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"SHANGRI-LABORATORY": PLACE AND PSYCHIATRIC
PUBLIC HEALTH IN HAWAII, 1939-1963

by

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DISSERTATION

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ABSTRACT

"SHANGRI-LABORATORY": PLACE AND PSYCHIATRIC PUBLIC HEALTH IN
HAWAII, 1939-1963

Akhil Mehra

Using twentieth century Hawaii as a case study, this study examines how

place concepts were used in thinking about mental health. Psychoanalysis, the

dominant model of American clinical psychiatry after World War II, neglected

place in favor of a more universal theory of early childhood events. In Hawaii,

however, the establishment of the public mental health system contrasted with

this psychoanalytic worldview. Instead of psychoanalysts, sociologists at the

University of Hawaii had an unusual amount of influence in theories about mental

illness and public health measures. From the 1920s to the 1950s sociology in

Hawaii was heavily oriented towards a mental health of human relationships with

specific places and the immediate external environment. In addition, sociologists

envisioned Hawaii as an exotic "laboratory" -- a unique menagerie of stunning

geographical features and polyglot inhabitants fit for scientific apprehension.

Place ideas colored conceptions of public mental health problems such as

juvenile delinquency, child abandonment, and conflicts within the family.

Moreover, particular relationships with place and the environment were

investigated in Hawaii's ethnic sub-populations, such as native Hawaiians, and

immigrant Japanese, among others.

By the 1950s, however, Hawaiian mental health experts migrated to newer

theories, which weakened the importance of specific place, and challenged the

notion of Hawaiian uniqueness. Modernization theory, for example, argued that

societies around the world progressed on a universal continuum of organization

and development.   In addition, Hawaii became a staging ground for Cold War

integrationism, which highlighted common ground between American and foreign

cultures. Finally, Hawaii's statehood was accepted in 1959 on the premise that

its multi-racial population revealed the optimal path for assimilating foreign

(particularly Asian) people. These ideological shifts weakened the claim for

expectionalism in Hawaiian mental health.

This work clarifies recent debate in the history of medicine about the role

of medicine in colonial domination. It argues that while aspects of psychiatry

were used as a local tool of statecraft, particular power considerations embedded

in medicine and psychiatry favor universalist domination in the field of ideas, a

form of intellectual colonialism.

CONTENTS

INTRODUCTION

THE PSYCHIATRY OF FRONTIERS

In 1908, more than two decades after his declaration that the frontier was the

prime shaper of the American character, the famed historian Frederick Jackson

Turner sharpened his argument. Turner downplayed the amorphous, universal

frontier he had made famous, in favor of a new argument about discrete, multiple

American environments. These environments created *sectionalism*, defined by

Turner as "a set of fundamental assumptions, a mental and emotional attitude"

that "resists national uniformity."[1]:

> Geographical conditions and the stock from which the people sprang are
> the most fundamental forces shaping sectionalism. Of these the
> geographic influence is particularly important in forming a society like that
> of the United States, for it includes in its influence those factors of
> economic interests, as well as environmental conditions, that affect the
> psychology of a people.[2]

Turner's sectionalism work was overshadowed by critics of the original

frontier thesis' lack of empirical evidence and overarching sweep. A current era

of historians has subsequently been reluctant to return to his work. Turner's

sectionalism work, however, presents new opportunities to engage with his ideas.

Particularly, while the original thesis demonstrated how the American national

character differed from the European, Turner's sectionalism work further

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[1] F J Turner, "Is Sectionalism in America Dying Away?," *American Journal of Sociology* 13, no. 5 (1908): p. 662.

[2] Ibid., 662.

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uncovered the nuances of regional psychology, outlining an interesting

foundation for a psychology of place.[3]

Despite Turner's familiarity with a wide range of social scientific

techniques, he did not borrow from psychology or medicine to substantiate this

psychological argument. [4] In fact, physicians since ancient times have charted

the complex interplay between place, and physical and emotional health.[5] In the

modern era, place based theories of illness have been challenged factors such

as the control of insect vectors of communicable disease, climate control, jet air

travel, and specific theories of the mechanisms of disease, from germ theory to

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[3] For information on the dynamic between Turner's better know frontier approach and his subsequent exposition of regional factors see Richard Jensen, "On Modernizing Frederick Jackson Turner: The Historiography of Regionalism," *The Western Historical Quarterly* 11, no. 3 (1980): 307-322 or Michael Steiner, "From Frontier to Region: Frederick Jackson Turner and the New Western History," *Pacific Historical Review* 64, no. 4 (1995): 479-501. Jensen also places Turnerian sectionalism in the larger historiographical context and describes the Turnerians' subsequent influence on theories of regionalism. Reliable general works of Turner and his ideas remain Ray Allen Billington's biography of Turner, and a history of the frontier idea. See R Billington, *America's Frontier Heritage* (University of New Mexico Press , 1974), and R Billington, *Frederick Jackson Turner: Historian, Scholar, Teacher* (Oxford University Press, 1973). Recent concepts of frontier have moved towards a comparative approach and away from Turner's environmental determinism, and Turner's ideas are now seen as over-simplistic. The historical approach of comparative frontiers, the most sophisticated current synthesis of frontier and regional theory, thus has yet to return to the psychology question.

[4] *Space* and *place* carry specific meanings in geography, and their use will follow these conventions in this dissertation. *Space* is an inclusive concept which has been used as a general description of the matrix of human social interactions or as a reference to the physical dimensions and geographic attributes of the environment. It is a larger, more non-specific construct than *place*, which refers to a specific location, to which some quality of human experience, relationship, or attachment develops. In this conception, the physical qualities of space are a necessary but not sufficient component of place. For more information, see R A Kearns and A E Joseph, "Space in Its Place: Developing the Link in Medical Geography," *Social Science & Medicine* 37, no. 6 (1993): 711-717.

[5] For a historiographical essay on this issue, at least in regards to physical health, see C B Valencius, "Histories of Medical Geography," *Medical History. Supplement* , no. 20 (2000): 3.; for ancient medicine's view of the relationship between environmental factors and mental factors see G Roccatagliata, *A History of Ancient Psychiatry* (New York: Greenwood Press, 1986).

molecular biology. Many of our contemporary medical theories ascribe disease

to a single factor that may operate without regard to geography or place.[6]

     This study argues that place thinking has been important in medical

thought well through the twentieth century, and that, ultimately, medical theory,

through a grammar of place, was intimately tied up with a singular non-medical

factor, the expansion of U.S. political, military, and cultural influence to far flung

parts of the world. Hawaii, which became an American territory in 1900, and a

U.S. state in 1959, serves as the dissertation's case study because place based

considerations have been prominent in many aspects of Hawaii's history,

including Hawaii's rapid assimilation from an isolated Pacific kingdom into one of

the fifty United States.[7]

     This dissertation details how, in twentieth century Hawaiian psychiatry,

place based thinking conflicted with universalist, integrationist theories of mental

illness, such as psychoanalysis. It covers the years 1939 (the year an outpatient

public mental health clinic was first set up in Hawaii) through 1963 (the year of

the implementation of the Community Mental Health Centers Act, in which the

federal government attempted to fundamentally change the system of public

mental health care in the United States).   Universalist medical theories had the

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[6] For a perspective on the reformulation of universalist theories of disease in the twentieth century, see D Loomis and S Wing, "Is Molecular Epidemiology a Germ Theory for the End of the Twentieth Century?," *International Journal of Epidemiology* 19, no. 1 (1990): 1-3.

[7] Islands like Hawaii also provide a natural point of investigation of principles related to place. For a geographical view, see R J Whittaker and J M Fernández-Palacios, *Island Biogeography: Ecology, Evolution, and Conservation* (Oxford University Press, USA, 2007). For a historical summary see J Connell, "Island Dreaming: The Contemplation of Polynesian Paradise," *Journal of Historical Geography* 29, no. 4 (2003): 554-581.

potential to create significant ideological tensions in a place like Hawaii, which local mental health experts were conditioned to view as unique and exceptional.

At the outset of the current study, mental health experts envisioned Hawaii as a globally unique place, a "social laboratory" of tremendous hybridizing power, in which a confluence of racially diverse people and variegated island geography intermixed to produce an exotic menagerie fit for scientific study. After World War II, instead of possessing its own exotic hybridizing power, Hawaii became thought of as a proving ground for the ideological reach of American assimilation. Internationalist and integrationist discourse promoted the idea of Hawaii as merely a part player in larger regional systems.[8] A corollary of Cold War integrationism was the successful assimilation of Hawaii's Asian immigrant workers and indigenous people. Public health and academic figures were involved in furthering assimilation, but not in the one-way manner that has been depicted in some narratives of the history of colonial medicine, as a "tool of empire." Medicine was indeed leveraged towards the concerns of the state, and as a tool of assimilation, particularly in the most important state-related public health issues, like juvenile delinquency and child abandonment. These problems were understood scientifically in theories formulated by public health officials and academic sociologists at the University of Hawaii. Instead of race, however, relationships with space were used to construe difference between organized society (as represented by health experts) and patients. However, assimilationist discourse seemed to sponsor or advocate interracial mixing. Experts' views,

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[8] The best source on this topic is P F Hooper *Elusive Destiny : The Internationalist Movement in Modern Hawaii* (Honolulu: University Press of Hawaii, 1980).

were fundamentally conservative, however, and to the extent that they accepted mixing between Hawaii's diverse people, they did not adopt the assimilationist boosterism of some of Hawaii's advocates in the popular culture and in government. In explaining their resistance, officials avoided overtly racist discourse, but a coded language, involving notions of place and space, evolved to discuss complicated interactions between people of radically heterogeneous backgrounds.

Hawaii's social composition was an important factor in Hawaiian urban settlement and Honolulu's ethnic neighborhoods highlighted the importance of place. In the late nineteenth and twentieth centuries, territorial Hawaii was populated by waves of Asian immigrants, particularly from Japan, who worked on sugar plantations as contracted laborers.[9] These immigrants mixed with an indigenous Hawaiian population whose society had undergone rapid change since first contact with Europeans only a century before. As this dissertation examines, displacement and assimilation of the indigenous and immigrant became important issues for Hawaiian mental health.[10]

Moreover, in Hawaii, there were no organized attempts at psychiatric public health prior to 1939, and few psychiatrists. Therefore, public health psychiatry was unusually influenced by local experts in the social sciences, which

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[9] For details of the Japanese immigration see Roger Daniels, *The Politics of Prejudice* (Berkeley: University of California Press, 1977), and Yukiko Kimura, *Issei: Japanese Immigrants in Hawaii* (Honolulu: University of Hawaii Press, 1992).

[10] As psychoanalyst Salman Akhtar has demonstrated, psychopathology can result from rapid dislocation of familiar attachment to places. Thus, Hawaii provides a rich backdrop of investigation for the psychological problems of migrant workers from Asia. See S Akhtar, "Things Are Us: A Friendly Rejoinder to Marianne Spitzform's Paper The Ecological Self: Metaphor and Developmental Experience?" *Journal of Applied Psychoanalytic Studies* 3, no. 2 (2001): 205-210.

allowed for the development of a detailed psychiatry of place. The local theories of psychopathology can be compared to wider-ranging ideas, which reveals the influences of place.

This dissertation will also examine public health psychiatry in Hawaii in its Cold-War context of the mid to late twentieth century. It follows the work of historian Christina Klein, who describes the intertwining of political and popular cultural agendas during the Cold War.[11]   Klein argues that the legitimacy of American world leadership after World War II rested upon a vision of the U.S. population as a harmonious blend of ethnicities, in which peaceful domestic integration, particularly of Asians and blacks, might serve as a model for diverse people unifying against Communism. Because of its large Asian population, Klein argues "Hawaii in the 1950s had an ideological value unmatched by any other part of the United States."[12]   However, in this study's time period, according to Klein, racial notions declined in favor of other, supposedly more benign characterizations of difference, such as "ethnicity". This study thus proposes the mechanisms by which place based thinking in Hawaiian psychiatry evolved with changing local and national political and medical structures, and details how experts metabolized attitudes about difference in the language of place and space.

"Placing" Hawaii in the Medical Context of Empire

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[11] Christina Klein, *Cold War Orientalism : Asia in the Middlebrow Imagination, 1945-1961* (Berkeley: University of California Press, 2003).

[12] Ibid., 260.

Hawaii was annexed by the United States in 1898 during the Spanish-American

War. While an American friendly, independent Hawaiian republic had been

established in 1894, and had courted annexation, there was no action from a

hesitant Democratic government. Racial fears also loomed large on the

mainland; due to an overwhelming majority population of immigrant Chinese and

Japanese laborers, Hawaii was viewed a bastion of malignant Asiatic influence.

However, in 1898, with American involvement in the Philippines, pro-

annexationists sold Congress on the importance of Hawaii as a trans-Pacific

military holding, despite the fears of racial contagion.[13]

Many authors have viewed Hawaii's annexation of Hawaii during the

Spanish-American War as an expression, if not the high water mark, of America's

late-nineteenth century imperial desires and tendencies.[14] However, Hawaii's

territorial years have yielded a greater diversity of views on what Hawaii

represented as part of a putative American empire.[15] Christina Klein has

examined writings about Hawaii in the 1950s in "middlebrow" media (such a

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[13] See W LaFeber, *The New Empire: An Interpretation of American Expansion, 1860-1898*
(Comstock Pub. Associates, 1998). General political histories of Hawaii include T Coffman, *The
Island Edge of America : A Political History of Hawaii* (Honolulu: University of Hawaii Press,
2003)., G Daws, *Shoal of Time : A History of the Hawaiian Islands* (Honolulu: University of Hawaii
Press, 1968)., N J Kent, *Hawaii, Islands Under the Influence* (University of Hawaii Press, 1993).

[14] See, for example, B Porter, *Empire and Superempire: Britain, America and the World* (New
Haven: Yale University Press, 2006)., N Ferguson, *Colossus: The Rise and Fall of the American
Empire* (New York: Penguin, 2005)., C S Maier, *Among Empires: American Ascendancy and Its
Predecessors* (Cambridge, Mass.: Harvard University Press, 2007). Porter and Ferguson have
made the case that the United States is an empire, with similarities to the British Empire of the
nineteenth century.

[15] For details of the statehood debate see R J Bell, *Last Among Equals : Hawaiian Statehood and
American Politics* (Honolulu: University of Hawaii Press, 1984)., A K Ziker, "Segregationists
Confront American Empire: The Conservative White South and the Question of Hawaiian
Statehood, 1947-1959," *Pacific Historical Review* 76, no. 3 (2007): 439-466., G Heefner, " A
Symbol of the New Frontier," *Pacific Historical Review* 74, no. 4 (2005): 545-574.

popular news magazines, musicals, and historical novels) and argues that these productions tempered America's identity as an ambitious imperial power.[16] On the other hand, journalist John Gregory Dunne has made a case for thinking about Hawaii as an "American Raj," in which the mythology of the Pearl Harbor attack in 1941 has ultimately disguised baser imperial motives.[17] A group of several Hawaii-based scholars has even rethought the polarity of Hawaiian colonialism by arguing that Asian immigrant settlement to Hawaiian sugar plantations in the late nineteenth and early twentieth centuries represents an equally complicit disenfranchisement of indigenous Hawaii agency.[18]

This study assumes that colonial or imperial structures continued to be at work in Hawaii of the period 1939 to 1963. Therefore, the study's main orientation and theoretical inspiration will derive from works in the history of colonial medicine. Indeed, the history of medicine in an imperial or colonial setting has become an important subfield within the history of medicine as a whole. Yet, there remain no agreements as to what defines medicine in the colonial or imperial environment, what the agenda of colonial medicine is, or whether adjustments to standard techniques of historiography must be developed. Since this dissertation finds its closest homology with the history of colonial medicine, it strives to respond to some of these concerns.

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[16] C Klein, *Cold War Orientalism : Asia in the Middlebrow Imagination, 1945-1961*.

[17] J G Dunne, "The American Raj; Pearl Harbor as Metaphor," *The New Yorker,* May 7, 2001, 46.

[18] Candace Fujikane and Jonathan Y Okamura, *Asian Settler Colonialism: From Local Governance to the Habits of Everyday Life in Hawaii* (University of Hawaii Press, 2008).

A major question has thus been "what is 'colonial' about colonial

medicine?"[19] In the history of medicine, there have been two basic answers to

this question. One side has argued that the fundamentally exploitative nature of

a hegemonic colonial power and a dependent colony set up the equally

exploitative conditions of colonial medicine. This "dependency theory" approach,

so called because of its emphasis on the theory of the fundamental structural

elements of colonialism, may follow Marxist or other economic theories.[20] On the

other hand, some approaches have downplayed the notion of a distinctive

character of medicine in a colonial situation in favor of critiquing the fundamental

imperial nature of Western medicine in itself, as a pursuit that attempts to

"colonize" "bodies" with techniques of repression and surveillance, one that has

natural sympathies with colonialism, but is not simply an emergent feature of

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[19] This question was posed in Shula Marks, "What Is Colonial About Colonial Medicine? And What Has Happened to Imperialism and Health?," *Social History of Medicine* 10, no. 2 (1997): 205-219.

[20] Lynn M Morgan, "Dependency Theory in the Political Economy of Health: An Anthropological Critique," *Medical Anthropology Quarterly* 1, no. 2 (1987): 131-154.

colonialism itself.[21] This "cultural critique" view often follows a theoretical

approach drawn from the writings of Michel Foucault.[22]

Another debate surrounds the role of science in colonial medicine.

Dependency theory emphasizes science and medicine as "tools of empire," vital

to economic and military domination.[23] On the other hand, some historians have

argued that European science was not a significant arbiter of colonial medicine in

certain contexts. Indeed, the historian of medicine Warwick Anderson questions

whether European bacteriological medicine ("germ theory") was truly the core

feature of medicine in the colonial setting, as has been traditionally argued.

Instead, in his own research in the Philippines, Anderson finds colonial public

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[21] The phrase "colonizing the body" is from David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993). Other examples of writing from this viewpoint are Warwick P Anderson, "Where Is the Postcolonial History of Medicine?," *Bulletin of the History of Medicine* 72, no. 3 (1998): 522-530., Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991),W Anderson, *The Cultivation of Whiteness: Science, Health and Racial Destiny in Australia* (New York: Basic Books, 2003), Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (Oxford: Routledge, 2001).

[22] Waltraud Ernst criticizes British historians of medicine of the 1990s of being "enthused if not obsessed" with Foucaultian theory and argues that the body of research "was dangerously close to simplistically construing state power as monolithic, at best allowing indigenous subjects to assert agency through various kinds of 'resistance.'" See W Ernst and P B Mukharji, "From History of Colonial Medicine to Plural Medicine in a Global Perspective," *NTM Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin* 17, no. 4 (2009), 448.

[23] One of the earliest versions of this now famous argument was offered by the historian Phillip Curtin, in two separate monographs. Curtin offered that Western Africa, the "White Man's Grave," was not colonizable until the 1850s due to lack of development of basic public health and sanitation measures. See P D Curtin, *The Image of Africa; British Ideas and Action, 1780-1850* (Madison: University of Wisconsin Press, 1964), and P D Curtin, *Death by Migration : Europe's Encounter with the Tropical World in the Nineteenth Century* (Cambridge England ; New York: Cambridge University Press, 1989). Daniel Headrick extended Curtin's work and placed medical developments, such as quinine, in the pantheon of other "mission critical" technological "tools of empire" such as steamships and repeating rifles. See D R Headrick, *The Tools of Empire : Technology and European Imperialism in the Nineteenth Century* (New York: Oxford University Press, 1981).

health's inspiration coming not from medical theory, but from "the military or the mission."[24]

An associated central problem in the history of colonial medicine (which also relates to place) is the role of "germ theory" in terminating the importance of climactic or place factors in colonial endeavors. The history of colonial medicine is replete with studies which have detailed how thinking about place, climate, and disease tempered European expansion into unfamiliar territory. [25] However once the bacteriological revolution and "germ theory" of the late nineteenth century occurred, the conventional history goes, Europeans could be much more confident about expanding to colonies.[26] But the centrality of germ theory accounts and the one-way acceptance of scientific knowledge are undergoing revision. For example, as David Arnold has shown, the development of European institutes of tropical medicine was just one succession of a long tradition of medicine studied and practiced in unfamiliar places.[27] Thus, Arnold's work has problematized a neat transition from climactic pathology to pathogen based "germ theory," and instead has demonstrated the persistence or hybridity of some aspect of place based thinking well into the early twentieth century. Recent revisions have similarly argued that "germ theory" had little

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[24] Anderson, "Where is the Postcolonial History of Medicine," 524.

[25] For a bibliographic summary see Ryan Johnson, "European Cloth and "Tropical" Skin: Clothing Material and British Ideas of Health and Hygiene in Tropical Climates," *Bulletin of the History of Medicine* 83, no. 3 (2009): doi:10.1353/bhm.0.0252., particularly page 544.

[26] For the history of previous approaches to bacteriology in tropical medicine see D Arnold, "The Place of 'The Tropics' in Western Medical Ideas Since 1750," *Tropical Medicine & International Health* 2, no. 4 (1997): 303-304.

[27] Ibid.

effect on the doing of medicine in colonial places.[28] But if germ theory was not

central to colonial medicine, then what was? We have not received many

answers to this question despite the assault on germ theory. Moreover, while

hinting at the persistence of place based ideas, historians have not detailed in

what ways placed based influences persisted beyond germ theory.

Race has played an important conceptual role in both the dependency

theory and the cultural critique versions of colonial medicine, and has crystallized

notions about difference between places. Racial theory operated in medicine's

treatment of both indigenous patients and transplanted colonial settlers.[29]

Medicine, in the dependency theory view, uses race and racism in colonial

exploitation, while in the cultural critical view, manipulation of race for the aims of

conquest is part and parcel of medicine itself.[30]   But in the Hawaii case, racism

and race based theories of mental illness were less overt. A local language

evolved to explain differences in susceptibility to mental illness. This dissertation

will examine how place concepts came to stand in for race or biological

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[28] See, for example, Nancy J Tomes and John H Warner, "Introduction to Special Issue on Rethinking the Reception of the Germ Theory of Disease: Comparative Perspectives," *Journal of the History of Medicine and Allied Sciences* 52, no. 1 (1997): 7; M P Sutphen, "Not What, but Where: Bubonic Plague and the Reception of Germ Theories in Hong Kong and Calcutta, 1894--1897," *Journal of the History of Medicine and Allied Sciences* 52, no. 1 (1997): 81-113.

[29] For a summary of medical geographic approaches to race and the threat of tropical degeneration, see Valencius, "Histories of Medical Geography," 15-16. Warwick Anderson provides one of the only "post-racial" explanations of empire, place, and medicine. He explains the process by which climactic anxiety related to race was transformed into thinking about Filipino "culture" which commanded change of Filipino behaviors regarding sanitation -- processes which allowed for American surveillance and inspection. See Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines.*

[30] See W Anderson, "Immunities of Empire: Race, Disease, and the New Tropical Medicine, 1900-1920," *Bulletin of the History of Medicine* 70, no. 1 (1996): 94-118.

difference, an important development since overtly racial explanations of medical

difference became rarer after World War II.[31]

The term "post-colonial" deserves mention here. In the last twenty years,

a number of writers on empire and colonialism associated themselves with this

term. This study employs geographer Brenda Yeoh's definition of the term, a

"conceptual frame which works to destabilize dominant discourses in the

metropolitan west, to challenge inherent assumptions and to critique the material

and discursive legacies of colonialism."[32] An implication of Yeoh's definition

concerns the presumed one-way export of knowledge from empire to colony, an

idea that sometimes surfaces in "political economy" or dependency theory

readings of colonial medicine.   Post-colonial studies have emphasized a

reversed or more dialectic relationship. As such, in a reversal of identity,

European empires can be seen as mirror reflections of colonial possessions and

attitudes.[33] In the Hawaii case, this dissertation will examine how medical

theories were exchanged between the continental United States and Hawaii.

While Hawaiian medical theories may not have been directly influential on

American psychiatry, Hawaii did become an important part of American cognitive

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[31] Christina Klein explains how the concept of "ethnicity" grew out of race based explanations of difference. See Klein, *Cold War Orientalism : Asia in the Middlebrow Imagination, 1945-1961*, especially chapters 1 and 6.

[32] Yeoh, *Contesting Space in Colonial Singapore : Power Relations and the Urban Built Environment*, 457.

[33] See Anderson,"Where is the Post Colonial History of Medicine," for further explanation of how the political economy of health re-creates national histories of a European form. For examples of work demonstrating a dialectic of influence between imperial center and colonial periphery see A M Burton, *After the Imperial Turn: Thinking with and Through the Nation* (Durham: Duke University Press Books, 2003), and B Porter, *The Absent-Minded Imperialists: Empire, Society, and Culture in Britain* (New York: Oxford University Press, USA, 2004).

space. The concept of "mental maps" -- pictographic representations of ideas about place and their relationships -- were developed by geographers Peter Gould and Rodney White, and explain the reification of places as projections of cognitive and psychological processes, a separate dimension of place that exists solely in the mind.[34]   As outposts of American "mental maps", what happened in Hawaiian psychiatry had the potential to shape American identity, particularly in the United State's role as transnational superpower.

This study is also informed by the connection between place and health, which has long been studied as a specialty of academic geography. The modern geographical study of mental health emerged in the mid-1960s as an ideological descendent of earlier movements that actually originated in psychiatry, and has maintained, as a review by geographer Chris Philo shows, an interest in the spatial distribution of mental illness, and the prevalence of mental illness in cities versus rural areas.[35] In addition, medical geography, an interdisciplinary discipline, to which both historians and geographers have contributed, concerns itself with the relationship between health and the environment. Medical geography impacts this dissertation because while there are internal histories of medical geography, in parallel, historians have also leveraged several prominent studies of how place influenced notions of health. Most of these studies are set in the nineteenth century or before.   For example, in *The Therapeutic Perspective*, John Harley Warner shows that the doctrine of specificity -- the

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[34] P Gould and R White, *Mental Maps* (Harmondsworth: Penguin, 1974).

[35] C Philo, "The Geography of Mental Health: An Established Field?," *Current Opinion in Psychiatry* 18, no. 5 (2005): 585-91.

expert knowledge of a patient's physical and environmental milieu -- trumped

universal medical knowledge in the antebellum American medical world.[36] The

power of place also had important bearings on the settlement of the Western

American hinterland in the early nineteenth century. As Conevery Bolton

Valencius has shown, antebellum emigrant Americans were strongly tied to the

idea of land as determinant of health. She concludes that the quest for

"salubrity" in migrating Americans was as powerful a motivation as the promise of

economic prosperity.[37]

Overview

In short, psychiatry, as informed by the social sciences, could be a tool of

political economy and statecraft, but its utilization was measured, complex, and,

at times, opposed over-rapid assimilation of Hawaii into the United States. In the

1940s and into the 1950s the territorial (and subsequently state) government did

not seek to increase the number of patients under institutional supervision; rather

it wholeheartedly tried to employ enough health educators to avoid the problems

of abandoned children and juvenile delinquents, which officials viewed as a great

drain on resources. At the same time, psychiatric medicine attempted to

assimilate disparate peoples to the basic rules of universal American behavior.

But resource problems and paying psychiatrists and mental health workers

severely hampered the growth of outpatient mental health services in the first

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[36] J H Warner, *The Therapeutic Perspective : Medical Practice, Knowledge, and Identity in America, 1820-1885* (Princeton, N.J.: Princeton Unversity Press, 1997).

[37] C B Valencius, *The Health of the Country: How American Settlers Understood Themselves and Their Land* (New York: Basic Books, 2004).

decade of psychiatric public health, from 1939 to 1950. On the other hand, Hawaiian mental health experts were not impotent lackeys passing on policy from the mainland. In fact, local psychiatric theories at times had an anti-imperial, anti-assimilative bent, and could be used by officials to criticize overly rapid "Americanization." Thus far from being a coercive, imported "tool of empire," Hawaiian psychiatry could be quite nimble, hardy, and locally informed in its practice. On the other hand, through the 1950s and 1960s, universal medical and psychiatric theories became more popular, subtly eroding the sense of uniqueness officials had about Hawaii. This was perpetrated not by scheming colonial administrators, but rank and file academics, often representative of the diverse immigrant culture of Hawaii itself.

This dissertation uses published sources, such as medical and social science journals, and unpublished archival material from Hawaii including conference proceedings and public health documents from the Hawaii Department of Public Health now stored at the University of Hawaii, the Hawaii State Archive, and the Queen's Hospital in Honolulu. In addition it uses unpublished M.S.W. theses and student papers from the Department of Sociology at the University of Hawaii at Manoa.

This study is the first to connect the "post-colonial" history of medicine to ideas about place and psychiatry after the second World War. It further examines the history of medicine in Hawaii informed by historical work on public health in a colonial context, which in itself is a novel contribution.   Numerous studies have examined how notions of tropical climate, as a function of place,

might be a projection of racial anxieties in the nineteenth and early twentieth centuries. However, no study has clarified how this tradition of place thinking might have survived in clinical thinking beyond the early twentieth century, nor have many ventures (in the history of medicine) been made beyond climate as a function of understanding how both government officials and their subjects might understand place.

Next, there remains an enormous gap in the current literature on the history of the concept of place as related to medicine. The gap begins at approximately the 1920s with the supposed waning of environmental influences influenced by "germ theory" and ends around the 1970s with the development of medical geography as an organized academic field.[38]   This leaves almost three decades in which place thinking in mental health is unaccounted for. This study attempts to fill in some of those gaps.

Finally, this study is one of the first to provide a post-germ theory thesis on the ebbs and flows of place thinking. While this introduction has covered the weakness of the germ theory thesis, few studies have offered a coherent alternative. Instead of germ theory, in the Hawaiian case, social scientific theory, influenced by geo-political concerns, narrow developments in medical thinking, and national narrative and mythologies drove medical theory, the integration of place, and the environmental notions of disease causation.

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[38] Connevery Valencius notes the waning of geographical influences at the turn of the twentieth century and asserts that "Historians concur that medical geography quickly faded as a concern of the popular realm." Valencius, "Histories of Medical Geography," 19. She notes a reformulation of medical geographic theory after World War II, and cites a 1951 article by geographer Jacque May as providing the structure for academic medical geography. However, her next example of substantive work on May's thesis does not occur until 1977.

This dissertation starts with developments on the mainland, and depicts the ideological backdrop upon which variations in Hawaii will appear more starkly. Chapter 1 provides a history of clinical psychopathologic modes of investigating environmental influences. Psychoanalysis was the dominant mode of American psychiatry in this dissertation's timeframe, and yet psychoanalysis never became popular in Hawaii. Psychoanalysis was rooted in an inherent distrust of the the senses, and thus tended to universally downplay the influence of the environment. Some of the universalist, deterministic theory in psychoanalysis also created major splits in American psychiatry as a whole and occasioned detailed dogmatic revisions to answer intellectual critiques. Furthermore, many other social sciences adopted psychoanalytic thinking and maintained a bias towards intra-psychic or early childhood relationships, thus limiting their appeal in Hawaii. While psychoanalysis was interested in some types of environmental events, which occasioned at times bizarre formulations, psychoanalytic theory was never a robust enough theory for adoption in multi-ethnic Hawaii. On the other hand, exploring the role of the environment on mental health had very practical applications, which continued to be investigated by some branches of the social sciences, either with or without a psychoanalytic explanation.

Chapter 2 covers the mental hygiene movement, a precursor to psychoanalysis, and traces its evolution to social psychiatry -- a discipline where psychiatry was wedded to academic sociology of the 1950s. The chapter demonstrates social psychiatry's interest in the problems and potentialities of cities and the discusses social psychiatry's distrust of suburbs. In contrast to

psychoanalysis, social psychiatry and sociology were friendlier to detailed local theories of psychopathology. This study describes the development of social psychiatry in the United States as a whole to provide a comparison for the development of social psychiatric ideas as practiced in Hawaii.

Chapter 3 transitions the study to Hawaii. It introduces Hawaiian exceptionalism, the idea that something distinct differentiated Hawaii from the rest of the United States and indeed the rest of the world. The chapter details the establishment of the public mental health system in Hawaii, with its roots in mental hygiene, and highlights the relative absence of psychoanalytic infrastructure or professionals. It also introduces the loaded terms that could be placeholders of deeper meanings of place and environment, like "attitude", and "family".

In Chapter 4, the study will cover the mental health of Native Hawaiians, including Native Hawaiian delinquency, marriage fluidity, and child social service placements. In the Hawaiian culture, place was intimately tied to kinship and household, and shifting homes was a normal response to external stresses or changes in status. However, this created conflicts with traditional American ideals of marriage and child welfare. In these conflicts, social scientific arguments were employed to both understand these problems, and to craft therapeutic environmental treatments.

Chapter 5 investigates understandings of the Japanese psyche that tied into ideas about Japanese immigration and race mixing. The Japanese were seen to be dependent upon their own isolated racial ghettos, which although anti-

democratic (and potentially politically subversive), prevented psychic chaos when the fragile Japanese psyche was overly Americanized.   Chapter 6 also begins to cover social scientific ideas about race-mixing and consequences for building and urban planning, and shows how new social scientific theory began to erode the detailed sense of geographic exceptionalism in Hawaii.

