Future Directions for the Study of Migration and Ethnicity in New Zealand: Comparative, Transnational and Multidisciplinary Approaches to Records of Insanity

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In his 1990 publication on Irish migration to New Zealand, historian Don Akenson recommended various approaches available for the study of ethnic history, such as demographic analysis, institutional history, community studies and biographical sketches. He also identified particular themes for investigating the Irish in New Zealand, including women, religion, sectarianism, community studies and intermarriage with Maori.[1] Such topics could equally be applied to other ethnic groups. Intriguingly, Akenson failed to propose comparative investigation of diverse migrant groups as a research agenda. Indeed, with a few exceptions, the extant historiography of migration and ethnicity in New Zealand is notable for its focus on one national or ethnic group, with little comparative engagement, either nationally or internationally.[2] As such, there exist individual works relating to the Scots, the Irish, the Chinese, and Indians, among others.[3] Individual articles in edited collections containing contributions about various ethnicities are also predominantly confined to one group rather than the pursuit of comparison.[4]

A second feature of the historiography concerning migration and ethnicity is its narrow regional focus. Much of the single-authored literature concentrates on one destination or undertakes analysis of communities, such as the Irish on the West Coast and in Canterbury, and the Highland Scots at Waipu.[5] Such approaches have produced fine-grained analyses, but the applicability of findings to other parts of New Zealand remains unknown, indeed they are often deemed atypical. The third main feature of the historiography is a focus on a particular disciplinary approach. Historians, for instance, have rarely utilized works of literature, film or material in the migrants' own language in the pursuit of issues relating to migration and ethnicity.[6] Nevertheless, scholars have deployed diverse methodologies including oral interviews and ethnographic observation.[7] A final point is that

much of the work on nineteenth-century migrants in particular generally emphasizes the successful adjustment and settlement of newcomers. But what do we know about those migrants who struggled with their relocation abroad? Analysis of the patient populations of lunatic asylums offers one avenue to address this question. This article therefore draws on records relating to madness in nineteenth-century New Zealand to suggest some ways forward for the study of migration and ethnicity. In particular, it recommends greater engagement with three approaches: comparison, transnationalism, and multidisciplinarity.

Comparison

Just as studies of migrant groups in New Zealand are limited in their comparative endeavours, so too are studies of the patient populations of New Zealand lunatic asylums. Here, the focus has typically been on issues of gender, class and family, without these categories being analyzed according to a range of variables including birthplace.[8] Analysis of the published data relating to asylum admissions in New Zealand, printed regularly in the *Appendices to the Journals of the House of Representatives*, reveals the following returns for country of birth for the major groups admitted to New Zealand asylums (Table One). As shown, the Scottish presence in asylums generally increased until the end of the nineteenth century before beginning a small decline. The admission of English migrants, by contrast, continued to rise in the early twentieth century while Irish migrants occupied the middle ground. Unsurprisingly, there is an increase in admissions of New Zealand-born patients over time.

Table One: Patients in Asylums at Year End

Year	England	Scotland	Ireland	Germany	China	Australia	NZ
1879	379	208	288	29	6	13	48
1882	438	217	373	26	16	18	79
1885	543	256	437	33	20	18	95
1888	569	274	476	34	25	20	125
1891	618	295	540	41	17	30	198
1894	647	318	559	53	20	33	294
1897	745	373	597	38	25	50	432
1900	788	409	631	46	31	58	539
1903	846	402	664	47	26	85	704
1906	843	386	621	41	26	100	988
1909	923	381	611	38	21	121	1255

Internationally, scholars have also pointed to disproportionalities in the ethnic composition of patients found in lunatic asylums, typically identifying the over-representation of Irish migrants. A number of theories attempt to explain this disproportionate level of incarceration, including claims that Ireland exported its insane and that the Irish were inherently predisposed to insanity.[9] Scholars such as John Fox, meanwhile, in his study of the Irish in Massachusetts, argued that 'higher rates of insanity among the Irish were a result of their higher rates of pauperism and not their ethnicity'.[10] Prejudice and the supposed isolation of Irish migrants are also proffered as explanations for mental illness among twentieth-century migrants.[11]

