A dysfunctional diaspora? Causes of mental illness among Scottish emigrants to Canada, 1867-1914

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ABSTRACT

Recent years have seen substantial developments in the study of migration. While scholarship emanating from donor countries often portrays migrants as adventurers or exiles, historiography in host lands focuses on successful adaptation, integration or assimilation. Yet difficulties in adjustment were commonplace. Migrants who were admitted to mental hospitals were at the extreme end of the spectrum of social dysfunction, but their experiences constitute a largely neglected area of diaspora studies.

This analysis of the relationship between migration and mental illness among Scottish emigrants to Canada 1872-1913 is rooted in the admission registers and case files of the British Columbia Provincial Asylum for the Insane, supplemented by the papers of government immigration departments whose gate-keeping and fire-fighting strategies both reflected and shaped the policies and practices of asylum doctors and directors.

At the heart of the study is an exploration of factors that triggered mental illness, including transition, an alien environment, disappointed expectations, homesickness, and the absence of support networks. Pragmatic responses, which are addressed briefly, included voluntary repatriation and forced deportation.

KEYWORDS
Scotland, Canada, emigration, mental illness

Introduction

Human mobility is woven firmly into the tapestry of Scotland's history. Approximately two million Scots emigrated in the 1800s, and a further two million in the twentieth century. Studies of that phenomenon tend to portray overseas migration as either adventure or exile, while historiography in the host countries generally focuses on successful adaptation, integration or assimilation. The reality is –not surprisingly– much more complex and nuanced. Inevitably, some of the threads in the tapestry were sombre, none more so than those which depicted the plight of migrants who were committed to psychiatric hospitals after becoming mentally ill. This dimension of diaspora studies has recently been addressed, particularly by scholars in the Antipodes, but the relationship between migration, mental illness, detention and deportation remains largely neglected in a transatlantic context. Yet North America was the destination of the vast majority of nineteenth- and early twentieth-century British migrants, including Scots, and Canada deported far more immigrants than any other British dominion, primarily on grounds of mental or physical incapacity or deformity.

Methods

The perceived causes of mental illness among Scottish –and other– migrants to Canada can be deduced by scrutinizing the admission registers and case notes of a variety of provincial asylums. This study is based primarily on an analysis of patient case files for individuals admitted to mental health services in British Columbia between 1872 and 1913, after which date privacy legislation prevents access to the archives. For most of the period under review (from 1878) patients were housed at the Provincial Asylum for the Insane in New Westminster, which was renamed in 1897 as the Provincial Hospital for the Insane.

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For comparative purposes, evidence is also incorporated from similar documentation in other Canadian provinces, from New Zealand, and from Scottish institutions. Provincial government reports and investigative commissions, federal legislation and medical journals have been consulted for insights into official responses, including voluntary repatriation and deportation, as well as custodial care. But nominal deportation records, which would have allowed individuals to be traced from initial detention to ultimate enforced departure, only survive from the 1940s, the lost documents being casualties of a past pruning policy by the federal archives.

Despite problems with retention and access, these sources open up a range of significant themes, including contemporary debates about care, custody and treatment, as well as practices of gate-keeping and removal. The central objective of this investigation, however, was to use the records to explore contemporary perceptions of the triggers for insanity among migrants, and, to a lesser extent, the consequences of such a diagnosis.

Results

British Columbia joined the Dominion of Canada in 1871, and a year later the new province opened its first asylum for the insane, in Victoria. Canada's most westerly province was dominated by immigrants, a demographic profile which was inevitably reflected in the large number of overseas-born patients admitted to the Provincial Hospital.

The challenges of transition to the new world were occasionally blamed for a patient's illness. Mrs C. from Edinburgh, who was admitted to the BC Provincial Asylum in 1890 and discharged to the care of her husband four years later, fell ill, according to her case notes, because of "indisposition and the long trip from Scotland to BC".[1] She had taken opium and attempted suicide. If the transatlantic voyage was a risk factor, then it might be expected that the much longer passage to the Antipodes would generate a higher casualty rate. Although that argument is weakened by evidence that conditions on the government-sponsored antipodean route were better than in the less regulated transatlantic business, recent scholarship on New Zealand's asylum records has identified a bad voyage experience as a factor in eight per cent of a sample of foreign-born patients admitted to Dunedin's public asylum within a year of arriving in the country. Some of the published government reports for New Zealand also mention symptoms of insanity among migrants manifesting themselves after a few weeks at sea.[2]