Chapter 6 further discusses the built environment and its relation to mental health in Honolulu. In the 1950s and 1960s, architects, city planners, mental health experts, and sociologists collaborated on ideas about how buildings, neighborhoods, homes, and stores might contribute to mental health problems in Honolulu. These discussions were the ultimate expression of locally formulated space and place based theories of mental illness. However, at the same time, some experts in Hawaii promoted a competing strand of universalist, integrationist thinking, popular in the American academy as a whole, that contradicted the notion of Hawaii as a unique place. Modernization theory, a philosophy of economic development ideas, placed Hawaii as but one example of an agrarian society progressing along a continuum, examples of which were common in the developing world.

In the conclusion, the dissertation explains how the Community Mental Health Movement of the 1960s can be seen as an extension of the universalist, integrationist theories that, in an Orwellian turn, seemed to strip locality from thinking about mental illness. The conclusion then replies to some of the major problems in the history of colonial medicine and poses some future scholarly issues. It encourages historians of colonial medicine to move beyond our current

modes of explanation of race, "germ theory," and climate, particularly when

working in the twentieth century. More importantly, this study redefines colonial

medicine as immigrant and indigenous health in the context of spatial dislocation

and stress. The conclusion visits the philosophy of psychiatry and its relationship

to power. It argues that psychiatry may be informed by other heuristics than the

medical model of normal and pathological tissue function; these other

perspectives cause psychiatry, more than other branches of medicine, to reify the

power structures from which it is derived. Psychiatry has a unique relationship to

power -- but Foucault's work on the subject has concentrated on the ineffables

between medicine and a generic, faceless state. The chapter ends with a

concrete discussion of the ways power relationships become embedded in

psychiatry, and concludes with the implications for power and colonialism when

American psychiatric theory is exported abroad, particularly in the area of global

mental health.

CHAPTER ONE

PSYCHOANALYSIS AND THE COLONIAL PROJECT

This chapter examines how place and space were regarded in psychoanalysis, the dominant therapeutic philosophy in American psychiatry from World War II to the mid 1960s. In this period, psychiatrists overwhelmingly sought psychoanalytic training, psychoanalysts dominated academic departments and important teaching posts, and psychoanalysis was popularized in American mass media and culture.[1]   Curiously, psychoanalysis was never the dominant psychiatric model in Hawaii. This inconsistency reveals much about Hawaii's idiosyncrasies in spite of its statehood and informs this dissertation's investigation of the colonial medicine.

Specifically, if colonial medicine was simply a projection of knowledge from center to periphery, then we would expect that psychoanalysis would be the dominant psychiatric mode in Hawaii. Moreover, following the theory of psychiatrist Frantz Fanon and psychoanalyst Jacques Lacan, a myriad of writers

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[1] For an articulation of the dominance of psychoanalysis see Nathan G Hale, *The Rise and Crisis of Psychoanalysis in the United States : Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995), particularly chapters 14-16. Other general sources on the history of psychoanalysis in the United States are Nathan G Hale, *Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876-1917, Volume 1* (New York: Oxford University Press, 1971); Edward Shorter, *A History of Psychiatry : From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997),Henri F Ellenberger, *The Discovery of the Unconscious; The History and Evolution of Dynamic Psychiatry* (New York: Basic Books, 1970); Gerald N Grob, *From Asylum to Community : Mental Health Policy in Modern America* (Princeton, N.J.: Princeton University Press, 1991); Justin D Suran, "Toward an Illusionless City: The Province of Psychiatry in Twentieth-century San Francisco" (Ph.D. Dissertation, University of California, Berkeley, 2003); Jonathan Engel, *American Therapy : The Rise of Psychotherapy in the United States* (New York: Gotham Books, 2008).

have described the creation of a colonial mindset or psychology, as a means by which colonial powers secure, assert, and promulgate power.[2] American psychoanalysis could arguably be part this process. Indeed, postcolonial theorist Ranjana Khanna has argued that psychoanalysis "is a colonial discipline," one that embodies an inherent colonial, racist and anti-feminist attitude.[3] Thus, psychoanalysis seems like it would be the ideal tool of empire -- the question, in Hawaii, is why wasn't it?

Of course, structural limitations and lack of psychiatric infrastructure challenged any kind of psychiatric project in Hawaii; even more so an outpatient discipline like psychoanalysis, which depended on well off patients and dense urban populations to support private practice. Despite these qualifications, this study argues that on philosophical and intellectual grounds psychoanalysis was poorly suited to Hawaii. First, while psychoanalysis minimizes the significance of the external environment, in a colonial setting, signifiers of place have a critical role. Moreover, as a system of medical therapeutics, psychoanalysis tended to downplay traditional colonial signifiers of status in favor a universal psychoanalytic theory of variation -- the metabolism of sexual impulses, impressed at an early age. Due to the centrality of this theory, psychoanalysis operated universally and had little need to acknowledge place. This made it

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[2] See, for examples, Jean Walton, "Re-Placing Race in (White) Psychoanalytic Discourse: Founding Narratives of Feminism," *Critical Inquiry* 21, no. 4 (1995): 775-804. http://www.jstor.org/stable/1344067, Tracey Sedinger, "Nation and Identification: Psychoanalysis, Race, and Sexual Difference," *Cultural Critique* 50, no. 1 (2002): doi:10.1353/cul.2002.0011, Christopher Lane, "Psychoanalysis and Colonialism Redux: Why Mannoni's" Prospero Complex" Still Haunts Us," *Journal of Modern Literature* 25, no. 3 (2003): 127-149.

[3] Ranjana Khanna, *Dark Continents : Psychoanalysis and Colonialism* (Durham, NC: Duke University Press, 2003), 6.

unsatisfying as a system of psychiatry in a place like Hawaii, where the significance of place was an overwhelming reality.

This chapter will also introduce psychobiology, a system of psychiatric theory that preceded psychoanalysis, that was developed by Swiss-American psychiatrist Adolf Meyer. This pragmatic, eclectic approach was better suited to a places like Hawaii. It ends with an introduction to the mental hygiene movement, a model of public health psychiatry which was founded on psychobiological principles.

What is the Relationship of Psychiatry to Psychoanalysis?

Psychiatry is an applied discipline of medicine that attempts to catalog, treat, and delineate the causes of mental illnesses. Medical responses to the problem of mental illness have been documented throughout the ages of history. As such, the history of medicine is directly relevant to present day psychiatry. However, because the substrate of psychiatry is mental phenomena, like emotions and thoughts, approaches to these problems coming from philosophy and psychology are directly relevant as well, in the same way that physiology and biochemistry are directly relevant for cardiology.[4] Psychoanalysis, likewise, is both a system of medical therapeutics, designed to be used in a clinical setting for patients with defined illnesses, and a philosophy of mind. While psychiatric medicine and psychoanalysis may be derived from competing, incompatible, philosophical

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[4] For the relevance of philosophy for psychiatry, see S Nassir Ghaemi, *The Concepts of Psychiatry : A Pluralistic Approach to the Mind and Mental Illness* (Baltimore: Johns Hopkins University Press, 2007).

foundations, in the post-World War II period psychoanalysis became the

dominant psychological and therapeutic system used in clinical psychiatry.

Historian Peter Homans has outlined three bodies of writing about

psychoanalysis, which include biographical investigations of Freud and other

central psychoanalytic figures, the extension of psychoanalytic language in

cultural and literary analysis, and the infiltration of psychoanalytic thinking into

deciphering "modernity."[5] However, despite these "landmasses" of literature,

there have been relatively few historical investigations of psychoanalysis as a

medical therapeutic system in the colonial setting.[6]   In his review, historian

Richard Keller noted the inherent tensions between the universalism of classical

Freudian psychoanalysis and the power dynamics of a colonial society, which

thrive on a need for hard distinctions between "normal" and "pathological."

Similarly, Christiane Hartnack's study of the reception of psychoanalysis in British

India shows how key aspects of Freudian theory were substantially reworked by

Indian psychoanalysts as a conscious statement of political and cultural

independence.[7]

Psychiatry was under no obligation to use psychoanalysis -- its hegemony

does not reflect a lack of alternatives. Any psychiatric theory will borrow from

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[5] Peter Homans, *The Ability to Mourn : Disillusionment and the Social Origins of Psychoanalysis* (Chicago: University of Chicago Press, 1989), 1-3.

[6] For a historiographical summary see Richard Keller, "Madness and Colonization: Psychiatry in the British and French Empires, 1800-1962," *Journal of Social History* 35, no. 2 (2001): 295-326.

[7] Christiane Hartnack, "Vishnu on Freud's Desk: Psychoanalysis in Colonial India," *Social Research* 57, no. 4 (1990): 921-49.

different thinking about causes. However, what constitutes psychopathology lies at a four corners of cause.[8] Any approach to psychiatry will mix and blend emphasis on each of the various components of psychopathology.

One model of psychopathology is the medical or biological model. This model asserts that psychopathology derives from a catalog of discernible pathological processes that have their functional root in disorders of biological material, be it organs, tissues, or cells. A focus is on disorders found to have their origin in nervous tissue or the brain. Disorders are discernible and diagnosable; they can be described phenomenologically and their course may be predicted. The environment can be important, in that environmental influences have as their substrate biological material and can trigger mechanical factors in tissues that produce pathology. A narrower view is that all mental phenomenal can be reduced to biological events, a kind of biological materialism.

A second model is the mind or psychological model. This model assumes that the mind is an emergent property, greater than the sum of the parts of brain and nervous tissue, its biological substrate. The mind asserts an organizing framework and may be subject to latent intent or motivations. The mind may also be split up into a hierarchy of cooperating or conflicting subunits. Psychopathology results from inhibitions, trauma, or frustrations of the mind's motivations and intentions. Theories of the environment's influence in the

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[8] Paul R McHugh and Phillip R Slavney, *The Perspectives of Psychiatry* (Baltimore: Johns Hopkins University Press, 1998), and Ghaemi, *The Concepts of Psychiatry : A Pluralistic Approach to the Mind and Mental Illness* have devised and analyzed other conceptual frameworks from which psychiatry may be based. In contrast to these works, which attempt a working out of an entire systems perspective to the field, this discussion's goals are significantly more modest -- they merely allow that any approach to psychiatry may place emphasis on each component.

psychological model may be well-developed and sophisticated. At the other extreme, psychological models may myopically reduce all events to intra-psychic phenomena. This introversion results in environmental phenomena being considered less relevant that the resultant effects on the mind.

A third psychopathological model in clinical psychiatry is the socio-environmental or contextual model. This model suggests that psychiatric illness comes from hardships, limiting frameworks, or discrepancies in the external world (like culture, poverty, or homelessness) or that psychopathology results from conflicts between people. A radical extension of this model is the supposition that mental illness does not exist; that all mental illnesses are socially constructed labels that may used to manipulate others or deprive them of naturally inborn rights. There may be overlap with psychological or medical/biological conceptions; however environmental theories will give primacy to environmental mechanisms over events in the mind or brain and may place emphasis on the actions of the environment across an individual's development. Furthermore, this model focuses on treating mental illness by ameliorating pathological mechanisms in the environment at large, and is less concerned with internal biological events or psychological or cognitive metaphysics.

Finally, the spiritual/existential model argues that metaphysical problems in meaning, purpose, identity, or spiritual wholeness are at the root of psychopathology. The existential model places at its forefront the problem of death and what may lie (or not lie) beyond it. Psychopathology results from

inability to confront this problem and make sense of existence. Existential

models often rely on psychological substrate, in that a theory of mind provides a

mechanism for accessing existential truths; at the same time, there is often a

"dualistic" aspect to an individual's psychology, in an emphasis on the alignment

of an individual's psychology with some greater reality. At the same time,

environmental influences may be important, but the individual's own psyche is

critical in organizing and integrating environmental realities into holistic meaning.

And while environment might be acknowledged, it is not privileged.[9]

Along with these rough models, psychiatry has its own intellectual heritage

which has placed it at the cross roads of two important epistemological traditions.

Debates about which is the proper tradition further complicate juxtapositions with

the above models of causation. This split in epistemology derives from a

nineteenth century debate about the philosophy of the sciences, and despite how

arcane it might seem for a modern conception of psychiatry, the debate is still

relevant.[10]

One version is that psychiatry belongs to that family of human sciences in

which relative truth is subjective and individual. We are entitled to our opinions

about things, but our interpretation is not necessarily more correct than someone

else's. The human sciences seek to understand shared emotions. If one takes

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[9] For a history of this viewpoint in American psychiatry, see Steen Halling and Judy Dearborn Nill, "A Brief History of Existential - Phenomenological Psychiatry and Psychotherapy," *Journal of Phenomenological Psychology* 26, no. 1 (1995): 1-45.

[10] The following two paragraphs come from Ghaemi's discussion of Wilhem Dilthey's concepts of *verstehen* versus *erklaren* in S Nassir Ghaemi, *The Rise and Fall of the Biopsychosocial Model : Reconciling Art and Science in Psychiatry* (Baltimore: Johns Hopkins University Press, 2010), chapters 14-16.

this view, then empathy is the magic wand of psychiatric therapeutics. If we can understand a patient and share some of her emotion, than we have comprehended a certain kind of reality. This reality may be deployed to good aims in the healing of the patient.

A competing model is that psychiatry belongs to the branch of hard sciences which seek to explain causality, to show us how psychopathology came to be. In this model, there is a "right" answer to psychopathological questions, and the answer may be articulated using a common language of scientific or mathematical laws. In this view, coming to answers about etiology and cause orients an approach to psychiatric practice focused on making explanations about things and correcting them based on our explanations.

Finally, a central philosophical problem in history has been the nature of the reality of the world around us, or our environment. Are our senses conveying to us the true nature of things, or are sensations transmitted to us with some error inherent? If it is true that there is some error inherent, than what is the true nature of things, how do we get at it, and what do we make of the aberrations of the senses? Do we plunge inward, distrusting the senses and our environment,

as a rule in trying to figure out "truth," or do we pragmatically partake in that which we know and is accessible to us?[11]

The history of medicine has grappled with these issues and, as a result, has shown periods of alternation between adherence to speculative metapsychological, theoretical, and philosophical thinking and heavily ground empiricism, relying on an objective measure of reality rooted in the senses. Especially in areas like psychiatry, where important biological or other mechanisms are unknown, speculation is necessary to formulate explanation. In the absence of proof, speculative ideas can be formalized into theoretical dogma or universal theory. On the other hand, empirical approaches in medicine reject universal dogmas or theories, preferring to treat an individual as a unique entity with an idiosyncratic personal environment. In this conception, treating what the patient is experiencing is more important than proving or being consistent with some theory, and doing what works for an individual patient is the golden rule.[12]

What Impact did Psychoanalysis Have on American Psychiatry?

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[11] See the discussion of epistemology in Ghaemi, *The Concepts of Psychiatry : A Pluralistic Approach to the Mind and Mental Illness*, especially Chapter 2, or Daniel J Robinson, *An Intellectual History of Psychology* (Madison, Wis.: University of Wisconsin Press, 1995). Other general works of psychiatry and philosophy include: K W M Fulford, Tim Thornton and George Graham, *Oxford Textbook of Philosophy and Psychiatry* (Oxford ; New York: Oxford University Press, 2006), Rachel Cooper, *Psychiatry and Philosophy of Science* (Montreal: McGill-Queen's University Press, 2007), Derek Bolton, "Shifts in the Philosophical Foundations of Psychiatry Since Jaspers: Implications for Psychopathology and Psychotherapy," *International Review of Psychiatry* 16, no. 3 (2004): 184-189. This discussion is not intended to exhaustively summarize the content of philosophy and psychiatry, but rather to start a discussion on philosophical grounds as to why psychoanalysis required or invited major revisions when practiced in colonial societies.

[12] For a discussion of the changing meaning of rational and empirical in nineteenth century medicine in John Harley Warner, *The Therapeutic Perspective : Medical Practice, Knowledge, and Identity in America, 1820-1885* (Princeton, N.J.: Princeton University Press, 1997).

If psychoanalysis has its own set of answers to these philosophical questions, what influence did it have on the philosophical foundations of American psychiatry as a whole, not only during the period of time in which it was dominant, but subsequently? One argument has been that twentieth century American psychiatry remained broadly eclectic in clinical practice, even at the height of the psychoanalytic period.[13] Other historians have seen psychiatry as a "house divided" in which psychoanalytic or psychotherapeutic clinical orientations were incompatible with biologically oriented psychiatry. Historian Edward Shorter describes American psychiatry at mid century as a struggle between two incompatible sections: a cultish psychoanalytic faction versus an ice-pick and electroshock wielding band of somatically oriented hospital psychiatrists.[14]   On the other hand, there are the recent arguments of historian Jonathan Engel and psychiatrist Nassir Ghaemi. These works argue that American psychiatry, writ large, was heavily influenced by psychoanalysis, both in methodology and philosophy. Engel's recent book suggests that psychoanalytic influence has been preserved in the anarchic sea of psychotherapies that evolved by the end of the 1970s.[15] Ghaemi ventures that psychoanalysis is still the overarching mode in psychiatry's current biopsychosocial model, the framework that is used

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[13] Historian Gerald Grob has advanced this view. See Grob, *From Asylum to Community : Mental Health Policy in Modern America*, especially chapters 5 and 11.

[14] Shorter, *A History of Psychiatry : From the Era of the Asylum to the Age of Prozac*. For a modern account of the tensions between biological psychiatry and psychoanalysis see Tanya M Luhrmann, *Of Two Minds : The Growing Disorder in American Psychiatry* (New York: Knopf, 2000).

[15] Engel, *American Therapy : The Rise of Psychotherapy in the United States*.

by the American Board of Psychiatry and Neurology to credential psychiatrists to this day.[16] From the perspective of these two authors, the tenacity of psychoanalytic thinking underscores the psychoanalytic absence in Hawaii as even more significant.

The Intellectual Heritage of Psychoanalysis

Freud is a central figure in the development of psychoanalysis. There have been three basic narratives in analyses of Freud's "project" -- his goals and intentions in promoting psychoanalysis as a scientific movement. One basic strain is that Freud's motivation was one of advancing the science of mind. For example, one of Freud's goals was to map out a unifying theory of the mind and relate this to medical, neurological theory of the day -- in other words, Freud sought a union of the biological and psychological models.[17] However, psychiatrists McHugh and Slavey have likened Freud's mission to the "modernist" project of Nietzsche -- an anti-positivist polemic that actually calls into question the deceptions inherent in historical progress.[18]   Moreover, there are accounts of a mystical or existential Freud, particularly in his thinking about ideas of collective or group psychology.[19] In these writings, Freud approaches a union of the psychological and existential approaches of psychiatry. Finally, several analyses have depicted Freud's work

[16] Ghaemi, *The Rise and Fall of the Biopsychosocial Model : Reconciling Art and Science in Psychiatry*.

[17] Robinson, *An Intellectual History of Psychology*, 314-19.

[18] McHugh and Slavney, *The Perspectives of Psychiatry*, 23-6.

[19] George B Hogenson, *Jung's Struggle with Freud* (Notre Dame: University of Notre Dame Press, 1983); David Bakan, *Sigmund Freud and the Jewish Mystical Tradition* (Mineola, N.Y.: Dover Publications, 2004).

as an alternative theory of sociology. Indeed, Freud arged that society

collectively played out the Oedipal drama.[20]   Thus, to the extent that Freudian

psychoanalysis influenced American psychiatry, we can say that there is a

distinct psychoanalytic position on the environment.

And what was the Freudian position on the nature of the environment? In

its most orthodox form, the Freudian position privileges intra-psychic

phenomena, downplays influences of the external or social environment (outside

of the immediate child-rearing period), and tends to distrust the senses as

conveyed through the conscious mind.[21] As Hale has shown, in the 1930s,

dispute over this position was responsible for a "psychoanalytical civil war", as

"dissident" analysts such as Karen Horney and Harry Stack Sullivan eclectically

reworked Freudian theory.[22]   In breaking with Freudian libido theory, which

emphasized early childhood events as the primary determinant of

psychopathology, they emphasized social and cultural factors in the development

of the ego. Dogmatism in psychoanalysis and the confining personal authority of

Freud ensured that these "neo-Freudians" were unwelcome amongst the

psychoanalytic establishment. At the same time, Engel suggests so-called

"dissident" analysts like Horney and Sullivan never actually veered far from

psychoanalytic doctrine and continued to privilege early childhood events as the

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[20] See Hogenson, *Jung's Struggle with Freud*, Homans, *The Ability to Mourn : Disillusionment and the Social Origins of Psychoanalysis*.

[21] For a working out of Freudian theory of mind, see M Cavell, "Interpretation, Psychoanalysis, and the Philosophy of Mind," *Journal of the American Psychoanalytic Association* 36, no. 4 (1988): 859-79.

[22] Hale, *The Rise and Crisis of Psychoanalysis in the United States : Freud and the Americans, 1917-1985*, chapter 8.

determinant of psychopathology.[23] Subsequent revisions of Freudian theory did

try to codify some recognition of external environmental events (this was the

genesis of American "ego psychology"), but the biases remained, and not all

practicing analysts were devoted to tracking the nuances of theoretical revision.[24]

Thus, despite revision and schism, orthodox psychoanalysis was still distrustful

of the environment and the senses. The bias of mind over matter persisted until

the 1960s. Psychoanalysis continued to maintain its essentially philosophical,

speculative, and introspective orientation.

Psychoanalytic Depictions of the Environment

In clinical psychiatry, the psychoanalytic emphasis on psychic form over physical

function was exemplified by writings in psychosomatic medicine, particularly in

the field of dermatopsychiatry. Psychosomatic medicine was a branch of

psychiatry that attempted to study psychological dynamics in general medical

illness. As the arbiter between the individual and the environment, in

psychosomatic medicine, the skin became the premiere organ to investigate

competing intra-psychic drives. Orifices, entrances, and fistulae were pathways

into the mind, and the physiologic processes of expulsion and retention attracted

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[23] Engel, *American Therapy : The Rise of Psychotherapy in the United States*, chapter 2.

[24] Hale, *The Rise and Crisis of Psychoanalysis in the United States : Freud and the Americans, 1917-1985*, chapter 13.

great interest.[25] For example, Mouchly Small, the psychoanalyst chairman of the

department of psychiatry at SUNY Buffalo, described in detail a patient who was

given an ileostomy, a stump of small intestine that had been surgically extruded

through his skin, in order to bypass severe colonic and rectal inflammation. The

man had discovered that stimulating the area gave him sexual pleasure. On one

occasion, in a kind of peep show, he asked Dr. Small to witness his autoerotic

ritual:

> He retreated behind closed curtains around the bed, removed the dressing and began
> rubbing the protruding ileum with a gauze pad.   As he did so, he smiled and appeared to
> enjoy watching the piece of small intestine. The ileum, which was flabby and pink,
> became more engorged with blood and took on a bright red hue. In addition it contracted
> and became stiffer; and after a short while, fecal contents began to flow out of the
> opening. When he was asked what this was all about, the patient laughed out loud and
> said, "You know, like when you rub down here" -- pointing to the genital area.[26]

Small's subsequent discussion reveals how the Oedipal drama and the

man's latent homosexuality contributed to this bizarre reversal of inside and

outside. The patient had never been able to masturbate normally because "he

had been caught handling his genitals by his mother" at the age of five. Mother

and son then had an abnormally close relationship while the father was largely

absent, and the patient's "dreams indicated the presence" of drives to kill off the

father. The man's genitals thus became "forbidden soil."   When the surgeons

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[25] See S Mouchly Small, "Validation of Libido Theory," *The Psychiatric Quarterly* 27, no. 1 (1953): 42-4, D R Gorham, "A Case of Narcissism with Auto-Fellatio," *The Psychiatric Quarterly* 28, no. 4 (1954): 673-685, J G Kepecs, M Robin and M J Brunner, "Relationship Between Certain Emotional States and Exudation Into the Skin," *Psychosomatic Medicine* 13, no. 1 (1951): 10-17, R J Levy, "The Rorschach Pattern in Neurodermatitis," *Psychosomatic Medicine* 14, no. 1 (1952): 41-49.

[26] Small, "Validation of Libido Theory," 42.

gave him a "new organ to play with," the patient demonstrated "the need to regress" to "pregenital interests."[27]

The dermis thus defined the boundary between internal and external, and subsequently the relevance of the external environment was seen as an indicator of internal, primarily sexual conflicts. In one fairly medieval experiment, for example, subjects' skins were blistered before entering into psychoanalytic free association. The amount of fluid exuded from the blister was then collected and correlated to the patient's emotional state. In one man the researchers evinced a "dermal orgasm," by playing the subject music, in this case, Maurice Ravel's *Bolero*, "which stirred up wild and primitive emotions from him."[28] At a repeat session, after re-playing the *Bolero*, the "orgiastic" response was more muted -- the patient was now "having sexual relations occasionally."[29] In another often cited event, a prominent analyst, in jest, gave an entire talk on the psychodynamic processes involved in the development of ingrown toenail and was subsequently shocked when he was applauded afterwards with no hint of irony.[30]

In the process, a new kind of psychoanalytic environment was created -- the intrabody environment. Previously ignored by clinicians, the patient's sense of the workings of the insides of his guts became an important factor

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[27] Ibid.

[28] Kepecs, Robin and Brunner, "Relationship Between Certain Emotional States and Exudation Into the Skin," 12.

[29] Ibid.

[30] For a retelling of this story see Jules H Masserman, "Faith and Delusion in Psychotherapy: The Ur-Defenses of Man." *The American Journal of Psychiatry* 110, no. 5 (1953): doi:10.1176/appi.ajp. 110.5.324.

experiencing disease; a new psychiatric rating scale was invented to query

patients on the multiplicity of feelings they might have about this terra incognita.[31]

Psychoanalysts also developed an interesting occupation with paranormal "psi"

phenomena, such a telepathy, faith healing, voodoo, and precognition. In their

affirmation of mind over matter, papers devoted to the topic pointed to the

existence of such phenomena in the everyday workings of disease and health.[32]

The power of mind was further articulated with citations to Einstein and

Heisenberg in a conciliatory marriage of nuclear and particle physics and

Freudian drive theory. Relativity theory promoted an interest in the role of and

patient's perception of time and memory in clinical cases.[33] Moreover, in the area

of psychosomatic medicine, many ersatz physical illness were reformulated into

expressions of frustrated drives and instincts. For example, the emigree analyst

Gotthard Booth developed a psychological theory of neurological illness where

the need for "control of sadistic impulses" resulted in epileptic attacks and

Parkinson's disease.[34] However, sweeping psychological determinism and

extended claims of miracle psychotherapeutic cures for organic illnesses

weakened the legitimacy of these positions.

Psychoanalysis as a Universal Medical Theory

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[31] W A Cassell, "A Projective Index of Body-Interior Awareness," *Psychosomatic Medicine* 26 (1964): 172-177.

[32] Gotthard Booth, "The Role of Physical Form in Psychodynamics," *Psychoanalytic Review* 47, no. 1 (1960): 51-62.

[33] See, for example, Joost A Meerloo, "Father Time II. A Continued Analysis of Subjective Conceptions of Time," *The Psychiatric Quarterly* 24, no. 4 (1950): 657-671.

[34] Ibid., 59, and Booth, "The Role of Physical Form in Psychodynamics."

Consequently, psychoanalysis seemed to be a universal medical theory as these factors seemed, to psychoanalysts, to be applicable in all patients at all times. In general psychoanalysis also eschewed racial difference and explained difference as a function of different ways of handling primitive drives, particularly the libido.[35] There were obvious differences between cultures, but orthodox analysts tended to attribute these to cultural patterns of child raising behaviors with importance for the Oedipal complex, such as toilet training or breast-weaning.

However, the dispersion of psychoanalysts in military duty during World War II exposed many to foreign cultures, which tested belief in psychosexual determinacy. Military experience in Puerto Rico confirmed the Yale psychoanalyst Albert Rothenberg's belief, for example, "that Puerto Rican people have difficulty with aggressive feelings."[36] While Rothenberg allowed the possibility of other environmental influences, he maintained a heavily Freudian stance. In one example, Rothenberg tried to explain the apparent paradox of the low rate of violence in Puerto Rico by citing breast weaning practices:

> An example of a cultural practice which seems to result partly from this personality pattern, and also helps to perpetuate it, is infant weaning and the use of pacifiers ... The widespread use of bottles and pacifiers described above is an example of a type of child rearing practice that may teach the child to repress and suppress anger. Wolf described a pattern in the mother-child feeding relationship of a rural farm subculture consisting of short moments of gratification which alternate with rejection and frustration which she feels makes for an accumulation of aggression.[37]

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[35] Sedinger has noted that psychoanalysis emerged with the foreclosure of race as an explanatory principle for behavior. See Sedinger, "Nation and Identification: Psychoanalysis, Race, and Sexual Difference."

[36] Albert Rothenberg, "Puerto Rico and Aggression," *The American Journal of Psychiatry* 120 (1964): 962.

[37] Ibid., p 967.

Then Rothenberg stressed the cultural recapitulation of the Oedipal conflict:

> Puerto Rican families, though large, frequently live in small quarters. Bed sharing and sleeping in the same room with parents is common. There is a good deal of bodily contact with family members and a high degree of sexual stimulation. Furthermore, because of the warm climate throughout the year, children are often scantily dressed.[38]

Yet psychoanalytic explanations could produce puzzling contradictions, even for the initiated. Working in the Pacific theatre during World War II, the Navy psychoanalyst James Moloney was startled by the stoicism and absence of psychosomatic illness among Japanese Okinawans. This he contrasted with the high rates of neuroticism he found in the Chammoro natives of Guam. Although both populations showed "the almond eyes of the Asiatic," Moloney rejected racial explanations out of hand. In fact, he explained, "I have satisfied myself that the so-called Oriental stoicism is a derivative of acculturation."[39] By acculturation, Moloney cited a familiar explanation, the more tolerant breast weaning practices of the Okinawans. However, cultural practices seemed more pervasive and influential then a simple psycho-sexual explanation. In particular, for the Chammoro, "for some reason, the Christian religion becomes confluent with or subjectively extends neurosis. The projections, the masochism, the identifications with the agonies of Christ, Mary and the mutilated martyrs and saints have a tendency to erase ego boundaries and many individuals seem to become unable to distinguish between themselves and Christ, or between

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[38] Ibid., p 969.

[39] James C Moloney, "On Oriental Stoicism" *The American Journal of Psychiatry* 103 (1946): 63.

themselves and the "little son" being "mutilated" by surgery."[40] Moloney tried to fit

these observations back into Freudian theory -- God became the "father" of the

Oedipal drama -- but his observations pointed to something more complicated

about "acculturation" than simple sexual reductionism.

In Hawaii, significantly, a few cases of empirical testing of psychoanalytic

assumptions did not seem to support psychoanalytic theory. For example, the

Chicago psychiatrist Bryant Wedge attempted to extend Moloney's work to

Okinawan immigrants in Hawaii. For all of Moloney's discussion of Okinawan

stoicism, Wedge found that Hawaiian Okinawans had high rates of psychosis,

which indicated that they were surprisingly psychiatrically disturbed. In his

understated style, Wedge asserted that the Hawaiian results "suggest a

vulnerability that exists despite mothering practices."[41]

The Culture and Personality School -- Psychoanalysis Goes Abroad

Such was the mark of psychoanalysis on theories of the environment. But

psychoanalysis was influential in other studies of different cultures, and as a

result brought its philosophical assumptions and positions with it. The discipline

of anthropology was particularly influenced, with attempts made to weld

anthropological with psychoanalytic theory in the study of national characters, a

forerunner of today's discipline of cross cultural psychiatry. While the theory did

not come from clinical medicine, the "culture and personality school" influenced

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[40] Ibid.

[41] Bryant M Wedge, "Occurrence of Psychosis Among Okinawans in Hawaii," *American Journal of Psychiatry* 109, no. 4 (1952): 258.

day to day thinking in the psychiatric clinic. In the anthropological view, this could

often represent the collective influence of a society's child rearing practices.

Attempts were made to apply anthropologic theory to the study of nations

in the period during and following World War II. Notably, workers in this area,

including anthropological luminaries such as Margaret Mead, Ruth Benedict, and

Clyde Kluckhohn, were initially employed by the Office of War Information with

specific defense goals in mind; at first strengthening national morale, then later

discovering and exploiting weaknesses of nations hostile to American interests.

This idea found further expression in "applied anthropology" -- the idea that

anthropologists might study social conflict in the United States with the idea of

informing specific policies.[42]

Practically speaking, many of these techniques were informed by

psychoanalytic theory and involved an emphasis in tracing the society's child

rearing practices and the experiences of children during early development.

Indeed, anthropologist Margaret Mead collaborated with psychiatric researchers

Erik Erikson, John Bowlby, and Harry Harlow. Bowlby and Harlow were pioneers

in attachment theory, a psychiatric theory that had close relationships with

psychoanalysis, while Erikson was an influential psychoanalyst. Mead's

approach to sexual problems and behavior of children in primitive societies

echoed a Freudian psychoanalytic framework.[43] Discussion of anthropology and

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[42] Federico Neiburg, Marcio Goldman and Peter Gow, "Anthropology and Politics in Studies of National Character," *Cultural Anthropology* 13, no. 1 (1998): 56-81.