When the published material relating to asylum admissions in New Zealand is analyzed in relation to census data for the country, a similar picture emerges of the disproportionate representation of the Irish-born. As Table Two shows, Scots entered asylums in proportion to their representation in New Zealand society. Irish migrants, by contrast, were over-represented while English migrants were under-represented. The major anomalies, therefore, relate to the Irish and to the English. These published statistics, however, are simply snapshots in time and we still have little knowledge of the overall numbers of patients admitted to New Zealand asylums. Nor do extant studies cross-reference a number of variables to enable a range of questions to be pursued, such as, how many Irish Protestant migrants were committed? Were certain ethnic groups more likely than others to have older migrants confined? Did causes of admission vary according to gender, age, and ethnicity among other variables? Current research is endeavouring to address these and other issues.[12]

Table Two: Proportion of Foreign-born Asylum Admissions by Comparison with Census Figures

Census Year	Scotland-born		Ireland-born		England-born	
	Census %	Asylum %	Census %	Asylum %	Census %	Asylum %
1878	20.0	21.9	18.2	29.0	44.3	38.5
1881	19.8	18.3	18.5	31.7	44.7	36.8
1886	19.7	17.9	18.5	32.1	45.2	37.9
1891	20.0	18.1	18.3	33.0	45.0	37.8
1896	19.3	18.1	17.6	31.0	44.5	38.0
1901	18.6	19.0	17.0	29.7	43.6	38.1
1906	16.9	17.7	15.0	28.4	41.3	38.6

Although no consensus has been reached as to why Irish admissions to asylums were disproportionately high, several of the explanations offered follow Nancy Green's model of convergent comparison. In this

conceptualization, Green suggests that by comparing two or more migrant groups in one place, any differences discerned will be a result of the groups rather than the place; in other words, cultural origins will be the reason for any disparity.[13] Comparison across geographic regions is also fruitful, and here Green's model of divergent comparison is useful – similar groups in different places of settlement are compared and perceived differences relate to the place of arrival, rather than point of origin.[14] The comparative approach is worthwhile not only as a means to test Green's models, but also because much of the official reporting on lunatic asylums in New Zealand reflected on differences between asylums in New Zealand, as well as how these colonial asylums varied from asylums elsewhere.

Official reports, for instance, compared patient populations according to the causes of admission as well as divergences between the sexes in the assorted asylums. One of the contrasts identified by the medical inspector in 1878 was Auckland's tendency to 'receive cases of a more hopeless kind than are sent to the rest of the Asylums'. The inspector also felt that Hokitika's insane population was drawn from a better class mentally and physically 'than those of any other Asylum in the colony. But the chief cause [of their superior health] undoubtedly lies in the manner in which they are kept continually occupied in healthful and varied employments'.[15] Two decades later, the contrast between Auckland's patients and those in the 'southern portion of the colony' was still discussed – but on this occasion Auckland's mild climate was considered responsible for attracting 'an undue proportion of incapable and defective individuals'.[16]

Contemporary comparisons of New Zealand asylums with those overseas frequently stressed the effect of funding differences. As asylums in New Zealand were state-funded (apart from the private asylum, Ashburn Hall), the central government was fiscally responsible for patients in New Zealand whereas in Britain and Ireland, 'the maintenance of the insane is a heavy local charge'.[17] This prompted concern among asylum authorities, with the Inspector of Asylums in 1884 anxious that patients in home asylums or showing 'insane tendencies' were being shipped to New Zealand to escape 'the burden of their maintenance at home'.[18] Within New Zealand, individuals might also be transferred to lunatic asylums in order to shift the burden of their care onto the state. Towards the end of the nineteenth century it was noted that in New Zealand, 'alone of all the colonies the care of the aged poor and paupers is by law thrown on the local bodies, who have, by local taxation, to find at least half the cost of their maintenance'. Efforts were therefore made by some local authorities to have these individuals admitted to asylums in order to avoid the cost associated with their maintenance.[19] Similarly in Victoria, Australia, it was felt that where 'the sick, and aged, and doting poor are a burden on local rates' there is 'an increasingly widespread