A newly-arrived immigrant might be unsettled by an unexpectedly challenging environment, and separation from everything that was familiar. Land agents' rhetoric portrayed British Columbia as a haven for genteel British settlers, but many immigrants had to struggle with the harsh reality of a raw frontier society. Further east, the featureless prairie environment seems to have been particularly alienating, while on the other side of the world, loneliness and isolation on New Zealand's Canterbury Plains also seem to have triggered the illness of at least one Scottish shepherd who was admitted to the Sunnyside Asylum in Christchurch in 1851 with a malady that was attributed to "secluded life on a station".[3]

Catalysts did not operate in isolation. Environmental alienation was often entwined with disappointed expectations, which might manifest themselves as an unproductive farm or urban unemployment. Disappointment was particularly acute among the gold miners who flocked to British Columbia in the nineteenth century: to the Cariboo in the 1860s and to the Klondike more than three decades later. A handful of prospectors who were committed to the BC Asylum were Scots. D., for example, a bachelor from the Isle of Lewis, was living in the Cariboo when he was admitted in 1892 with delusions. According to the medical certificate, "he thinks himself poisoned, robbed and disturbed in his work … hears voices around his cabin".[4] Another Scottish miner claimed to have made over $40 000 from gold mines in the Cariboo, to have shares in every mine in the district, and to have built up a ranch of over 600 head of cattle from one cow in two years.[5] Meanwhile, back in Scotland, the records of Inverness District Asylum include details about 33-year-old M., who was admitted in 1866 with a diagnosis of "melancholia" of two years' duration. A former gold miner in Ballarat, Australia, his case notes refer to his delusion of possessing "a whole gold field in Australia" as well as the information that his brother was an inmate of an asylum at Musselburgh, near Edinburgh. Two years later M. was discharged to the care of friends, not because of any change in his condition, but "for want of accommodation here".[6]

An alien environment, or disappointed expectations, could trigger or exacerbate homesickness, which, in

extreme cases, could lead to mental breakdown. Although it was not explicitly identified as a cause of illness in any of the BC Provincial Hospital register entries, it can sometimes be deduced from family correspondence that survives in patients' files. For example, C. from Leith died in 1902, sixteen years after admission. Some time before his death an undated letter from C's sister to the medical director contained the poignant statement and request: "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, where we could at least see him? I would come out and see him, if I could."[7]

Temperament and lifestyle, like homesickness, are not identified as catalysts in the official record, but their significance emerges implicitly from the British Columbian case histories in the descriptions of individuals who were clearly rolling stones or chronic migrants. The extraordinary and sustained itinerancy of many individuals prior to admission is particularly evident in the case of Glasgow-born H., aged 25, who was sent to the Provincial Hospital from the local jail in Victoria in 1910 after being arrested for vagrancy and drunkenness. He had crossed the Atlantic at the age of nineteen,

> landing at Philadelphia, but only remained there for about 4 months, then he returned to Scotland. After spending only a month in Scotland he returned to Philadelphia. Went to Mexico for a few weeks then to Mobile for 4 months, then to New Orleans and from there to Los Angeles…Remained about 6 months in California then shipped on a boat for Africa and was away on this trip for a year. Returned to 'Frisco and from there worked his way up the coast to Seattle from where he went to Alaska in 1907. Was in Dawson for 15 months then came down to Victoria and went into the Jubilee Hospital where he remained for 3 months suffering with ulcer of the stomach.[8]

Frequent concomitants of constant movement were solitude and the absence or breakdown of family and community support networks. Mention has already been made of the loneliness that was associated with an unfamiliar living and working environment. Such physical isolation, along with the absence of support mechanisms that characterised frontier societies, could not only trigger mental breakdown, but also exacerbate its consequences. It might also involve a gendered dimension, since married women who suffered desertion, family breakdown, domestic violence, post-natal depression or bereavement were particularly vulnerable to dysfunctional or absent support networks. Many of them were left alone at home for long periods, as their husbands engaged in multiple occupations: logging, mining, or cannery work. Men tended to be admitted to the asylum for violent or dangerous behaviour, or because they had broken down on their job. Women were more likely to be admitted for depression, for threatening harm to themselves or others, or because they were unable to perform their domestic duties.[9] There is, however, a disturbing undertone in some of the BC Asylum records that hints at domestic abuse, as in the admission in 1910 of J. from Nairn. Her admission record stated that the cause was "abuse of [*sic*] drunken husband and hard times", compounded by childbirth, but within a month she had been discharged to the care of her allegedly abusive husband.[10]