[43] Nancy Lutkehaus, "Margaret Mead: Public Anthropologist," *Anthropology Now* 1, no. 1 (2009): 29-35.

national culture likewise often centered on psychoanalytic themes and their

extension into early childhood patterns of feeding or bowel regimens.[44]

Psychoanalytic Influence and Parallels in the Other Social Sciences

Psychoanalytic determinism affected or was compatible with a zeitgeist of

determinism in many of the other social sciences. Central among potential

approaches to the environment in the post World War II era was the discipline of

ethology. Ethology emerged in the mid to late 1960s as an observational,

naturalistic method of investigating biological phenomena, particularly of wild

animals in their natural habitats. Adherents of ethological methods include such

well know figures as primatologist Jane Goodall and anthropologist Margaret

Mead.[45] In addition three ethologists, Konrad Lorenz, Nikko Tinbergen, and

Lorenz's mentor Karl Von Frisch, won the Nobel Prize in Medicine in 1973.

Konrad Lorenz's studies on the process of imprinting in birds in the 1930s

were perhaps the best known works on ethology in clinical psychiatry. In this

series of experiments, Lorenz demonstrated how newly hatched chicks would

attach to the first moving object presented to them after their birth (in this case,

Lorenz himself). Lorenz used this observation to argue that certain complex

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[44] Kyoshi Ikeda. A Comparative Study of Mental Illness Differences Among the Okinawan and Naichi Japanese in Hawaii. Master of Arts Thesis, University of Hawaii, June, 1955, Harold D Lasswell, "The Data of Psychoanalysis and the Social Sciences," *American Journal of Psychoanalysis* 7, no. 1 (1947): 26-35, William H Sewell, Paul H Mussen and Chester W Harris, "Relationships Among Child Training Practices," *American Sociological Review* 20, no. 2 (1955): 137-148. http://www.jstor.org/stable/2088317, and *Personal Character and Cultural Milieu: A Collection of Readings,* ed. Douglas Gilbert Haring (Syracuse: Syracuse University Press, 1956).

[45] Leonard S Zegans, "An Appraisal of Ethological Contributions to Psychiatric Theory and Research," *American Journal of Psychiatry* 124, no. 6 :729-739. http://ajp.psychiatryonline.org/cgi/content/abstract/124/6/729.

behaviors were instinctual and innate to a species. An extension of Lorenz's

methodology was to separate animals from their parents at an early age to

separate innate or instinctual behaviors from learned behaviors. Ethological

approaches further related to the problem of the environment by replicating the

environment experimentally in natural settings. The logical problem for a

psychiatric theory of environmental disease causation, however, was that

Lorenz's work seemed to confirm the deterministic instincts that Freud's theory

also postulated. Fixed action patterns, instinctually packaged suites of behavior,

were shown to be alive and well in experimental animals. The environment only

participated in sending a "releasing" signal for these instinctual behaviors. While

Lorenz argued against a simple extrapolation of his work to complex human

behavior, his work, at face value, seemed to sink theories of environmental

causation in humans.[46]

Similarly, in the early 1950s the British psychiatrist John Bowlby became

interested in the work of Lorenz and the ethologists. Bowlby's early experiences

in a school for juvenile delinquents led him to the belief that early maternal

separation led to delinquency and antisocial behavior later in life. In Bowlby's

subsequent work on homeless children, he began to reject the prevailing British

theories of object relations which, as he thought, did not put enough emphasis on

the external environment of the child. Object relations theory was an extension

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[46] A discussion of the similarities between psychoanalysis and ethology may be found in Gerald Alper, "Ethology and Psychoanalysis," *Journal of Contemporary Psychotherapy* 21, no. 4 (1991): doi:10.1007/BF00945895; see also Ingo Brigandt, "The Instinct Concept of the Early Konrad Lorenz," *Journal of the History of Biology* 38, no. 3 (2005): 571-608. http://www.jstor.org/stable/4331969.

of Freudian thinking and saw the maternal-child connection as one determined

by the primitive biological drives on the part of the infant for food, sex, or

violence. Bowlby rejected that so-called "cupboard theory" -- the idea that the

common currency of the infant mother connection was food -- and posited that

bond was attachment, a kind of deeply instinctual bond of affection.

Bowlby formulated his theories publicly in 1958, and they received much

attention in Britain. The work of American primatologist Harry Harlow in the late

1950s gave empirical credence to Bowlby's theoretically grounded work and

helped popularize affect theory for American psychiatrists. Harlow, who

collaborated with Bowlby, designed a series of experiments that in effect

validated Bowlby's theories experimentally. In them, Harlow separated young

monkeys from their mothers and left them with inanimate "surrogates," or dolls.

One set of surrogates was relatively life-like and covered with cloth; another was

constructed of rough wire but would dispense as much milk as the young monkey

would take. The young monkeys clung to the surrogates that were swaddled in

cloth and overwhelmingly preferred these to the wire mothers, despite the easy

access to food. This confirmed that the primary connection between mother and

infant (at least in the monkeys) was not oral gratification through nursing (as

posited in psychoanalytic theory) but rather closeness, warmth, and attachment.[47]

Despite Bowlby and Harlow's interest in the environment, their experiments recapitulated the teleology of psychoanalysis. There was still a primacy of early childhood events. The currency of affection had changed from the cold instinctual urges of Freud to that of warmth and attention. But Bowlby and Harlow's work did not initially provide a substrate for the explanation of culture beyond the child-rearing practices already under investigation by anthropologists and psychoanalysts.

Cold War and Military Psychiatry

Despite the lack of formal theory about the role of environment, American psychiatry had a pragmatic bent. The issue of environment and displacement was profoundly relevant in military psychiatry. The travails of war exposed troops to environmental stress and deprivation through combat duty, physical deprivation, and psychological and physical trauma. Environmental concerns were paramount for the health of soldiers: whether in the sufferings of prisoners of war or the deployment of troops to unfamiliar corners of the globe. At the

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[47] For Bowlby's adoption of ethology and Harlow's work and its relation to Bowlby, see S J Suomi, F C van der Horst and R van der Veer, "Rigorous Experiments on Monkey Love: An Account of Harry F. Harlow's Role in the History of Attachment Theory," *Integrative Psychological & Behavioral Science* 42, no. 4 (2008): 354-369; Inge Bretherton, "Attachment Theory: Retrospect and Prospect," *Monographs of the Society for Research in Child Development* 50, no. 1 (1985): 3-35. http://www.jstor.org/stable/3333824; Inge Bretherton, "The Origins of Attachment Theory: John Bowlby and Mary Ainsworth," *Developmental Psychology* 28, no. 5 (1992): doi: 10.1037/0012-1649.28.5.759; Bretherton 1985, Van Der Horst 2008 Frank van der Horst, Helen LeRoy and René van der Veer, ""When Strangers Meet": John Bowlby and Harry Harlow on Attachment Behavior," *Integrative Psychological & Behavioral Science* 42, no. 4 (2008): doi: 10.1007/s12124-008-9079-2.

same time, the mobilization of large numbers of psychoanalytically trained

psychiatrists (both in World War II and in the new Cold War conflict of Korea)

opened the eyes of the rank and file psychiatrist to the power of environmental

influences and some of the shortcomings of psychoanalytic theory.

For example, the psychiatrist Robert Lifton's work on repatriated American

prisoners of war framed relations with the environment through the lens of

traumatized soldiers. Lifton supervised the transfer of a cohort of POW's to the

United States after being liberated from Korean camps. The decision to transport

the troops by ship rather than by air was performed such that it would allow a

gradual transition period during which the troops would be slowly reacclimatized

back to American hometown life.[48] During the voyage Lifton made careful notes

on the engagement of the prisoners with their environment. Initially, "The

average repatriate was dazed, lacked spontaneity,

spoke in a dull, monotonous tone with markedly diminished affectivity. At the

same time he was tense, restless, clearly suspicious of his new surroundings."[49]

Gradually, through the use of group psychotherapy conducted on ship, the former

prisoners "became increasingly reactive, but in a generally belligerent, irritable,

and critical fashion."[50] When the ship arrived in San Francisco, "observers were

extremely moved by the sight of mothers literally reaching up to the ship for their

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[48] Robert J Lifton, "Home by Ship: Reaction Patterns of American Prisoners of War Repatriated From North Korea," *The American Journal of Psychiatry* 110, no. 10 (1954): 732-739.

[49] Ibid., 735.

[50] Ibid., 735.

sons. In marked contrast was the blandness and lack of outward emotion displayed by the repatriate group."[51]

Lifton seemed to suggest, in this sad scene of infant mother attachment, that the trauma of the environmental and affective deprivation permanently damaged the attachment apparatus of the repatriated prisoners.   He quotes a poem penned by three prisoners regarding their ambivalent expectations of coming home:

I know you are curious about my life in this strange
land
As a prisoner of war in Korea, but how could you
understand?

You ask about the treatment, was it good or was
it bad?
I answer, it's all over now and I am very glad.

You ask if I was captured, if I was wounded too,
Yes, I was badly wounded, but what does that mean
to you?

I realize your idle interest, curiosity and wonder too,
But even if I tried, I couldn't explain all this to you.

I hope this answers your questions, please forget
you ever knew
That I was ever a prisoner, for I want to forget
it too.[52]

Lifton highlighted the leitmotif of rapid dislocation and displacement in the total experience of all soldiers. Initially, troops "did not have sufficient opportunity to fully integrate themselves into their new assignments or develop the essential, supportive emotional ties which evolve in the experienced, smoothly functioning

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[51] Ibid., 735.

[52] Ibid., 737.

combat unit."[53]   Military transfer and mobilization contributed to a well known

phenomena of apathy and disconnection termed "pipeline syndrome."

Dislocation, rapid mobilization, the breaking of affective ties: all of these were

potentially severe environmental stresses. No mention was made of early

childhood sexuality, toilet training, breast feeding, or other psychoanalytic

explanatory fetishes.

The Physical Environment and Sensory Deprivation Research

Not incidentally, the 1950s saw a rash of studies on sensory deprivation in

human subjects. In humans, it was well known that even short periods of

sensory deprivation rapidly led to the onset of psychotic-like symptoms or severe

depression. Research on the senses had been part of experimental psychology

since the nineteenth century. But classical experimental psychology eschewed

experimentation for practical application. The 1950s research was unashamedly

practical; clinical psychiatrists became actively involved. Indeed, cold warriors

would have to staff lonely missile stations.

The Canadian psychiatrist T.J. Boag's 1952 article on the mental health

issues of small Army weather station teams in the Arctic is a study on the

interpersonal dimensions of isolation.[54]   Boag observed the groups of unattached

young men who volunteered for this hardship duty, and concluded that the

greatest danger was not the harsh climate, but rather the willingness of the men

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[53] Ibid., 738.

[54] T J Boag, "The White Man in the Arctic; A Preliminary Study of Problems of Adjustment," *The American Journal of Psychiatry* 109, no. 6 (1952): 444-449.

to seal themselves from the external environment. Boag noted that the men who

failed to venture outside the Army shelters or interact with the local Eskimo

population invariably encountered irritability or depression. Even protective,

heavy clothing could be more a curse than blessing, since it sealed men off from

their environment. Withdrawal from camp life, attending to oneself before others,

apathy, and individual involution portended a syndrome of depression and

irritablity. Boag concluded that a narrowing of attention to the self portends

failure in the Arctic. As such the interpersonal environment becomes an

expression of the physical:

> It is apparent that most of the inhabitants who have permanent quarters of varying
> degrees of comfort are not directly subjected to climatic stresses as a main factor, but
> retire from them into the security of their accommodation. It is then that the difficulties in
> interpersonal relations that constitute the main stress become really effective, insofar as
> everyone is cooped up, within a limited amount of space, in a situation from which there
> is no real possibility of withdrawal.[55]

Similarly, Philip Solomon, a Harvard psychiatrist who had served in the

Navy during World War II, detailed a wealth of deprivation experiences

experienced historically by shipwreck victims, explorers in the Arctic, and

prisoners of war. Solomon and his research group related deprivational torture or

“brainwashing” employed in prisoner of war camps to experimental research on

sensory deprivation. Solomon even cited the work of Robert Lifton on Korean

prisoners of war which argued that environmental deprivation could occur simply

when an elaborate system of control over the external environment was exerted

on prisoners:

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[55] Ibid., 446.

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> For years, until his education had progressed to the desired point, the prisoner spent his life in a cell so small that when the inmates (the prisoner and the 7 or 8 Chinese who formed the confession team) wished to turn over while sleeping at night, they could do so only together at a given signal from the team leader. Little wonder that gradually the "external milieu replaced the internal milieu." [56]

Sensory deprivation might occur in any significant alteration of the external environment. Lack of variety, autonomy, and control in the external environment could replicate the phenomena of simple external sensory deprivation. Researchers would induce sensory deprivation experimentally through a number of techniques. Water immersion tanks warmed to internal body temperature, padded rooms, earplugs, limb guards, and goggles, even PCP and LSD experimentation combined to form a macabre gallery of deprivation induction techniques:

> The subject is paid to do nothing 24 hours a day. He lies on a comfortable bed in a small closed cubicle, is fed on request, goes to the toilet on request ... He wears frosted glass goggles that admit light but do not allow pattern vision. His ears are covered ... His hands are covered with gloves, and cardboard cuffs extend from the upper forearm beyond his fingertips, permitting free joint movement but with little tactual perception ... The results are dramatic.[57]

What do we make of these experiments? Why were there so many? There were a number of reasons. Experimental investigation of the senses had a long history in the experimental psychology of nineteenth century Germany. But these experiments were both recapitulations of that earlier work and something altogether different. Above all, they were wholly practical for military application. Ziskind, for example, suggested his research might be of use to

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[56] P Solomon "Sensory Deprivation; A Review," *The American Journal of Psychiatry* 114, no. 4 (1957): 357-363.

[57] D O Hebb, "The Mammal and His Environment," *American Journal of Psychiatry* 111 (1955): doi:10.1176/appi.ajp.111.11.826.

"astronauts, jet pilots, and radar sentinels," no doubt increased in numbers during the Cold War.[58] What they were not were detailed theories on environmental influence on culture. The studies underscored the important interactions between an individual organism and his or her environment, but only in the most reductive, practical way.

Conclusion

Psychiatrist Nassir Ghaemi has argued that postmodern Western society, on the wings of philosophical positions staked out in psychiatry and in the culture as a whole, has willed into being a contemporary anarchy of thinking about psychiatric illness.   Ghaemi states that philosophies need not be read by non-philosophers to become influential; rather "when those ideas are part of the climate of cultural opinion, we imbibe them with our mother's milk."[59]

Thus, a culture will condition its own set of ideas about mental illness. This brings us back to the central conundrum of this chapter. Psychoanalysis was the dominant medical philosophy in the United States from the end of World War II to the 1960s. And yet, its influence barely registered in Hawaii. The answer to this discrepancy of absence lies in an inductive conclusion about the nature of medicine practiced in colonial settings.

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[58] E Ziskind, "An Explanation of Mental Symptoms Found in Acute Sensory Deprivation: Researches 1958-1963," *The American Journal of Psychiatry* 121 (1965): 939-946.

[59] Ghaemi, *The Rise and Fall of the Biopsychosocial Model*, 65.

Psychoanalytic theory, as documented in this chapter, was notable for two important features. The first was a wholly inflexible universalism. While previous authors have demonstrated that psychoanalysis could be adapted to colonial settings, in the Indian case for example, psychoanalysts necessitated severe re-workings of central aspects of Oedipal theory. That kind of re-working had been attempted in the United States and resulted in theoretical civil wars, schisms so drastic that they occasioned professional and personal excommunications. Second, psychoanalysis only awkwardly accommodated the physical environment and, overall, minimized the role of the environment beyond the early childhood milieu. Finally, other approaches in the social sciences either followed the instinctual or early childhood determinism of psychoanalysis or were too coldly practical and reductionist to provide a comprehensive theory of cultural and environmental influence.

If psychoanalysis did not work in Hawaii because of its universalism and depreciation of the environment (and thus of space and place), then perhaps it is these features that characterize colonial medicine. Moreover, this conclusion seems to argue (admittedly inductively) against implications of psychoanalysis, and thus of psychoanalytic psychiatry, in the colonial project. Since psychoanalysis was marginal, the next chapter will examine the philosophies that did inspire psychiatric thinking in Hawaii. It describes the intellectual crystallization of social psychiatry from Adolf Meyer's psychobiology and demonstrates why social psychiatry became the dominant mode of psychiatric thinking in Hawaii.

CHAPTER TWO

SOCIAL PSYCHIATRY AND THE PROBLEMS OF RURAL AND URBAN

"Are we commuting to disaster? Harried young housewives are seeking escape

in alcohol and stolen affairs. Husbands, frantic for success, stay later and later in

the city. Teen-agers, their every wish too easily gratified, steal and engage in

open sexual promiscuity."[1] So proclaimed the cover of psychiatrist Richard

Gordon's 1960 book *The Split Level Trap*. In it, Gordon delineated the crisis he

felt was growing in the new suburbs of the socioeconomically mobile.

The growth of middle class suburbs, made possible by mechanization and

automation in the home building industry, was impressive. Especially in the

West, metropolitan populations swelled, driven by the labor demands of World

War II and the postwar baby boom.[2] New housing starts grew twenty-fold

between 1944 and 1950.[3] Many of these new housing projects were in the

suburbs. In the American Progressive era of the late nineteenth and early

twentieth centuries, public health experts had been suspicious of rapid population

growth in unforgiving urban environments.[4]   Now the newer work of Gordon and

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[1] Richard E Gordon, Katherine Gordon and Max Gunther, *The Split-Level Trap* (New York: Dell, January, 1962).

[2] Carl Abbott, *The Metropolitan Frontier : Cities in the Modern American West* (Tucson: University of Arizona Press, 1995), xviii.

[3] David Halberstam, *The Fifties* (New York: Fawcett Columbine, 1994), 134.

[4] Nancy Tomes, *The Gospel of Germs : Men, Women, and the Microbe in American Life* (Cambridge, Mass.: Harvard University Press, 1998), investigates how public health efforts influenced the domestic hygiene practices of ordinary Americans, particularly in urban environments during the Progressive Era. See also Hans Pols, "Anomie in the Metropolis: The City of American Sociology and Psychiatry," *Osiris* 18 (2003): 194-211.

other researchers, who called themselves social psychiatrists, suggested that even outside of the city, mental illness might be both more pervasive and insidious in American society.

Indeed, with the implementation of mass psychiatric screening of enlisted troops in World War II, public officials were receiving alarming statistics about the prevalence of mental illness in the population. In some surveys, upwards of twenty percent of recruits were found to have a serious psychiatric disorder.[5] Public health planners sensed that resources in many communities were being overburdened by a flood of psychiatric patients. The significant mental needs of returning World War II veterans further taxed the public mental health system.[6]

These developments helped usher in the discipline of social psychiatry. Social psychiatry was the application of social science methods to psychobiology, the eclectic American psychiatric system which was influential from the early twentieth century. Social psychiatry's major expression was the epidemiological community study, which attempted to assess the severity and burden psychiatric illness in a community.[7] Social psychiatry also drew from the mental hygiene movement, an activist, public health campaign of the early twentieth century that

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[5] See Nathan G Hale, *The Rise and Crisis of Psychoanalysis in the United States : Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995), chapter 13 for a concise description of psychiatric efforts during and after World War II.

[6] For a regional description of California's efforts of psychiatric rehabilitation after World War II, see Justin Justin D Suran, "Toward an Illusionless City: The Province of Psychiatry in Twentieth-century San Francisco" (Ph.D. Dissertation, University of California, Berkeley, 2003), Chapter 2.

[7] For a history of collaborations between social sciences and psychiatry, see Pols, "Anomie in the Metropolis: The City of American Sociology and Psychiatry."

centered on the population-wide prevention of milder forms of mental illness prevalent outside of the mental hospital.

This chapter continues to add to the history of social psychiatry by illustrating continuities between it and older reformist and popularizing strains in psychiatry, in this case the mental hygiene movement of the earlier twentieth century.   In addition, this chapter argues that social psychiatry privileged the idea of a person's interaction with the physical environment as a causal element in mental illness, which stood in direct opposition to orthodox psychoanalytic theory. Finally, the chapter investigates criticism of American suburban life as a demonstration of how spatial politics informed social psychiatry. Likewise, in Hawaii, social psychiatry, and not psychoanalysis, was the chosen explanatory model of mental illness; the allowance for the influence of space and place was one of social psychiatry's evolutionary advantages over psychoanalysis in the colonial setting.

The Mental Hygiene Movement and Psychobiology

 The American mental hygiene movement, which dates from the early twentieth century, was both an activist social reform movement and an applied interdisciplinary clinical philosophy that aimed to prevent mental health problems in the population at large through early intervention, public education, and political mobilization.[8]   Because it was practiced in the community, at the level

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[8] For a history of the mental hygiene movement, see Johannes C Pols, "Managing the mind: The culture of American mental hygiene, 1910-1950" (Ph.D. Dissertation, University of Pennsylvania, 2007).

of population, mental hygiene favored broad social or environmental theories of psychopathology.

This was a departure for psychiatry, which had been concerned through most of the nineteenth century with the parochial logistics of treating hospitalized patients in mental asylums.[9] By the 1910s and 1920s, however, the dominant clinical philosophy was that of the influential Chair of Psychiatry at Johns Hopkins, Adolf Meyer, whose open-minded theory of psychobiology included not only physiological and psychological components, but also factors of social and personal adjustment in the maintenance of mental health. In the wake of the Great Depression, the "somatic" oriented psychiatrists of mental institutions moved away from this eclectic model to a heavily medically influenced conception of psychiatry. They emphasized body or physiologically based treatments that were to be applied in psychiatric hospitals. The somatic psychiatrists placed psychiatry firmly in the fold of medical disciplines, pushed for increases in the training of medical doctors in psychiatry, and argued for limitations on the authority and independent practice of other professions, such as social work and psychology. The politics of the somatic psychiatrists were likewise conservative. The faction of "mental hygienists," on the other hand, were oriented towards the community, and practitioners of the movement operated far afield of the mental hospitals, in institutions such as clinics, schools,

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[9] For a history of asylum psychiatry, see Nancy Tomes, *The Art of Asylum-Keeping : Thomas Story Kirkbride and the Origins of American Psychiatry* (Philadelphia: University of Pennsylvania Press, 1984); Joel T Braslow, *Mental Ills and Bodily Cures : Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997); Gerald N Grob, *The Mad Among Us : A History of the Care of America's Mentally Ill* (New York: Simon and Schuster, 1994).

and the military. Mental hygienists advocated the application of psychiatry beyond the institutionalized mentally ill to the psychological problems of the general population as a whole, including problems not traditionally thought of as mental illnesses, such as unhappiness, neurosis, and juvenile delinquency. Doctrinally, the mental hygienists were more open-minded than the somaticists, borrowing the structure of psychopathology from Meyer's psychobiology, but also having a discourse with psychoanalysis, which was building popularity in the 1930s. Mental hygienists favored cross disciplinary cooperation and promoted the coordination of psychiatrists with other allied mental health disciplines. Mental hygiene's politics were radical.   For example, Frankwood Williams, one of the early leaders of the mental hygiene movement, increasingly flirted with Communism and made several trips to the Soviet Union to report on the mental health system there. However, as mental hygiene became more politically radical, support for the movement faded, particularly in light of the abuses of Stalinist Russia. By the 1940s the movement had fragmented due to lack of finances, theoretical incoherence, and mismanagement of the National Committee on Mental Hygiene.[10]

Adolf Meyer's psychobiology was a natural complement to mental hygiene as Meyer's orientation emphasized problems of adaptation to the social environment.[11] The National Committee on Mental Hygiene, the banner

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[10] Pols, "Managing the mind: The culture of American mental hygiene, 1910-1950"; Hans Pols, "Divergences in American Psychiatry During the Depression: Somatic Psychiatry, Community Mental Hygiene, and Social Reconstruction," *Journal of the History of the Behavioral Sciences* 37, no. 4 (2001): 369-388.

[11] Pols, "Managing the mind: The culture of American mental hygiene, 1910-1950," 442.

organization for the mental hygiene movement, was explicitly set up to bring

Meyer's adaptational psychobiology out of the asylums and into the community.[12]

At the same time psychoanalysis was introduced to the United States and was

becoming more popular. But, as the last chapter has described, psychoanalytic

assumptions eschewed notions of the environment, making it a poor basis for an

activist system of public health.   That tension became evident as mental

hygienists began to flirt with psychoanalysis in the 1930s. On the other hand,

some techniques of mental hygiene, such as psychotherapy, provided natural

affinity with psychoanalysis.

Mental hygiene psychotherapy was a Meyerian undertaking, which its

practitioners referred to as "dynamic" or "genetic-dynamic" psychotherapy. For

example, the psychobiological psychiatrist Edward Billings, writing in the journal

Mental Hygiene in 1939, outlined the theoretical and practical aspects of

Meyerian psychotherapy, or "distributive analysis."[13] While well aware of the

Freudian approach, Billings approached many of the same issues as the

Freudians, albeit in a language shorn of the Freudian emphasis on childhood

sexual development. For example, instead of using the transference between

patient and doctor to uncover repressed sexual or traumatic thoughts from

childhood, in Meyerian psychotherapy, the transference became practically

oriented in the here-and-now:

> The patient's attitude and reactivity to the therapy must be constantly scrutinized and
> evaluated. For example, if the patient cannot or will not cooperate because of his personal

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[12] Ibid., 23.

[13] Edward G Billings, "General Principles of Psychotherapy," *Mental Hygiene* 23 (1939): 25-50.

rigidity or resistance to the procedure, this fact is brought to his attention and discussed in the hope of modifying the difficulty.[14]

While Freudians might find the marrow of clinical work in uncovering the mechanism of traumatic repression and bringing it to light in the transference, in the Meyerian view, there was less speculation about etiology. Repression in the psychotherapy was rather a common sense obstacle to be dealt with, and delicately:

> Often certain life material of the patient that is necessary for the continuation or completion of treatment is more or less inaccessible because of the patient's sensitivity about discussing the facts or because he has forgotten about them, or because, if he should be allowed to divulge them he would be upset to such an extent as to jeopardize his progress.[15]

Finally, rather than spawning a navel gazing therapeutic relationship that continued without a specified end, distributive analysis sought a practical partnership with clear endpoints, and adaptation -- not transformation -- was the goal.

> The object of treatment is to return the patient to his usual, or to a different, but more logical, status in life -- not to create a dependent or an over self-analytic personality, with diminished spontaneity. The analytic-synthetic treatment should be brought to a close as soon as possible.[16]

Thus, the Meyerian approach milled the same psychotherapeutic grist as the Freudian, but was practically focused in the here and now, with the patient viewed as both acting and being acted upon by his immediate environment. Moreover, as Billings explains, therapy in the consultation room was only half of

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[14] Ibid., 37.

[15] Ibid.

[16] Ibid., 38.

the treatment. Direct work with the patient could not commence unless "the psychiatrist is aware of, and has properly evaluated, the situation, after study of the patient's personality in terms of his environment."[17] In other words, in the Meyerian system, the physician was to deliberately analyze in the environmental milieu influences such as "climate, geographical factors, working conditions, and the like."[18] Billings then invoked the elaborate psychobiological formulation of Meyer, one in which the psychiatrist painstakingly ventured into all the possible immediate environmental issues pertinent to the patient including influences of "race, group, and family", "educational, vocational and recreational" factors as well as economic factors, and "toxic, infectious, and traumatic" physical issues.[19]

The Psychoanalytic View of the Environment

It is important to contrast how differently psychoanalysts viewed the importance of the immediate environment, and how they thought psychoanalysis applied itself to public mental health. It was largely a one-sided relationship, as the psychoanalysts, while granting the legitimacy of mental hygiene in purpose, stuck to their own dogma more, well, doggedly.   As psychoanalysis became more accepted in American psychiatry, hygienists, in their open mindedness and eclecticism, got stuck in a doctrinal morass by both espousing psychoanalytic determinism and the impact of the immediate environment.

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[17] Ibid., 33.

[18] Ibid., 34.

[19] Ibid.

For example, a 1937 article, again in the largely convivial *Mental Hygiene*

(the main organ of mental hygienists) illustrated the tenacity of psychoanalytic

determinism even in a public health perspective. It was authored by Franz

Alexander, the Director of the Chicago Institute for Psychoanalysis, and one of

Freud's most persistent American bulldogs. Alexander reiterated that in the first

days of mental hygiene, the movement was divided between two camps; the

somatic psychiatrists, who argued that "mental disease is inherited and based on

some organic process in the brain" and those that were environmentally and

sociologically oriented. Alexander positioned psychoanalysis as the clear-

headed middle ground between the two "radical" positions.[20] While

acknowledging Freud's general interest on hereditary influences, Alexander

opined on the nature of the environment for the analyst:

> For the psychoanalyst, environmental influences mean something even more specific ... The object of study is the individual with his specific emotional problems. This minute study of individual life histories shows us that the most important factors in personality formation are the early experiences of childhood. [21]

The environmental influences operating around the child included the milieu

surrounding such early events as "the development of teeth" and "traumatic

feeding difficulties."[22] Over and over again, Alexander stressed the primacy of

early environmental influences: "Every neurosis or psychosis is essentially such

a regressive process," "analytical experience teaches us that the resistance of

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[20] Franz Alexander, "Psychoanalytic Aspect of Mental Hygiene and the Environment," *Mental Hygiene* XXI, no. 2 (1937): 58-75.

[21] Ibid., 73.

[22] Ibid., 73.

an individual in the struggle for existence is dependent upon the experiences of

his early childhood," and "the tendency of the child's sexual drive to attach itself

to those persons upon which the child has been dependent." The immediate

environment, whose fundaments had been painstakingly elaborated on by

Billings in his article on Meyerian psychotherapy, was reduced by Alexander to a

mere set piece upon which the dramas of early childhood environment were

played out. At the end of the article, Alexander finally copped to the logical

extension of his views on mental hygiene:

> The deep origin of fears and hostilities is in the early childhood development. I see the
> function of mental hygiene in the disruption of this vicious circle just as this vulnerable point,
> through scientific control of childhood development.[23]

To a mental hygienist already working on the issues of childhood development,

this assertion may not have garnered much criticism. But since many hygienists

were working with older children or adults, it is puzzling why they remained as

open to psychoanalysis as they did.

Mental Hygienists Take on the Physical Environment

Mental hygienists thus approached psychoanalytic ideas in the 1930s and 1940s,

but psychoanalytic determinism ruined the coherence of hygienist ideas about

the environment. Hygienists were, in the end, catholic about psychological

theory, and while their writings show some evidence of psychoanalytic influence,

they struggled to re-emphasize adaptation to the immediate environment as their

primary explanatory mode. For example, the psychiatrist J.S. Plant, who

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[23] Ibid., 70-75.

authored several works in mainstream psychiatric publications on the relationship between urban density and mental health problems, identified something "going on" in crowded living conditions such as apartment houses. However, while Plant found the open display of sexuality threatening in cramped quarters, he did not privilege a sexual explanation.[24]   Instead, to Plant, children growing up in such an environment lost a sense of individuation -- they became dependent on others and external tools to maintain their identity -- and were incapable of being alone.[25]

Mental hygiene was eclectic enough in theory that it could even draw adherents from the asylum doctors. While historians have commented on the split between hospital somaticists and "extramural" hygienists, some mental hygiene efforts came straight from doctors with asylum postings.[26] For example, in 1940, Delaware's state hospital superintendent Mesrop Tarumianz consulted with school districts to set up mental hygiene programs in classrooms.[27] Tarumianz's program utilized "human relations" classes in the seventh and eighth grades. These classes operated on the assumption that children's shyness could be a precursor to more serious mental illnesses, such as schizophrenia. Broad environmental etiologies were considered; for example, since African

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[24] J S Plant, "Some Psychiatric Aspects of Crowded Living Conditions," *American Journal of Psychiatry* 86, no. 5 (1930): 849.

[25] Ibid.

[26] Depictions with a focus on the fractured state of psychiatry are found in Pols, "Divergences in American Psychiatry During the Depression: Somatic Psychiatry, Community Mental Hygiene, and Social Reconstruction," and Edward Shorter, *A History of Psychiatry : From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997).

[27] M A Tarumianz and H E Bulllis, "A Preventive Mental Hygiene Program for Schools," *American Journal of Psychiatry* 99, no. 3 (1942): 398.