struggle on the part of hospital officers, guardians of old people's homes and refuges, and Charitable Aid Boards to get persons who are troublesome from senile decay admitted to the public asylums'.[20] Such undertakings inevitably resulted in the overcrowding of asylums and here again international contrasts were evident. While New Zealand and Australia admitted patients even if asylums were full, claims were made that Britain, the United States and Canada did not.[21] The problems surrounding the overcrowding of asylums prompted proposals to adopt a system of boarding out patients in private homes in New Zealand, similar to that operating in Scotland, but as an 1892 report noted, 'there prevails among our people an unreasonable aversion to have anything to do with persons of unsound mind'.[22] Yet in cases when asylum authorities attempted to levy the cost of a patient's maintenance against family and friends, 'no unnecessary delay occurs in the removal of harmless patients'.[23]

Medical authorities also made comparisons concerning the causes of insanity at home and abroad. W.A. Skae, the Inspector of Lunatic Asylums in New Zealand, noted in 1877, *'delirium tremens* is regarded by many medical men in this country as insanity, and many cases of it are sent to Asylums, but such cases are rarely sent to Asylums in England, even by mistake'.[24] The Inspector also commented on the high rate of recovery and low death rate in colonial asylums, but acknowledged, 'I have known several patients discharged as recovered who certainly would not be considered recovered in England'.[25] Specific comparisons in this respect were made between recovery rates at Dunedin compared with the Cumberland and Westmoreland county asylum.[26] Although rates varied between asylums, the overall high rate of recovery in the colony was attributed to the 'favourable nature of the cases admitted'.[27] The presence of the elderly in New Zealand's asylums in the late nineteenth century, meanwhile, was ascribed to the absence of infirmaries as in 'older countries'.[28]

Ascertaining the varied causes of admissions to colonial lunatic asylums is fraught with difficulty. Again, official published statistics can only provide a snapshot in time. As published data from 1899 reveals, the major causes of insanity were generally perceived to be physical or moral, including congenital and heredity factors, drink, masturbation, epilepsy, and senile decay. Other official explanations included childbirth, disappointment, fright, religion, and solitude, among a host of reasons.[29] Medical officers followed the practice of segregating a particular cause for the purpose of official published data, but also acknowledged that in many cases several causes combined together.[30] Indeed, this is strikingly apparent when perusing the casebooks. As well as doctors, patients and their family and friends cited a range of potential explanations for committal to an asylum, including the effect of the voyage out. Significant life events were seen as key to explaining

mental health.[31] But were certain ethnic groups susceptible to particular causes? As Roland Littlewood and Maurice Lipsedge have indicated in their study of migrants' mental health in twentieth-century England, 'Each ethnic group seems to have its own characteristic pattern of difficulties'.[32] They found, for instance, that Scottish and Irish migrants possessed higher rates of alcoholism compared with other groups.[33] Cross-referencing causes of admission with birthplace will enable investigation of this kind.

A comparative approach also aids the exploration of ethnic identities in New Zealand. Where investigations on ethnic groups have been undertaken using asylum records, the analysis has generally been confined to one group. Yet such a restricted focus results in tentative conclusions. In her study of Maori patients in the Auckland asylum, for instance, Lorelle Burke cites a number of cases where doctors described patients along lines of 'racial' difference, identifying, for example, those performing a war dance, learning English, displaying ornaments, and desiring Maori food.[34] Yet without a comparative dimension it is difficult to know to what extent these elements were confined to Maori. Similar studies undertaken in other colonial destinations are also suspect. Catharine Coleborne notes that Chinese patients appearing in casebooks for colonial Victoria, for instance, were represented as 'dangerous, or 'incoherent, or both'.[35] Descriptions of their bodies and reference to their speech were also noted. But the comparisons made with white male admissions fail to engage with ethnic origins. Were these white male admissions foreign-born or Australian-born?[36] Studies of other ethnic groups, as well as of male and female patients, indicate that Chinese patients were not alone in being regarded as dangerous and incoherent.

