men newly arrived in London.

> Galahad make for the tube station … and he stand up there on Queensway watching everybody going about their business, and a feeling of loneliness and fright come on him all of a sudden. He forget all the brave words he was talking to Moses, and he realise that here he is, in London, and he ain't have money or work or place to sleep or any friend or anything, and he standing up here by the tube station watching people, and everybody look so busy he frighten to ask questions from any of them.[16]

Towards the end of the novel, when the main characters are reflecting on their experiences, their disappointment—even bitterness—becomes apparent.

> Looking at things in general, life really hard for the boys in London. This is a lonely miserable city … Here is not like home where you have friends all about. In the beginning you would think that is a good thing, that nobody minding your business, but after a while you want to get in company, you want to go to somebody house and eat a meal, you want to go to excursion to the sea, you want to go and play football and cricket. Nobody in London does really accept you. They tolerate you, yes, but you can't go in their house and eat or sit down and talk. It ain't have no sort of family life for us here.[17]

The persistent loneliness of the immigrant, unassuaged by many years in London, is reinforced in the reflections with which the book ends.

> Under the kiff-kiff laughter, behind the ballad and the episode, the what-happening, the summer-is-hearts, he could see a great aimlessness, a great restless, swaying movement that leaving you standing in the same spot. As if a forlorn shadow of doom fall on all the spades in the country. As if he could see the black faces bobbing up and down in the millions of white, strained faces, everybody hustling along the Strand, the spades jostling in the crowd, bewildered, hopeless. As if, on the surface, things don't look so bad, but when you go down a little, you bounce up a kind of misery and pathos and a frightening—what? He don't know the right word, but he have the right feeling in his heart. As if the boys laughing but they only laughing because they fraid to cry, they only laughing because to think so much about everything would be a big calamity—like how he here now, the thoughts so heavy like he unable to move his body.[18]

What better account could there be of latent depression?

The Challenges of Pluralism

These literary perspectives also reinforce the insights gained from case studies about the challenges of pluralism amongst first- and second-generation immigrants. In the case of Shama and Mohammed and their parents, the reflections conveyed by the community workers echo those of many families, irrespective of their origins, but anxieties are increased for those challenged by an unfamiliar culture. The teachers and social workers could recognize this, but without proper communication with the family they had nearly embarked on a potentially very damaging course of action. There were pressures on this family which clearly threatened the mental health of its members. Both Shama and her mother showed clear symptoms of mental illness, although they were not recognized as such. There was a risk here of a huge harm, including the breakup of a family, but this was avoided, and some greater understanding achieved, in cooperation with a specialist, culturally based organization. The case of Shama and Mohammed took place in the mid-1980s but it is repeating for recent migrants in many parts of Britain and in other countries. It is also not just an Asian story, it can be relevant to families from different parts of Europe, from the Middle East and from Africa. Health, education and social workers often feel inadequate in assessing needs, problems and strengths in the context of unfamiliar cultures. This applies particularly to the upbringing of children and to conflicts between generations and sexes. We may give lip service to strengths but do we really believe in them? For example,

there may be strong praise for supportive, disciplined Asian family systems and the high standards these are intended to uphold. However, such support may quickly dissolve in the face of complaints about excessive parental control of children, particularly daughters, and the rigidity of gender roles. While crass and extreme reactions to unfamiliar cultures are probably less common in the twenty-first century than they were a generation ago, a serious question remains. What are the implications of pluralism in response to individual and family problems? When conflicts arise how can individual interests be protected, according to reasonable interpretations of the prevailing values of the countries to which migrants have come?

In Britain there may now be clear answers to some dilemmas. For example, the government has outlawed female genital mutilation and advocates policies to diminish its occurrence, but such measures have only been strongly pursued in the last few years.[19] Similarly, schools are expected to intervene if they suspect a pupil is being required to enter into a forced marriage abroad. Questions about the extent to which young people should undergo rigorous Muslim teaching are more complex. In the current international political climate it is easy for people to claim that this is at the heart of radicalization, that it encourages such extremes as Islamic State and jihad. There are, however, huge and appropriate anxieties about challenging religious freedom. There are also those who, reflecting on the consequences of some extremes of Christian education, argue that such a history demonstrates the importance of challenging further examples of fundamentalist religious teachings. Others will be anxious about imposing constraints on some forms of religious teaching but not others. They will argue that tolerance leads to moderation in the end, while prohibition encourages the perpetuation of extremes. This is not simply a vibrant intellectual debate, it is a source of great concern to policy makers and of real pain for individuals.

In twenty-first-century Britain there are many individuals and families who experience the acute anxiety and conflict of dealing with challenges to their most deeply held values. Further stress arises when they are regarded, as frequently happens, as failing to make appropriate adaptations and thus, perhaps, not fully deserving their status as citizens. This can be the context for mental distress, which for some people will develop into illness. All this can be exacerbated when politicians, from most parties, talk more about the problems of immigration to Britain than about its merits for the country. The General Election of 2015 clearly showed these attitudes, with policies promising much-reduced immigration and the curtailment

of benefits for people who, although lawfully in Britain, have not lived in the country for a prescribed length of time. The overall message is: 'you as individuals are at best tolerated, but mostly unwelcome'.