American children would be discriminated against, they were likely to be lonelier or more isolated. Amelioration of the shyness or "recessiveness" problem could be accomplished in several ways. First, the teacher could engage the child selectively in front of the other children, highlighting the shy child's strengths. Seating arrangements might also be changed so that the child was more integrated with the rest of the class. Finally, human relations classes involved a kind of group therapy. In it, the most precocious children in the class were informed that the shy child "frankly ... [was] headed for an unhappy life if he does not learn to be part of a group. The challenge of helping bring the shy child into group activities is given the class leader who is pledged to secrecy." [28] The children were then encouraged to free associate in a manner which reflected Meyerian distributive analysis:

> The teacher generally tells a short story, reads an excerpt from literature, or gives a personal anecdote as a stimulus for discussion. The children are encouraged to discuss freely the problems presented in these stimuli, to give an appraisal of the solution offered, to speculate on the motivations lying back of the behavior, and to indicate from their own personal experience situations parallel to those presented in the stories, dramas, etc. In this retelling of emotional experiences, often bringing out into the open problems they have never discussed before, a better understanding of their actions results.[29]

Thus, the classroom became an environment where physical space correlated with loneliness and disintegration. Marginalized, "recessive" children sat on the outside of class and literally had to be physically reintegrated with the more gregarious class members.

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[28] Ibid., 401.

[29] Ibid.

The Invention of Social Psychiatry

American psychiatry has had a rich discourse on the problems of civilization. In the nineteenth century asylums tended to be located in rural spaces. Asylum architectural features, such as prominent walls, reflected the goal of separating patient from the overly stimulating environment of the outside world.[30] By the mid-twentieth century, psychiatrists continued to conclude that the city posed major mental health risks for people. However, by the 1950s other groups began challenging this idea. Sociologists, breakaway psychoanalysts and psychiatrists, anthropologists, and others began using alternative methods to measure the effects of urban environments on mental illness, and sometimes concluded that cities were less dysfunctional than they appeared.

Sociologists, in particular, took the lead in studying mental illness in cities. They became known as "social psychiatrists," and while they collaborated with clinical psychiatrists, their efforts were influenced primarily by sociological, not medical, theory.

The first issue of the journal *International Journal of Social Psychiatry* was published in 1955.   Founding editorial board member and psychiatrist Thomas Rennie had trained as an internist at Harvard, then followed with a residency in psychiatry at Johns Hopkins, where he specialized in the (Meyerian) psychotherapeutic treatment of psychosomatic illnesses. Rennie had mental hygience credentials as well -- he had been commissioned by the National

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[30] For the asylum and city, as well as architectural elements see Pols, "Anomie in the Metropolis: The City of American Sociology and Psychiatry," and Tomes, *The Art of Asylum-Keeping : Thomas Story Kirkbride and the Origins of American Psychiatry*.

Committee for Mental Hygiene in the 1940s to run a rehabilitation clinic for World

War II. Rennie's manifesto in the opening edition of the journal was the first

attempted to define social psychiatry.[31]

Rennie started by arguing that psychiatrist's education ill suited him to be

of service to his community. By working in a confining clinical environment, one

patient at a time, the psychiatrist was ineffectual in ameliorating public

misconceptions about mental illness, particularly the high rate of psychiatric

disability in the general population. Moreover, Rennie asked, what about milder

expressions of mental illness, such as the psychosomatic illness that made up a

large part of general hospital admissions?

Rennie then argued that, to be effective, public psychiatry had to make

use of quantitative and epidemiological research. As such, the new field of social

psychiatry simply could not be approached on the level of the individual patient.

This was a common argument from the mental hygiene movement. However,

the methods were new:

> Thus it appears that the time has come to establish a working relationship between the social scientist and the psychiatrist. In their co-operative effort new possibilities of research and investigations into human behaviour will inevitably arise. Growing evidence accrues that the inter-disciplinary approach to some problems of mental health and illness has brought about a new development in psychiatry worthy of the name social psychiatry.[32]

A focus on family dynamics and interactions with environment would further yield

tremendous insight. Social psychiatry might be used "not only with the mentally

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[31] Thomas A C Rennie, "Social Psychiatry-A Definition," *International Journal of Social Psychiatry* 1, no. 1 (1955): 5-13.

[32] Ibid., 10.

ill but with the problems of adjustment of all persons in society toward a better

understanding of how people adapt."[33] Rennie went on:

> Social psychiatry is etiological in its aim, but its point of attack is the whole social framework of contemporary living. To approach such a task clearly calls for the participation of cultural anthropology, urban and rural sociology, individual and social psychology, psychiatric social work, bio-statistics, and the particular insights of clinical psychiatry.[34]

Rennie's description of social psychiatry thus mirrored the adaptationist

psychobiology of Adolf Meyer. Rennie advocated extending psychiatric principles

from the psychiatric hospital to the whole population and stressed psychiatry's

extension to the domain of milder mental illnesses seen in the community.   None

of this was new, and all these arguments had been advanced by mental

hygienists at least twenty years before. But while hygienists allowed

interdisciplinary communication with social workers, clinical psychologists other

medical para-professionals, social psychiatry was even more eclectic, opening

up the entire epistemology of medicine to visitation by a host of disciplines in the

social sciences. These other disciplines privileged, at times, entirely different

orientations from the philosophies of knowledge to which psychiatry was

accustomed.

The resulting appellation of social psychiatry, with its emphasis on

interdisciplinary collaboration, "inadvertently altered professional boundaries."[35]

Specifically, the willingness of psychiatrists to partner with a whole new group of

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[33] Ibid., 12.

[34] Ibid., 12.

[35] Gerald N Grob, *From Asylum to Community : Mental Health Policy in Modern America* (Princeton, N.J.: Princeton University Press, 1991)., 102.

professionals threatened the professional legitimacy and authority of medicine over mental illness, and in fact, altered the balance of the profession for decades to come. In his address at the 2009 American Psychiatric Association Annual Meeting (APA), the new President of the APA Alan Schatzberg (himself a biologically oriented psychiatrist and co-founder of his own pharmaceutical company) bemoaned what he viewed as the "loss of pride" which stemmed from "egalitarianism that reduced the importance of our own roles and suggested that perhaps a medical degree was not necessary."[36]

The Suburban Boom

In his 1955 manifesto**,** Rennie had also suggested social psychiatry could answer the question "what is the real meaning of urban or rural living?"[37] Rennie was a lead author of the famous Midtown Manhattan Study, a social psychiatric epidemiological study *par excellence* which sprawled across a better part of the 1950s. The study had attempted to estimate the incidence of serious psychiatric illness in a neighborhood on the East Side of Manhattan.[38] The study showed a relatively high rate of community psychopathology; however, by that time nobody seemed to be surprised about the high rate of psychiatric illness in a big city. The

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[36] Alan F Schatzberg, "Response to the Presidential Address," *The American Journal of Psychiatry* 166, no. 10 (2009): doi:10.1176/appi.ajp.2009.166.10.1105. http://ajp.psychiatryonline.org.

[37] Rennie, "Social Psychiatry-A Definition," 12. See also E M Gruenberg, "A Review of Mental Health in the Metropolis: The Midtown Manhattan Study," *The Milbank Memorial Fund Quarterly* 41, no. 1 (1963): 77-94.

[38] Leo Srole, S Langner, S T Michael, M K Opler, and T A C Rennie, *Mental Health in the Metropolis: The Midtown Manhattan Study* (New York: McGraw-Hill, 1962).

mechanism of mental illness was also a familiar one -- specifically that low socio-economic status was correlated with poorer mental health. But if the Midtown Study was nothing new, the city's fortunes were starting to change in the eyes of other social psychiatrists. As Hans Pols has shown, the Midtown Manhattan Study actually rehabilitated the fortunes of the city by suggesting that socio-economic fortune (in other words, class) was more important than urban space as the causative factor in mental illness.[39] Moreover, by the 1950s the old bias of city as place of mental health danger was being replaced with a "counter narrative" of cities as places with pockets of exceptional vitality.[40] But if the relation between space and class was being liberalized in the cities, these factors seemed to coalesce in suspicion of the new mobile suburbs that blossomed at the end of World War II.

The American suburban boom of the 1950s was predicated on the enormous mobilization of people to the industrial cities that would provide the munitions, ships, and machinery for the armed forces during World War II. Cities that supported the aerospace, shipbuilding, and defense industries, particularly on the West Coast, experienced huge surges in population.[41] Adding to these demographic shifts were repatriated soldiers from World War II and their children, as the baby boom began in earnest. In the West, ample physical space

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[39] Pols, "Anomie in the Metropolis," 207.

[40] Ibid.

[41] For the demographic changes underlying growth of the suburbs, see Carl Abbott, *The Metropolitan Frontier : Cities in the Modern American West*. For a historiographical treatment of suburbs, see R McManus and P J Ethington, "Suburbs in Transition: New Approaches to Suburban History," *Urban History* 34, no. 02 (2007): doi:10.1017/S096392680700466X.

supported the growth of lands surrounding metropolitan areas, enhancing the complexity of the function of space surrounding the city.

Developments in housing manufacturing and financing were also significant. The housing industry had been severely depressed during World War Two. A severe lack of inventory during the war portended severe housing shortages following cessation of hostilities. A sympathetic federal government was sensitive to the problem and allowed legislation friendly to homebuilders as well as liberalized the supply of low interest loans for returning GI's to finance housing purchases. At the same time, logistical expertise, mechanization of the home building process, and the entrepreneurship of home builders spurred a building boom in mass-produced slab foundation, subdivision-style homes. The growth was spectacular. In 1944 there were 114,000 new housing starts; by 1950 there were 1.7 million. [42] Home ownership rates increased by the steepest percentage in the nation's history, and by 1960 more Americans owned homes than did not.[43] It was also a time of unprecedented geographic mobility. From 1940 to 1950, the percentage of the U.S. population moving grew more rapidly than at any other time during the entire twentieth century.[44]

Many of these housing starts were in planned suburbs built on the outskirts of large cities, usually on the grounds of rapidly cleared farmland. Critics of these developments argued that rapid suburban growth excessively

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[42] See Halberstam, *The Fifties*.

[43] F Hobbs and N Stoops, "Demographic Trends in the 20Th Century (Census 2000 Special Reports, Series CENSR-4)," *Washington, DC: US Government Printing Office* (2002), 26.

[44] For demographic data, see http://www.census.gov/hhes/migration/data/cps/historical.html

taxed their parent cities for basic services.   Automobiles clogged previously rural

roads, and the new communities, it was feared, would overwhelm the parent

cities' plumbing and water resources.   Cultural critics lambasted the new

subdivisions for their conformity and the materialism of their residents.[45]

Suburban Studies

Two major social psychiatry studies of the suburbs emerged in the 1950s to early

1960s and documented the new suspicion of the suburbs as locus of mental

health dysfunction. These studies served to shift an earlier preoccupation with

the mental health problems of the cities.

The team of Richard Gordon, a psychiatrist, and his wife, Katherine, a

sociologist, produced the 1960 book *Split Level Trap*.   An at times salacious

read, the book was drawn from the Gordons academic work but aimed at a

popular audience. The Gordons based their work on epidemiological data

comparing the prevalence of mental health problems in a New Jersey suburb

with rates in rural areas.[46]

The Gordons were particularly focused on the problems of young married

women with children in the suburbs. Disconnected from institutions which the

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[45] See, for example, Harry Henderson, "The Mass-Produced Suburbs," *Harpers* (1953): 25-32.
and Hal Burton, "Trouble in the Suburbs," *Saturday Evening Post* (1955). For a summary of "pop"
cultural criticism of the suburbs, see S E Fava, "The Pop Sociology of Suburbs and New Towns',"
in *New Towns and the Suburban Dream: Ideology and Utopia in Planning and Development*, ed.
Irving L Allen (Port Washington, NY: Kennikat Press, 1977).

[46] For examples of the Gordons' academic work see Richard E Gordon and Katherine K Gordon,
"Emotional Disorders of Children in a Rapidly Growing Suburb," *International Journal of Social
Psychiatry* 4, no. 2 (1958): 85; idem, "Social Psychiatry of a Mobile Suburb," *International Journal
of Social Psychiatry* 6, no. 1-2 (1960): 89.

Gordons argued protected women in more established communities, the desperate housewives of "Disturbia" endured anomie and alienation in the loneliness of their suburban villas. Their husbands were cast by the Gordons as disinterested, materialistic social climbers. Sexual tension was the final common pathway of overly busy husbands and isolated, lonely wives.

Like the *Split Level Trap*, *Crestwood Heights* (1956) was a popular book which drew from the research of a team of social scientists collecting epidemiological data.[47] Crestwood Heights was an older established suburb; however the anomie and loneliness that the Gordons depicted in *Split Level Trap* seemed to be equally as threatening as its younger counterpart. *Crestwood Heights* demonstrated how aspects of the older mental hygiene movement became hybridized with social psychiatry in the suburbs. As Brian Low illustrates, the Crestwood Heights study was conceived of by the Canadian National Committee on Mental Hygiene, and was conducted by John Seeley, an American sociologist who had trained at the University of Chicago.[48] In the study, Seeley depicted suburbanites as clueless naive parents, who looked to "experts" in scientific child raising, and as a result, rejected their natural instincts on how to care for their children. The result was a generation of children who had unprecedented liberty, but manifested it in destructive ways, such as sexual acting out.

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[47] John R Seeley, R Sims and E W Loosley, *Crestwood Heights* (New York, Basic Books, 1956).

[48] Brian J Low, "The New Generation: Mental Hygiene and the Portrayals of Children by the National Film Board of Canada, 1946--1967," *History of Education Quarterly* 43, no. 4 (2003): 540-570.

A notable aspect of Crestwood Heights was the careful attention Seeley paid to the use of physical space within the house. Seeley seems to suggest that inhabitants of suburban dwellings moved through the space like automatons in a stage play, without any connection to the objects or the other persons inside of it. For example:

> The Crestwood House is adapted for the "staging" of "productions" and this characteristic is brought to the fore especially whenever formal hospitality is practiced ... The guests play the role of audience, their attention and presence are concentrated upon the center of the stage, on those areas reserved for display and hospitality ... In the wings, food and other symbols of hospitality are prepared, to be introduced as needed. The hall or reception room is unusually important. Here the opening scene is played, with its seldom remembered but inevitably significant opening verbal exchanges.[49]

Seeley went on in great detail to point out the exhibitionistic "staging" of the "picture windows" in the front of the house, where there "is an air here of not only of display, but of coquetry as well."[50]   He concluded that Crestwood homes "seemed oddly reminiscent of a series of department store windows, charmingly arranged, harmoniously matched in color, but rather cold and empty of life."[51]

The Fallout of Social Psychiatry

The cold anomie, the sexual teasing (yet sexual frustration), and the divorce of people from the physical environment despite the bountiful groomed yards and the trappings of wealth painted the suburb as an alienated purgatory of repression and isolation.

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[49] Seeley, Sims and Loosley, *Crestwood Heights.*, 49.

[50] Ibid.

[51] Ibid.

As Kenneth Jackson writes in his landmark history of the suburbs, the way each culture chooses its pattern of physical residence belies the values and beliefs of the culture.[52] What were the social psychiatrists trying to tell us about the postwar culture of suburbia and what impact did their view have on the mental health professions as a whole?

It is a question worth asking, because social psychiatry was instrumental for the orientation of a reformist national mental health policy that was increasingly looking beyond mental hospitals.[53] In 1955, in the wake of extensive public criticism of the conditions in state hospitals, the APA and AMA Council on Mental Health convened a radical re-examination of mental health in the United States. The result was the Joint Commission on Mental Illness and Health (JCMIH), an interdisciplinary board of both psychiatrists and behavioral scientists, appropriated and funded by Congress. The JCMIH, which initially had a focus on the problems of overcrowded mental institutions, seemed to be swayed by the interest in social psychiatry. By 1958, as the JCMIH prepared its final report, its members sought to use its close associations with Congress to effect specific changes in mental health policy. The final report was published in 1961, the delay likely reflecting political expediency, as the Kennedy administration took over from the Eisenhower administration in 1960. In short, the JCMIH report reflected the prevailing ideology of social psychiatry -- the

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[52] Kenneth T Jackson, *Crabgrass Frontier : The Suburbanization of the United States* (New York; Oxford: Oxford University Press US, 1987).

[53] For the political history of community mental health: Grob, *From Asylum to Community : Mental Health Policy in Modern America*; Gerald N Grob, "Government and Mental Health Policy: A Structural Analysis," *The Milbank Quarterly* (1994): 471-500.

importance of public education, the role of the environment, the need for funding

and psychiatric manpower, and a belief that the mentally ill could properly be

taken care of in the community. However, the JCMIH in effect institutionalized a

heavily environmental philosophy of psychiatry, which derived much of its

scientific work not from psychiatry or medicine, but from sociology.   That

influence came from a small cadre of political insiders and psychiatric elites

charged with implementing the recommendations of the JCMIH in 1961.

In particular, Robert Felix, the first director of the National Institute for

Mental Health, left the imprimatur of academic sociology on the entire project. [54]

NIMH had been created in 1946 to respond to growing concern about high

mental illness rates in the U.S. population and corresponding shortages of

psychiatric manpower. A clinical psychiatrist in the U.S. Public Health Service,

Felix's early influences had come from National Committee on Mental Hygiene.

As Bloom explains, NIMH's early role was as that of an advisory council to the

federal government on matters of mental health policy, and it was headed solely

by psychiatrists. However, Felix's interest in psychiatric epidemiology led him to

quantitative sociologists. Thus, NIMH's early research agenda facilitated the

epidemiological studies being done by social psychiatrists. Felix's NIMH

awarded large grants to social psychiatrists, including August Hollingshead and

Frederick Redlich, whose 1958 study on social class and mental illness would

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[54] The most comprehensive discussion of Felix's role and influences in NIMH comes from Samuel W Bloom, *The Word As Scalpel: A History of Medical Sociology* (New York: Oxford University Press, USA, 2002). Bloom also provides a view of the confluence between sociology and psychiatry told from sociology. See also Murray Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press US, 1981).

become one of the archetypal papers in social psychiatry.   Not only was

sociology supported materially, but Bloom argues "Felix quietly and consistently

relied heavily on the help of sociologists in his leadership of NIMH."[55] Thus,

when Felix's task force ran with the sociologically oriented JCMIH

recommendations, they advanced the construction of an elaborate system of

federally funded community mental health clinics in the social psychiatry model.

The resultant Community Mental Health Centers Act was passed in 1963, and as

Grob writes took on a messianic character.[56]

Conclusion

Felix and the NIMH were so influenced by academic sociology that some of

sociology's concepts became cornerstones of key conceptions of the role of

environment in mental illness. For example, the 1963 Community Mental Health

Centers Act redefined the older ecological idea of geographic place and

substituted for it the new idea of "catchment area," a geographical and

administrative unit determined by prevalence of mental illness and by availability

of mental health services. However, the catchment area concept had the effect

of elevating statistical and demographic measures over older ecological, spatial,

or geographic understandings. Moreover, enthusiasm for the vibrancy of cities

among sociologists (along with distrust of suburbs) allowed for the location and

building of intercity community mental health centers, as well providing for the

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[55] Bloom, *The Word As Scalpel: A History of Medical Sociology*, 166.

[56] Grob, *From Asylum to Community : Mental Health Policy in Modern America*., (page).

housing of thousands of formerly hospitalized mentally ill in dense urban environments.

Without Felix's essential ouster of psychoanalysis through the aegis of the Community Mental Health Centers Act, social psychiatry's influence on American psychiatry is hard to define. Social psychiatry's philosophical underpinnings, based on the eclecticism of Meyer's psychobiology, allowed a place at the psychiatric dinner table not only for different approaches within psychiatry, but, as Thomas Rennie defined it, also for far flung fields and disciplines outside of medicine itself. In all, psychobiology, mental hygiene, and social psychiatry were significant for opening psychiatry to a public health perspective, and for easing the transition out of the more deterministic psychoanalytic model. These transition points, and their corresponding doctrinal flexibility, allowed for fundamental re-definitions of what constituted psychiatric illness, a feature that would be critical in the Hawaiian context.

CHAPTER THREE:

MENTAL HYGIENE AND HAWAIIAN EXCEPTIONALISM -- ORIGINS OF

PUBLIC MENTAL HEALTH IN HAWAII

Mental hygiene, and its epistemological descendant, social psychiatry, were

important influences in Hawaii, and their footprints were evident in Hawaii's

public mental health development.   Until 1959, Hawaii remained a U.S. territory,

an indistinct appellation somewhere between occupied territory and full

statehood. Hawaii had an autonomous civilian government, with an elected

legislature, which provided for essential health and welfare services. Hawaii's

doctors, public health officials, and concerned citizens reflected the Territory's

diverse ethnic makeup. Thus, Hawaii's public health system was essentially

devolved to Hawaiian officials to determine policy for themselves.

However, while there was no direct colonial authority, the historian Paul

Hooper has emphasized that territorial Hawaii was neither free to operate without

impunity, nor was it guaranteed laissez faire treatment by Washington. This was

underscored by two important events. The first was the infamous 1931-1932

Massie Affair, in which Thalia Massie, a Honolulu based Naval officer's wife,

accused a group of local boys of sexually assault.[1] The trial resulted in an

acquittal; however Massie's husband, Thomas, along with Thalia Massie's

mother, kidnapped one of the accused men and murdered him in an act of

revenge.   The two vigilantes were pardoned (to the local mixed race population,

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[1] For a monograph work on the Massie Affair, see David E Stannard, *Honor Killing: Race, Rape, and Clarence Darrow's Spectacular Last Case* (New York: Penguin Group USA, 2006).

seemingly unfairly) by the Governor of Hawaii. This ugly affair triggered

significant racial tensions in Hawaii and attracted unwelcome publicity from the

mainland; so much so, that the Governor's pardon was nearly forced by pressure

from Congress. The Congressional action "would trigger the dissolution of the

Territorial government" and substitute, in its place, a military government.[2] The

second sentinel event, according to Hooper, was the 1934 Jones-Costigan Sugar

Control Act which, to Hawaiian sugar interests, haphazardly imposed punishing

import tariffs on Hawaiian products. Thereafter, statehood seemed to be the most

reliable preventive to undue or flippant federal supervision. Furthermore,

statehood would promote Hawaiian tourism and the maintenance of the federal

government's economically valuable military presence.   Until statehood could be

achieved, Hawaiian officials were inclined to avoid the attention or ire of the

United States.

Hawaiian statehood proponents advanced their cause by portraying

Hawaii as a hybrid-racial utopia, an inherently harmonious society that

transcended national origins. The idea of racial utopia was necessary to

convince continental doubters of the safety of admitting Hawaii to statehood, and

to temper fears about the loyalty and assimilability of Hawaii's predominantly

Asian population.[3] The trope of Hawaiian utopian exceptionalism thus posited

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[2] Paul Frankilin Hooper, *A History of Internationalism in Hawaii Between 1900 and 1940* (University of Hawaii), 22.

[3] For Hawaiian statehood see Gretchen Heefner, " A Symbol of the New Frontier," *Pacific Historical Review* 74, no. 4 (2005): 545-574; A K Ziker, "Segregationists Confront American Empire: The Conservative White South and the Question of Hawaiian Statehood, 1947-1959," *Pacific Historical Review* 76, no. 3 (2007): 439-466; Roger J Bell, *Last Among Equals : Hawaiian Statehood and American Politics* (Honolulu: University of Hawaii Press, 1984).

Hawaii as distinctive shangri-la: an exotic, sensual, and harmonious preserve

that allowed for unhindered race mixing. A metaphor for utopian exceptionalism

was that of the racial laboratory, where Hawaii's unique demographic and

geographical conditions could be studied. In mental health, in this view,

environment and place trumped other modes of explanation (such as biology,

culture, or ethnicity); moreover, the hybridized race mixing resulted in a distinct

Hawaiian psychology.   However rhetoric did not measure up to the messy, on

the ground reality of Hawaiian public health. Public health workers noted

significant differences, variations, and anomalies among Hawaii's diverse

population. Officials were aware that an excessively racial or culturally focused

program of public health would likely invite charges of racism, which would

threaten popular acceptance of important public health programs. Therefore,

public health officials self consciously tread lightly around racial or cultural

issues.

Hawaiians were aware that the melting pot trope was a thinly veiled deceit

-- in fact, if more fluid than in other places, racial, ethnic, and cultural identities

were retained and significant for day to day affairs in twentieth century Hawaii.[4]

As a compromise solution, in their own dealings, public health workers and

educators allowed certain rhetoric that, while loaded with racial meaning to

insiders, would not draw attention to the issue. Thus, public health practitioners

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[4] For a description of racial identity as significant in Hawaiian politics see Tom Coffman, *The Island Edge of America : A Political History of Hawai'i* (Honolulu: University of Hawai'i Press, 2003). For comparisons between the race relations experience in the United States with Hawaii see Beth L Bailey and David R Farber, *The First Strange Place: Race and Sex in World War II Hawaii* (Baltimore: Johns Hopkins University Press, 1994).

cloaked racial distinctions in the language of attitudes, behavior, and habits that belied detailed relationships of people to space and place.

After Hawaiian statehood, public health administrators, practitioners, and theorists drifted from Hawaiian utopian exceptionalism. The dominant clinical paradigm for understanding mental illness became the epidemiological and statistical model of social psychiatry, and explanations involving unique Hawaiian environmental influences fell away. Moreover, after 1963, Hawaiian psychiatry was to fall under the nationwide Community Mental Health Act. Under this law, generalized assumptions about economic changes, industrialization, and the influence of cities and suburbs became the most important academic influences. Universalism pecked away at the older model of Hawaiian exceptionalism. For example, modernization theory, an academic assimilationist philosophy of the Cold War utilized extensively in foreign policy formulations, posited Hawaii as but an example of modernizing forces globally. Furthermore, in psychiatry, the catchment area concept of community mental health replaced neighborhood as the unit of urban geography. The loss of exceptionalism also threatened a revision of complex understanding and observation about forces involved in determining mental health in Hawaii, including racial tensions.

This chapter will examine early developments in the Hawaiian mental health system, from 1939 to about 1955, a period which mirrored the development of the mainland mental hygiene movement, but with a significant allowance for local autonomy and flexibility. Hawaiian officials avoided embarrassing or divisive racial and cultural explanations for psychopathology,

and adopted a nuanced vocabulary of environmental influences. Despite this, the Hawaiian mental health system grew haltingly and retained a significantly consultative, if not directly clinical role. In addition, in Hawaii, a doctrinally eclectic psychopathological model invited the contributions (and thus magnified the tensions) of diverse mental health workers such as psychiatrists, social workers, psychologists, and even the lay public.

History of Public Health in Hawaii

The pre-annexation Kingdom of Hawaii (under King Kamehameha III) appointed an independent Board of Health in 1850.[5] In the area of mental health, an asylum had operated on School Street in Honolulu as early as 1862 and also served alcohol and opium addicts. However, the asylum operated on a custodial rather than a rehabilitative model.[6]   The United States annexed Hawaii in 1898, and the Hawaiian Organic Act of 1900 established a territorial government for Hawaii. U.S. citizenship was extended to citizens of the previous Hawaiian government but excluded Asian immigrant plantation laborers. An eleven member Board of Health served the territorial government and directed public health operations.[7]

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[5] Richard C Lee, "Public Health Contrasts in Hawaii, 1850-1953," *Public Health Reports* 69, no. 4 (1954): 403-9; Robert A Kimmich, "100 Years of Hawaiian Psychiatry," *Hawaii Medical Journal* 15, no. 4 (1956): 345-7.

[6] Ibid.; See also R D Kepner, "Report on the Territorial Hospital,"July 31, 1937, Mamiya Medical Heritage Collection, Hawaii Medical Library.

[7] Lee, "Public Health Contrasts in Hawaii, 1850-1953."

In the area of psychiatry, the 1920s brought two important developments for both mental institutions and public mental health measures. In 1921, the Territorial Legislature founded the Waimano Home for the Feebleminded, a facility designed to house and treat patients with cognitive problems or mental retardation. Patients were sent to the Home through the court system or through approval of the Board of the Home; this soon presented difficulties, as neither the courts nor the Board appointees were able to determine standards of diagnosis. Thus, in 1922, the legislature funded a clinic to consult on admissions to the Waimano Home and in other cases where determination of mental illness was important. The Psychological and Psychopathic Clinic was set up under the auspices of the University of Hawaii, ostensibly to keep it free from political influence.[8] The Psychological Clinic served a specialized research and consultative function at inception[9] -- it did not function as a general mental health clinic, nor was it envisaged as such.

Psychiatric manpower in the 1920s was minimal. Honolulu had only two semi-private outpatient practitioners of psychiatry in 1924. In 1929, a small short term psychiatric unit was founded in Honolulu at the Queen's Hospital. In 1930, the 524 bed Territorial Hospital for the Insane, a longer term custodial facility, was established at Kaneohe, away from Honolulu on the windward side of Oahu.[10] However, there was no outpatient department at Kaneohe, and in 1937, there

[8] See Karen R Takemoto, ""Unquestionably Lolo" A History of Waimano Home (1921-1961)" (Master of Education Thesis, University of Hawaii, August, 1984).

[9] Stanley D Porteus, "Psychological Service in Hawaii: The Work of the University Clinic," *University of Hawaii Bulletin* 18, no. 5 (1939): 3-17.

[10] Kimich, R. "100 Years of Hawaiian Psychiatry."

were still just four physicians on staff, only two of whom had any psychiatric training, for a census of 875 patients. In 1937, when the hospital was surveyed, there were no specific program or treatments for psychiatric illness.[11]

Therefore, prior to World War II, there was little psychiatric infrastructure in Hawaii. Moreover, other medical professions were ignorant of or hostile towards psychiatry. Margaret Catton, a social worker who had worked on the general medical wards at Honolulu's Queen's Hospital, described the mood in the early 1930s:

> I tried to interest several physicians in the establishment of a psychiatric service but for the most part they were indifferent, or said there wouldn't be enough work in Honolulu to keep a psychiatrist from starving. For those who could afford it taking a trip for a change of environment was one means of treating mental illness. Narcotics was another and many patients were sent to the Territorial Hospital which probably would not have been the case had we had practicing psychiatrists on our medical staff. [12]

A turning point came in 1931 with the visit of Clifford Beers, the nationally recognized mental health advocate and a founding member of the National Committee for Mental Hygiene. Beers addressed a packed Honolulu audience, and his visit resulted in the Republican Governor of Hawaii, Lawrence Judd, appointing an Advisory Council on Mental Hygiene. After Judd left office in 1934, the committee was dissolved. Beers was determined to press the cause of mental hygiene in the territory, however. Working through Catton, in 1935 Beers obtained the funding for a Hawaiian "demonstration project," and Nebraskan

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[11] Kepner, "Report on the Territorial Hospital."

[12] Margaret L Catton, "The Background of the Mental Hygiene Movement in Hawaii Leading to the Establishment of the Bureau of Mental Hygiene," (From a paper read to the Hawaii chapter of the American Association of Social Workers, November 27, 1940, 3, Mamiya Medical Heritage Collection, Hawaii Medical LIbrary).

Florence Brugger, a newly minted psychiatric social worker, was assigned to the

job. Brugger was posted on a general medical ward at Honolulu's Queen's

Hospital. Although she did not at first have any direct mental hygiene work, she

managed to gain the confidence of the hospital's doctors. In her spare time,

Brugger gave lectures to local organizations, and she resurrected and expanded

Governor Judd's mental hygiene advisory committee.[13]

In 1937, University of Colorado Professor Franklin Ebaugh, former student

of Adolf Meyer and a recognized expert on mental hygiene, was scheduled to

give a summer seminar at the University of Hawaii. Realizing there was an

opportunity to take advantage of Ebaugh's expertise, Brugger and Catton

enlisted their allies among the local doctors, who in turn approached the

Honolulu Chamber of Commerce. The result was a proposal made to Ebaugh to

conduct a mental hygiene survey of Hawaii. Ebaugh agreed and arrived in June

1937.

The "Ebaugh Report," as it was called, reiterated Ebaugh's

psychobiological orientation and recommended expanding preventive efforts

outside of the Territorial asylum. In his report, Ebaugh touched on the differences

between mental health on the mainland and on Hawaii and was circumspect on

issues of race:

> Hawaii has special features which influence the problem of mental health. Realizing that
> much of mental illness has its roots in conflict and frustration situations in the family and
> the community for Hawaii is racially mixed with consequent cultural conflicts, having also
> several racial groups with unequal sex ratio which makes normal family life difficult. In

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[13] Ibid.

addition the economic opportunities are somewhat limited by the island geography and industrial development.[14]

Ebaugh speculated that the frequency of mental illness in Hawaii was higher than that in the mainland states. The critical difference, in Ebaugh's view, was the availability of outpatient mental health treatment on the mainland. In Hawaii, early intervention could slow the progress of psychosis and prevent subsequent commitment to the Territorial Hospital. Ebaugh thus concluded that the first order of business was the establishment of an outpatient psychiatric clinic.