By adopting a comparative approach, we can also see that medical officials equated 'national' characteristics with various foreign-born patients including, 'a quick tongued jerky little Irishwoman of low class', a 'Dull sleepy dejected looking Chinaman who stands in a slouch attitude with his eyes closed', and, 'A big broad loosely built slouchy German. Typical good humoured German features'.[37] Another patient admitted to Seacliff in Dunedin was considered to be 'a typical high spirited old highlander and when taxed with being too lively he says, "too much highland blood in me." '[38] Also committed was, 'A typical fair haired light complexioned Scandinavian' and, 'A tall fair flaxen haired Swede with blue eyes'.[39] Such judgements reflect developments in science and anthropology from the 1860s which characterized different ethnicities with particular emphasis on skin and hair colour, stature and physiognomy.[40]

Medical officials paid particular attention to language – a central feature of ethnic identity – and comments on language differences appear prominently in case files across a range of ethnic groups. As was observed of one migrant, 'He knows no English, but is constantly seen to pace to and

fro muttering to himself and occasionally shouting in italian'.[41] Meanwhile, an Irish woman was considered 'Totally unable to hold any conversation. Talks Irish chiefly. Occasional[l]y speaks a little English. Has been talking energetically to the pictures on the walls'.[42] A Welsh migrant, meanwhile, 'rattles off a torrent of what is possibly that language'.[43] Gaelic speaking Scots also attracted attention. An 80-year-old hailing originally from near Campbelltown in Ayrshire was observed to be 'continually talking. Sometimes Gaelic. Sometimes senseless English'.[44] Of another migrant, Isabella, it was recorded: 'Highland – speaks a little English'.[45] John, meanwhile, 'Says he can only curse in Gaelic'.[46] Aspects of the Scots language were also noted, as in the casebook of Agnes, a 75-year-old widow who was reported to say that, 'people is aye best at their ain hame, especially if they are no verra weel'.[47] Accents similarly generated commentary including that of Alexander who, 'Thinks he may be in Scotland. Speaks with a Scottish accent'.[48] Such remarks illuminate elements of a patient's ethnic identity, but medical authorities generally incorporated them into comments on a patient's behaviour, for instance pacing and muttering, and talking energetically. Again, such commentary spans a number of migrant groups, enabling challenges to the exceptionalism derived from concentrating on individual ethnicities in non-comparative contexts. While not made explicit, reference to language might also have reflected medical concerns that difficulty in speaking English was a contributing factor to migrant maladjustment in the colony.

If comments on language were made in relation to patients across a range of ethnicities, specific aspects of an ethnic identity were attached to particular groups. Among elements of Scottishness identified in the asylum records were references to Robert Burns. Of one patient it was revealed that, 'His memory of distant events is perfectly clear as evidenced by his history which he gives clearly & minutely. He can repeat many verses of Burns . . . He had a good memory of past judgments as to the words and character of authors whom he has read such as Burns & Tannehill [*erased:* upon] about whom he will converse with evident appreciation'.[49] Chinese patients, meanwhile, were associated with opium smoking, such as Sing who was diagnosed as, 'Suffering from the combined effects of opium smoking and starvation'.[50]

Interestingly, initial findings reveal that among those born abroad, English-born and Australian-born migrants in New Zealand asylums were rarely discussed in connection with their ethnic identity. What explains this discrepancy? One potential explanation may relate to the ethnicity of medical superintendents commenting on patients. Yet while most had received education and training in Scotland, their ethnicities differed. James Hume, for instance, was a Scot while Truby King was the son of English-

born migrants. Of greater explanatory power is that English migrants were the majority foreign-born group in New Zealand in the nineteenth century, and numerically more dominant in admissions to lunatic asylums, which might explain the lack of attention given to them in this respect. That the Australian-born similarly failed to attract comment, might be attributable to regular flows of people across the Tasman Sea. The identification of distinctive features among Scottish patients in the strongly Scottish settlement of Dunedin is also of interest. It shows, for instance, that Scots were viewed distinctly from the English (despite emphasis in the historiography on their shared Britishness). Recognition of the Scots as distinctive may also reflect the education and work experience in Scotland of the medical superintendents associated with Dunedin's public asylums.[51]