Such an approach to migration is not just the rhetoric of politicians responding to their constituents' claims that immigration is the cause of many of their woes and a major threat to their future. Some limitation of immigrants' social benefits is also seen as necessary by people with a deep knowledge of migration, who regard it as a major benefit to both to migrants' countries of origin and their destinations, and who wish it to continue. Economist Martin Rhus, in a thoughtful and detailed study of the context and consequences of international migration—which he sees as both inevitable and welcome—argues that restricting immigrants' benefits will entail some fiscal trade-off in the receiving countries. It is impossible, he argues, to legislate for unlimited access to all social benefits for all immigrants, whatever their background. To require this would mean limiting immigration only to the most qualified and wealthy. Continued relatively open migration therefore requires some limitation of social benefits while core civil and economic rights remain protected, for example, the right of association, choice of employment, equal pay and equal employment protection. Social benefits which might be limited for a period could include access to public housing, some social security benefits, health provision and education.[20]

While such policies are intended to make immigration more palatable to the receiving society and so allow it to continue, they can have unintended consequences. For example, children who accompany their immigrant parents may be far less well provided for than native children. This may damage their life chances and be to their disadvantage and, if they remain in the country to which they were brought, perhaps to its longer-term disadvantage as well. If they remain apart from their parents for a substantial period before joining them the reunion may not go easily. This will not trouble receiving countries if parents return home but, as Euphemia and Bella have shown, families who reunite in their new country may face problems which require help from public agencies.

In the political climate prevailing in Britain in 2015 it is as challenging as it has ever been to argue for attention to be paid to the mental health of immigrants and their families. Indeed, general statements about needs and problems are likely to be dismissed. However, case studies can illustrate, in an accessible way, the impact of migration on the mental health of some families, and they can point to ways of helping which may both alleviate and prevent mental health problems. These include ensuring that

exclusion from some public services will not gravely damage an individual, as happened to Bella in the first case study. Denial of the financial support which enables parents to work may mean that immigrant children receive the poorest quality day care. Contemporary regulation means that these children will not experience the horrors endured by Bella but deliberate policies to deny some children equal access to good quality day care and education, and to limit their parents' income, are not the best ways to promote mental health.

More positively, the Shama and Mohammed case study shows how cultural understanding, prompted through collaboration with a specialist agency, protected children's rights while also supporting their parents. Training for 'cultural competence' is now recognized as fundamental in work with immigrants and their families.[21] This includes awareness of the impact of workers' cultures and world view on their work, knowledge of the cultures of people who use services (and these service users are often the best informants), gender appropriate services and support for workers faced with challenging cultural conflicts or expectations. Also, at a basic level, governments and their embassies could provide clear information for immigrants about their rights to services and sources of advice and assistance. This does not have to be seen as an encouragement for immigration but as a practical guide to encourage self help. Such information might include an account of the risks and advantages of bringing children to Britain or leaving them abroad. Immigrants, typically, are resilient, ambitious and courageous people. They are determined to improve their own lot in life and the conditions and prospects of those they love. These qualities provide some protection against the inevitable hardships of migration. Nevertheless, such hardships can and do cause mental distress and illness. Many of these stresses can be eased, and some prevented, by quite simple interventions, which include the resources of immigrant populations. Common humanity and political expediency require such provision, and the past can inform the present, not least in the challenging current climate of mass migration into Europe from the Middle East and beyond.

Notes

1. Roland Littlewood and Maurice Lipsedge, *Aliens and Alienists. Ethnic Minorities and Psychiatry* (Taylor & Francis e-library, 2005; originally published Harmondsworth: Penguin, 1962).
2. Dinesh Bhugra et al., 'WPA Guidance on Mental Health and Mental Health Care in Migrants', *World Psychiatry*, 10: 1 (February 2011), 2–10.

3. Hiranthi Jayaweera, 'Health of Migrants in the UK: What Do We Know?', The Migration Observatory at the University of Oxford, Briefing Paper, 30 September 2014 http://www.migrationobservatory.ox.ac.uk/sites/files/migobs/Briefing%20-%20Health%20of%20Migrants%20in%20the%20UK_0.pdf.
4. See, for instance, 'How mental illness loses out in the NHS', a report by The Centre for Economic Performance's Mental Health Policy Group (LSE, June 2012) http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf (date accessed 28 October 2015).
5. Eliot Joseph Benn Rose, with Nicholas Deakin et al., *Colour and Citizenship: A Report on British Race Relations* (London: Oxford University Press, 1969).
6. Juliet Cheetham, Walter James, Martin Loney, Barbara Mayor and William Prescott (eds), *Social and Community Work in a Multi-Racial Society: A Reader* (London: Harper and Row in association with The Open University Press, 1981); Shama Ahmed, Juliet Cheetham and John Small (eds), *Social Work with Black Children and their Families* (London: Batsford, in association with British Agencies for Adoption and Fostering, 1986).
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CHAPTER 12