The Chamber of Commetrce was impressed enough with Ebaugh's report that they invited him back to Honolulu in 1938 to start a demonstration psychiatric clinic at Queen's Hospital. The Clinic was privately funded until 1939, when the Legislature approved a permanent clinic to be headed by a newly founded Bureau of Mental Hygiene (operating within the older Department of Health). Edwin McNiel, the resident psychiatrist of the Payne Whitney Clinic in Manhattan, was recruited to be the clinic director, and Florence Brugger stayed on as psychiatric social worker.[15]

In the first year, the clinic saw 442 cases on Oahu and on short demonstration trips to the neighbor islands. Caucasians (143) made up most of the initial cohort, with Japanese (82), Hawaiians and mixed Hawaiians (36),

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[14] Franklin G Ebaugh, "Mental Health in Hawaii; A Survey of Mental Hygiene Facilities in Honolulu, Hawaii." July 1937, 5. Manuscript Copy; Mamiya Medical Heritage Collection, Hawaii Medical LIbrary. See also Franklin G Ebaugh, "Recommendations for a Mental Health Program in Hawaii," *The American Journal of Psychiatry* 95, no. 4 (1939): doi:10.1176/appi.ajp.95.4.873. http://ajp.psychiatryonline.org.

[15] Catton, "The Background of the Mental Hygiene Movement in Hawaii Leading to the Establishment of the Bureau of Mental Hygiene."

Portuguese (33), Filipinos (30), and Chinese (16) making up the rest of mix. In

clinic reports, there were again hints at some of the cultural challenges

encountered:

> Superstition is the result of ignorance and fear, and because of this is often involved in cases of mental illness. A Hawaiian woman moved into a different house, and thoughtlessly cut down the plants of the former owners. She then became fearful, worried, and upset because she had violated on old superstition. She began to hallucinate and heard voices crying at night. Her neighbors decided that she was kahunaed. The cure -- putting poi in cupcakes at the four corners of the house -- did not help the woman's mental illness.[16]

There were more prominent controversies, however. One contentious

topic was differentiating the functions of the new Mental Hygiene Clinic and those

of the older Psychological Clinic, which had been functioning under the

directorship of Stanley Porteus since 1921. Porteus, a psychologist, was an

obstacle to physicians like McNiel and the Public Health Department leadership.

Porteus argued that the need for a separate mental hygiene clinic was not

pressing enough, and when there appeared to be some confusion on the part of

Chamber of Commerce Board members and the public about the functions of

psychologists versus psychiatrists, Porteus submitted some long columns to the

Honolulu Star Advertiser clarifying the point.[17] In addition, Porteus sparred with

the clinic leadership on where to locate the new Bureau of Mental Hygiene's child

guidance program, with Porteus arguing that the program should be housed at

his University clinic.

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[16] Chamber of Commerce of Honolulu, "A Few Facts That Show the Wisdom of Establishing the Bureau of Mental Hygiene and the Psychiatric Clinic," March 1939, 4. Mamiya Medical Heritage Collection, Hawaii Medical Library.

[17] Stanley D Porteus, "Psychiatry and Psychology," *Honolulu Star-Bulletin*, June 21, 1938.

Another chronic complaint was the difficulty of recruiting mental health staff from the mainland to work at the Clinic and in the Bureau of Mental Hygiene's programs. The major problem was that the pay for psychiatrists and psychiatric social workers was too low to attract workers to a "hardship post." McNiel further seemed to be plagued by bureaucratic red-tape in his efforts to expand the clinic. Because he did not have a Territorial Medical License, he was originally refused malpractice insurance, and then the Medical Board required him to retake the examination, for which he had to take a leave of absence. In 1943, he left the clinic post in a huff, citing "selfish interests" of the commissioner of Public Health and Porteus, who he branded a "local pseudo-expert."[18] In addition, McNiel suggested that the Director of the Board of Health was not in favor of supporting the clinical mission of the Bureau. While the Ebaugh report had conceived of the mental hygiene clinic as a center of primary preventive work, in reality the Clinic was overburdened with clinical and consultative demands. In turn, the private sector was enlisted to help with education of the public, and thus the Territorial Mental Hygiene Society was founded in 1942.

Mental Hygiene Efforts in Hawaii

Hawaiian mental hygiene writing of the time was derived from the clinical model of psychobiology, which viewed mental illness as the breakdown in interaction of an individual with his environment. For example, Queen's Hospital pediatrician Joseph Palma's 1938 *A Guide to Mothers in Hawaii* was a short handbook with

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[18] See "Dr. McNiel Files Sharp Report Before Departure," *Honolulu Star-Bulletin*, September 22, 1943.

lengthy sections on childhood behavior and the home environment.[19] Palma also

made some regional speculations as to how the Hawaiian climate might influence

habits and hygiene. He began the book with a quote from Hippocrates' "Airs,

Waters, Places" and stated that "With our delightful year around climate inviting

outdoor life, too much time is devoted to play and not enough to rest" and

recommended that children have a set-aside rest period during the weekend. [20]

Palma then discussed the theoretical basis for his ideas about child-rearing. He

minimized "the bogy of repressions" of Freudian developmental theories, then

articulated a dynamic model of genetic and environmental influence: "It is the

logical application of the genetic-dynamic theory which regards the child as

driven forward in his orderly sequential development by his genetic endowment,

and aided, modified, restrained, or deflected by the environment of home, school,

and the tests of everyday life." [21] Then Palma gestured towards the attitudinal

environment as "In almost a literal sense the physician can reach the mind of the

infant by altering undesirable attitudes in the parents."[22]

     Palma used the term "environment" fairly indiscriminately. In one passage

environment referred to the home, in others, the parent-child relationship, the

schoolroom, and the social relationships of the playground. Thus, while Palma

did not deliberately craft a theory of environment, he emphasized that

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[19] Joseph Palma, *A Guide to Mothers in Hawaii* (Honolulu: Honolulu Star-Bulletin, 1938).

[20] Ibid., 90.

[21] Ibid., 84.

[22] Ibid.

environment was conjured up, as it were, through a process of behaviors, attitudes, and habits.

Repeatedly, in public health adminstrators echoed the idea and language that public attitudes about mental hygiene created the environment which gave rise to mental health issues. Public attitudes and behavior created the *materia medica* of preventive work. In 1962, with the transition to community treatment in the near horizon, Governor William F. Quinn, speaking at a conference of mental rehabilitation, continued the metaphor, stating that "We can be vaccinated to prevent a disease, take a pill perhaps to cure one, but we have no simple magic formula to motivate people. People motivate themselves, and we can only try to provide the atmosphere to encourage them to do what we, as leaders of health workers, feel is beneficial."[23] The conference was full of exhortations to provide, again and again, "education" to the public. But what was meant by education? The idea existed that any gains achieved by better clinic or mental hospital facilities or practices would be negated without a corresponding shift in lay attitudes among patient's families or employers. Education would also allow the public to get the affected person into treatment earlier, thus performing a preventive function. Thus, by extension, in preventive work, treating "the public attitude towards mental illness" became a realistic means of re-tooling the environment. Conversely stereotypes and unsympathetic treatment by the public could "infect" a community, in and of itself precipitating psychiatric illness.

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[23] *Proceedings of Governor's Conference on Rehabilitation of the Mentally Ill Adult*, Sponsored by William F. Quinn, Governor, State of Hawaii (September, 1962), 4.

The Territorial Mental Hygiene Association made the primary efforts to change the attitudinal environment in a setting where practitioners were overwhelmed with clinical responsibilities. The main method of changing public attitudes involved a mass media campaign of public education. This included radio addresses, lecture series, newsletter articles on specific psychiatric illnesses, book reviews, case presentations, a pamphlet library, educational window displays, and sponsorship of an annual mental health week.

The Mental Hygiene Society's newsletter to the public, *Better Mental Health for Hawaii*, initially published in 1945, was an exhaustive reporter of all things psychiatric in Hawaii. Starting in 1947, each edition carried a long feature article written by a prominent local mental health official. These articles attempted to get at the nuts and bolts of what happened in the territory's psychiatric facilities. An early article covered what locals could expect should they become committed to the Territorial Hospital for the Insane. Cheerfully detailing the opportunities for treatment with an arsenal of lobotomy, electroshock therapy, and malaria treatment, at least the article admitted that "the staff is still too small for the number of patients, wards are overcrowded, [and] equipment is inadequate."[24]

Indeed, a leitmotif was dispelling unhelpful fears about the mental health professions. This was illustrated in articles such as "What does the Psychiatrist do with Billy" or in case vignettes that illustrated, in real world terms, the harmful outcome of negative public attitudes. In one such example, the Association

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[24] "If You Become Mentally Ill," *Better Mental Health for Hawaii* 3, no. 4 (1947), 1.

penned a fictional transcript of an apparently Native Hawaiian boy with

delinquency and mental retardation who was referred to a wahine (female) Pupil

Guidance counselor:

> "Took me a long time to find out I could trust her and she understood how a guy like me felt. You wouldn't think a wahine would have that much sense. Feels good though to have somebody you can talk to and know they won't yell and pick on you all the time. Just sit there and treat you like a regular guy. She talked to the principal and my teachers, and even went home and saw grandmaw ... Going to the Psychological Clinic wan't bad too ... After that, the principal and the wahine asked me about what I liked to do. I showed her the surf board I was making when she was up my house and she said maybe I could take shop. That's swell and now maybe I can get a good job, doing what I like, when I get out of school."[25]

In these vignettes, the atmosphere created by parents or the school was

also singled out as an area to target with education. In another case, Bobby's

mother was mystified by the child's fussy behavior and tantrums at mealtime.

The diagnosis was a psychological one -- children "enjoy mastering an emotional

adult". The treatment was to modify the "atmosphere" on one hand, and to

minimize emotional standoffs and conflicts, on the other:

> The child is responding to the atmosphere created by the adults in the situation ... At school the atmosphere is friendly and relaxed ... With patience and consistent treatment on the part of the teacher, Bobby realizes that nothing is to be gained by refusing his food, and being a normal intelligent child he accepts the routine without major conflict ... consistent and logical handling will smooth out the rough spots. When parents and teachers take it easy, apply certain basic nursery school techniques and work to create a secure and relaxed atmosphere, controls will develop naturally.[26]

"Attitude" and "atmosphere" suffused the behavioral environment, while "habit"

and "routine" were the royal road to remediating the negative environment.

These exhortations were nothing new to mental hygiene as a whole. Any mental

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[25] "Do Say Do and Don't Say Don't," *Better Mental Health for Hawaii* 4, no. 1 (1948): 2.

[26] "Hoomaha," *Better Mental Health for Hawaii* 4, no. 1 (1948): 2.

hygiene textbook written in the period might contain the same language. But with Hawaii's unique racial situation even the race of the children picked for the case vignettes was oddly indeterminate.

Indeed, there was very little attribution to race or cultural issues as a contributor of mental health problems in the official literature of the the Mental Health Association, or by public health officials. Although efforts were made to delineate mental health services by race, very seldom were race or cultural issues cited directly as targets of intervention. For example, the 1962 Governor's Conference on Rehabilitation of the Mentally Ill devoted an entire working group to problems of public mental health education. While acknowledging "Cultural or racial factors may be an influence," the report did not contain any further explanation of this conclusion, nor did the recommendations to make any specific recommendations targeted towards any particular ethnic group[27].

The exclusion of more detailed mention of racial or ethnic factors in the public mental health literature seems odd considering the historical evidence arguing that race and ethnic divisions in Hawaii were active and intense and often surfaced in other issues, such as politics, labor, and land issues. Several writers have mentioned a peculiar disconnect between the popular American conception of racial harmony in Hawaii versus the gritty, on the ground reality of racial politics and ethnic divisions, what John Dunne has termed "the melting pot cult."[28]

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[27] *Proceedings of Governor's Conference on Rehabilitation of the Mentally Ill Adult*, Sponsored by William F. Quinn, Governor, State of Hawaii (September, 1962), 10.

[28] John G Dunne, "The American Raj: Pearl Harbor Reconsidered." The New Yorker, 7 May 2001.

One explanation is that mental health authorities in Hawaii were proud of the system they had set up and wanted to be measured by the same standards federal officials might use to evaluate a program in any other state.   Official publications through the 1960s almost unanimously marveled at how efficiently the mental health system worked or how quickly it had grown, and state officials appeared proud that per capita mental health expenditure was one of the highest of all states. Thus, officials had little interest in laying bare specifics of how ethnic or racial factors might impact mental health. But their writings contained a shorthand for more complicated ideas in amorphously cited factors like "education," "attitudes," "atmosphere," and "environment." These terms became loaded with specific meaning for an audience of Hawaiian mental health insiders.

There is one more collection of evidence to suggest that officials were anxious to tread lightly on the issue of race in relation to mental health. There was experience with these kinds of explorations, and they had not gone particularly well. The experience had come with Hawaii's resident psychologist Stanley Porteus. Porteus was an emigree Australian who had worked since 1913 at a clinic near Melbourne for the treatment of retarded children. Porteus had been recruited to be the director of the University of Hawaii's Psychologic Clinic, by way of his tenure at the Vineland Training School in New Jersey, an institution famous for its linkage to eugenicist Henry Goddard (who adapted I.Q testing for use on American children). Porteus had developed his own test for feeblemindedness, dubbed the Porteus maze, which he applied to research work in Australia and later in his travels and work with Africans and Australian

Bushmen.   Porteus was also instrumental in the activity of the Department of

Mental Hygiene in the years following the Ebaugh report. However, his studies

were tainted by associations between his work and that of scientific racists.[29]

In his indictment of Porteus, the University of Hawaii historian David

Stannard cites the many contemporary negative reviews of Porteus' most

notorious book, the 1926 *Temperament and Race*. Moreover, Stannard argues

that Porteus continued to support eugenicist publications that suggested

connections between heredity and biological superiority.[30]   In addition, Karen

Takemoto's thesis (somewhat unfairly) suggests that Porteus' directorship of the

clinic had resulted in a disproportionate percentage of ethnic minorities being

committed to the Waimano Home for the developmentally disabled.[31] Due to

these controversies, in 1975, the Board of Regents of the University of Hawaii

was forced into renaming Porteus Hall (which had been informally dubbed

"racism hall") on the Manoa campus.

Porteus was certainly an outspoken figure. As advisor to the Bureau of

Mental Hygiene, Porteus defended the turf of his Psychological Clinic against the

new psychiatric interloper.   Porteus had responded to the proposed placement of

child guidance duties under the new psychiatric clinic by a barrage of unilateral,

lengthy editorials in the *Honolulu Star Bulletin* in which he deliberated on the

differences between psychology and psychiatry and advocated spending less

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[29] See David E Stannard, "Honoring Racism: The Professional Life and Reputation of Stanley D. Porteus," *Social Process in Hawaii* 39 (1999): 85-125.

[30] In particular, Stannard argues this was apparent in Porteus being a continued advisory member of the physical anthropology journal *Mankind Quarterly* well into the 1960s.

[31] Takemoto, "Unquestionably Lolo."

money on the new clinic and more on improving conditions at the Waimano

Home (where he was a consultant). Porteus' public writings seemed to invite

further controversy, suggesting his reputation was known popularly. Three days

after his last article on the differences between psychiatry and psychology, it was

announced in the same newspaper that a Portuguese civic group was sending

Porteus "a letter of protest" over *Temperament and Race*.[32] The book had

passages, according to Stannard, which pointed out the " 'educational

retardation' of the Portuguese, who ostensibly were white--but who ranked next

to last on this measure, barely beating out the Hawaiians" and highlighted the

"'considerable mixture of negro blood' and the suspicion that the Portuguese who

migrated to Hawai'i were the descendants of 'political and other prisoners'."[33]

For all of Porteus' faults, and contrary to his reputation amongst modern

Hawaiian historians, he is not an easy figure to pigeonhole and is more complex

than a simple caricature of a closet racist. He was a polymath and certainly a

well informed and qualified commentator on social and psychological issues in

Hawaii. Certainly he was not afraid to take on the the issue of how Hawaii's

geographic, racial, and demographic particulars might impact mental health.

Porteus was probably most revealing in his work as historian. Although Stannard

has accused Porteus of publishing in the vanity presses, the Hawaiian Historical

Society commissioned Porteus in 1962 to write a history of the papers presented

at the meetings of the Honolulu Social Science Association, a scholarly

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[32] "Portuguese Group Criticizes Porteus," *Honolulu Star-Bulletin*, August 9, 1939.

[33] David A Stannard, "The Professional Life and Work of Stanley D. Porteus: A Report on the Proposed Renaming of Porteus Hall," *Institute for the Study of Academic Racism* (December 1, 1997), http://www.ferris.edu/isar/bios/Porteus/stannard.htm (accessed August 9, 2011).

anthropological society founded in 1882. Porteus edited the volume and his

selection of essays reveals something about his views, as does his actual

commentary.

In this volume, Porteus proved to be a credible agitator. He directly

acknowledged racial conflict as a tarnish on the underside of the golden

Hawaiian melting pot.   Porteus then summarized Honolulu's response to

prostitution and venereal disease during World War I and appeared surprised

that the hard handed response the city employed was actually effective. He went

on to discuss sex education and criticized another essayist for being too prudish

as "What the bees and the birds and the Samoans do is mere window dressing

and an evasion of plain speaking."[34] In another section, Porteus articulated his

own bit of Lamarckism:

> The Maori branch of the Poynesian race had a long and fairly severe winter to prepare for; their land did not have the all year-round productivity that Hawaii offered. Hence, providence, foresight, anticipatory effort was thrust upon them. Life was not easy, and with the toughening of physical fiber came a bind or conservative tendency in belief and customs. So the Maori remained more steadfastly Maori then the Hawaiian remained Hawaiian. The whites who came to the islands also suffered a change. It does not seem too much to expect that an easier climate, a pleasing range of natural beauty, had a mellowing effect on the New England missionaries and their physical and spiritual descendants.[35]

The Lamarckian suggestion, gently advanced, did not pass muster in post-

Boasian anthropology. The important point here is that while Porteus theorized in

print, it would not be surprising if similar ideas existed at the highest levels of

Department of Health, the Governor's office, and the Mental Hygiene

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[34]Stanley D Porteus, *A Century of Social Thinking in Hawaii* (Palo Alto: Pacific Books, 1962), 120.

[35] Ibid., 151.

Association. Porteus' musings were the explicit articulations that became

obscured by the amorphous official lexicon of "atmosphere," "attitude," and

"habits."

Conclusion

With the advent of community mental health in the 1960s, not only had language

shifted, but a new psychopathological model, social psychiatry, had emerged,

which downplayed explicit biological differences in mental health problems.

Community mental health also offered a new language, but while the language of

mental hygiene could carry loaded meanings in Hawaii, the new social

psychiatric language obliterated the special placeholders of regional influence.

At the same time, even cultural differences were downplayed in a new rhetoric of

health internationalism and modernization theory that generalized the

development struggle across diverse nations. Moreover, in a new anti-colonial

world, associations to scientific racism were even harder to come to terms with.

Hawaii could be a purgative, as Gretchen Heefner writes, "a broader ritual

cleansing ground that could reconcile U.S. Cold War policies with its ideals of

democracy and self governance."[36] Community mental health, with its neutral

language of epidemiology and its emphasis on economic modernization was a

better model for this foreign policy than the older local, but more sophisticated

appreciation of racial tension in mental health issues.

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[36] Heefner, " A Symbol of the New Frontier," 562.

After a halting start, public psychiatric treatment grew robustly in post-war Hawaii. After 1947, key vacancies at the Bureau of Mental Hygiene were filled. Queen's Hospital started its own outpatient department in 1947 and saw over 200 patients in its first year. By 1953, the caseload at Queen's had increased to over 2,000 cases. New buildings were added to the Territorial Hospital to address overcrowding, and commitment procedures were made more stringent. In addition, once Porteus retired, the Psychological Clinic at the University of Hawaii was folded into the Bureau of Mental Hygiene. Specialized clinics for the treatment of alcoholism entered service in 1957. On Oahu, by 1960, there were 4 separate mental health clinics operated by the Departmental of Health, serving 1421 children and 841 adults.[37] The neighbor islands also had thriving clinics and in some cases their own satellite mental hygiene associations. The next chapters will examine the loaded language of mental hygiene, place, and race in their clinical application in these settings.

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[37] *Annual Report, State of Hawaii Board of Health, 1960* (June 30, 1960).

CHAPTER FOUR

NATIVE HAWAIIANS, HOUSEHOLD CONTINUITY, AND THE PROBLEMS OF

MARGINAL MEN

In 1944, the Honolulu radio station KGU produced a series in conjunction with

the Honolulu Board of Health called "How to Keep Well." Each week, a public

health official went on the radio to opine on subjects as diverse as "Dengue

Fever" and "Good Health through Pure Food and Drugs."   Mental hygiene topics

were well represented. The chief psychiatric public health official in Hawaii,

William Shanahan, penned his own public addresses on both child and adult

mental hygiene for the series.[1]

In his discussion on child mental hygiene, Shanahan stated boldly, "One of

the first things a healthy child needs is a family."[2] Shanahan stressed the

requirement of two involved parents to create a healthy "indelible imprint" for a

child's "formative years."[3] In particular, Shanahan pointed out the perils of

children moving from household to household, as in cases of abandonment by

one or both parents. "Repeated or frequent shifting from home to home or

institution to institution," irreparably harmed the child.[4] Laxity around parental

responsibility led to unnecessary displacement of children to state institutions for

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[1] Board of Health, Territory of Hawaii, *"How to Keep Well" : Radio talks delivered Sunday March 12-Sept. 17, 1944, no. 1-27*, Hamilton Hawaiian Library, University of Hawaii at Manoa, Honolulu, HI.

[2] Ibid., 50.

[3] Ibid., 50.

[4] Ibid., 51.

"trivial reasons."[5] Shanahan concluded, "We should all remember that no matter

how well administered and operated an institution for children is it cannot hope to

take the place of home and parents." [6] Shanahan went on to discuss other

mistakes parents frequently made. He depicted children as impressionable

subjects to be managed systematically with "expectations and requirements,"

and "training and discipline."[7] Parental affection was to be even-handed;

indulging children or favoring one child over the siblings would "almost certainly

result in behavior problems."[8]

      Shanahan did not identify any specific parents or groups in his address.

In fact, he took pains to specify that the recommendations were "sufficiently

general so that they can be applied to practically any child."[9] However, given

Hawaii's well known ethnic and demographic particulars, Shanahan's dedication

to generalities seems forced.   Indeed, this chapter argues that mental health

officials like Shanahan deliberately avoided advancing elaborate racial or cultural

formulations for mental health problems, particularly of Native Hawaiians.

However, in a seeming contradiction, mental health officials drew many ideas

from research in academic sociology, which was *exquisitely* tuned into how race

or culture might produce mental illness. These contradictions were resolved by

weaving sociological ideas into a culturally neutral language of relationships to

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[5] Ibid., 51.

[6] Ibid., 51.

[7] Ibid., 51.

[8] Ibid., 53.

[9] Ibid., 50.

place. In their flexible re-conceptualizations of mental illness as diseases of continuity of space, mental health officials proved how pliant and locally driven ideas about psychiatry could be, even in a colonial setting.

Hawaii's Public Mental Health System and its Influences

The Bureau of Mental Hygiene, the branch of the Hawaii Board of Health that administered outpatient mental health clinics and coordinated education and outreach, was the lynchpin of Hawaii's public mental health system.[10] The Bureau consulted with other government departments that required some capacity for psychiatric assessments, such as the Oahu prison, the Child and Family Court system, and the Department of Public Instruction. In 1955, the organizational structure of the Bureau of Mental Hygiene was reorganized and the Bureau's name was changed to the Division of Mental Health, although the Division retained a similar menu of services to its predecessor.[11] In the 1950s and 1960s, the system of public mental health clinics also grew significantly. By

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[10] Jane Lyum Chung, "A Study of the Development of the Bureau of Mental Hygiene 1939-1952" (M.S.W. Thesis, University of Hawaii, February, 1955). Chung also notes that, initially, the Bureau of Mental Hygiene was charged with administering the inpatient psychiatric unit at the Queen's Hospital.

[11] For a more detailed description of organizational changes to the Bureau in 1955, see Sau M W Goo *et al.*, "A Study of the Socio-Cultural Characteristics of Patients Known to the Mental Health Clinic, Bureau of Clinical Service, Division of Mental Health, 1957" (M.S.W. Thesis, University of Hawaii, June, 1958), 9.

1965, on Oahu alone, public mental health clinics had some 2,700 patients under care.[12]

There were significant ideological connections between the Hawaiian mental health system and research coming from the Department of Sociology at the University of Hawaii. This was promoted by cross membership on committees by members of the Department of Public Health and by faculty members from the Department of Sociology, placement of the Sociology Department's students in psychiatric clinics, cross publication in journals, and mutual training of psychiatric social workers. The Department of Sociology's research unit published its own series of occasional papers and a journal, *Social Process in Hawaii,* which put forward complex sociological formulations on problems that were confronted daily in the clinical setting by public health officials and often contained contributors from medicine or social work.

While the previous chapter demonstrated how public health administrators were delicate with matters of race and culture, in contrast, the self stated mission of the Department of Sociology was to upend the smug exhortations of racial harmony that sometimes were offered by Hawaii's boosters both at home and on the mainland, or in the words of one sociologist, to publicize "the undercurrents of tensions and discriminations, of ethnocentrisms and island parochialisms, which

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[12] The largest percentage of these patients were Japanese (who made up 27.7% of of the total), followed by Caucasian (24.7%) and Hawaiian or part Hawaiian (1.5% and 17.8%). In the outpatient clinics, the population was mostly adults (2147) with 642 children, pretty evenly divided between male and female. See Hawaii Department of Health Mental Health Statistical Section, "Psychiatric Outpatient Program, State of Hawaii, Fiscal Year 1965-66," December, 1966. (State Archives of Hawaii, Honolulu HI).

the over-sentimentalized reference to "the aloha spirit" conveniently belies."[13] In

the case of Native Hawaiians, these complex dynamics were softly obscured by

a nuanced lexicon which evolved for discussing these topics, in which "family,"

"attitudes," "education," and "household" carried loaded meanings. These broad

terms, used extensively in official documents meant for public consumption,

carried special meanings, especially when referring to Native Hawaiians. In these

writings, the Bureau of Mental Hygiene stressed the importance of maintaining

stability of family and household. These concepts were directly relevant to the

Bureau's consultative work with institutionalized Native Hawaiian patients, as

officials in the Bureau saw first hand the problems caused by disruptions in family

life.

Sociological Writing on Native Hawaiians

European anthropologists writing at the beginning of the twentieth century had

been the first to call attention to how Hawaiian kinship structures colored basic

conceptions of institutions such as family and the state. According to Hawaiian

ethnographer Charles W. Kenn, traditionally Hawaiians saw state and society not

as a political entity, but as an extended familial structure, a conglomeration of

clans with different kinship ties, represented by a patriarchal king. As a result,

"Hawaiians had no term for family in the modern American sense."[14] In

particular, the notion of household was fluid. The society was seen as one large

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[13] Romanzo Adams Social Research Laboratory, University of Hawaii, *Reflections on Hawaii and Thailand* (Report No. 30) (July, 1961), 1.

[14] Charles W Kenn, "Some Hawaiian Relationship Terms Re-Examined," *Social Process in Hawaii* 5 (1939): 46.

extended family; as such Kenn explained that children were freely bequeathed to other relatives as markers of family status. These fluid parental dynamics were managed without formal laws and instead governed by faith and tradition, as "to refuse such a request would bring bad luck to the child throughout life."[15] Hawaiians continued to practice even more informal means of child adoption, "regardless of blood relationship."[16] However, Kenn concluded, while these informal parenting relationships had their place in traditional society, "today they make for apparent disorganization."[17]

When social work students at the University of Hawaii were placed into the Bureau of Mental Hygiene's psychiatric clinics, they cross fertilized the mental health system with similar ideas from academic sociology. For example, a 1957 study of patients at a Honolulu mental health clinic reiterated the incommensurability of native Hawaiian culture with the Western, Christian notion of marriage and household.[18] The study implicated Hawaiian ritual culture in explaining psychiatric illness among Native Hawaiian children. The analysis focused on the Hawaiian tradition of *kapu,* a system of supernaturally endowed taboos and rules. *Kapu* enforced the physical separation of men and women during the day and allowed for interaction of the sexes only at nighttime, and only through informal sexual contact. Thus, "natural parenthood rather than formal

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[15] Ibid., 47.

[16] Ibid., 49.

[17] Ibid., 50

[18] Goo et al., "A Study of the Socio-Cultural Characteristics of Patients Known to the Mental Health Clinic, Bureau of Clinical Service, Division of Mental Health, 1957."

family organization was the determining factor in family life; the fluidity of sexual

life made the functional parent the nucleus of the society."[19] In addition, the study

found that " 'marriage for the Hawaiians was little more than a social contract,

which was dissolved according to the dictates of temperament, habit, inertia, and

fancy.' "[20] Significantly, "common law marriage, the elastic relationship with no

legal ties appear to appeal to the Hawaiians."[21] Moreover, "extra-marital affairs

were permissible" in traditional Hawaiian society.[22] And while "the Hawaiians

place a high value on children" the child's place in the family was fluid; children

could be "exchanged between two families to symbolize and cement the close

bonds of the relationship."[23]

While sociologists studied these cultural issues from some distance, for

public health officials, Hawaiian family relationships were a relevant clinical issue.

Indeed, these kinship traditions came to be seen as more and more problematic;

officials could not merely overlook them as benign cultural beliefs. They became

seen as the core of all psychiatric issues affecting children. Thus, the family

court system was one area where psychiatric preventive efforts were made. For

example, as early as 1953, the District Court of Honolulu operated a family

counseling program. A report from the program's inaugural year found that "poor

attitudes and conceptions of the meaning of marriage and lack of understanding

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[19] Ibid., 15.

[20] Ibid., 16. Quotation original was from Ernest Beaglehole, *Some Modern Hawaiians (University of Hawaii Research Publication, No. 19)*, (Honolulu : University of Hawaii, 1939), 51.

[21] Ibid., 16.

[22] Ibid., 16.

[23] Ibid., 17.

of moral and spiritual values,"[24] was a major problem. Later, legislation would

implement mandatory waiting periods for marriage, and would involve the state

earlier and more aggressively when social workers and counselors noted marital

problems in their patients.   Officials even considered a mandatory program of

pre-marriage counseling.

The Mental Health System on Household Stability

By 1965, the Oahu Steering Committee on Mental Health had advanced these

ideas to conclude that the underlying problem in islanders' mental health was

that of "broken families" -- those in which one parent had been lost to death,

divorce, or abandonment. In addition, a related problem was the so-called

"uncompleted family" of the unmarried mother and child. The authors argued

that broken families caused "suffering" and "inadequacy" for the remaining family

members.[25] Even the absent parent was permanently marred by "ambivalence,"

and "loss of self esteem."[26] Moreover, loss permeated to the extended family

and repeated over generations as "any developmental handicap that the children

of broken families experience may, in turn, have its impact on the developmental

chances of their children."[27] The Committee estimated that almost 14,000 of

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[24] Social Service Department, "Family Counseling in the District Court of Honolulu, Territory of Hawaii, Report of First Year's Experimental Operation" (May 31, 1954) (University of Hawaii, Hamilton Hawaiian Library, Honolulu, HI).

[25] Oahu County Steering Committee, Comprehensive Mental Health Planning, "A Report of the Task Force on Community Mental Health Services for Adults" (May, 1965) (Hawaii State Archives, Honolulu, HI), 22.

[26] Ibid., 22.

[27] Ibid., 23.

103,000 families on Oahu were headed by single parents -- about half of the 14,000 met the definition of "broken family." This translated into approximately 17,000 children, with the State providing aid to 1,193 of the 14,000 families.[28]

Again, spatial and household continuity were critical variables. In another example, Board of Health publication identified maternal deprivation as a material factor in childhood psychiatric illness. But its definition of "deprivation" belied a notion of spatial continuity -- the absence of a "warm, intimate, and continuous relationship with his [a child's] mother (or permanent mother substitute) in which both find satisfaction and enjoyment." Officials found the greatest threats to household continuity in Native Hawaiian or mixed Hawaiian families. Extrapolating from a study of Oahu families, the rate of deprivation in the mixed-Hawaiian community was estimated to be as large as 4 to 6%.[29]

In clinical practice, a maternal health clinic on the impoverished windward coast of Oahu in the Nanakuli Valley provided more raw material for the analysis of the impact of broken families. The authors noted that the "largely Hawaiian and part Hawaiian" clinic population was "notably lacking in the knowledge of health and disease due to limited education, the influence of older people in the home who hold strong cultural beliefs about health and disease, and the high rate of social breakdown."[30] Social breakdown led to broken families, and the

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[28] Ibid., 23.

[29] Oahu County Steering Committee, Comprehensive Mental Health Planning, "A Report of the Task Force on Community Mental Health Services for Pregnant Women, Infants and Their Mothers" (March, 1965)(Hawaii State Archives, Honolulu, HI), 43.

[30] Maternal and Child Health Services Branch, "Report on the Nanakuli Health Conference" (August 31, 1964)(Hawaii State Archives), 3.

authors noted that the part-Hawaiian group in particular made up the overwhelming majority of out of wedlock patients.