A further priority for comparative studies of migration and ethnicity in New Zealand is to consider cross-cultural encounters which, to date, have largely focused on interaction with Maori.[52] But how did migrant groups interact with each other? Again, asylum records offer some insight. Chinese were one of the ethnic groups in the asylum to attract the attention of fellow patients. Scotsman Dugald, for instance, 'Says he has several Chinamen to behead', while Richard claimed the 'Govt has offered him £5 for every chinamans head he can procure'.[53] Thomas meanwhile reportedly, 'broke a pane of glass in a window "to get at the Chinamen"' while John, 'killed a chinaman in 1885'.[54] Chinese patients were seemingly alert to such threats with one Chinaman claiming in 1892, 'He does not sleep at night because he says some Europeans want to kill him'.[55] Such fears may reflect his experience as a miner – such discrimination occurred just as readily on the goldfields as in the cities. Indeed, the negative responses to Chinese in the asylums echoed anti-Chinese discrimination in New Zealand more broadly. The main thrust of this discrimination was the alleged ability of Chinese to subsist on low wages, claims that they were diseased, and accusations that they were immoral in part because they were not Christian. A number of deterrents were implemented by the state to prevent their immigration including a literacy test, poll tax, and thumb printing.[56] Hostility erupted in 1905 when English migrant Lionel Terry, a proponent of racial purity, murdered an elderly Chinese man in Wellington. Found guilty, Terry's death sentence was commuted to life imprisonment which was spent in Sunnyside and Seacliff asylums on account of Terry being found insane.[57]

Irish migrants, both Catholic and Protestant, also attracted hostility from other patients. Sophia, for instance, 'Refuses to do any work and has a great antipathy to Irish persons'.[58] Suffolk-born George, meanwhile, feared particular Irish: 'he spoke of certain Irishmen who were going to shoot him and all the family'.[59] Sometimes the antagonism towards Irish patients came from fellow Irish of a different religion. Catholic Irishman Thomas,

for instance, 'has conceived an antipathy against Donnelly, a Protestant Irishman in the same yard, but has never assaulted him'.[60] And, occasionally, those of a similar religious background were derided, though the following example also reflects marital discord. As Catholic migrant Mary Ann wrote to her husband, 'you are nothing to me so don't dare to ever come to see me any more, not ever you Blazon rotten old liar of an Irish Fenian, Brazon looking Irish Fenian'.[61]

Indeed, the Fenian and Orange division, readily explored among historians of the Irish in New Zealand,[62] also found expression within the asylum. Fermanagh-born Patrick, for instance, took great offence at allegations he was a Fenian: 'A great number of the patients in this Asylum are always [*word illegible*] out that I have committed offences against the queen and belong to several Fenian Societies – It is a fraud to say so and a lie – they must be a bit affected in the head or they would not talk that way'.[63] New Zealand born John, meanwhile, alleged that, 'the Fenians & the Gaelic Society have been persecuting him holding him down & trying to make him take fits. He says that they tried to strap him says he will have revenge on them yet. Says that he knows them by sight & would attack the first one he meets'.[64] George, on the other hand, claimed 'his brains are destroyed by poison which he got on the coast given by Fenians'.[65] Contradictory statements surrounded the Protestant Duncan, 'A short stoutly built Irishman', who claimed, 'he has been expelled from the orange lodge at Queenstown though he knows little of the members of the lodge and never belong to it'. It was noted that he 'Has delusions of persecution, having he says been turned out of an Orange Lodge at which he was a member'.[66]

On the whole, these passages do not provide any insight into the ways in which cross-cultural encounters shaped the identity formation of individuals. They do though reflect the more negative aspect of such engagements rather than the positive, probably because negative elements attracted greater commentary from medical authorities. Nevertheless, these interactions demonstrate the need for systematic scrutiny of cross-cultural relations in the British World beyond encounters with indigenous peoples. In New Zealand this is especially important in order to move beyond a tradition of labelling migrants as simply British or Pakeha (non-Maori).