Catalysts such as an unsettling transition, a threatening or disappointing environment, homesickness, or the absence of support mechanisms, were implied rather than explicitly identified in the medical records. But the admission registers articulate very clearly the factors to which the asylum doctors attributed the illnesses of those under their care. Reflecting contemporary medical theories and political rhetoric, heredity was frequently cited, not only in British Columbia, but by medical practitioners across Canada, the other Dominions, and the United States, the clear implication being that Britain was exporting the insane. When patients were admitted to the BC Asylum their family histories were recorded in as much detail as possible, with documentation of any previous hospital committals of the patients themselves, or of family members.

The practice was just as common on the other side of the world, exemplified by the case of Annie, a native of Caithness, who was admitted to the Seacliff Asylum in Dunedin in 1901. Aged 53, she had been in New Zealand for ten years, preceded by two years in Tasmania. Her sister, according to the medical notes, was an inmate of Sunnyside Asylum at Montrose in Scotland, while her brother, who had been born an imbecile, was boarded out.[11] Meanwhile, back in Scotland, among the many psychiatric patients whose illness was ascribed to heredity we find C., a native of Forres, who was initially admitted to the Inverness District Asylum in 1903 with a diagnosis of acute mania and melancholia. He was subsequently transferred to Aberdeen Royal Asylum and then to Elgin,

where he died in the town's Asylum in 1907. Intriguingly, his medical record included the information that he was a former emigrant to Colorado, where he had worked as a cowboy.[12]

"Bad habits" –especially venereal disease and alcohol abuse– also featured prominently in the questioning of patients and the assessments of doctors at the turn of the nineteenth century. The ambiguities surrounding the labelling of alcohol abuse as a cause, symptom or consequence of illness or some other problem are well illustrated in the case of James from Shetland, who was admitted to the BC Provincial Hospital in 1899. The admission register's account of him as a man of "no occupation" whose illness had been caused by "inebriety" is contradicted, however, by a letter from James to his mother which is preserved in Shetland Archives. Penned in 1891, a year after his arrival in Vancouver, it was bitterly critical of the misleading propaganda that James claimed had lured him to a city where, despite allegedly having some training in medicine, he had been forced to resort to a succession of menial jobs which barely kept him above the breadline. It is unclear from the evidence whether his plight was a consequence of alcoholic intoxication, or whether he descended into alcoholism as a result of unfulfilled expectations, but James's case is a reminder that medical diagnoses clearly involved value judgements.[13]

Moral evaluations could also involve race and ethnicity. Recent research on New Zealand asylum records has demonstrated a particularly strong thread of ethnic stereotyping in the medical reports and official returns, often connected with linguistic traits or physiognomy.

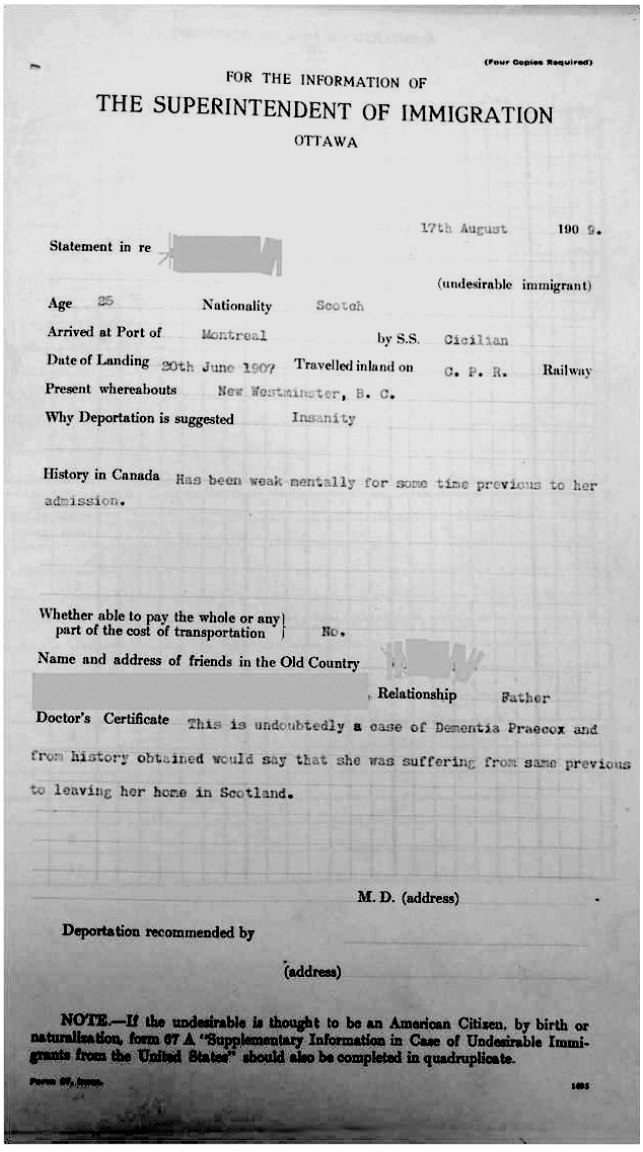
Figure 1. Specimen Ward at Inverness District Asylum, 1903 (Highland Archive Service, Inverness, GB0232/HHB/3/12/12, by permission of NHS Highland).