Besides highlighting the sanctity of continuous households, officials used notions of place in inventive ways, seemingly skirting provocative issues of race and culture in writing about the problems of broken families. They managed to do this by skillfully navigating between Hawaiian exceptionalism (the idea that Hawaii was somehow categorically different than any other place) and universalism (the converse idea, that Hawaii recapitulated events in the United States or the rest of the world). In this case, instead of repeating the well known sociological research on the causes of liberal household relationships in Hawaiian culture, the officials spun the problem of the broken family on the virulence of cultural ideas coming from an alien (but increasingly influential) "American" mainland culture. For example, in analyzing the problems of broken families (of which Native and mixed Hawaiian families were frequently over-represented), the Oahu Steering Committee on Mental Health in 1965 blamed the American cultural "refusal to accept discomfort."[31] In addition, the principle of the "pursuit of happiness" meant "a disappointing marriage is regarded as something to be discarded or replaced through divorce."[32] Overall, it was assumed that "American values" had a significant influence on the "ethnic groups of Oahu" in perpetuating family break-ups.[33]

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[31] Oahu County Steering Committee, Comprehensive Mental Health Planning,"A Report of the Task Force on Community Mental Health Services for Adults," 26.

[32] Ibid., 26.

[33] Ibid., 26.

In this example, in flip-flopping from a Hawaii determined social problem to an American determined problem, officials showed that, while conversant with Hawaiian sociological research, they were prepared to abandon it in their public writings. Here, officials retreated into a logic that universal statehood provided -- it allowed officials to call attention to public health matters without appearing to implicate Native Hawaiian culture.   But the co-mingling of two cultures was an immensely complicated dynamic, especially in Hawaii's mixed race population. The next section examines the "marginal man" concept, a sociological idea that was reified into an explanation for the propensity to certain kinds of psychiatric problems in people of mixed cultural backgrounds.

The Marginal Man Idea

The idea came from the polymathic University of Chicago sociologist Robert Ezra Park's 1928 article, "Human Migration and the Marginal Man."[34] Park and the Chicago School's sociology of normative, cooperative human interactions proved to be very influential in Hawaii -- several faculty members from Hawaii's Department of Sociology had trained directly under Park in Chicago.[35]   Park's interactional sociology privileged stories of encounter between unfamiliar people,

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[34] Robert E Park, "Human Migration and the Marginal Man," *American Journal of Sociology* (1928): 881-893.

[35] See Stow Persons, *Ethnic Studies at Chicago, 1905-45* (Urbana: University of Illinois Press, 1987); S S H Lee and R Baldoz, " A Fascinating Interracial Experiment Station": Remapping the Orient-Occident Divide in Hawai'i," *American Studies* 49, no. 3-4 (2010): doi:10.1353/ams. 2010.0027. For the Chicago School and American Sociology see also Fred Matthews, *Quest for An American Sociology: Robert E. Park and the Chicago School* (McGill-Queen's University Press, Montreal, 1977); Robert C Bannister, *Sociology and Scientism : The American Quest for Objectivity, 1880-1940* (Chapel Hill: UNC Press Books, 1991).

a narrative of "migration and the incidental collisions, conflicts, and fusions of people and cultures."[36] In his marginal man writings, Park highlighted the spectrum of outcomes when cultures collided. On the one hand, a system of complete segregationary apartheid might result; on the other hand, the two cultures might mix completely and become a glorious melting pot. But Park asked, what about the in-between cases, "on the margin between two cultures and two societies, which never completely interpenetrated and fused?"[37] Park argued that the outcome of the situation was the "marginal man," a person who had internalized his liminal condition to the point that the experience "tends to become a personality type."[38] Features of this personality were "spiritual instability, intensified self consciousness, restlessness, and *malaise*."[39]   Park concluded his essay by emphasizing the relevance of the marginal man as a research subject: "It is in the mind of the marginal man -- where the changes and fusions of culture are going on -- that we can best study the processes of civilization and of progress."[40]

Thus, the marginal man had a matching personality type, a psychology and psychopathology, with cultural origins.   Further elaboration came from sociologist Everett Stonequist, who had been Park's student at the University of Chicago. Stonequist, in 1937, authored an entire monograph on the marginal

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[36] Park, "Human Migration and the Marginal Man," 882.

[37] Ibid., 892.

[38] Ibid., 893.

[39] Ibid., 893.

[40] Ibid., 893.

man idea,[41] in which he elaborated on the personality dimensions of marginal man and also delineated between racial and cultural forms of marginality. Stonequist did not think the marginal condition inevitable; however, when present, it could be pervasive, causing "personality as a whole" to be "oriented around the conflict." Consequently, "the individual then seems almost to be 'obsessed' with his problem; his moods are reshaped."[42]

Park and Stonequist had both visited and taught at the University of Hawaii, and, in the case of Park, his ideas were significantly influenced by interviews made on a survey of race relations in the American west. Hawaiian sociologists found a bounty of examples to illustrate the marginal man theory. Sociologist William C. Smith, for example, had worked with Park on his race relations survey. Smith was more optimistic than many other authors in assessing the prospects of marginality. The Hawaiian hybrid "marginal man" in general could be an "interpreter" and "intermediary;" he had the capability of diffusing racial tension overall, and thus it was possible that, in this position, the hybrid could command political power: " ... they represent not only the two groups from which they have their origin but other groups as well ... Furthermore, the other groups ... will be more likely to give their support to such a cosmopolite than to a pure-blood representative of any one particular group."[43]

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[41] Everett V Stonequist, *The Marginal Man: A Study in Personality and Culture Conflict* (New York: Scribner/Simon & Schuster, 1937); see also Idem., "The Problem of the Marginal Man," *American Journal of Sociology* (1935): 1-12.

[42] Stonequist, "The Problem of the Marginal Man," 10.

[43] William C Smith, "The Hybrid in Hawaii As a Marginal Man," *American Journal of Sociology* (1934): 467.

This idea seemed to be intact nearly a quarter century later in sociological research.   Otomar Bartos, an Assistant Professor of Sociology at the University of Hawaii, surveyed leadership qualities in undergraduate students and found that although Caucasians enjoyed the highest overall prestige, student leaders often emerged from other marginal racial groups.[44] Bartos concluded, "these data are consistent with the personal observations of the authors and many others involved with student activities."[45]   The positive idea of marginal man uniting two cultures (particularly in the realm of politics) continued to crop up in a study of adult patients at the mental hygiene clinics. While native Hawaiians "found it difficult to adjust to formalized and academic training," "the part Hawaiian have been able to make better adjustment." As a result, "future leaders will be drawn from the part-Hawaiians as a result of their superior educational achievement unless the pure Hawaiians elevate their appreciation of education or spur their children on to achieve scholastically."[46]

Writing in 1934, sociologist William Smith had elaborated a popular hierarchy of racial mixing that had an influence on mental health thinking about marginality. Smith believed that some race mixtures were more advantageous than others, and he had a dim view of mixed Hawaiian-Caucasians. He described the "consensus" that "Chinese-Hawaiian is a superior product," an

[44] O J Bartos and R A Kalish, "Sociological Correlates of Student Leadership in Hawaii," *Journal of Educational Sociology* 35, no. 2 (1961): 65-72.

[45] Ibid., 72.

[46] Goo et al., "A Study of the Socio-Cultural Characteristics of Patients Known to the Mental Health Clinic, Bureau of Clinical Service, Division of Mental Health, 1957," 19.

almost "religious creed to which all subscribe."[47] The Chinese-Hawaiian

combination seemed to embody all the positive aspects of marginality, managing

to mix the "industriousness" of the Chinese with the "political status" of the

Hawaiians. On the other hand, the Hawaiian-Caucasian hybrid was the other

face of the marginal man Janus, in which all of the negative aspects of

marginality seemed to produce a mixture that was haunted by a permanent

inadequacy, a kind of psychologized chip on the shoulder. The Hawaiian-

Caucasian suffered from "mixed mind", was "less stable" and hardworking than

other marginal counterparts, and was "self conscious and sensitive."[48]   Spurned

by pure whites in Hawaii, mixed race Caucasians could externalize their anger

and become inveterate "Haole-haters."

Smith's writings were influenced by stereotypes and racial tropes. Smith

allowed that some of the peculiarities of race-mixing personality types could be

genetically transmitted; his references included Stanley Porteus' notorious book

Race and Temperament. Echoes of this type of thinking found their way into

psychiatric beliefs about the psychological implications of race-mixing and thus

were present in views of public health policy. However, in public health

formulations, attention was drawn away from the biological basis of race, and

specific cultures were not targeted as problematic. Rather it was the condition of

marginality in itself that turned race and culture into a psychiatric issue -- the

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[47] Smith, "The Hybrid in Hawaii As a Marginal Man," 460.

[48] Ibid., 462.

marginal condition, tempered by conditions such as segregation and social interactions, became its own "personality."

The idea that the Hawaiian-Caucasian was burdened by a marginal hypersensitivity remained an influential idea. Such was the case of Ronnie, a mixed-race Hawaiian boy who was presented at a social work case conference in 1962. At the time of presentation, Ronnie was living in a private orphanage and was receiving social work consultation from a private agency serving "destitute" children of Hawaiian ancestry. In a family arrangement deemed typical for patients of Hawaiian ancestry, Ronnie's mother had died and his father had remarried his former wife's older sister, who had neglected him in favor of her own children. The state removed Ronnie from his family at the age of eight.[49]

The presentation was critical of the family. Ronnie's father was not involved in his care and was considered "impulsive, dominating, abusive of his wives and daughter and also irresponsible."[50] Ronnie had several other siblings including a sister who "had a child out of wedlock and has been regarded as impulsive and assaultive by people who have worked with her."[51] As a Hawaiian-Caucasian Ronnie seemed to have a chronic problem with low self esteem; he was oversensitive and predisposed to think he was being mistreated.   For example, he had impulsively quit a job at a service station after reading his paycheck incorrectly. The consensus was that he was "self destructive" and

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[49] Division of Mental Health, *Proceedings of the Institute for Social Workers, Honolulu 1958*, University of Hawaii, Hamilton Hawaiian LIbrary, Honolulu, HI.

[50] Ibid., 27.

[51] Ibid., 27.

needed to transition his life out of the group home. Guest psychiatrist Henri

Ellenberger acknowledged the cultural issues and suggested that coming from a

mixed heritage had produced some of these problems and that "certain

behaviors evidenced by various family members need to be considered and

evaluated within the mores of the Polynesian family."[52]

In another example, an analysis of children's admissions to a Honolulu

mental hygiene clinic found a high rate of conflicts between part-Hawaiian

children and their mothers, "which seemed to be related to their cultural

backgrounds." In particular, given the matriarchal character of the Hawaiian

family, the conflicts "may perhaps indicate a breakdown of this particular

custom."[53] In addition, "Among all of the racial groups, the Part-Hawaiian

applicants most frequently expressed their problems in socially unacceptable

behavior."[54] The analysis had been supervised by Katherine Handley, a faculty

member in the University of Hawaii's School of Social Work. Handley had close

connections with sociology and in 1950 had given a course with Andrew W. Lind,

the prolific Hawaii sociologist, "emphasizing the significance of psycho-cultural

factors in the development of personality and behavior."[55]

The idea of a marginal "personality" persisted in mental health and

sociology for decades after its original iteration, though not without criticism about

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[52] Ibid., 29.

[53] Betty Michiko Tanji, "A Study of the Cultural Problems Presented by the Applicants at the Intake Interviews at the Bureau of Mental Hygiene, Honolulu, Oahu from January through December 1953" (M.S.W. Thesis, University of Hawaii, June, 1955), 75.

[54] Ibid., 74.

[55] *A Short History of the School of Social Work, University of Hawaii at Manoa 1936-1986*, ed. Frederick Y Smith, http://www.hawaii.edu/sswork/history.html., 5.

the concept's lack of scientific rigor and specificity.[56] However the concept had a

long life. A composite sketch of the personality type was attempted in 1955:

> His hypersensitivity is seen in his excessive worry about the future. He is characteristically apprehensive about any new venture, and seems to be trying to find causes for being unhappy. He sees life as simply a bad experience. Things often seem to go wrong no matter what he does, and he finds it difficult to enjoy himself. Closely related to this general gloominess and ambivalence mentioned above is a restless feeling that gnaws at him. He feels he should be doing something about his unhappy situation, but finds it difficult to know what to do.[57]

Marriage and Marginality

Mental health officials saw interracial marriages, particularly Caucasian-Hawaiian

pairs, as creating problematic marginal men, for which there could be permanent

psychopathology leading to social problems, such as crime and delinquency.

There was a direct line from family structure to personal psychopathology: "since

personality development takes place within the family setting, background

knowledge of the family structure is very important in understanding the way in

which cultural factors and emotional reactions shape the behavior of a growing

child."[58] Those family structures which involved displacement, abandonment,

and poorly formed households were a shorthand for talking about native and

mixed race Hawaiians.

In particular, desertion of children was directly linked to interracial

marriage. Noted one observer, "not only are the tensions within the family

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[56] A W Green, "A Re-Examination of the Marginal Man Concept," *Social Forces* 26, no. 2 (1947): 167-171.

[57] A C Kerckhoff and T C McCormick, "Marginal Status and Marginal Personality," *Social Forces* 34, no. 1 (1955): 48-55., 52.

[58] Goo et al., "A Study of the Socio-Cultural Characteristics of Patients Known to the Mental Health Clinic, Bureau of Clinical Service, Division of Mental Health, 1957," 192.

greater but also it seems easier for mixed couples to slip out of their marital

responsibilities by way of separation."[59] Given the boosterism of Hawaii as racial

utopia, this was not a foregone conclusion, with some researchers finding no

essential difference in divorce rates for interracial couples. However, while the

harmonious aspects of interracial coupling were often trumpeted by laypeople or

politicians, influential researchers in the social sciences and mental health

remained suspicious. For example, the work of demographer Robert C. Schmitt,

who had published in the *Hawaii Journal of Medicine*, went the furthest in trying

to document, statistically, the effects of interracial marriage. A 1963 study

showing that interracial marriage might be correlated with poor socio-economic

status was protested as racist in the local newspaper, though Schmitt and his co-

author protested that the findings were not personal, as both authors had

themselves married women outside of their race.[60]

Conclusion

This chapter began with a description of the forces thought to be involved in

perpetuating mental illness -- a coded language of family, household, and

environment. Depending on the author, audience, and venue, researchers and

administrators might be more or less explicit about racial or cultural explanations

for psychopathology. In general, mental health administrators, working in the

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[59] Caroline Lee, "Cultural Factors of Desertion in Hawaii," *Social Process in Hawaii* 5 (1939), 60.

[60] For details on the controversy, see F L Schuman, "Aloha: Racial Relations in the 50th State," *The North American Review* 249, no. 2 (1964): 44-52.. For similar research by Schmitt, see Robert C Schmitt, "Demographic Correlates of Interracial Marriage in Hawaii," *Demography* 2, no. 1 (1965): 463-473.

most public forums, handled these issues the most delicately. The first part of

the chapter examined discussions about the importance of "family" and

"household." These terms were informed by writings in contemporary sociology,

which held that the problem of abandoned children stemmed from laxity of Native

Hawaiians towards Christian concepts of marital and household stability, extra-

marital sexual relationships, and a communal attitude towards the raising of

children. These "attitudes" burdened the institutional mental health system with

wardless children who were seen as being at high risk for delinquency and

psychopathology. When faced with explaining these issues to a public with

whom administrators needed to develop trust and allegiance, elaborate re-

conceptualizations of the problem as one of spatial continuity served to downplay

blaming specific Hawaiian cultural practices. Furthermore, Hawaiian statehood

and its consequent cultural universalism allowed officials to shift the mechanism

of broken families from indigenous Hawaiian practices to the contagion of

pleasure-seeking "American" cultural values. The second part of the chapter

discussed the durable concept of the "marginal man," but showed that the

concept had different implications depending on whether one was talking the

positive or negative qualities of marginality. When the negative aspects of

marginality were invoked, they frequently referred to mixed Hawaiian-

Caucasians.

CHAPTER FIVE

THE JAPANESE IN HAWAII AND THE CULTURAL ENVIRONMENT OF THE

GHETTO

In James Michener's historical novel *Hawaii*, Akemi is a Japanese woman who

comes of age in an impoverished post World War II Tokyo. While many people

are starving, and girls of her age have sold themselves into prostitution to feed

themselves, MIchener's character quietly maintains her dignity. Akemi is a

progressive woman, and a feminist. She fashions herself a "modenne" or a

female intellectual in the Parisian fashion, who listens to Beethoven, and speaks

in perfectly-dictioned Japanese. Working in a jazz bar in Tokyo, she meets a

Hawaii-born American soldier of Japanese ancestry. A romance blossoms, and

they marry. Akemi prepares to move from Japan and acknowledges that despite

their shared Japanese heritage, her new life in Hawaii will take some getting

used to. But she is shocked at the provincialism of Japanese immigrant culture

in Hawaii. All the local families are from the same agrarian prefecture outside of

Hiroshima.   Her educated diction clashes with her in-law's pidgin banter, and she

is incensed when her mother in-law asks her to dumb down her speech. The

husband ends up being a bore, with none of Akemi's aesthetic sensitivities. She

despairs of the materialism of Japanese life in Hawaii:

> "What is it they're working for? In Japan, a man and woman will work like idiots to get
> tickets for the theater or to buy a beautiful ceramic. What do they work for here? I'll tell
> you what for. So that they can buy a big black automobile, and put the old mama-san in
> the back, and drive around Honolulu and say, 'Now I am as good as a haole." [1] (962)

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[1] James A Michener, *Hawaii* (New York: Random House Publishing Group, 1986), 962.

Akemi becomes isolated and depressed. One day she receives a visitor, a

young American-born Japanese professor of sociology. Professor Yamazaki is

doing a study of war brides like Akemi, fellow Japanese-born girls who married

American soldiers.   Akemi unburdens herself to the professional but sympathetic

sociologist and ventures a probing question:

> "Tell me truthfully, Yamazaki-sensei, do you think any society which has as its ideal a long, black automobile can ever be a good place to live?"
> Dr. Yamazaki considered the question for some moments and replied: "You must understand that the visible symptoms of success which our Japanese here in Hawaii are following are those laid down by the established Haole society. A big home, a powerful car, a boy going to Yale whether he learns anything or not ... these are the symbols people living in Hawaii must accept. You can't suddenly require the Japanese to prove themselves superior to the symbols upon which they've been raised."[2]

Michener seemed to be referring to the work of Yukiko Kimura, a real life *emigre*

Japanese sociologist at the University of Hawaii, who had earned a Ph.D. from

the University of Chicago and published, among other works, studies of

Japanese war brides. But Michener's optimistic reading of Kimura's work would

have incensed the University of Hawaii's sociology department. In fact, Kimura

and others stressed the dangers of rapid assimilation and detailed the

psychological damage resulting from the erosion of traditional culture among

second generation Japanese in Hawaii.

Michener's book was published in 1959, the same year in which Hawaii

received statehood. While the book was enthusiastically reviewed on the

mainland, some local readers charged it with being "terrible, inaccurate" and

"melodramatic."[3] University professors, experts in Hawaiian history, and local

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[2] Ibid., 966.

[3] Marion W Lindley, "Reactions to Michener's Hawaii," *Social Process in Hawaii* 24 (1960), 41.

civic leaders weighed in, criticizing the book for being too sensationalist and for

blurring the line between historical fiction and actual fact.   But beyond the

academic arguments, there were hints of a more visceral revulsion to the book, a

feeling that bubbled up from "the inner rooms and out onto the sidewalks and into

lounges," as if Michener had let out of the closet some of Hawaii's darker

secrets.[4]

Michener's novel, which detailed the fates and fortunes of the various

ethnic groups that settled Hawaii, borrowed heavily from ideas in academic

sociology. *Hawaii* celebrated the local emergence of a new kind of multicultural

personality, "The Golden Man," the idea of which Michener's protagonist readily

admits came from "a group of sociologists in Hawaii."[5] The Golden Man was

indeed a thinly disguised send up of the marginal man concept, "a man at home

in either the business councils of New York or the philosophical retreats of

Kyoto," and with an "awareness of the future" and a "rare ability to stand at the

conflux of the world."[6] However, by basking in the glow of the melting pot

rhetoric, Michener risked misrepresenting the intricacies and complexities of the

real Hawaii. There were in fact "discrepancies between code and conduct,"

argued the Hawaiian sociologist Andrew W. Lind:

> Such a characterization of social relationships in any region, however accurate it may be
> in general terms, is obviously vulnerable as a summary of actual facts, since there are
> bound to be individual violations of the code, and the inevitable disparity between the

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[4] Ibid., 41.

[5] Michener, *Hawaii*., 891.

[6] Ibid., 891.

profession of racial equality and the actual practice sometimes results in the charge of pharisaism by the critically minded.[7]

As chapters three and four have shown, since the early 1940s sociologists at the University of Hawaii sought to re-examine the unique complexities of interpersonal life in Hawaii. They abandoned older formulations attributing behavior and cultural practices to race or genetics. Invoking the metaphor of Hawaii as "laboratory" of racial relations, sociologists embarked on a quest to explain the social origins of behaviors, beliefs, and attitudes; however this happened to be the *prima materia* of mental hygiene and public health psychiatry. The Hawaiian territorial government was tasked with modernizing treatment for its wards in mental institutions, prisons, and orphanages, and sought to prevent the future growth of these costly dependent populations, creating a philosophical congeniality with social scientists. In their prevention efforts, government officials, mental health officials, clinicians, and sociologists frequently collaborated. This allowed for the diffusion of locally formulated sociological theory into thinking about mental health problems well into the 1960s.

The Japanese in Hawaii

No other group in Hawaii was studied as comprehensively as the Japanese, the largest ethnic minority.   Popular stereotypes depicted the Japanese as "unassimilable."   At the same time, it was thought that this tenacious cultural

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[7] "Trends in Post-War Race Relations in Hawaii," *Romanzo Adams Social Research Laboratory Report* 25 (1959), 1.

rigidity served the fragile and self-negating individual Japanese psyche. This

delicate balance between needs of the individual and the collective preserved

Japanese identity and allowed for the maintenance of mental health; conversely,

any disruptions to the balance would cause psychopathology. Experts thought

that with the preservation of specific practices and diversions, this dynamic

tension could be maintained among immigrant Japanese in Hawaii. Above all,

Japanese mental health was served by the physical and psychological confines

of the Japanese ghetto. Physical and psychological separation from Hawaii's

other people was a necessary evil to slow the breakneck destabilization of

assimilation. But with the weakening of traditional ties to institutions like family

and religion, the introduction of unstructured American style leisure time, and the

physical admixture of races and cultures that was the norm in polyglot Hawaii,

this fragile environment was seen as constantly under threat.

History of the Japanese Migration and Demographics

As the largest ethnic minority in Hawaii, since 1900, the Japanese had

constituted between thirty to forty percent of the local population, about 150,000

people by 1932.[8] The industrialization of Japan in the Meiji Restoration of the

1890s took a very heavy toll on the Japanese peasantry, increasing their tax

burden dramatically and forcing many into poverty. At the same time, the

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[8] Andrew Lind, "The Changing Japanese in Hawaii," *Social Process in Hawaii* 4 (1938). See also Roger Daniels, *The Politics of Prejudice* (Berkeley: University of California Press, 1977), 3. This was about half the total number of all Japanese immigrants to the United States proper at the time. This proportional over-representation meant that Hawaii was ground-zero for thinking about the process of assimilation for Japanese-Americans.

Hawaiian sugar industry was growing rapidly and required a constant supply of inexpensive contract laborers. The Hawaiian-American sugar planters had not had great success with Chinese laborers, who tended to leave the plantations after their term of service and who were becoming more economically and politically powerful in Hawaii. With the Chinese Exclusion Act in 1882 effectively shutting off this labor source, the American sugar planters turned to Japan for the recruitment of workers. A "high percentage of the immigrants," notes historian Roger Daniels, were from a small agricultural area in Japan near the city of Hiroshima.[9]

Daniels writes that 1901-1908 was the high-water mark for Japanese labor immigration to the United States with the number of immigrants during that period numbering 127,000.[10]   These workers were dubbed the "issei" generation, deriving from the Japanese word for "first" -- their children, second generation Japanese born in America were called "Nisei." The earlier immigration was heavily male and for the most part unmarried. This demographic feature has resulted in a phenomenon dubbed the "the lost generation." That is, during the peak period of Japanese immigration, the laborers could only marry once they had established themselves financially, necessitating a return to Japan to have a marriage arranged. A "picture bride" system of arranged marriages operated to get around the long return voyages, but this still demanded that the bachelor be able to financially provide for a family. This meant that many of the men of this

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[9] Ibid., 6.

[10] Ibid., 1.

period had significantly younger wives, and that the men were of much older age when they first had children. As Daniels writes, "In the years to come, the absence of this generation would exacerbate the tension between Issei father and Nisei son, although it should be noted that "rejection" of the immigrant parents by the second-generation children is one of the classic motifs of the history of immigrants in America."[11]

Pre-war Japanese Life in Hawaii: Issei ghetto psychology

Before World War II, Japanese life in Hawaii was extremely segregated with separate schools, neighborhoods, temples, and civic organizations. Much was written about the ghettoization of the Japanese, but strangely, it was almost viewed as a positive, as if the closed Japanese societies were protective of a character based on shame and disappointment, so fragile that exposure to the outside would elicit a painful feeling of "inferiority" which would cause the Japanese psyche to crack. Indeed, according to Bernard Yamamoto, a sociologist at the University of Hawaii, "The fact that those Japanese tended to group themselves into strong, well-knit communities of their own, helped to bring about favorable adjustment of their individual members to the Hawaiian environment, and thus at first prevented disorganization of their group."[12] On the other hand, when Japanese had settled more "indiscriminately" outside of the the

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[11] Ibid., 14.

[12] Ibid., 51.

ghetto, "owing to their minority situation in a heterogenous environment," there

was a "breakdown of their own culture, and disorganization set in quite early."[13]

Other researchers, while appreciating the protective features of the

ghettos, made efforts to document some of their more doleful aspects. Yukiko

Kimura, the Japanese-American sociologist who worked extensively on the

subject of Japanese assimilation, identified a ghetto psychology of the issei

which was characterized, above all, by a sense of "inferiority," "failure, of being

deceived, of animosity toward their fate," and predicated on an almost universal

disappointment upon migration from Japan and arriving in Hawaii.[14] The reasons

for disappointment were myriad: extremely harsh working conditions,

homesickness, the language barrier, geographical isolation, lack of female

companionship, and above all failed expectations to make great deals of money

either promised to them or imagined. Also hampering the assimilation of issei

was the initial desire of many to return to Japan after their three years of contract

labor were up. Thus, the first wave of immigrants did not take time to establish

roots based in property and never made much of an investment to learn English.

Nor, as resident aliens, did they have any political rights or representation. This

intensified their isolation. As Kimura writes:

> Someone once commenting about the Japanese asked the writer, "Why don't the Japanese
> assimilate? Italians, Germans, and most other Europeans become Americans quickly". In
> addition to reasons of biological, economic, and cultural differences is the the fact that while
> Europeans are urged to become Americans, and every effort is made to help them, the
> Japanese were labeled as alien and unassimilable and every effort was made to exclude

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[13] Ibid., 51.

[14] Yukiko Kimura, "Psychological Aspects of Japanese Immigration," *Social Process in Hawaii* 6 (1940), 13.

them. It was only natural then that being excluded from American citizenship, immigrants from Japan should remain loyal to their native land.[15]

In reaction to this, Kimura argues, there was a compensatory elevation of customs, ceremonies, and practices from the old country. These were not merely in the service of recreation, but devices intended to "develop a counter or superiority complex."[16] The Nisei, or second generation, children became part of the currency of this compensatory response, as the immigrants made a "conscious effort" to prevent their children from being Americanized. The resultant fallout resulted in "real tensions" between generations of parents and children.[17]

The Effects of Pearl Harbor and World War II

The bombing of Pearl Harbor and America's entry into World War IIIsei forced the Issei Japanese out of their protective physical and psychological ghettos. The resulting enforced assimilation, along with public shedding of any ties to Japan, was concerning to many experts given the profound changes that were forced upon the issei in short order. In Hawaii, the FBI arrested and imprisoned many prominent Japanese religious leaders. However, the Japanese had allies among a cadre of sympathetic figures in the territorial, military, and federal governments. In addition, a self imposed drive to full assimilation (linguistic, cultural, and otherwise) was coordinated by Japanese Hawaiian civic organizations. As a

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[15] Ibid., 15.

[16] Ibid., 16.

[17] Ibid., 16.

result, Japanese internment camps, while considered (there had been a plan to evacuate all Americans of Japanese ancestry from Oahu to the neighboring islands), never materialized in Hawaii as they did in the western United States. But experts fretted that the forced assimilation of the ghettoized Issei did not come without a significant perceived price:

> Immediately after the outbreak of war, rumors circulated that any objects which were "Japanesy" were incriminating and that many Issei were being interned because of possession of them. During the days that followed almost every Japanese family had a thorough house cleaning and all objects which were kept for sentimental reasons were pulled out of trunks and destroyed. In many families, the kamidana or family shrine which occupied a special niche on the wall and to which daily rites were performed had been taken down and burned, sometimes with appropriate ceremonies. Flags and emblems of the enemy, portraits of the members of the imperial family, and photographs of uncles and cousins in uniforms were destroyed. Books, magazines, periodicals, and personal letters were also burned."[18]

Kimura perceptively described the psychological effects of this rapid assimilation. Again the "sense of extreme insecurity" was a theme. They became the most "insecure" racial group in Hawaii, and "the whole social structure of their community" was "undermined."[19] Physical deprivation and the changes necessary in dress and food habits were challenging enough. However, Kimura suggested that the most severe consequence of the forced assimilation was the arrest of religious leaders and the resulting lack of religious structure to deal with the challenges. Kimura concluded that "the loss of domineering control and guidance" provided by religious figures "is greatly missed by them [Issei]." Similarly, the opening of unstructured time proved a stressor as "the elimination

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[18] Kimie Kawahara and Yuriko Hatanaka, "The Impact of War on An Immigrant Culture," *Social Process in Hawaii* 8 (1943), 38.

[19] Yukiko Kimura, "Some Effects of the War Situation Upon the Alien Japanese in Hawaii," *Social Process in Hawaii* 8 (1943), 18.

of the organized activities" provided by religious institutions was something upon which they "depended."[20]

The second psychological blow was that many issei were forced to rely upon their American-born children to guide them through the assimilation process. Kimura notes the certainty and satisfaction that the Japanese have in following the formal rules and absolute authority that passed from parents to children. During the war, with suspicion and rumor flying rampant, issei parents had to rely on their children for assistance with legal and linguistic matters. Many issei signed over control of property or business to their children.   This "radical disruption of the traditional roles of the members of the family" was seen to be profoundly disorganizing, more so because the children, according to Kimura, took their new found authority and flaunted in the faces of their parents. As a result, many authors noted that juvenile delinquency rose with the erosion of "parental authority."[21]

Social Science to the Rescue

The extensive research that had been put into the Japanese situation by the Department of Sociology at the University of Hawaii attracted civilian and military attention. A war research laboratory was set up in 1942 at the behest of "civilian and military agencies" and their desire for "specialized consultation on subjects which often only the sociology department -- with its long history of research into

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[20] Ibid., 19.

[21] Ibid., 22-3.

local problems of population, immigration, cultural survivals and change, and race relations -- was in a position to supply."[22] The sociologists Andrew Lind and Bernard Hormann were the main staff members initially, and in 1943, the laboratory was given official status by the University of Hawaii.

Thus, interestingly, against the backdrop of general anti-Japanese sentiment in the United States, there was an effort to understand more completely the psychology of Japanese culture, ostensibly in a way that might be helpful from a military standpoint. Independently, on the mainland, the Office of War Information hired a phalanx of anthropologists to study Japanese culture. In charge of the Japanese project was anthropologist Ruth Benedict. The result of this effort was Benedict's 1948 book *Chrysanthemum and the Sword*, a work that was to prove influential in thinking about the mental health of the Japanese in Hawaii, while drawing from the research and the themes already assembled and conducted by Kimura and other Hawaii sociologists. Benedict had been forced to conduct the book's study without the benefit of field research in Japan. The book's message of the carefully balanced dynamic tensions in the Japanese psyche revolved around the two central symbols -- the samurai sword, which stood for violent aggression (but also orderliness, a respect for authority, and hierarchy) and the chrysanthemum (the flower of the emperor) as an image of organic grace and beauty that was, nonetheless, held in place by a stiff rod that pulled the flower compliantly into place.

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[22] Andrew W Lind, "Sociological Studies in War Time Hawaii," *Social Process in Hawaii* 9-10 (1945), 5-6.