Is Migration Good For You? A Psychiatric and Historical Perspective

James Finlayson and Marjory Harper

Does migration make one more or less prone to mental illness? Preceding chapters have addressed that question from different disciplinary perspectives, time periods and locations. It remains highly pertinent: in 2013, according to the United Nations Population Fund, 3.2 per cent of the world's population (232 million individuals) lived outside their country of origin.[1] A Gallup poll two years earlier, based on research in more than 150 countries from 2005 to 2010, found that approximately nine per cent of the world's adults wished to move to another country permanently.[2]

Psychiatric Studies

The dislocating effect of migration on mental health has not been ignored by psychiatrists. It has long been recognized that change in general can trigger depression,[3] but the classic study linking psychiatric illness with migration was published by Ørnulv Ødegaard in 1932.[4] In comparing the level of mental illness among Norwegians who had emigrated to Minnesota with those who remained at home, Ødegaard found a doubling of the incidence of schizophrenia among Norwegians in America compared with those in Norway. Schizophrenia is, of course, the term used by psychiatry to designate perhaps the most severe psychiatric disorder, one characterized by false beliefs (delusions), hallucinations (false experiences), and other significant psychological and behavioural abnormalities.

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Subsequent studies, including recent publications, have made similar findings about increased levels of schizophrenia in first- and second-generation migrants. A meta-analysis in 2005 found first-generation migrants were 2.7 times more likely to develop schizophrenia than the host community, while the relative risk for the children of migrants was 4.5 per cent.[5] Within the UK, the Medical Research Council's AESOP[6] study—a careful major multicentre study looking at the incidence of major psychiatric disorder in different groups—found that people of Afro-Caribbean origin have a much heightened risk of psychoses compared with white groups. It found that Afro-Caribbeans were 9.1 times more likely, and black Africans were 5.8 times more likely than white British groups to suffer from schizophrenia.[7] The incidence of schizophrenia in Afro-Caribbeans living in the Caribbean, however, is much lower than among those living in the UK—not dissimilar to that among white groups in the UK.[8] The reason for the increased rate of schizophrenia is uncertain. It may be attributable to individual or institutional racist attitudes and practices, which may contribute to socioeconomic deprivation, and a distrust of public agencies, which can result in inadequate healthcare.[9] While other migrant groups have also manifested higher rates of psychiatric disorder than white British groups, the differences have been less marked than among the Afro-Caribbean population.[10]

What about other types of psychiatric disorder? Not surprisingly, refugees and asylum seekers, who have often experienced horrific events, are known to have an increased risk of Post Traumatic Stress Disorder.[11] There is, however, no clear consensus as to whether migration is associated with an increase in anxiety, mood disorders and depression. One meta-analysis has found that there is no conclusive evidence for a significantly heightened risk of mood disorders among migrants,[12] and while most studies have shown an increase in the incidence of depression among migrant groups,[13] the relative risks are much smaller than with schizophrenia. Analysis is complicated by the fact that there are dramatic local, national and global differences in the incidence of depression. In the 1990s women who lived in rural areas of the Basque country had less than a four per cent incidence of depression.[14] At the other extreme women in Pakistan have been found to have a greater than 60 per cent incidence of depression.[15] In the 1970s classic studies that were undertaken in London and the Western Isles of Scotland found the incidence of depression among women in the Hebridean island of North Uist and the London borough of Camberwell to be respectively, 4.5 per cent and 13 per cent.[16] One could imagine that

in the hypothetical case of 100 'average' women from Camberwell emigrating to North Uist and 100 to rural Pakistan, even if there was no change in their incidence of depression, then the rates of depression would appear to be misleadingly high in the Hebridean context and misleadingly low in Pakistan. A researcher might erroneously conclude that migration had generated, respectively, a harmful or a beneficial effect on the woman's mental health.

A recent study involving Tonga and New Zealand offers a more objective evaluation of a randomized sample of migrants and non-migrants.[17] The Kingdom of Tonga—an archipelago of Pacific islands—has experienced high rates of out migration, not least to New Zealand, initially for employment, but by the 1990s primarily for purposes of family reunification. Under the Pacific Access Category Program, introduced in 2002, New Zealand grants permanent entry to 250 Tongans a year, over and above those who qualify under the points system. These individuals are chosen by a random ballot, successful applicants being given six months to obtain a fulltime job offer in New Zealand that meets an income threshold equivalent to the minimum wage.[18] The survey measured, among other things, the mental health of participants who migrated between 2002 and 2005, using the Mental Health Inventory, a simple five-question questionnaire, requiring responses on a five-point scale. The results were then compared with those who remained in Tonga because they had not been selected in the ballot.[19] The results of the survey, according to the investigators, 'call into question the view that migration means misery'.[20] They identified significant objective improvements in the income and spending of those who had left Tonga, while subjective outcomes included an improvement in the migrants' mental health but a decrease in their happiness, compared with non-migrant applicants.