Among British immigrants, Gaelic-speaking Scots were most likely to be singled out on ethnic grounds. One patient in the Seacliff Asylum, Dunedin, a native of Campbeltown, was described in his case notes as "continuously talking. Sometimes Gaelic. Sometimes senseless English", while another "says he can only curse in Gaelic".[11] On the other hand, a linguistic marker was used to describe the habits of only one Scots-born patient in the BC Provincial Hospital. One of the two medical certificates that accompanied K. when he was sent from Nelson to Vancouver in 1907 reported that he "talks and shrieks in Gaelic continuously. Will not answer any questions, nor talk in English, merely yells in Gaelic." The second certifying doctor corroborated his colleague's assessment, reporting that "the patient was crying out in an unintelligible language."[14]

Discussion

The absence of ethnically-based judgements from the assessment of British patients in the BC hospital records is surprising. In the eugenics-dominated decade before the First World War, Canadians were preoccupied with the idea that weak-minded immigrants from Britain, especially England, were polluting their society and draining their economy because they did not fall under the current deportation law. Further east, in Ontario, an article in the *University Monthly* in 1908 used statistics from the Toronto Asylum to suggest that immigrants made up a disproportionate part of the population of mental hospitals in that province: 20 per cent of Ontario's population was foreign born, but between 40 and 50 per cent of its asylum population. Voicing arguments that were frequently aired by contemporary Canadian politicians and journalists, the article went on to link the alleged preponderance of so-called "English defectives" in the admission registers of Toronto asylums with "the wholesale cleaning out of the slums of English cities".[15]

Also notable in the BC admission registers and case files are the relatively few diagnoses that attributed insanity to religious delusions. In only fifteen cases out of a sample of 1210 records was a diagnosis made with reference to "religion", "religious excitement" or "religious study", and those fifteen patients came from a wide range of denominations. This profile is in stark contrast to evidence sampled from Ontario more than three decades earlier, when "religious excitement" was commonly invoked as a trigger for insanity, with Methodism the most frequently cited denomination. The disparity can be explained partly by differences in time and place, for in the febrile political environment of Upper Canada in the 1830s and 1840s, Methodism –at least *American* Methodism– was seen as a subversive influence, which allegedly intensified the threat of invasion from the south. Such issues were simply not relevant in the Pacific North West at the end of the century, and the contrast provides yet another reminder –as in the case of James from Shetland– that medical diagnoses were shaped by the



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FOR THE INFORMATION OF

THE SUPERINTENDENT OF IMMIGRATION

OTTAWA

17th August 190 9.

Statement in re [redacted] (undesirable immigrant)

Age 25 Nationality Scotch

Arrived at Port of Montreal by S.S. Cicilian

Date of Landing 20th June 1907 Travelled inland on C. P. R. Railway

Present whereabouts New Westminster, B. C.

Why Deportation is suggested Insanity

History in Canada Has been weak mentally for some time previous to her admission.

Whether able to pay the whole or any part of the cost of transportation No.

Name and address of friends in the Old Country [redacted] Relationship Father

Doctor's Certificate This is undoubtedly a case of Dementia Praecox and from history obtained would say that she was suffering from same previous to leaving her home in Scotland.