Transnationalism and networking

Quite apart from the need for greater comparative study in the field of New Zealand's migrant and ethnic history, there is also a requirement for transnational approaches, as recommended by Kevin Kenny in his work on the global Irish. As Kenny argues:

> Nation-based comparisons cannot capture the fluid and interactive processes at the heart of migration history . . . But a strictly transnational

approach can underestimate the enduring power of nation-states and the emergence within them of nationally specific ethnicities . . . What is needed is a migration history that combines the diasporic or transnational with the comparative or cross-national. Only then can the history of American immigration and ethnicity be integrated into its wider global context.[67]

Asylum records offer considerable evidence of transnationalism. These records reveal an international flow of medical ideas and statistics. Considerable discussion was expended, for instance, on debating the merits of smaller asylums, with examples drawn from around the world, including Scotland: 'That small Asylums of from forty to ninety patients can be thoroughly well managed without resident Medical Officers is shown by the County Asylums of Haddington, Banff, and Elgin, in Scotland. These institutions are spoken of year after year by the Scotch Commissioners in Lunacy in terms of great satisfaction'.[68] Apart from engaging with the opinions of Scottish and English medical authorities, the views of French, Belgian, and German medical experts were also cited.[69] Visits were also made to New Zealand by the superintendents of other asylums worldwide, including Durham and Melbourne.[70] Consistent engagement with the 'statistics of insanity' worldwide took place.[71] Engagement with international medical scholarship is also apparent in references made in official reports to papers read at the Intercolonial Medical Congress and publications in the *British Medical Journal* and *Journal of Mental Science*, among others.[72] Additionally, colonial ideas and scholarship flowed back to the metropole**.**

As practised by migrants, transnationalism can be defined as 'the processes by which immigrants build social fields that link together their country of origin and their country of settlement'.[73] Evidence of such linking efforts can be seen in patients' correspondence with their networks in the homeland. To give some examples, one patient, 'wrote to her brother in Ireland on this day informing him that she is well'.[74] Another said he 'wishes to go home to friends in Scotland from whom he shows letters asking him to return and offering a home'.[75] Letters from David's father in Wolverhampton to his son at Seacliff instructed: 'your passage is paid to Glasgow, and to join your sisters at once in Dunedin, and I sincerely hope that you will come, and do not Grieve your parents by not coming'.[76] And of John in 1888 it was noted he, 'has received letters from Home enclosing sufficient money to pay his passage to England. He will likely be discharged in a few days and I am making arrangements for his return Home'.[77] Transnational networks were crucial in securing the return home of some migrants.

Such examples of migrants returning home might be seen as evidence of their social isolation in New Zealand. Historian Miles Fairburn has developed an atomization thesis which claims that, 'The scantiness of kinship

ties deprived colonists of a base for the development of community ties'.[78] According to Fairburn, 'Community structures were few and weak and the forces of social isolation were many and powerful. Bondlessness was central to colonial life'.[79] A significant cause of this atomization, Fairburn maintains, was that 'most colonists . . . had already severed their links with place, family, friends, community in the great uprooting that led them to New Zealand'.[80] As such, he contends that 'this deficient framework of association' resulted in extreme loneliness, aggression, and intoxication.[81] Investigations of the Irish, however, have cast doubt on Fairburn's thesis though whether the robust social ties characterizing their settlement abroad are found among other migrant groups awaits further study.[82]

The issue of atomization is central to investigations into the role of the family in asylum admissions and discharges, a key area in studies of madness.[83] A recent study analyzing household structures in England drew on census manuscripts to reveal that most admissions to Exminster asylum were from deeply rooted, physically less mobile families.[84] No such record linkage analysis is possible in New Zealand where original census manuscripts were destroyed. Studies are therefore reliant on data found in casebooks which point to the presence or absence of kin ties. While quantitative analysis is required to give statistical substance to the extent of family involvement, qualitative data reveals that patients had a variety of kin connections. Yet, the extent to which these were simple household ties between husband, wife, and children, rather than extensive networks of siblings and other kin connections remains to be verified.