From Benedict to Mental Health -- Hierarchy and Intergenerational Conflict

Paralleling Benedict's writing, mental health workers saw conflicts between issei parents and Nisei children as an important source of disorganization and confusion for the Japanese in Hawaii. Americanization of the Nisei generation eroded their sense of filial piety, the Japanese belief in unquestioned respect for the moral and ethical authority of elders. The notion of hierarchy was thought to imbue *all* social relationships in the Japanese psyche, which was clearly at odds with egalitarian American society. The Japanese psyche was dependent on a "feudal" concept of relationships between liege and vassal. This hierarchical relationship extended to the relationship between parents and children.[23]

Indeed, Japanese mental health depended on authority from above. Kimura had again suggested that it was not material deprivation that stressed the Japanese during the war, but the loss and imprisonment of their community and religious leaders, who had provided them with a spiritual and ethical anchor for their day to day behavior. Finally, the entire compass of filial piety was thrown on its head during World War II, when parents had to accept direction from their more Americanized children to avoid internment. Moreover, demographic considerations such as the large age difference between youth and their parents and language barriers distanced children from their parents. First person narratives of Japanese-American undergraduate students, published in the journal of the Department of Sociology, depict estranged families and bitter conflicts, with a pronounced lack of emotion and affect from parents to children.

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[23] Emma K Himeno, "Kalaheo Village, a New Community," *Social Process in Hawaii* 43 (1959).

One second-generation girl noted "in no other place do the conflicts and

accommodations of culture become more evident than in the Japanese home,"

and lamented the absence of "the close intimate feeling that exists in American

homes." Moreover, the fact that the girl's "parents never display affection for one

another" bled into a further "noticeable lack of companionship between parents

and children in the spending of leisure time."[24]

Intergenerational Conflict and the Problem of Delinquency

Other sociologists found alternative explanations beyond expressed emotion in

the family. Bernard Yamamoto, writing in 1939, identified the mixing of Japanese

with other cultures, and with the American culture in particular, as the primary

cause of intergenerational conflict in the Japanese and thus of juvenile

delinquency among the second generation Nisei Japanese. In Yamamoto's

formulation, overly restrictive Japanese parenting denied children access to

American style leisure activities, such as movies or school dances. Since those

activities were posited as outlets for adolescent sexual energy, denying them

would surely lead to delinquent children. A case history of a 17 year old Nisei

boy reveals how mental health consultants to the juvenile court might have

explained the boy's crimes:

> The boy is very conscientious about his studies, being alone most of the time. At the time
> he had committed the offense (he had entered a haole's home with the intention of
> having sexual intercourse with one of the girls of the family) he was not a member of any

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[24] Misako Yamamoto, "Cultural Conflicts and Accommodations of the First and Second Generation Japanese," *Social Process in Hawaii* 4 (1938), 43.

club. He has found it hard to make social contacts, particularly with girls. His mother objected to him learning to dance.[25]

Delinquency was an important topic because not only did it involve problems of the individual psyche, but now these problems extended into the public realm. In delinquency and other matters involving the court system, such as child abandonment, criminal proceedings, or civil commitment, officials in the government actively consulted medical experts who were influenced by social explanations of psychiatric disease.

A similar idea advanced by Yamamoto was that Japanese children might become confused about how to to regard their elders based on exposure to American teachers in school. Mental health experts believed that unquestioned filial piety, particularly towards the father of the family, was a core organizing principle of the Japanese psyche. Exposure to a different model of intergenerational relationship, in the form of more permissive American teachers would perplex Japanese youth and cause them to disrespect their own parents.

Leisure Time, Sexual Promiscuity, and Gender

Leisure time became a proxy for the loss of structure and hierarchy in Americanized Japanese. Unstructured American leisure time allowed for the falling apart of traditional hierarchies, with potentially disastrous consequence for the relations between men and women and for sexual promiscuity.

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[25] Bernard K Yamamoto, "The Assimilation of the Japanese and Juvenile Delinquency," *Social Process in Hawaii* 5 (1939), 53.

Yukiko Kimura, the sociologist who served as the model for Michener's sympathetic researcher, stressed the innate capability of the Japanese to assimilate, but cautioned that healthy assimilation evolved over generations, in contrast to the speed of such processes in Hawaii.   In her work with Japanese barber girls, Kimura provided a realistic model by which assimilation processes seemed to be more healthy.   Kimura studied the attitudes and behaviors of young (age 14-30) Japanese girls who had cut their school educations short and apprenticed to barber shops for men. It was common for Japanese girls to be apprenticed as barbers as they learned a skill and could make money for their families.   Kimura notes that despite the "intimate" contact the young Japanese girls had with their male clientele, their behaviors seemed very much oriented towards their traditional culture, with almost no contact between the girls and the clientele outside of working hours, and with most girls marking a preference for marrying a Japanese man. To Kimura, the long hours of work, the limited American educational background of many of the girls, and the traditional apprenticeship system conspired to "slow" the process of Americanization. Kimura suggests that the real enemy was unstructured leisure time -- with more leisure, the natural process of the girls would be to assimilate more pathologically to the American culture. Simply put, keeping the girls busy was the largest protective factor.

First Hand Narratives

Despite predictions made about the terrors of assimilation, we should wonder if

the pronoucements were *too* severe and overgeneralized. Many authors seem

to have anticipated the wholesale snapping of the delicate wire of the Japanese

psyche in the American context. However, while the writings of actual Japanese-

Americans in Hawaii attest to the difficulties of assimilation, they also explicitly

demonstrate the resilience and adaptability of human beings to complicated

cultural environments. These writings often appeared in the journal published by

the Department of Sociology at the University of Hawaii and ironically seem to

contradict some of the more dire predictions written by professional sociologists

that appeared in the same journal. Andrea Sakai, for example, was a Nisei (child

of first generation Japanese immigrants to Hawaii) who was born in Japan, but

emigrated back to the mainland US at a young age, and then to Hawaii as an

adult. Interestingly, this first hand account, while acknowledging the difficulties in

assimilation, largely portrayed a successful narrative. Sakai noted, the following,

while employing the metaphor of the marginal individual to herself:

> Writing about oneself may be difficult, but there are certain advantages to be found in
> the process. The systematic examination of some of the factors which shaped me has
> replaced a tenuous and at times painful comprehension of my personal adjustment with
> an objective realization that I am part of a large over-all pattern. The orderly picture
> from un-awareness, to disorganization, and the subsequent path toward personality
> adjustment in terms of my culture, race, family, and other environmental factors has
> been both therapeutic and educative ... In recognizing the significance of culture and
> personality development in the human being with its ramifications in adapting to a new
> culture I have enlarged my concepts of marginalism and consequently of myself.[26]

In another case, a girl who had emigrated with her family from Japan to Hawaii

wrote that despite a large number of "adjustments," she "was successful in some,

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[26] Andrea Sakai, "Reflections: An Autobiographical Sketch," *Social Process in Hawaii* 22 (1958), 44.

not so in others. I am still far from being completely well adjusted."[27] Despite

these challenges, however, first person narratives did not justify the alarmist,

schizophrenic psychic cleavage predicted by some experts.

Clinical Literature

Clinical social workers were the real marginal men and women of Hawaii's

mental health system. The word "marginal" is used here exactly as it had been

used in sociological writing -- meaning interpreters and integrators of various

disciplinary (medicine, psychoanalysis, sociology, mental hygiene) approaches to

the mental health problems of Hawaii, both at the level of the individual and the

public health.   But the Japanese psyche was posited as so powerful that it

threatened to overwhelm even the marginal status of the Japanese-American

clinical social worker. For example, a 1939 article, written to help social workers

hone their assessment techniques when working with clients of different ethnic

groups, mentions the special vulnerabilities of Japanese clinicians. Again arose

the idea that assimilating American ideals, for the Japanese, involved a particular

threat to psychic integration -- the "shifting scene" would prove difficult for the

Oriental mental health worker, who might be blindsided by unconscious cultural

affiliations:

An intelligent, skillful, second generation Japanese worker whose own bringing up had
been more Oriental than Occidental found herself in the position of having to work
through with a young Japanese client her hostility to a father who had rejected and
condemned her. The worker's own feeling of filial piety was so entrenched that she felt "it

[27] Joyce Nishimura, "The Adjustments of a Young Immigrant," *Social Process in Hawaii* 22 (1958), 33.

was not right for Mitsue to feel that way about her father," and it was some time before she could free her own feelings to the point where she could allow the girl to express hers.[28]

While the author softened this statement further on by acknowledging that *all* mental health workers must disentangle themselves from their own cultural biases and suggested that it was the peculiarities of the Hawaiian setting that engendered a "complexity of patterns" that "puts one's understanding and objectivity to a greater test than might be the case in a more homogenous setting," the article is still an example of how pervasively the cultural environment of the Japanese was thought to influence psychic integration.[29]

The Influence of Psychoanalysis?

Psychoanalysis offered another kind of explanation for how culture might influence adult behavior and provided a competing model to the sociological model of psychopathology. In the 1950s authors attempted psychoanalytic explanations of entire cultures, suggesting that certain shared practices relating to child-rearing (nursing or sleeping with children, for example) had the power to shape entire cultural mindsets. However, the psychoanalytic viewpoint never took hold in Hawaii to the extent that it influenced psychiatry on the mainland.

For example, in Ikeda's study of schizophrenia, the author attempted to locate adult psychopathology in early child rearing practices specific to mainland Japanese. For example, as Ikeda explained, the Naichi (mainland) Japanese

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[28] Eileen Blackey, "Cultural Aspects of Case Work in Hawaii," *Social Process in Hawaii* 5 (1939): 30-45, 38.

[29] Ibid., 39.

were thought to be "marked in their behavior by frustration-aggression themes."

These violent ideas stemmed from "basic frustrations laid down in early

childhood" and manifested in adult behavior such as "suicide to repay insults,

sexual aggression among males, masochism and hysteria among females,

aggressive behavior under the influence of alcohol, and neurotic conformity and

compulsive obedience to conventions."[30]

Again, these problems were explained by "the rather severe, early, and

even punishing practices involving around bladder and bowel training."[31]   Ikeda

hypothesized that the harshness of early child rearing practices by the Japanese

would predict a disproportionately high proportion of related psychopathology,

such as schizophrenia. A 1955 study analyzed a sample of hospitalized

Japanese psychiatric patients with other kinds of psychiatric patients. Despite a

long introductory section, in which Ikeda first summarized existing psychoanalytic

theory to explain how early child-rearing practices among the Japanese might

lead to schizophrenia, in the end the author did not find any correlation. In the

explanation of the findings, Ikeda instead offered a host of sociological

explanations for the patients' illnesses such as altered patterns of labor or child

care in a plantation environment.

What can we take from this study? First, it is the only homegrown study

that tested a psychoanalytic explanation of Japanese psychopathology in Hawaii.

Ikeda's literature review is heavily psychoanalytic, but in the end, the author

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[30] Kyoshi Ikeda, "A Comparative Study of Mental Illness Differences Among the Okinawan and Naichi Japanese in Hawaii" (Master of Arts Thesis, University of Hawaii, June, 1955), 16.

[31] Ibid., 17.

found more evidence for social or cultural factors in mental illness rather than childhood nursing and toilet training.

The Ultimate Source of Disorganization -- Americanization and Globalization

It was the American culture to which many writers pointed to as the ultimate disorganizing factor; the bugaboo of race-mixing was played down as many authors seemed to accept this in Hawaii as a simple matter of demographics. Mental health experts in academics and government were fundamentally conservative, while at the same time understanding about the special demographic and racial situation in Hawaii. They accepted race mixing as a matter of course. However, they did not welcome rapid cultural change as eagerly as James Michener's novel seemed to advocate, nor as the mass of other Hawaiians let on at times, especially since the tonic of racial harmony was a frequently played trump card in the argument for Hawaiian statehood. Fundamentally, these elite Hawaiians, often from diverse racial backgrounds, accepted race mixing and integration but were weary of the speed at which it was happening and particularly of the consequent "Americanization" that seemed to occur in its wake. It was not just race then, but the jarring transformation of rapid cultural change, the seeming willingness of Hawaii's residents to forget long traditional ties and sources of organization and authority, which were suspected as the motive forces behind many of Hawaii's social and public health problems. Writers pointed to the oft familiar theme of disorganization, in which they were

distrustful about the pace and quality of immigrant assimilation in Hawaii. This

theme was particularly germane to the Japanese, who were viewed as being

unable to handle rapid cultural change.

Maybe this, then, is the source of the dreadful feelings that pervaded

Hawaii's intelligentsia with the publishing of Michener's seemingly glib novel.

Real Hawaiians knew that the "Golden Man" idea was fraught with insincerity and

ambiguity. Michener had in effect stolen the concept, popularized it wholesale,

and seemed to embrace its rapid adoption, while certain kinds of Hawaiians had

always been more circumspect and contained about this kind of boosterism. In

the Japanese, mental health experts stressed the inherent fragility, even

preciousness of the psyche, and its vulnerability in contact with others cultures.

The Japanese psyche was prone to the catastrophic snap -- this was the brittle

metaphorical wire supporting the chrysanthemum that Ruth Benedict had

described. Consequently, certain aspects of Japanese culture in Hawaii -- long

work hours, lack of leisure time, and closed, ghettoed communities -- were

accepted as the lesser of two evils. In the minds of sociologists, any exposure to

American culture would inevitably create "chaos" in the psyche of the vulnerable

Japanese. And while in theory integrating two radically different cultures might

seem difficult, first hand accounts of Hawaii-dwelling Japanese do not support

this idea. Instead, these narratives attest to the remarkably resilient nature of

both the Nisei and Issei Japanese to hold two different cultural frames without

serious psychiatric consequences.

CHAPTER SIX

MENTAL HEALTH AND THE BUILT ENVIRONMENT

In 1962, a large conference convened in Honolulu with the theme of "Planning for Mental Health." During one of the breakout sessions, an interesting discussion arose. The members of the breakout session were discussing the destruction of the Kukui slum in Honolulu. It was agreed that the slum was a blight and an eyesore. Moreover, its ugliness contrasted with Hawaii's beautiful natural environment. Attendees noted that the aesthetic stewardship was codified in the state's constitution, which explicitly required the government "to develop sightliness and physical good order."[1]

The interesting part was that the panelists of this breakout session (which included prominent architects, physicians, and city planners) were *opposed* to the idea of bulldozing the slum. Although the neighborhood contained "structures for human habitation that should cause this community embarrassment," destroying Kukui, with it's "temples and society buildings" and "expressions of man's creative spirit" would lead to "mental disarrangement as well as the physical destruction, because it removes all the continuity of heritage."[2] As one panelist lamented:

> Isn't the greater crime the breaking up of the neighborhood entity whereby the people ... had broken themselves into little groups, living groups, with all of their attachments. And now we are dislocating them, breaking them up, forcing them to go into outer areas ... [W]

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[1] *Proceedings: Conference on Planning for Mental Health*, comp. State of Hawaii Mental Health Division, Department of Health (Honolulu, June 21, 1962), 28.

[2] Ibid., 29.

e are forgetting to take into consideration the impact of our designs, our very handsome renderings on family life.[3]

The Conference's keynote address had been given by Richard Gordon, the prominent social psychiatrist and popular chronicler of suburban anomie.[4] Gordon's argument was that aggressive economic striving by middle-class Americans ("social climbing") led to psychosomatic illness. Frequent, disruptive moves led to rootless communities populated by alienated and lonely families -- and these essentially social issues underlay psychiatric problems. While Gordon's address stimulated discussion, the idea that psychiatric problems stemmed from social causes already had a rich provenance in Hawaii. Since the mid-1920s there had been a discourse between sociologists at the University of Chicago and the University of Hawaii. The methods of the Chicago School, in the hands of Hawaiian sociologists, helped to establish the idea of Hawaiian exceptionalism, a notion that geographical, demographic, and racial factors created a unique interface for human interactions. Hawaii was to be a Shangri-laboratory of sociological research -- an exotic menagerie of social interactions and couplings between people of diverse backgrounds.

This chapter will analyze the contrast between this highly unique heuristic and an alternative universal model of sociology that developed in the 1950s and 1960s. In addition, it will demonstrate the heavily sociological orientation of psychiatric public health in post World War II Hawaii. Far from an isolated

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[3] Ibid., 29.

[4] Ibid., 14-27.

discipline, sociology's significant cross fertilization with public health meant that sociological theories translated into an actual system of clinical therapeutics.

Chicago Sociology

The University of Chicago's Department of Sociology was founded in 1892 by intellectuals who had modified and condensed German anti-positivist social theory into a professional discipline. German (indeed, European) sociology in the late nineteenth century, in general, was not well institutionalized, and some of the founders of academic sociology came from other academic fields, such as economics, philosophy, and history. German social theorists reacted against British and American evolutionary sociology and took a significant interest in the social lives of the working classes. Advancing this theme, Chicago sociologists opposed the idea of the competitive Darwinian society and although Chicago adherents accepted that the laws of the social world could be derived from the biological sciences, they argued that the biological imperative was cooperation, not Darwinian competition. Moreover in delineating the moral orientation of a normally functioning society, Chicago sociologists also derived an inherent system of ethics behind normal social actions.[5]

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[5] For a compact general history of sociology and bibilographic essay, see Roger Smith, *The Fontana History of the Human Sciences* (London: Fontana Press, 1997), 531-572, and 968-974. For more comprehensive views on the origins and development of Chicago Sociology, see Martin Bulmer, *The Chicago School of Sociology : Institutionalization, Diversity, and the Rise of Sociological Research* (Chicago: University of Chicago Press, 1986); S J Diner, "Department and Discipline: The Department of Sociology at the University of Chicago, 1892--1920," *Minerva* 13, no. 4 (1975): 514-553; and Fred Matthews, *Quest for An American Sociology: Robert E. Park and the Chicago School* (McGill-Queen's University Press, Montreal, 1977).

Another feature of Chicago Sociology was its methodology. American sociology became institutionalized in Chicago by an ambitious group of young professors and academic leaders who were steeped in the German tradition of applying graduate study to contemporary events, in the setting of lively, intimate seminars. The sociologist William I. Thomas also introduced a tradition of academic field research, in which sociologists collected interviews and life histories directly from laboring people in their own gritty, working environments. Thus there was no shame in an academic getting hands dirty while doing research. Another pivotal figure was the sociologist Robert Park, who came to the Department in 1913. Park had been a newspaper journalist, among other things, prior to his post in the Department of Sociology, and the methods advocated by W.I. Thomas provided a natural attraction. Chicago sociology, based on participant-observation, was further suffused with a sense of place. Its proponents were wide-eyed in wonder at the drama of life put in full view in the different neighborhoods of Chicago.[6]

Transfer Between Chicago and Hawaii

There was a rich transfer of sociologists between Hawaii and the University of Chicago. In the process of conducting a series of research studies on race relations in the Western United States, Robert Park himself had been a visiting professor at the University of Hawaii from 1921 to 1922. Romanzo Adams completed his Chicago Ph.D. in 1904 and was recruited as the first chair of the

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[6] For method and institutional arrangements in Chicago sociology see Edward Shils, "Tradition, Ecology, and Institution in the History of Sociology," *Daedalus* 99, no. 4 (1970): 760-825.

University of Hawaii's Sociology Department in 1920. A majority of other faculty

members at the University of Hawaii also had Chicago pedigrees. Andrew Lind,

who studied under Park in Chicago, came to Hawaii in 1927 to conduct his

dissertation research and received his degree in 1931. Lind would serve as the

head of the department's research laboratory from 1934 to 1961.[7]

Romanzo Adams and the other sociologists were confronted with the

novel cultural complexity of Hawaii; on the other hand ,their training in Chicago

prepared them for observing and measuring these dynamics. Adams'

assessment was that Hawaii was indeed a glorified melting pot. When

Europeans first arrived in Hawaii in small solitary ships, they were incapable of

posing a compelling military threat.   As a result, they were forced to accept the

indigenous Hawaiians as equals. In addition, as Andrew Lind paraphrased, "the

doctrine or profession or racial equality -- actually quite orthodox in terms of our

American national documents such as the Declaration of Independence and the

Constitution -- is in Hawaii re-enforced by the the solid foundation of ingrained

habits and customs."[8]   Lind was referring to a culturally enforced tolerance that

Hawaiians had to members of other races.   This mutual bonhomie created a

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[7] Sun-Ki Chai, "Sociology in Hawaii: Past, Present and Possible Future" (Presentation given at the Hawaii Sociological Association Annual Meeting, February 13, 2010), http://www2.hawaii.edu/~sunki/conference/Hawaii%20Sociological%20Association%7B2010%7D.pdf (accessed August 23, 2011).

[8] Andrew W Lind, "Hawaii in the Race Relations Continuum of the Pacific," *Social Process in Hawaii* 25 (1962).

tradition of "unorthodox" racial serenity that "by historical accident" was unique to Hawaii.[9]

The Chicago style manifested itself in the research that was being done in the Department of Sociology at the University of Hawaii, frequently by undergraduate sociology students. For example, a 1938 ethnography of the Aala slum district in Honolulu was a testament to participant-observer methods. The student-author had lived in Aala for an entire year collecting information on the area's inhabitants while he "earned his room and board in one of the smaller restaurants located in the area," getting to know everyone from the neighborhood's vagrants to its shoe shine boys.[10]   The author's turf in the Aala was a "transition area" with "high land values, dilapidated buildings, small individual shops, tenements, and Oriental hotels."[11] The author then traced the origins of the various groups living in the area. For example:

> Sociologically, the most interesting group are the Koreans. With the exception of one who operates a bar, all of them are owners of tenements in which the Hawaiians, Puerto Ricans, and others are roomers. When questioned as to her attitude towards the

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[9] See Romanzo Adams, "The Unorthodox Race Doctrine of Hawaii," in *Race and Culture Contacts*, ed. E B Reuter (New York: McGraw-Hill, 1934); Lind, "Hawaii in the Race Relations Continuum of the Pacific." Recent scholars have criticized Adam's enthusiasm for melting pot type assimilation, as recapitulating essentialist stereotypes. See Jonathan Y Okamura, "The Illusion of Paradise," in *Making Majorities: Constituting the Nation in Japan, Korea, China, Malaysia, Fiji, Turkey, and the United States*, ed. Dru C Gladney (Stanford: Stanford University Press, 1998); Lori Pierce, "Creating a Racial Paradise," in *Race and Nation: Ethnic Systems in the Modern World*, ed. Paul R Spicard (New York: Routledge, 2005); S S H Lee and R Baldoz, "A Fascinating Interracial Experiment Station": Remapping the Orient-Occident Divide in Hawai'i," *American Studies* 49, no. 3-4 (2010): doi:10.1353/ams.2010.0027. A criticism of the above works is that they assume a central premise of Adam's work was boosterism of the idea of racial paradise in Hawaii, though Adam's contemporaries were careful to state his more measured actual record on this issue.

[10] Kiyoshi Kaneshiro, "Assimilation in a Slum Area of Honolulu," *Social Process in Hawaii* 4 (1938): 16-27, 16.

[11] Ibid., 17.

prostitutes living in her building, the reply of one of the Korean landladies was "Me, I no care. Me only sell room. 'Nother men make business me no boss. Me, I get money 'nough." At another tenement, the writer approached a young Korean girl of high school age, who, with her mother was the proprietor of the building. After learning of the occupation of the tenants, the question was put to her: "What are these Portuguese and Haole women doing? Aren' t they married?" "Oh, they're prostitutes," she replied unhesitantly.[12]

The author notes that the *belle indifference* was "typical of the attitudes of this area which indicate a relative absence of community organization and morale." With the dominant diversion being "money acquisition," the individual set out to commander a trade of the lowest common denominator, "the product of which is a complete indifference with him."[13]

Factors like this combined to create "social distance" and "barriers to social contact" for the members of the community. The "blind drive to accumulate wealth" created "enemity (sic)" amongst the shopkeepers, with many of them staying open 364 days of the year, one hoping to do outdo the other. Interactions were also split on ethnic or racial lines. While there was no outright "racial antagonism" simply because the business owners depended on other groups for customers, the author noted that members of this diverse community were "distinctly divided" by race. Pecuniary interests came before all others, and people "regard everyone merely as a prospective customer." As a result, "geographically, the people live only a few yards away, but socially they are miles apart."[14]

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[12] Ibid., 19.

[13] Ibid., 19.

[14] Ibid., 19-20.

There was also a strong suggestion of how physical forms of buildings or structures determined interactions. Descriptions of living areas, and interactions born of them were vivid, even photographic. While social distance prevailed in the community, within the family crowded spaces led to jarring intimacy:

> Let us enter one of the buildings to see the actual living conditions of the people. The shop on the ground floor is the living room. We go through the store or through a narrow lane to get into the living quarters. In the rear of the shop, the kitchen is situated behind high counters in such a way that it may not be seen and yet be accessible from the shop at all times if and when there should be no customers. The back door leads to the backyard, which is of solid concrete paving, walled in by the backdoors of the people who share it. Empty crates, boxes, rubbish, and other refuse, are piled near the walls, and the odor which fills the air is quite nauseating to the unaccustomed ... In another home of a restaurant owner, the family of seven lived and slept in one compartment, while the rest of the people, composed of boy and girl employees, were segregated in two different rooms partitioned by Japanese folding screens. From a girl just out of high school comes this remark: "Gee, I envy all my friends who live in cottages. They seem to have a room all by themselves, but here I don't know which is mine because we all share the house and like it. That's all![15]

Portending the themes of Richard Gordon, social distance resulted from abandoning community for mobility and transience, the congeners of aspiration and striving. Social distance was manifested even in the contracted dimensions of the inner-city slum. Leisure time activities of the slum's inhabitants, described in colorful detail, were performed mechanically, without a sense of purpose or intention. Even religious beliefs were superficial and transitory. When the author asked a minister why so few Hawaiians attended the services, the answer wass "Well, you see, people in Honolulu don't live regularly at one place -- always moving."[16]

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[15] Ibid., 23.

[16] Ibid.

Racial Assimilation and Park's Race Relations Cycle

Another concept that involved the physical environment was that of assimilation, the process by which immigrants might integrate new attachments to their adopted home. The concept of immigrant assimilation had an extensive history even before it was utilized by sociologists in Hawaii. Again, developments by sociologists at the University of Chicago shaped important facets of the concept. Three models of assimilation had emerged to explain assimilation in the United States by the 1920s.[17] "Anglo-conformity" proposed that immigrants eventually manifested the characteristics of America's "core" Anglo-Saxon character. Another model, "the melting pot," articulated a hybridized product, of which the Anglo-Saxon heritage was but one component. A third model, "cultural pluralism," envisioned a multiplicity of ethnicities, that operated more or less unchanged in a kind of "symphony."[18] The actual mechanisms of assimilation were not well detailed in Chicago work, and no model (Anglo-Conformity, melting pot, or pluralism) ever won out. In addition, a emphasis on the experience of assimilation (rather than the mechanics) highlighted the transformation of rural peasants into metropolitan workers and the resulting implications of living in an "urban, impersonal, and individualistic world."[19]

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[17] This discussion comes from R A Kazal, "Revisiting Assimilation: The Rise, Fall, and Reappraisal of a Concept in American Ethnic History," *The American Historical Review* 100, no. 2 (1995): 437-471. See also M M Gordon, "Assimilation in America: Theory and Reality," *Daedalus* 90, no. 2 (1961): 263-285.

[18] Kazal, "Revisiting Assimilation: The Rise, Fall, and Reappraisal of a Concept in American Ethnic History," 442.

[19] Ibid., 443,

Again, the work of Chicago sociologists W.I. Thomas and Robert Park was influential.   With Florian Znaniecki, a Polish aristocrat, Thomas had written *The Polish Peasant in America*, which investigated the changes in social relationships brought about by successive foreign invasions and the weakening of family ties in the old country. These changes were compared to the Polish immigrant's support of benevolent organizations and charities following migration to the United States. However, the calculated preservation of older community ties counted in itself as part of assimilation, and thus in the act of trying to preserve their roots, the immigrants became inevitably Americanized.[20]   Also important were Robert Park's and William Burgess' concept of the race relations cycle, formulated in 1921. Park and Burgess' cycle was a dialectical model of four progressive phases of interaction that had important implications for the role of geography and buildings in race relations. In *competition*, the first phase, latent settling and habitation of places occurred in accordance with the laws of the marketplace, for example the formation of ethnic neighborhoods based on proximity to a factory. In the second phase, *conflict*, came an awareness of one's own group in opposition to others and the resultant creation of social behavior and institutions with a competitive ethos. The third phase, *accommodation*, marked the capitulation of resistive, competitive forces, with integration of outside influences. Finally, in *assimilation*, un-self conscious integration was the norm.[21]

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[20] Stow Persons, *Ethnic Studies at Chicago, 1905-45* (Urbana: University of Illinois Press, 1987), Chapter 3.

[21] This summary is from Matthews, *Quest for An American Sociology: Robert E. Park and the Chicago School*, Chapters 5-6.

Historian Fred Matthews characterized Park's race-relations cycle as "Olympian." By Olympian, Matthews meant detached -- and that detachment was found in the writings on race relations in Hawaii. Sociologists in Hawaii used a gentle assimilation model that tended towards advocating a melting pot, with allowances made for the necessity of phases of cultural pluralism.   Writers stressed the slow pace and time required for full assimilation. On the other hand, writers were open about racial conflict and suggested that zones of racial interaction inevitably resulted in disorganization and crime, all part of the process as Parks had described.   Spatial dynamics controlled who interacted with whom and thus the geographic orientation (and exceptionalism) of Chicago-Honolulu sociology was maintained. That meant was that race mixing was inevitable. It would certainly lead to problems such as crime and delinquency. Those problems would be exacerbated if the cycle was pushed too quickly. Thus many writers urged an essential conservatism and thus skepticism about the pace of social change in Hawaii and were uncomfortable with the process of assimilation happening too quickly.

Assimilation met the built environment in the importance of community institutions like stores, restaurants, bars, and parks. These places served as microcosms of an entire neighborhood, and if formal race-mixing did not occur at large in the community, it could happen (or at least be discerned) in these special areas. For example, one sociology student used a Chinese-run store in the racially mixed neighborhood of Palama as a "peepsight" to observe changes in racial relations in the neighborhood during World War II. The neighborhood itself

was interesting for study, as it was "a decidedly disorganized area," "where most of the city's delinquents come from."[22] Something was palpably distinct about it, "in view of the crowded and generally decadent conditions."[23] The store's clientele was as mixed and varied as the neighborhood. Moreover, "comments" overheard in the store formed the basis for analyzing "concern for the changing relations between the sexes and and the generations brought about by the war."[24] A major factor seemed to be patronage of the store by American soldiers, who frequented bars and shops in the area in their free time. As a result, "young girls have suddenly become grownups. Local boys have lost some of their girl friends to the newcomers. Parents have not been able to keep their daughters at home."[25] Moreover, interracial marriages and couplings were on the increase. One particular incident involved a Hawaiian woman who had a baby with an American soldier out of wedlock. The couple married several months after the child was born. The author was shocked that the neighborhood was in outright denial, with "general opinion" being "that they were married when they started to live together."[26] "The talk in the store on this incident was surprisingly disinterested," the student noted -- "The people seemed to feel that such things occur, so why get excited?" The event hinted at the breakneck pace of racial

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[22] Hester Kong, "Through the Peepsight of a Grocery Store," *Social Process in Hawaii* 9-10 (1945), 11.

[23] Ibid., 11.

[24] Ibid., 14.

[25] Ibid., 14.

[26] Ibid., 16.

assimilation in Hawaii, because the process was "inevitable when groups of people come together and especially when the social code permits it."[27]

Hawaiian sociologists retained a measured assessment of race mixing in neighborhoods, marveling at the sociological dynamics while being careful not to adopt a tone of naive boosterism. This attitude continued in the post-war years, as the dramatic demographic changes brought about by World War II affected the generation in its immediate wake. The post-war era also saw the first development of a modern subdivision suburban community, Kalaheo, on Oahu's windward side. Echoing some of the themes found in the writings of Richard Gordon that were suspicious of suburbs, a sociological analysis highlighted aspects of the Caucasian suburban community that were very different from the older, crowded, and racially mixed areas of urban Honolulu. Kalaheo was yet too new to "have developed very much of an in-and-out for coffee kind of neighborliness."[28] Again, the pursuit of material wealth, this time in the form of "middle class striving for higher status," resulted in interpersonal "reserve" and "preoccupation with whatever contributes to higher status." While racial antipathy was "carefully submerged," the author did glean some insights about interracial dynamics that mirrored themes discussed earlier in this study. For example, an ethnic Hawaiian family was noted to be the first to "[break] the ice" between neighbors, presumably because of their tradition of extended, casual child-raising. While " 'on guard' at first, to avoid making social blunders," a part-

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[27] Ibid., 16.

[28] Emma K Himeno, "Kalaheo Village, a New Community," *Social Process in Hawaii* 43 (1959), 58.

Hawaiian family had started feeding a neighbor's boy who arrived for breakfast each day. As a result, now "not only the children but the adults go to each other's homes for coffee and meals."[29]

Sociology as Therapeutics

By the conference of 1962 that started this chapter, it was well accepted that social scientists would have a role in influencing clinical and administrative planning in the Department of Health and other long range planning activities in the state government. In the opening address to the conference, Leo Bernstein, the Acting Director of Health, told the audience that " there appears to be a direct relationship between the physical form of our cities and the well-being of their their inhabitants." Attendees recommended "including mental health personnel and social scientists and considering long range planning in relation to housing" while the city's planners intended to "include social scientists and their in-service training program."[30] Thus, the sociological approach had become a therapeutic approach. By the end the discussants could conclude:

> When you bring in a thousand new people from all the outside islands, people of different cultural backgrounds, without quite the same interests, and you put them together in a housing development or an apartment house without adequate recreational facilities for the children apart from their relatives, the housewives will take a long time finding common denominators with each other that will help them to render to each other mutual baby-sitting services, mutual child-care services, and actually just discussion over the fence kind of chatter which does accomplish a great deal about 'how do you handle such and such' and 'what is a good school' or whatever other kinds of questions housewives will answer for each other, as well as in their pleasurable conversation.