The complexities of evaluating changes in wellbeing among migrants should caution us against making a direct link between migration and mental illness or health. Generally, studies that have compared the mental health of migrants to that of the community from which they emigrated have not found that the emigrants have had a greater level of mental health problems.[21] The Tongan study related much more to anxiety and depression than to the less common, but much more severe, psychotic disorders where the evidence is stronger that migration may have a harmful effect. The Tongan research was conducted soon after the migration had taken place, and some studies (including those on psychotic disorders among Afro-Caribbeans) have suggested that it takes time for the adverse effects

of migration to manifest themselves.[22] It is almost impossible to take into account all the variables between migrants and non-migrants, and to compare their mental health consistently within constantly changing frames of reference. Even Ørnulv Ødegaard's monograph, which recognized confounding factors, such as differences in the age structures of the migratory and non-migratory populations (factors which have often been ignored by those who have quoted his findings), was based on individuals who were admitted to hospital, and fails to allow for different thresholds of hospital admission in the donor and host countries. Non-migrants should, arguably, have more social support in their own country, and should therefore be more likely to be able to remain in their own communities when mentally distressed than those who had left, particularly recent migrants. Ødegaard mentions this possibility but—questionably—dismisses it. He also found that people admitted to hospitals in America had been ill for longer, but did not address directly if they were more unwell.[23]

Ødegaard's open acknowledgement of the weaknesses of psychiatric diagnoses is still relevant today. Although we talk of psychiatric 'illnesses', we should, in the absence of a known causative pathology, refer instead to psychiatric 'disorders'. Diagnoses are essentially a language of agreed communication among professionals, and identification of the underlying pathological processes has been slow.[24] Codification of psychiatric disorders was implemented in response to the chaotic laxity of earlier diagnoses, in the hope that their consistent use would facilitate the discovery of the brain abnormalities thought to cause these conditions. But classification systems are under increasing attack and, as John Swinton reminded us earlier in Chap. 2, the latest edition of the most influential psychiatric classification system—*The Diagnostic and Statistical Manual of the American Psychiatric Association*—has not only failed to gain wide acceptance but has been greeted with some derision.[25] Of course, this is not to deny the validity of psychiatric distress or that psychiatrists have discovered (usually serendipitously) treatments that can be remarkably effective in reducing such distress. In trying to understand whether migration is harmful, the use of specific psychiatric diagnostic labels may be unhelpful.

How do these observations relate to the experiences of one of the authors as a general practitioner and psychiatrist in the Scottish Highlands and Islands for more than 30 years? James Finlayson's background is one of continuity rather than change; he lives on the croft that has been in his family since his five-times great grandfather returned from the Napoleonic Wars, and he has spent virtually his entire career working in very remote

and rural areas. The economy, society and culture of those areas have, however, been shaped—practically and psychologically—by centuries of outward movement, and migration in both directions continues to have profound effects on his patients: indeed, it is probably the main issue that he has encountered in his professional life.

Migrations to and from the Highlands: Historical and Personal Experiences

Since the mid-eighteenth century migration from the Highlands and Islands—particularly overseas migration—has generated more debate and denunciation than any other dimension of Scottish population movement. Pejorative images of enforced clearance and involuntary exile have dominated popular perceptions and some scholarly writings, generating a persistently negative and sometimes misleading one-dimensional image of a diaspora whose members were actually marked by variety rather than uniformity of background, motives and experiences.[26] Harnessed to the history and historiography of outward migration has been a complex—and often blurred—blend of bitterness at enforced expulsion and collective guilt at the abandonment of ancestral land, with its associated betrayal of the concept of *duthchas* that was so central to the traditional culture of clanship.[27] Yet getting out was also seen as getting on, whether the destination was Glasgow, London or Vancouver. What did that mean for those who stayed behind? Was continuity of residence perceived—by both themselves and others—as failure and lack of ambition rather than stability? Equally, what was the fate of migrants who did not fulfil parental or community expectations of educational, occupational or economic improvement?

These are not academic issues relating to a bygone age. The Scottish Highlands and Islands are not frozen in the static Romantic Victorian time warp favoured—ironically—by some tourist literature. It is ironic because it is that very tourist industry that has been one of the major engines of cultural change. Out migration remains an ongoing phenomenon, not least from the Western Isles. When James Finlayson went to the Outer Hebridean island of Harris as a GP in 1981 the practice population was over 1,800, but now it is around 1,200, and the persistent haemorrhage from many parts of the Highlands can have a demoralizing effect, which both undermines the huge investment that has been made in regional revitalization and challenges the fashionable discourse that this process has been successful.[28] It is a vicious circle of the relentless departure

of school leavers with aspirations to enter the professions, few of whom return to meet the need for those professions in their home areas. The practical outcome is that it is difficult to staff hospitals with enough highly qualified permanent staff, to provide schools with enough teachers to deliver a wide range of subjects, and to find people to work as social carers, looking after an elderly population. Local pride means that these are sensitive issues but, in the privacy of the consulting room, many patients have told Finlayson that their own migration was triggered partly by frustration at the inadequacy of the local infrastructure, particularly in terms of health and education.

More specifically, how has out migration impinged upon the mental health of Highland communities? In the early to mid twentieth century a sense of loss or frustration was often engendered as a result of the cultural expectation that one son and one daughter would remain in the family home to look after elderly parents while the other siblings left for higher education, and/or to find jobs in the city or overseas. Those who left were expected to support the family financially, in a variation of a long-standing tradition that had, since at least the early eighteenth century, seen Highlanders migrate seasonally to the Lowlands to supplement the family income.[29] Later, the responsibility for providing personal care devolved primarily on a daughter, who might have to give up work elsewhere and return to look after her parents.[30] The selection process could depend on birth order, the availability of funding for higher education, or inclination. Sometimes the one who stayed had a medical or psychiatric problem—or perhaps nascent substance misuse—that militated against migration, often in a vicious cycle.