Nevertheless, networks of family and friends in the new lands are evident, and often played a role in the migration process, either accompanying the migrant abroad or encouraging them to the colony. Londoner William, for instance, voyaged to Otago on the *Carnatic* with one of his brothers, while Scotswoman Ann, allegedly 'assaulted and violated by two ploughmen', moved to New Zealand on the *Parsee* with her unmarried sister.[85] Of Galway girl Maria, 'Her uncle sent for Maria & her sister & paid their passages'.[86] Kin networks were also influential in arranging for the transportation of patients back to their homelands. One Chinese migrant was admitted in 1900 and within two years, it was revealed, 'A fellow countryman took him away and he went back to China'.[87] A younger brother of Denis from County Antrim, 'was somewhat eccentric in manner though not that way before coming to New Zealand & on account of this they sent him home again as he did not like living in this country'.[88] While such cases indicate how extensive transnational and national connections were among asylum populations, we also need to be alert to migrants who seemingly operated without these networks.

The migration pathways pursued by migrants prior to arrival in New Zealand offer further evidence of transnationalism and networking in many

migrant diasporas – pathways which can often be illuminated through a focus on migrant correspondence. But migration trajectories are notoriously difficult to unearth given the scarcity of sources for the nineteenth century. This is one area in which lunatic asylum records offer tantalizing glimpses. From a sample analysis of 176 foreign-born patients at Dunedin who recorded whether or not they had spent time in other countries before arriving in New Zealand, 62% (n = 109) indicated that they had been in other countries. An overwhelming majority of those, four-fifths, spent time in Australia before arrival in New Zealand, either solely in Australia (71%; n = 77) or in Australia as well as another destination (9%; n = 10). Analysis of data at the Auckland asylum for a later time period, 1903 to 1910, also shows that one-third of the foreign-born committals during the period resided elsewhere before arriving in New Zealand, with Australia again the favoured destination (41% had spent time there).[89] Only occasionally is there indication of prior admission to an asylum in other countries. In most cases, the first admission was seemingly in New Zealand and therefore, for those migrants who had spent time elsewhere, several years after departure.

This finding is supported by data concerning the timing of admissions to New Zealand's asylums. Preliminary analysis reveals that of a sample of 350 foreign-born patients in the Dunedin public asylum for whom there is information on the number of years spent in New Zealand, the single largest group of 8% (n = 29) were admitted to the asylum having spent one year or less in the country. But if we extend the analysis further according to decades, 44% (n = 154) were confined having spent ten or less years in New Zealand, 34% (n = 118) had spent between 11 and 20 years in the colony, and 18% (n = 64) had spent 21 to 30 years in New Zealand. Just 4% (n = 14) were in New Zealand for more than 31 years before admission to Dunedin's public asylum. This differs from the analysis of later admissions at Auckland where one-quarter were resident for ten years or less before committal, while half were confined having spent between 11 and 20 years in New Zealand.[90] So despite a strong contingent entering the asylum in their first year in New Zealand, migrants were more likely to be admitted some years after settlement, providing support for Littlewood and Lipsedge's thesis which contends that mental illness among migrants is more evident after several years of settlement when 'the new life in the adopted country has fallen short of expectations'.[91]

Multidisciplinary engagement

In their study of the mental health of migrants in Britain, transcultural psychiatrists Littlewood and Lipsedge drew on theories from social anthropology, and multidisciplinary engagement offers a further direction for studies of migration and ethnicity in New Zealand. To date, most studies in

this country have reflected the disciplinary training of the scholar involved although there is increasing engagement with methods, concepts, and theories from other disciplines. Indeed, studying the patient populations of asylums demands an awareness of the techniques and insights gleaned from other disciplines including sociology, anthropology, literature, and psychiatry.

To take one example, the issue of heredity – that is, whether family members of the patients were labelled as insane – is a major aspect of madness explored in psychiatry. Nineteenth-century medical authorities in New Zealand, as elsewhere, expressed ongoing concern with the issue of heredity. As reported in 1880, 'That hereditary predisposition was only ascertained to exist in 40 cases is rather a proof of the difficulty of getting information than a reason for supposing that it was not present in a great many more'.[92] Casebooks also display such concern. Despite the patchy data, the casebooks for asylum committals in Dunedin show that of the sample so far collected, 8.6% (n=64) of patients were recorded as having a history of insanity in the family. Sometimes it was simply observed that a family member was odd or insane. On other occasions, however, the name of an asylum in the homeland or in the colony where a relative was confined was provided.