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[29] Ibid., 57-9.

[30] *Proceedings: Conference on Planning for Mental Health*, 11-13.

Now if you don't have those features taken into consideration, many of those youngsters are going to become delinquents. They're going to, with their boyish energies are channeled and positive, useful directions that might have been channeled by their grandparents in the community in which they grew up but now have nothing to direct them. They're very likely to find their outlets and the results will be broken windows, stolen hub-caps as they get older, joy-rides in automobiles, sexual forays and other kinds of sprees.[31]

So what affect did these ideas have on actual clinical practice? The emphasis on social factors in mental illness was not a new idea in Hawaii.   Sociology had, by the end of World War II, emerged as a powerful force in shaping ideas about mental health through the work of medical sociologists and social psychiatrists. However, the question of how sociology came to influence medical practice in Hawaii requires some detail.   First, the University of Hawaii had always had some role in Hawaii's public mental health infrastructure, dating back to the days of Stanley Porteus' consultative work for the territorial government in the 1920s and 1930s. But the confluence of work in the social sciences came to clinical bearing in the training of psychiatric social workers at the University of Hawaii, who were formally steeped in sociology.

Psychiatric public health efforts depended on newly minted social workers. Moreover, social work students, armed with theories from the social sciences, conducted detailed analyses of patients in public mental hygiene clinics and hosted conferences on the nuances of work with patients from different backgrounds. By 1922, Romanzo Adams, the first Chair of the the University of Hawaii's Department of Sociology, had set up sociology courses for clinical social workers. The University of Hawaii inaugurated a school for social workers in 1936, under its first director, Eileen Blackey, who had a "conviction that culture

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[31] Ibid., 30.

was a major determinant of behavior, life style, and philosophy of living."[32] A

faculty of five oversaw formal accreditation in 1948. Sociology and mental health

remained connected in the School of Social Work's teaching program. For

example, in 1950, the school offered the course "Cultural Factors in Social Work

Practice," which stressed "the significance of psychocultural factors in the

development of personality and behavior;" the course operated continuously

until 1970.[33]

As psychiatric caseloads grew, social service agencies, staffed with social

workers, were utilizing and formalizing psychiatric consultation more than ever.

In addition, they were gaining practice conducting affairs independently from

physicians. Writing in 1959, Myron Chevlin, the director of Child and Family

Services in Honolulu, stated that "the majority of cases can be handled fully with

the application of the professionally trained caseworker's knowledge and

experience" and noted that a psychiatrist's consultation was only required in "9%

of the 1100 cases served annually."[34]

Psychiatric public health was also influenced by the Department of

Sociology's journal *Social Process in Hawai*i, a series of occasional papers

originally titled "What People are Saying and Doing in Hawaii," as well as articles

by Department faculty in important national journals. Behavioral scientists and

clinicians were required to sit on public planning and development boards and

[32] *A Short History of the School of Social Work, University of Hawaii at Manoa 1936-1986*, ed. Frederick Y Smith, http://www.hawaii.edu/sswork/history.html, 4.

[33] Ibid., 6.

[34] Divsion of Mental Health, *Proceedings of the Institute for Social Workers, Honolulu 1958*, 20, University of Hawaii, Hamilton Hawaiian LIbrary, Honolulu, HI.

frequently led or served other social service agencies.[35] The Department of

Sociology also benefited from the prestige of government sponsorship during

World War II; research improved and became more ambitious, more students

were recruited, and connections between sociology and social work were

enriched. Consequently, the number of publications increased, and sociologists

became more influential than ever in aspects of government and urban planning.

At the national level, under the influence of psychiatrist Robert Felix, the National

Institute of Mental Health (NIMH) was becoming more influential in national

health policy and sought the outright participation of sociologists.

This confluence of factors much advanced the understanding of local

factors in mental health issues. Chicago School sociology already promoted

careful, journalistic methods and the importance of the spatial dynamics

occasioned by the physical forms of neighborhoods, parks,and buildings.

However, by 1965, universal theories of mental illness challenged the idea of

Hawaii's uniqueness as a sociological laboratory, originally pioneered by

Romanzo Adams and the first generation of sociological researchers in Hawaii.

With the advent of a national community mental health system and Hawaiian

statehood, the concept of place in Hawaii gradually lost its original, hyper-local,

geographic meaning.

The Shift to a Global, Universal Emphasis

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[35] See, for example, *Proceedings: Conference on Planning for Mental Health*, 58.

Sociologists Bernhard Hormann and Andrew Lind led the shift from a hyper-local to a global emphasis in the 1950s. These writers represented the second generation of sociological theorists at Hawaii after Romanzo Adams. Hormann, who was descended from German immigrants, had been an undergraduate at the University of Hawaii, and joined the faculty in 1939.   By 1956, he was dismantling Hawaiian exceptionalism. While paying homage to the often repeated factors that made Hawaii unique (island geography, isolation, plantation infrastructure, pleasant climate, and unique racial composition), Hormann found that the sociologist "looking at Honolulu soon finds a rather typical American city." He drew similarities between Honolulu and the great ports of call of the American eastern seaboard and added that the racial ghettos of Honolulu's past had become much more rare, following a pattern derived from the mainland.[36]

Hormann also retreated from the older Chicago model of assimilation, with its emphasis on racial conflict and accommodation. Instead Hormann offered a Hawaii which, far from being an outlier, represented orthodox processes happening in similar areas around the world. As such, a new theme for the work in the department was to be "Social Process in Hawaii Mirrors the World in Transition." What *happened* in Hawaii was not necessarily unique, but the *opportunity* it afforded for study was. Thus the laboratory metaphor was maintained, but the case for Hawaiian exceptionalism was not. Hormann also de-emphasized the focus on race and race relations, instead choosing to focus on social and economic factors he felt Hawaii shared with the rest of the world.

[36] Bernhard Hormann, "Certain Ecological Patterns of Honolulu," *Social Process in Hawaii* 20 (1956): 23-9, quotation from page 23.

Rather than unique local factors, generalizable economic conditions drove

disorganization, delinquency, and psychiatric illness.   Hormann frequently cited

the quantitative sociology of Hawaii demographer Robert C. Schmitt, who

favored terse statistical analyses. Hormann found, in Schmitt's work, a

reiteration of original socio-economic zones that had been identified in Chicago.

Another factor Hawaii shared with the rest of the world was urbanization.

Following Hormann's universalism, sociologist Andrew Lind observed that

"Hawaii has become so thoroughly integrated within the modern world economy

that its major city, Honolulu, appears to many observers like just another,

although smaller American city" and conversely that "Hawaii has become

overwhelmingly an urban area in which all other types of communities are being

supplanted by towns and cities." Thus, Hawaii was losing its exceptional status

even faster than other rural states, and Honolulu was quickly "assuming the

character of any American city."[37]

The History of Modernization Theory

In moving from older models of factors defining the life of people in a geographic

area, modernization theory became an important influence in the work of

Hormann and Lind. Modernization theory was a body of work that advanced the

idea that societies around the world progressed on a continuum of organization

and development.   Along with the dismantling of colonial empires and the

emergence of new third world nations, modernization theory emerged as a

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[37] Andrew W Lind, "Community Types in Hawaii," *Social Process in Hawaii* 23 (1959), 18-19.

theoretical discipline during the Cold-War.[38] Calling for a comparative evaluation

of the differences between "traditional" and "modern" societies, modernization

theorists also attempted to clarify the requirements to move from one phase of

development to another. In this framework, "modernization" meant a series of

mutually reinforcing changes in economic organization, political structures, and

social values. Modernization theory involved four central tenets: " (1) 'traditional'

and 'modern' societies are separated by a sharp dichotomy; (2) economic,

political, and social changes are integrated and interdependent; (3) development

tends to proceed toward the modern state along a common, linear path; and (4)

the progress of "developing" societies can be dramatically accelerated through

contact with the knowledge and resources of modern ones."[39] Modernization

theory recapitulated evolutionary-based sociological theories, with all their

potential biases. [40]

The pendulum had swung to the need for Hawaii to have some regional

significance in Pacific affairs, what historian Paul Hooper has identified as

"internationalism" and "the most persistent, if not dominant theme in modern

Hawaiian history."[41] After World War II, several internationalist organizations,

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[38] Dean C Tipps, "Modernization Theory and the Comparative Study of National Societies: A Critical Perspective," *Comparative Studies in Society and History* 15, no. 02 (1973): 199-226.

[39] M E Latham, "Ideology, Social Science, and Destiny: Modernization and the Kennedy-Era Alliance for Progress," *Diplomatic History* 22, no. 2 (1998): 200. See also J C Alexander, "Modern, Anti, Post, and Neo: How Social Theories Have Tried to Understand The 'New World' of 'Our Time'," *Zeitschrift für Soziologie* 23, no. 3 (1994): 165-197.

[40] A A Mazrui, "From Social Darwinism to Current Theories of Modernization: A Tradition of Analysis," *World Politics: A Quarterly Journal of International Relations* (1968): 69-83.

[41] Paul F Hooper, "A History of Internationalism in Hawaii between 1900 and 1940" (Ph.D. thesis, University of Hawaii, University of Hawaii, September, 1972), 1.

which attempted to find common ground between the United States and countries abroad, placed Hawaii at the center of their activities. Like modernization theory, Hawaii-based internationalism had the potential to question the uniqueness of Hawaii and to downplay regional differences in favor of more accommodating theories about how places operated in a world system.

For example, the development of Pan-Pacific Internationalism, a movement which found common cultural ground in the Pacific Rim, was marked by the founding of the Institute for Pacific Relations (IPR).[42] The Institute for Pacific Relations was birthed by Honolulu businessman Frank Atherton in the 1920s. Atherton recruited an impressive array of international delegates to discuss Asia-Pacific issues. The IPR held major international conventions well into the 1950s and sponsored its own research docket. Land use and demography research was used to explain social problems in East Asia, while the IPR funded Romanzo Adam's and Andrew Lind's race relations work in Hawaii. However, conflicts about the group's headquarters and its profile in international politics divided the group. One faction criticized Hawaii as an intellectual desert where no research of substance was happening with relevance for the broader Pacific. The response from Atherton and the Hawaiian contingent was to insist upon the importance of detached research, particularly into important local factors. But the localist group lost in the 1934, when the IPR relocated to New York to follow a more globalist, activist agenda.

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[42] Paul F Hooper, "The Institute of Pacific Relations and the Origins of Asian and Pacific Studies," *Pacific Affairs* (1988): 98-121.

Historian Christina Klein has explored the internationalism that developed in the wake of the Cold War.[43] "Integrationism" was an international diplomatic and cultural orientation that emerged as another pole of Cold War containment. Articulated by intellectuals like the historian Arthur Schlesinger, integrationism argued that the West should identify universal bonds that might united diverse communities of the "free world." This would be an antidote to the Marxist dogma which created commonalities between diverse Communist countries. Integrationism was an infectious ideology for intellectuals in the social sciences, because it drew from familiar themes in the social and psychological sciences -- particularly ideas in sociology about the determinants of community and the needs of of the self versus the needs of others.

Events in Hawaii symbolized the confluence of integrationism and modernization theory. For example, the 1955 Conference on Race Relations in World Perspective, organized by the Hawaii Department of Sociology, was a major international meeting in which sociologists extrapolated commonalities between the Hawaiian scene and the rest of the world. Congress' founding of the East-West Center in 1960 also placed Hawaii at the intersection of East meets West intellectual rhetoric. The East-West center sponsored visiting foreign students in Hawaii and was self consciously aimed at winning the hearts and minds of foreign intellectuals who would export the ideals of American academic and democratic freedom; it was to be a deliberate ideological weapon in the Cold War.   Finally, historian Gretchen Heefner has written about how the Hawaiian

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[43] Christina Klein, *Cold War Orientalism : Asia in the Middlebrow Imagination, 1945-1961* (Berkeley: University of California Press, 2003).

statehood debate could be framed in the advantages that Hawaii statehood could

provide. As a model of integrating power, Hawaii represented the possibility of

winning more territory for the United States, despite complex racial dynamics.[44]

Frontier theory in Hawaii Sociology

Hawaiian writers were similarly attracted to the idea of frontiers. In the same way

that Frederick Jackson Turner essentialized the frontier experience to a character

type, Hormann and Lind's elaboration of frontier led to a metaphorical transition

of the older idea of Hawaii as exotic social laboratory. Bernhard Hormann

borrowed heavily from modernization theory and suggested that frontiers were

rapidly disappearing through the forces of modernization. Hormann defined

frontiers as areas of communication, interaction, and engagement where there

were previously barriers. Hormann explained that Hawaii offered more "stages"

or "frames" for interaction due to isolation and dense population. These factors,

admitted Hormann, made Hawaii unique. But rather than an exotic laboratory,

Hawaii was more akin to a microscope or an incubator, a hotplate for the rapid

modification of social behaviors and interactions, that paralleled the world in

economic development.

> Hawaii is an ideal place for studying -- in a readily deducible human context, with
> available or ascertainable statistical data, and with ease of access to case studies --
> problems of change, social frontiers, marginal men, social processes; second, since in

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[44] G Heefner, " A Symbol of the New Frontier," *Pacific Historical Review* 74, no. 4 (2005):
545-574; See also Paul F Hooper, *Elusive Destiny : The Internationalist Movement in Modern
Hawaii* (Honolulu: University Press of Hawaii, 1980). See also F Paisley, "Cultivating Modernity:
Culture and Internationalism in Australian Feminism's Pacific Age," *Journal of Women's History*
14, no. 3 (2002): doi:10.1353/jowh.2002.0073. for a gendered reading of female internationalism.

the world, such problems are rapidly overtaking situations of stability and structure, research on Hawaii naturally illuminates research on this dynamic changing world. [45]

Thus, in contrast to a microsociology of individual actions made popular by Chicago sociologists, Hormann found in Hawaii the presence of an "*emerging world civilization,*" a "perspective common to cosmopolitan people modern world society."[46]

As "frontier" became a stand in for the forces of modernization, "community" became a term that lost associations to specific geographic areas or ethnicities. In return, community came to mean areas defined statistically or demographically. With the 1963 Community Mental Health Centers Act, the term "community" was particularly important in mental health, but the usage was determined by the modernization faction in the Department of Sociology at the University of Hawaii. In fact, Horman addressed the Hawaii Public Health Association in 1958, and physicians and sociologists cross published in *Social Process in Hawaii* and the *Hawaii Journal of Medicine*. Hormann's definition of community blurred technical distinctions between the environment, the family, and the community. In certain circumstances one concept could subsume the other two. As a federally mandated program informed by sociologists, the Community Mental Health Act of 1963 likewise ensured that "community" was imbued with an impotent theoretical blandness. While allowances might be made in subsuming diverse places under the rubric of "community," "community"

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[45] Bernhard L Hormann, "Social Frontier, East-West: An Introduction to the Articles," *Social Process in Hawaii* 26 (1963)., 13.

[46] Ibid., 13.

was a universalist, federal notion, itself a congener of modernization theory.   In

Hawaii, local planners did little to bend the idea of community to a specifically

Hawaiian model and instead made theoretical and planning assumptions from

the other states, casting aside a sense of historical or demographic uniqueness,

which in earlier sociological research had pulsated with racial specificity and

loaded meanings in terms like "family" or "attitude" or "environment." Instead,

"community" became a meaningless place-holder for ideas that had lost a sense

of specific geographic or interactional pathopsychological thinking.   For example,

in their preparation for the Community Mental Health Act of 1963, the Oahu

planning commission co-opted epidemiological data from New York and

Maryland on the rates of psychiatric illness and blindly extrapolated them to

Oahu without discussion as to the cross-applicability of epidemiological data from

the mainland.[47]

Conclusion

Hormann and Lind's enthusiastic adoption of modernization theory competed

with the model of public health psychiatry that had previously operated out of

local concerns. Modernization theory had the effect of displacing local autonomy

in the field of ideas. It also implied that national systems to address mental

health issues would work in Hawaii. This fit in very well with the Community

Mental Health Centers Act of 1963, in which the federal government, informed by

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[47] Oahu County Steering Committee, Comprehensive Mental Health Planning, "A Report of the
Task Force on Community Mental Health Services for Adults," (May, 1965)(Hawaii State Archives,
Honolulu, HI).

ideas from academic sociologists, re-engineered the model of treatment of seriously mentally ill in asylums and expanded community based outpatient treatment and prevention program in mental health. Moreover, it occasioned the conversion of Hawaii's public mental hygiene clinics into community mental health centers.   Thus, modernization theory and the Community Mental Health Centers Act may be seen as two expressions of academic sociology, but a sociology quantitatively informed and characteristically different in emphasis to Chicago sociology.   It was this expansion in the field of ideas that most closely represented the dynamics of colonial medicine.   Its most striking feature was the complicity of Hawaiian sociologists Lind and Hormann and other administrators. As if to confirm this, Frank Lombardi, the Hawaii State Planning Director, made the following remark at the 1962 conference which opened this chapter:

> Now I can remember a couple of years ago when the legislature used to meet, about half of them would have Aloha shirts on. As you see, I'm trying to maintain the old tradition, but we're becoming more and more like Los Angeles or Houston or every other place in the United States. We're losing the things of pride that we like to think about when we think about Hawaii and why we're living here. And this is not an easy thing to define, but through these standards that the federal government is perpetuating, all of the United States, of course, takes on the same kind of standard so that you have highways here that have the lane widths and the right-of-ways the same as in Texas where they've got land to burn which we don't have and public housing and health programs and so on.[48]

While aware of growing homogenization, Hawaiian officials advanced universalism.   But a policy of universalizing Hawaii was never dictated by an impersonal colonial office. Rather, the constraints of academic fashion, and universal standards of professional competency brought about Hawaii's loss of uniqueness.

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[48] *Proceedings: Conference on Planning for Mental Health,* 35.

CONCLUSION

PSYCHIATRY, PLACE, AND POWER

Psychiatry contains unique opportunities, even more than other fields of

medicine, to reflect the power structures from which it derives. Hawaiian public

health psychiatry, from 1939 to 1963, was influenced by the social sciences

(which have also been shown to reify power structures) and allowed for the

concerns of local social management and the recasting of social problems

through the lens of mental illness and the language of place. In this local sense,

public health psychiatry acted as a tool of local political economy, but was not in

itself a tool of trans-national imperialism. However, in another sense, a universal

psychiatry, originating from the mainland United States and founded in the idea

of liberation from mental institutions and coercive government (the Community

Mental Health Centers Act of 1963), eroded the idea of the uniqueness of Hawaii

and re-defined mental illness as geographically unvarying. Here, psychiatry

acted as a means of domination in the field of ideas. The power dynamic leads

this study back to a question posed in the introduction: does colonial medicine (in

the form of Hawaiian psychiatry) reflect the needs of the colonized society, or is

there something about power and domination unique to western medicine itself?

In order to answer this question, the term "colonialism" requires some

precision. Geographer Ronald Horvath's definition, which is both flexible and

precise, allows for multiple subtypes of colonialism, defined by power and the

physical relationship between colonized and ruled. Horvath starts with the idea

that the fundamental characteristic of colonialism is domination by one group

over another, above the level of the family.[1] Next, Horvath explains that in

colonialism, the domination must be "intergroup;" in other words, it must occur in

a culturally "heterogenous" society, where specific sub-groups of sufficient

difference can be identified. When intergroup domination involves "significant

numbers of permanent settlers in the colony from the colonizing power," Horvath

terms the process "colonialism." When the dominant group attempts to rule from

a distance, without the presence of permanent migratory settlers, this is

"imperialism." Next, in both colonial or imperial domination, the next classification

depends on the intent the dominant group has for the subjugated group.

According to Horvath, this may be extermination, assimilation, or relative

equilibrium. Finally, Horvath distinguishes between domestic processes, "within

the confines of a recognized autonomous political unit (polity)," or international

processes. In effect, Horvath's basic idea of colonialism is "domination at a

distance." Following Horvath, a definition of *colonial medicine* might be "medical

practice or theory that furthers of the basic goal of colonialism (domination), while

emphasizing the consequences of migration and of assimilation on the health of

settlers."[2]

    According to these definitions, during the period studied, from 1939 to

1963, Hawaii was a colonial society. The United States attempted to assimilate

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[1] While this study acknowledges other alternatives to a definition of colonialism which might assign domination a different ranking of importance in the model, this does not undermine the usefulness of Horvath's heuristic which allows for the existence of several forms of colonialism arranged by interchangeable factors.

[2] R J Horvath, "A Definition of Colonialism," *Current Anthropology* 13, no. 1 (1972): 47-48.

Hawaii's diverse immigrant population in pursuit of American political, military, and economic interests. Settler migration both from the mainland and from Asia had been a self conscious goal of Hawaii's American-aligned sugar planters.[3] Moreover, a substantial military presence in Hawaii allowed the United States to project power over the Pacific and into Asia. Medicine certainly served both the local political economy and more far-ranging American geopolitical goals. In the local political economy, the dominant group was a diverse cadre of government officials and academics, either drawn from the same population whom they served or who had migrated to Hawaii in order to pursue personal or professional aspirations. In all, these officials were fairly representative of Hawaii's polyglot immigrant population. The psychiatric public health system reflected the concerns of the local government, initially rather half-heartedly, as the system nearly suffocated from lack of administrative support. Public health officials stressed the stability of household and marriage, largely because the government was tasked with the disposition of abandoned children and juvenile delinquents. In another example, while officials viewed the isolation of Japanese in ghettoed communities as problematic, they accepted this arrangement as less dangerous than the evil of over-rapid assimilation. In general, public health officials were suspicious about race-mixing; sociology's hostility towards social mobility and physical movement supported a generally conservative vision of social order. Thus, public health psychiatry could be a tool of statecraft that reflected the interests of local elites.

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[3] C Fujikane and J Y Okamura, *Asian Settler Colonialism: From Local Governance to the Habits of Everyday Life in Hawaii* (University of Hawaii Press, 2008).

Hawaiian psychiatry also served the interests of the United States as a

transnational power. Modernization theory, while an academic creation,

addressed diplomatic concerns and the geopolitical realities of the Cold War.[4]

Cold War "integrationism," as much a cultural movement as an academic theory,

was a counter-part of Communist containment and placed Hawaii as a part of an

over-arching world system.[5] The Community Mental Health Act of 1963

reoriented the therapeutic philosophy for the nation's entire mental health

system, on behalf of a few academics in the federal government. Medical

theories could universalize psychiatric understanding to diverse people in all

places and allowed for the export of public health ideas and medical theories

from the mainland to Hawaii. Both universal academic theories (such as

modernization theory) and universal medical theory (like Community Mental

Health) had real-world therapeutic and public health implications and can be

seen as forms of colonialism, a domination of the universal over the local in the

field of ideas.   Universalism was institutionalized and reified in the East-West

Center, in the Institute of Pacific Relations, in the University of Hawaii

Department of Sociology under Lind and Hormann, and in ideas such as

Michener's "golden man." Local expertise (and conservatism over race mixing

and social mobility) was replaced by statistical knowledge and quantitative

constructs, such as in the work of demographer Robert Schmitt. Hawaiian

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[4] Dean C Tipps, "Modernization Theory and the Comparative Study of National Societies: A Critical Perspective," *Comparative Studies in Society and History* 15, no. 02 (1973): 199-226.; M E Latham, "Ideology, Social Science, and Destiny: Modernization and the Kennedy-Era Alliance for Progress," *Diplomatic History* 22, no. 2 (1998): 199-229.

[5] Christina Klein, *Cold War Orientalism : Asia in the Middlebrow Imagination, 1945-1961* (Berkeley: University of California Press, 2003).

mental health planners extrapolated population data from states like Maryland

and applied them to estimates of mental illness in Hawaii. And the subtle

language of racial distinction, expressed in a grammar of place, began to lose its

nuanced meaning.

If psychiatry indeed facilitated colonialism, what about Warwick

Anderson's suggestion that Western medicine motivates domination in and of

itself, that there is something inherently colonial embedded within the structure of

therapeutic practice?   To investigate further this "cultural critique of medicine," it

is important to examine some theories of power in medicine in general.

Power and Medicine

As French literary theorist Jean-Pierre DuPuy writes, "if there is one

thinker who placed the relations between power and life at the heart of his work,

and who therefore had to conceptualise medicine as knowledge and as power

over life, it is undeniably Michel Foucault."[6] DuPuy asserts that Foucault's

understanding of power derives not from explicit conflicts between groups of

people, but, in fact, through the singular mundanity and ubiquity of the

"microphysics" of social relationships.   But Foucault's postmodern analysis of

power is less interested in larger issues, the "Newtonian physics" of power.

DuPuy notes that Foucault followed Nietzsche's essentially nihilistic view that the

dynamics of power could never be analyzed following a rational system of

investigation, as all systems are subject to the same derivations and biases of

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power. The dynamics of power were only discernible through one fact -- whose

interests won out in the end?[7]

Foucault writes that power has been leveraged since the sixteenth century

in a fight for the control of "subjectivity" between a kind of true individuality and

the state's form of the individual. Foucault adds, " the main objective of these

struggles is to attack not so much 'such or such' an institution of power, or group,

or elite, or class but rather a technique, a form of power."[8] In so doing, Foucault

is trying to look beyond superstructural readings like Marxism. However, while a

useful heuristic for illustrating forms or techniques of power, Horvath's defintion of

colonialism requires identifying specific actors, the groups seeking domination

over others. So we will have to go beyond Foucault's quantum physics of power.

A "historicist" approach, as outlined by historian Dorothy Ross, does allow

some attempt at analysis. By historicism, Ross means that historical

explanations are products of their time and both benefit and suffer from the

viewpoints and expectations of the age from which they are derived. But these

viewpoints are perceptible and change from era to era; as such historical method

cannot be universal. Her work has shown that, in the eighteenth and nineteenth

centuries, bypassing historicism, American social science constructed itself as an

apparently universal and objective set of disciplines derived from natural laws;

this legitimated American exceptionalism and a capitalist political economy of

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[7] Foucault, in fact, was not absolutely nihilistic -- for example, he does put forward a complex but indistinct theory for researching power through observing institutional histories, or for looking at the obverse of certain ideas. See M Foucault, "The Subject and Power," *Critical Inquiry* 8, no. 4 (1982): 777-795., 791-3.

[8] Ibid.

consumption and exploitation.[9] Similarly, Dorothy Porter has shown how

twentieth century British social scientists working in medicine changed from a

disease model of social inequality to a model emphasizing individual

responsibility over behavior, reflecting changes in culture brought about by the

social sciences and their relationship with government.[10] Both historicist and

traditional historical approaches on the social sciences thus shed light on power

when they are employed in medicine -- there is thus no need to succumb to post-

modern nihilism about methods.

Indeed, other authors in the social sciences have plainly outlined how

power operates both positively and negatively in the medical encounter, both on

the level of the doctor-patient relationship and in the relationship of medicine to

society.[11] In mental health, the notion of power differential is hardly surprising --

many psychotherapies, including psychoanalysis, require tracking the dynamics

between therapist and patient and try to make use of this knowledge

therapeutically.[12] Finally, the British psychiatrists Philip Thomas and Patrick

Bracken have advanced the idea of "postpsychiatry" -- a form of psychiatric

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[9] See Dorothy Ross, "An Historian's View of American Social Science," *Journal of the History of the Behavioral Sciences* 29, no. 2 (1993): 99-112.   For historicism, see C G Rand, "Two Meanings of Historicism in the Writings of Dilthey, Troeltsch, and Meinecke," *Journal of the History of Ideas* 25, no. 4 (1964): 503-518.

[10] Dorothy Porter, "From Social Structure to Social Behaviour in Britain After the Second World War," *Contemporary British History* 16, no. 3 (2002): doi:10.1080/713999468.

[11] For a review, see P Måseide, "Possibly Abusive, Often Benign, and Always Necessary. On Power and Domination in Medical Practice," *Sociology of Health & Illness* 13, no. 4 (1991): 545-561.

[12] Elements of power in psychotherapy include the therapist's "frame" of treatment -- the office, the blocked off time, professional boundaries, and the requirement of payment. For an articulation, of these elements, which Sullivan has termed the "masculine" aspects of therapy, see B S Sullivan, *Psychotherapy Grounded in the Feminine Principle* (Wilmette, Ill.: Chiron Publications, 1989).

practice informed by the critiques of the antipsychiatry movement of the 1960s and by post-modern critics like Foucault.   Thomas and Bracken demonstrate concretely how power may be returned to "service users," in the case of a woman who was encouraged to "produce her own interpretation of her psychotic behaviour."[13] That power operates in psychiatry, therefore, is not much of a revelation. In the Hawaiian case, power allowed a universal, assimilationist psychiatry to eventually became institutionalized. Definitional categories were based on the American assimilative norm. A more interesting question is the mechanism by which power structures became reified and exported in medical discourse, both in the Hawaii case and in the practice of psychiatry cross culturally.

Psychiatrist Paul McHugh and Philip Slavney's perspectives approach is a good place to fashion an answer. McHugh and Slavney argue that beyond the medical model for which it is most well known, modern psychiatry employs different conceptual models for different psychiatric conditions. Psychiatric attention may be called to conditions belonging to three other perspectives: the dimensional, the behavioral, and the life story perspective. The perspectives model takes us beyond simply the normal and pathological to a new understanding about how psychiatry might relate to power.

The behavioral dimension is of particular interest in Hawaii. In placing psychiatric attention on behavior, (in other words, what people are doing), McHugh and Slavney show that no abnormal physiological pathology is

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[13] P Bracken and P Thomas, "Postpsychiatry: A New Direction for Mental Health," *BMJ (Clinical Research ed.)* 322, no. 7288 (2001): 727.

necessary for a behavior to be called a disease. Of course, this means that all

conditions on the behavioral dimension will necessarily carry the qualification that

the behavior causes the patient "a significant amount of distress" -- in fact, this

term often signifies that a condition has been drawn from the behavioral model.

With this criterion, however, nearly anything running counter to a society's norms

or values might be considered a psychiatric illness. The behavioral dimension is

thus the slipperiest of the perspectival slopes.

The necessity and persistence of the behavioral dimension has caused

some observers to argue that the our modern psychiatric system is a folk

psychiatry, a catalog of illnesses that doesn't necessarily "carve nature at its

joints," but rather simply does a decent job of cataloging the commonly accepted

expressions of mental illness.[14] The Hawaiian public psychiatric system evolved

its own official "folk" psychiatry, one in which the main psychiatric problems

corresponded to the needs of the state. While beyond the scope of this study, it

remains a fascinating question how a Hawaiian lay folk psychiatry would

compare to the official version.

The export of a folk psychiatry that becomes generalized into a universal

system has serious implications. In modern cross cultural psychiatry, an aim is a

reproducible, universally valid catalog of psychiatric conditions. But when that

catalog includes behaviors or other conditions that that have been included

because they cause dysfunction in the index culture, power structures of the

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[14] For explanations of folk psychiatry, see N Haslam, "Dimensions of Folk Psychiatry," *Review of General Psychology* 9, no. 1 (2005): doi:10.1037/1089-2680.9.1.35 ; H Fabrega, "Cultural Relativism and Psychiatric Illness," *Journal of Nervous and Mental Disease* 177, no. 7 (1989): 415-425.

exporting system can become reified world wide. This is exactly what recent

criticisms of the spreading of modern psychiatry have suggested.[15] For example,

in his recent book, Ethan Watters argues that our folk psychiatric systems are our

most pernicious export.[16] These criticisms have shown not only that the

discovery of American psychiatric illness in other cultures may be invalid, but,

more disturbing, that this export may occasionally spread destructive forms of

expression of American psychiatric illness into cultures worldwide (for example,

Watters correlates the recent dramatic increase of eating disorders in Hong Kong

with trans-national media and entertainment). Pharmaceutical companies'

discovery of these new markets for lucrative psychiatric indications may further

reify and spread the expression of American style psychiatric illness worldwide.

The Hawaii case demonstrates that the export of American psychiatric

illness has been occurring at least since American global pre-eminence following

World War II.   This export had implications for American national power as well.

With the renewed interest in the psychiatric outcomes of displaced peoples and

refugee health, we may well come to understand the export of concepts like post

traumatic stress disorder, particularly in displacement conflicts, as a new form of

colonialism recapitulating themes of the requirements for western intervention

and management.

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[15] J Thakker and T Ward, "Culture and Classification: The Cross-Cultural Application of the DSM-IV," *Clinical Psychology Review* 18, no. 5 (1998): 501-29.

[16] For this idea, see Ethan Watters, *Crazy Like Us : The Globalization of the American Psyche* (New York: Simon and Schuster, 2010).

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