> It is really difficult. My father is really losing the place. He always drunk [sic] a lot but it is worse now. He often dirties himself and there is only me to deal with it. I can't ask my son to help and he has his own problems. I suppose I do drink a bit too much myself but since my husband died it is so lonely. In the summer it isn't too bad. There are people in the holiday homes. My brother comes back for a while but he gets annoyed with us drinking together.[31]

Of course, these dilemmas are not unique to Highlanders, but the entrenched tradition of economically driven migration from a remote region perhaps meant that perceptions of a contrast between winners who left and losers who stayed remained visible well into the twentieth century, as it did in much of Ireland. An individual's sacrifice for the sake of the

wider family was certainly a familiar experience among many of Finlayson's patients, some of whom relinquished not only lucrative employment but also marriage opportunities because of parental injunctions. The frustration of lost opportunities and restricted lives among those who had stayed behind in an apparently decaying environment was exacerbated by the critical, superior or uncomprehending attitude of migrants when they came back to visit. 'Why don't you grow wheat on these empty moors like we do in Alberta?' was a question posed by Finlayson's own emigrant relatives, and echoes the Irish resentment of 'returned Yanks' who paraded their smart apparel, their cash, their self confidence and their modernizing ideas.[32] Disgruntlement might be further compounded when—with the passage of time—the spinsters and bachelors who had stayed behind to care for aged parents were left without the benefit of such family care from a younger generation in their own old age. Yet James Finlayson has often been surprised at the degree of emotional resilience shown by such individuals, despite the profoundly dispiriting experience of spending one's last years in solitude, in a dying community whose holiday homes had once housed many families of permanent residents. Their resilience may be attributable to the strength of past or present social networks, akin to the way in which involvement in traditional structures—the life of crofting or religious belief, for example—has been found to protect against depression.[33]

Unsettlement is not confined to those who never left their native communities. Finlayson has encountered migrants who harbour a sense of guilt because of their absence, whose attempts to compensate and play their part in the care of parents can cause tensions within families and in their dealings with health and welfare authorities.

> You must do something. Granny is getting so frail, she had another fall last week. My brother is just not reliable, goodness knows what he makes for food. There was just a pile of fast food wrappers in the bin when we came. We can't stay after tomorrow. We have our commitments. The council don't do anything. Something must be done.

He has encountered others who returned to settle in their home area because of problems: poor physical or mental health, substance misuse, redundancy, or an inability to cope with the pace of life and work in the city. Their experiences of dislocation in an environment they perceived as familiar, perhaps coupled with an inability to live on their savings, are similar to those of some of the Irish returners described by Arnold Schrier.

> There is the warmth and welcome from all. But there is something the heart seeks but does not get, because nothing can bring back old acquaintances either of scene or personal reminiscences. A change over the face of nature. So that the returned emigrant is as hazy as those who receive him. He is wedged in betwixt the old and the young. The old have altered beyond recognition. The young he has never seen. And it takes some time before he gets his bearings.[34]

Retirement-based return migration can be equally unsettling. Younger retirees from occupations that have traditionally attracted large numbers of Highlanders—the military services, the police force and the merchant marine—tend (perhaps not surprisingly) to slot back into their native communities more easily than those who retire and return later in life from professional positions in southern cities, their longer absence usually resulting in a greater disjunction between memory and reality as they try to resettle in a place that has sometimes changed beyond recognition.

Demographic change in the Highlands is not confined to the outward and return migration of the native born. There is also a long tradition of inward movement, comprising in particular military personnel, construction workers, travelling salesmen, and those in the catering and hospitality industries. Since the seventeenth century there have been military bases in the Highlands, initially to subdue rebellious Jacobites, subsequently to act as a focal point for the Highland regiments so iconic in the heyday of the British Empire, and in the mid twentieth century as an integral part of Britain's Cold War defence strategy. The presence of an army base in a remote location like Benbecula (where it began as a wartime airfield) has had a huge effect on the local community, not only because of the decision of ex-service personnel to stay (or return) permanently, but also because of the vulnerability of the local economy and social structures when policies made in distant places threaten or bring about closure or curtailment.[35]

Temporary migrants from Ireland, and later German Prisoners of War, Poles, Displaced Persons and Canadian Forestry Corps veterans, as well as men from other parts of Scotland, supplied many of the navvies for the Highlands' hydro electric construction schemes in the early and mid twentieth century.[36] The rootless environment of some of these construction sites brought social problems, not least of alcohol abuse and other issues associated with a sudden surge in population. In 1946, for instance, there were only four offences recorded in the Inverness-shire village of Cannich, at the centre of the Glen Affric construction scheme. In 1948, however, by which time the population of Cannich had risen to 2,000, 190 offences

were recorded, and the Inverness County Police Committee billed the North of Scotland Hydro Electric Board for the extra constables it deemed necessary to send to Glen Affric to deal with the huge, floating population.[37]

From further afield other familiar figures in the Highlands and Islands in the mid twentieth century were the Indian travelling salesman, some of whom settled with their families, operating within a context of multiple cultural identities—a few even learning Gaelic—who established successful retail businesses until challenged by larger competitors. Their children can be stuck in a void between three cultures.