Peter, for instance, was a 21-year-old single farm labourer from Wyndham, who towards the end of May 1900 was committed to Seacliff asylum. It was his first attack of insanity and he had been suffering for about two months. According to his father's report, Peter's mother was sent in 1876 to Hume's Asylum for three months after childbirth. The Seacliff casebook reported that she had committed suicide three months before Peter's admission and that it was thought due to attending to Peter. The casebook also reported that an uncle on Peter's father's side had committed suicide.[93] While inquest testimonies relating to Elizabeth's death provide conflicting interpretations concerning her behaviour, her medical practitioner believed, 'She was suffering from melancholia and was subject to fits of depression at times. She had had a good deal of extra work and anxiety in attending to one of her sons who was not in the best of health and this in all probability produced her illness. I am of opinion she took her life while suffering from one of these fits of depression'. The verdict was 'drowned herself in the Wyndham river during a fit of temporary insanity'.[94]

Such data is often treated sceptically by scholars, but by deploying the technique of record linkage and connecting material on the admissions of family and friends at lunatic asylums, and other details relating to their lives, it can be verified. To give an example of this approach, in 1901 Annie, a 53-year-old Presbyterian housewife living at Balclutha, was committed to the Seacliff asylum in Dunedin. According to her casebook entry, this was not Annie's first attack of insanity, as three years earlier she spent seven

months at Dunedin's private asylum, Ashburn Hall. Born at Wick, Annie had spent two years in Tasmania and ten years in New Zealand. The asylum casebook also holds a letter Annie wrote to her husband in February 1911, a decade after her admission, declaring, 'Had I been at Home the doctors would not have dared to as this upon me, but here, advantage has been taken of me as I have nobody in the colony but yourself that knows anything about me'. After 13 years in the asylum, Annie was eventually discharged in January 1914, and apparently left for England, the medical officer noting that relatives at home had been agitating for her removal and had paid for a nurse to accompany her.[95] The issue of hereditary insanity is raised in Annie's case file in connection with her sister Catherine who was noted as being confined at the Montrose Asylum in Scotland while her brother John, an imbecile from birth, was boarded out. Research on the Montrose records confirmed Catherine's admissions, where she was termed a 'suspicious, scheming deluded creature, a most persistent letter-writer – she misconstrues the simplest acts into deeds of malice and persecution'. Catherine's casebook record also revealed that her sister Annie was residing in Glasgow in 1924 and had written to the asylum seeking information about Catherine.[96] A further case is that of Andrew, a 65-year-old single labourer, who entered Seacliff in 1891. According to his report, 'Melancholy moods run in the family' and an unidentified sister was noted as having been 'wrong in the head', having spent time in the Perth asylum.[97] Records of the Perth asylum reveal that his sister was admitted in 1841 and 'is hereditarily predisposed to Insanity and one of her sisters died Insane'. It was noted that her brother removed her later that year.[98]

Conclusion

The study of New Zealand's migrant and ethnic history, then, is a fruitful field of analysis with a range of topics demanding investigation including gender, language, immigration policies, associational culture, the influence of migrants on New Zealand society, responses to ethnic discrimination, new and old migrants, and the multigenerational descent group. As this chapter has suggested, however, it is by taking comparative, transnational, and multidisciplinary approaches that such topics have most to offer migration and ethnic history, as well as New Zealand Studies more generally. Lunatic asylum records are a reminder that we need to focus on migrants other than those who settled successfully and also to recognize that those who were not admitted to asylums may also have experienced difficulties before and after migration. Attempted suicides, broken hearts, self-medication with alcohol, and intolerable psychological pain were felt by those outside as well as inside the asylum, and these aspects of individual lives are as evident in society today as they were in the past.

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