M. D. (address)

Deportation recommended by

(address)

NOTE.—If the undesirable is thought to be an American Citizen, by birth or naturalization, form 67 A "Supplementary Information in Case of Undesirable Immigrants from the United States" should also be completed in quadruplicate.

Figure 2. Statement of deportation of insane immigrant from Canada, 1909. Library and Archives Canada.

political, social and cultural context within which doctors and administrators operated.

Value judgements did not simply influence medical diagnoses: they also shaped the attitudes and actions of families, administrators and politicians, as well as the patients themselves. These different constituencies did not always sing in harmony, and there were particular tensions between federal and provincial authorities over detention and deportation.

The most obvious response to insanity across Canada was the establishment of institutions of confinement. Initially these were jails or poorhouses, followed by custom-built asylums, reflecting the birth of institutional psychiatry. Committals were made by a variety of individuals, including justices of the peace, prison governors, and patients' families. Some of the latter regarded the asylum as a place to dump unwanted relatives; others as a sort of medical "pawn shop", where they deposited and sometimes collected spouses, children, parents or siblings as financial or other circumstances dictated. In other cases, however, they were a last desperate resort, when families could no longer cope at home.

Asylums were the responsibility of the provinces, whose priority was generally to balance the books and reduce chronic overcrowding by encouraging families to take responsibility for their relatives. Sometimes this may have worked to the detriment of the patient, as in the case of J. from Nairn, who was released into the care of the very husband whose ill-treatment may have contributed to her illness. If the insane migrant had relatives in the Old Country, asylums encouraged repatriation. As the Medical Superintendent of the BC Provincial Hospital wrote to an (English) patient's sister in 1903: her brother should be sent home because numbers of the hospitalized insane were increasing, wards were overflowing, and the provincial government "does not feel disposed to keep for the rest of their lives a lot of young men who really do not belong to it".

There was, however, a growing federal overlay to that provincial scenario. If the practical care of insane migrants was a provincial responsibility, the development of *policy* lay with the federal government. And by the late nineteenth century it was a policy influenced very much by eugenics. While it involved gate-keeping at ports of departure and entry, through screening and quarantine, more emphasis was put on subsequent fire-fighting through deportation.

Canada's determination to rid the country of individuals who were –or were likely to become– public charges meant that it deported far more immigrants than any other country in the British Commonwealth. Almost two decades before the British North America Act brought the Dominion into existence, unofficial deportation had been the response to the first recorded case of insanity in the Pacific Northwest. In 1850, a year after the Crown colony of Vancouver Island was created, a deranged Scottish immigrant allegedly assaulted the jail doctor, John Helmcken, and was placed on the next ship back to Scotland.[16] Following Confederation in 1867, insanity was

Table 1. Birthplaces of patients in the British Columbia Provincial Hospital, 1872-1901 (including readmissions).

Australia	4	Manitoba	5
Austria	6	Mexico	2
Bahamas	1	New Brunswick	27
Bavaria	1	New Zealand	1
British Columbia	55	Newfoundland	5
Belgium	3	Norway	15
Bohemia	2	Not known/not stated	116
Canada (unspecified)	5	Nova Scotia	27
China	102	Ontario	152
Denmark	3	Prince Edward Island	10
England	244	Philippine Islands	1
Finland	11	Prussia	3
France	5	Quebec	47
Germany	26	Roumania	1
Greece	1	Russia	2
Holland	1	Scotland	80
Hungary	1	Sweden	29
Iceland	77	Switzerland	2
India	3	USA	99
Ireland	77	Wales	5
Italy	11	West Indies	2
Japan	7	**TOTAL**	**1277**

Table 2. Main birth countries of patients 1872-1901.

British Isles	406	China	102
Canada	320	United States of America	99

Table 3. Top ten occupations of patients, 1872-1901.

Labourer	221	Fisherman	24
Housewife	168	Sailor	20
Farmer	96	Cook	19
Miner	89	Logger	18
Carpenter	36	Blacksmith	15

placed at the centre of the definition of a deportable immigrant, and remained in that position well into the twentieth century.

As a result of that legislation Scots were regularly included in those whom the BC Provincial Hospital slated for deportation. But they were not singled out in any way for such a fate, for while the examples in this study are all taken from Scottish patients, there is no indication in the records examined that the Scots were exceptional or different in any way from the other ethnicities that formed a significant part of the population of Canada's most westerly province.

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