> I don't know, my parents really want the best for me and [I] got a good husband from their village back home, he does love me, but he doesn't speak much English. I've even got Gaelic! He doesn't understand me wanting to go out with my friends—'what's wrong with me?' he will say and get angry and this upsets me and makes him upset as well.

More recent arrivals from the Indian subcontinent, who work mainly in ethnic restaurants, tend to be unmarried men, whose long hours and cramped living conditions—let alone the vulnerability to deportation for those who have been brought in illegally—predisposes them to loneliness, insecurity and mental distress.

> I was not a chef. I studied in College but there was no work. My cousin had come to [the] UK so I got money from my family and came too. I was in England but came here when I met someone who offered work here. It is very lonely. I know no one. The work is very long. We stay in a flat, all six who serve in the restaurant. There is little money and I am tired.

Some have even been victims of enslavement.[38] By contrast, Italian and Chinese migrants have tended to establish family-run catering businesses, the former dating back to the nineteenth century and the latter to the 1960s. Few towns and villages, even the remotest in the Highlands, do not have a well-established and apparently integrated Italian or Chinese catering business, and strong family structures appear to have clear benefits in terms of mental health.

Building on all these traditions of inward migration, recent decades have seen a significant inward movement of different categories of non-Highlanders from the rest of the UK and beyond, creating new challenges for both the incomers and their host communities. Some—particularly retirees—come

for nostalgic reasons associated with remembrances of past vacations. James Finlayson has frequently had to arrange support for people who had failed to plan for the difficulties associated with the frailties of old age in a remote area where they have no family ties.

> It was wonderful, so beautiful, we were very happy, it was what it was like in the country when we were young. Everyone was so friendly and helped us settle in but I have a bad leg since my stroke and can't look after the garden. It used to be very productive. My wife is getting very forgetful with Alzheimers. One of us needs to drive to get to the village and I don't know how long I can do this. Our family are abroad. I just don't know what we will do.

Such people are often less resilient than the native-born Highlanders who, as they age, engage in planned short-distance migration, from isolated locations to villages, and then from villages to towns, or to the region's one city (Inverness). This pattern of 'micro urbanization' acknowledges the need for access to services, but, more importantly, the emotional and practical benefits of living in communities rather than in isolation.

> Doctor, you wonder why I left the croft, it had happy memories, but they were memories—it was so lonely in the dark nights, it is just so good to see the street lights and know there are people around me.

In the course of over 30 years practising medicine in the Highlands and Islands, Finlayson has come to the firm conclusion that people cannot thrive on their own, they need to be part of a community. Yet it is well known that remote and rural areas commonly attract those who have rejected conventional lifestyles to pursue peace and seclusion, sometimes in communities but often in complete isolation. Immigrants to the Highlands are often seeking the solitude that locals struggle to deal with. Some are attracted to an ill-defined Celtic spiritualism in a region that has long been a repository of urban projected myths. From an unhistorical Celtic Christianity[39] to an Ossianic Celtic Twilight[40] to the inventions of Lilian Beckwith,[41] the Highlands have fulfilled the sophisticated urbanites' quest for an idyll that would have gladdened the heart of Jean Jacques Rousseau.

> There is something here, you can't see it, but you can feel it. I could not experience it in the south but here it is closer. The night is dark but I stand

> out and see and almost hear the stars. I am not religious like the people here but profoundly spiritual about nature. It is wonderful having this to myself.

Sometimes the search for a particular spiritual dimension can be related to significant psychological distress. There are also those who move to the Highlands with the almost pantheistic expectation that the natural beauty of the environment will assuage the problems in their lives. In Finlayson's experience they are almost invariably disappointed. 'I hoped the mountains and lochs would cure me but it has not worked', lamented one of his patients. 'I feel just how I always felt but I am trapped, having spent my money on the move.'

Some of these disappointed individuals become rolling stones, serial migrants who move from place to place in an attempt to find solace, perhaps in even more remote locations. Other patients whom he encountered as a GP were driven to the physical edge of the land by the delusions and hallucinations of a psychotic state in an attempt to escape the terror of their psychosis.

> They listen to everything you say and then they have their say. They laugh at everything I do. They know everything. I realized it must be the FBI, they have got the CIA involved. I lived in America once, you know. It was terrible, they told everyone about me. I decided to come where there are less people but it isn't any better—it is worse. Yesterday was the worst ever I realized, I know this sounds crazy but it is true, they can do it, they can control things, they knew I am here, they were telling me they knew where I am. They got the sheep to come right beside the house, all of them, it meant they could control everything and there is nowhere to go.[42]

Many of these stories are both tragic and challenging. Finlayson has encountered individuals who, despite being ill for years, had never come to the attention of mental health services in the city. Only when they moved to a small community did their problems become apparent, posing a significant burden for small under-resourced rural psychiatric services.

Some people have come to the Highlands because of long-lasting difficulties in interpersonal relationships. Individuals with personality disorders, unable to relate to others, have gone to live as hermits in remote bothies or caves, visiting the local village intermittently for supplies.

> I just don't like people and they don't like me and we cause trouble for each other. I don't mind saying I have been violent in the past. I decided to get away from everyone and everything. The bothy is great, miles from the

> road. No one knows of it and I come down only to get cash and to get food to keep me going.

In an unpublished audit of people attending Finlayson's psychiatric clinic in one part of the Highlands over a six-month period, out of 40 patients with a psychiatric disorder, 18 had the diagnosis of personality disorder. All had been migrants to the Highlands.

In other cases migrants have come to the Highlands because of difficulties with the authorities elsewhere, for instance because of accusations of child neglect, and are seeking to escape from the surveillance of the state. Pre-existing psychiatric disorders may well be aggravated, rather than alleviated, by the new environment, perhaps exacerbated further by frequent changes of residence.

> We left quickly, but had nowhere to stay so were glad to get a leaky caravan in a field in Perthshire. Someone told the social work and they began to ask questions so we moved to near Inverness. There were too many people about so we moved to this place we found on the web but we were reported again and they say they will take the kids off us if they don't go to school.

It is, of course, much more common for migration to the Highlands to be a result of individuals and couples seeking a better environment for themselves or their children. At the upper end of the income scale are those who, in an economically active period of their lives, decide to invest in alternative lifestyles and occupations: tourism, crafts, or horticultural pursuits are particular favourites. But while the capital realized from the sale of property in southern cities may allow them to purchase substantial properties, they often encounter serious difficulties, both in making money and in integrating into their new communities. The tourist industry in particular—while it is the cornerstone of the region's economy—is one of the most difficult and stressful ventures in which to engage,[43] belying the idyllic images portrayed in a library of 'back to the land' books. Financial difficulties can be accompanied by the psychological pressures of dealing with the indigenous population's prejudice against incomers, who are criticized for inflating property prices, speaking out on local issues and imposing their will on local communities. Sometimes referred to, pejoratively, as 'white settlers', they are resented in a way that was not previously the case with Indian, Italian and Chinese immigrants, or is currently evident in attitudes to Eastern Europeans.[44]

But if wealth can generate jealousy and even ostracism, poverty can create a different kind of vulnerability. Finlayson has had to deal with the traumatic experiences of incoming families with fewer resources, sometimes from troubled inner city areas, whose restricted choice has led to the unwise purchase—perhaps from a magazine or the internet, and frequently sight unseen—of a house which has turned out to be little more than a shack in a bleak, inhospitable location with incessant rain and no employment opportunities.

> It looked so good but we had not thought of the wind, it did not stop. The rain came right into the house and we could not afford a builder. We had to put plastic over the ceiling and then move into a caravan. The kids had colds all the time from the wet from the gas heating. I could not get a job, it was so depressing.

Of course, other migrants from the south are successful. Finlayson would not see them at a psychiatric clinic, but many have told him of their joy in settling down in a pleasant environment, comparatively free from crime, with good academic potential for their children. From his experience the crucial factors seem to be securing employment and linking into a supportive social circle.

> It is good here. People have time to talk to you, and it's good for the kids. In the city you could not let them out of your sight, here it feels safe. We have got much more room in the house here than we had in a flat before. I like driving around for my work, in the south you are stuck in traffic all the time—it is so crowded.

For many decades the traditional industries of the Highlands—fishing, crofting and small-scale manufacturing—have been in decline, replaced by tourism as the region's economic mainstay. The tourist hotels formerly drew labour from the comparatively well-populated parts of the Highlands and subsequently from Lowland Scotland. Since 2004, however, the hotel trade has recruited increasing numbers of economic migrants from the Eastern states of the EU, not least in the tourist area of the central Highlands where Finlayson was providing psychiatric services.[45] He suddenly (and it was a remarkably sudden transformation) realized that he was no longer seeing the regular stream of young Scottish hotel workers who presented with the typical problems of our society. The Eastern Europeans who had replaced them—often skilled graduates doing poorly paid manual work—did not seem to trouble the psychiatric services very

much at all, although several studies now suggest that these immigrants were likely to have suffered psychiatric distress but were unwilling to seek specialist help.[46]

The most obvious and extensive migration of recent generations, however, has been the influx to several parts of the Highlands of workers attracted by public and private investment in a range of ventures. 'For 200 years the Highlander has been the man on Scotland's conscience', declared William Ross, Secretary of State for Scotland, when in 1965 he introduced into the Westminster Parliament a new Bill for promoting Highland development through government intervention.[47] In attempting to compensate for past centuries of expulsion, extraction and economic exploitation, the resulting Highlands and Islands Development Board subsidized major enterprises, such as the pulp and paper mill at Corpach and the aluminium smelter at Invergordon, as well as smaller projects connected with tourism, fishing, Harris tweed and Caithness glass.[48] Industrial employment opportunities for incomers were not entirely new in the 1960s: work on the nuclear breeder reactor at Dounreay, which began in 1955, had bought many newcomers to Caithness, and within a decade the county's population doubled.

Ironically, however, the history of both the pulp and paper mill and the smelter is a rerun of the familiar story of the boom and bust life cycle of industries which exploited the Highlands without offering long-term regeneration to the region. The pulp mill opened in 1965 and closed in 1980 with the loss of 400 jobs. The smelter opened in 1972 and closed in the early 1980s with the loss of 900 jobs. Their boom and bust days overlapped with the ups and downs of the North Sea oil industry's impact on the Highlands. Perhaps most notably, the 50 inhabitants of the hamlet of Kishorn in Wester Ross underwent a complete change in their way of life when work began in 1974 on building a fabrication yard for the Anglo-French consortium Howard Doris in that remote location. Over 4,000 people went to Kishorn to build the Ninian Central platform, which was completed in 1978. At the height of activity the workers' camp housed 2,000 men, supplemented by two accommodation ships moored in the loch. Caravans littered the landscape, every available bed was taken up, men slept in cars and tents in midwinter to cash in on the high wages, and entertainers were paid £2,000 a night appearance money. It was a scene reminiscent of nineteenth-century American or Antipodean gold rushes but, as on those frontiers, the good times did not last. Kishorn's capability was for building concrete platforms, and when the preference changed to

steel jackets, as it had by the end of the 1970s, the fabrication yard was doomed, the last order was floated out in 1987 and the yard closed in 1988 after Howard Doris went out of business.

The rise and fall of such industries obviously had major social consequences and implications for the mental health of migrants and the indigenous population alike. In Chap. 10 Arnar Árnason contended that uncertainties about Iceland's economic and cultural identity in the wake of the 2008 economic crisis triggered both a migration from rural hinterlands to urban centres, and an increased incidence of depression and anxiety. The Scottish Highlands and Islands, it might be argued, have gone through similar experiences, although the timing was different and the initial flight was from the country's post-industrial urban heartland to the rural hinterland, or at least to micro urban clusters. We might speculate whether it is possible to make a case for a similar increase in levels of depression and anxiety among those migrants, either in the heyday of the Highland industries or after their decline.

Each individual industrial—or post-industrial—complex in the Highlands has developed its own particular psychology, the degree of integration with the local community depending partly on the relative size of the new industry and the percentage of local people who were employed in it. Lasting social and health-related problems have been created in towns like Alness and Fort William as a result of families coming, as it was termed colloquially, 'up the road' from the post-industrial wilderness of central Scotland, only to find their hopes of a rekindled economic opportunity were short lived. While some returned 'down the road' when the plants closed, others stayed, perhaps (in the case of Alness) to work in the oil industry, but often to slide into long-term unemployment in communities that were socially and demographically unstable. Social housing schemes—in these locations and across the region as a whole—have been a mixed blessing, and patients have often lamented to Finlayson that they have been 'typecast' and 'prejudged' because they lived in a street which had gained a bad reputation.

> I don't say I live in -------. If I am looking for work, I just say ----- you have got more chance till they see if you are OK. I think people look at you differently if they think you live where I do. There is some trouble and my neighbour is a druggie but it is not as bad as people think.

Perhaps even more susceptible to stigmatization and marginalization than redundant industrial workers, however, are the travelling people of the Highlands. Their itinerant lifestyles and summer migrations have been disrupted by the loss of their traditional employments, they have often found it difficult to settle in permanent dwellings and they have a significantly reduced life expectancy.[49] Many lament the end of their travelling days and attribute their social, psychiatric and substance misuse problems to this disruption of their traditional way of life.

> It was better on the move, there was things we did, people would welcome us, we did things for them, now there is nothing to do. There is a lot more drink and the young ones get into drugs, they don't listen, they don't want to know.

To conclude, is migration beneficial or detrimental to mental health? Neither the scholarly literature nor James Finlayson's own experience enable him to answer the, perhaps simplistic, question of whether migration, *per se*, causes psychiatric disturbance. He would contend that the diversity and complexity of actual patient narratives discussed in anonymized form in this chapter militate against an objective evaluation: the lifestyle of a teleworking professional is very different from a Filipino deckhand living in the forecastle of a Hebridean fishing boat, and much depends on the vicissitudes of the individual's life journey.

Nor can we make a case for the exceptionalism of the Highlands and Islands. Many of the psychiatric conditions Finlayson has encountered are prevalent elsewhere, and it is not possible to identify a unique pattern of psychiatric disorders that is a consequence of the interaction of peripheral location, economic vulnerability and migration. While there does seem to be an association between major psychotic problems (schizophrenia) and migration, the nature of the link remains obscure, and when we do not know the aetiology of schizophrenia it is difficult to understand why the process of migration might lead to an increased incidence of that condition, particularly for second-generation migrants. Schizophrenia is rare, while depression and anxiety are very much less common, and there is much weaker evidence for making a correlation between migration and the latter, non-psychotic conditions. Perhaps the main lesson of these reflections is that we need to be extremely cautious in drawing definitive, medicalized conclusions from untested generalizations or applying diagnostic classification labels to the diverse cultures and contexts that have populated this book.

Notes

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