ABSTRACT

TRANSNATIONAL TRAUMA:
TRAUMA AND PSYCHIATRY IN THE WORLD AND TAIWAN, 1945-1995

Harry Yi-Jui Wu
The Queen's College
University of Oxford
2012

Doctor of Philosophy
History
Trinity Term

This study considers the history of trauma, both as a psychiatric concept and as a diagnosis, and its social and cultural representation from a transnational perspective after WWII. The intellectual evolution of trauma was determined by various medical, social and cultural variables, institutions, and people who wielded influence in the postwar world order as well as diverse local contexts. This thesis focuses on the globalisation and localisation of such concept and diagnosis shaped by international and local mental health experts at the World Health Organization and the National Taiwan University Hospital. Through the efforts of these experts, trauma not only became one of the most globally diffused psychiatric diagnoses, but also a hyperbole appropriated by Taiwanese psychiatrists to account for extreme forms of social suffering.

Studies have criticised the universality and the Anglo-American-centred approach to the history of traumatic psychiatry. Scholars have also begun to explore *transnational* histories of psychiatry by systematically comparing or tracing the diffusion routes of psychiatric topics. Their methods of enquiry and problems solved, however, differ. My research analyses a disparate collection of evidence at the level of international organisations and from local aspects, allowing not only a critical reconsideration of trauma in the trend of global medicine, but also its reception, contestation and appropriation in the non-Western contexts. Guided by the works of medical historians, literary critics and cultural anthropologists, this project combines archival research with oral history interviews to challenge the existing historical accounts of trauma, and provide evidence of the limited capacity of globalised psychiatric norms and their reception and appropriation beyond the imagination of world citizenship. It argues that such scientific artefacts were not only produced through mutual reference between Eastern and Western experiences, but also measures of instrumental rationality employed by postwar internationalists to engineer their modernity in the Global South.

LONG ABSTRACT

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This thesis considers the history of trauma, both as a psychiatric concept and as a diagnosis, and its social and cultural representation from a transnational perspective after World War II. The history of trauma not only illustrates the transformation of a disease concept, but also highlights the multiple influences acting to shape such concept. The intellectual evolution of trauma was not only determined by various medical, social, and cultural variables, but also affected by institutions and people who wielded strong influence in the postwar world order as well as diverse local contexts.

My thesis traces the trajectories by which a psychiatric topic became socially and culturally mediated in the course of its global and local transformation. Specifically speaking, it focuses on the globalisation of such concept and diagnosis shaped by the World Health Organization and its localisation by mental health practitioners at the National Taiwan University Hospital. The former acted for the global health authority to engineering their rationales in developing countries, and the latter represented a typical laboratory to realise the former's imagery. These sites form scenarios for a transnational history of psychiatry to occur, not only allocating the exchange of Eastern and Western knowledge and experiences, but also permitting

the measures of instrumental rationality employed by postwar internationalists to impose their modernity in the Global South.

Among historians who have criticised the universality and the Anglo-American-centred approach to the history of trauma, some have begun to explore *transnational* histories of psychiatry on various psychiatric topics. Their methods of enquiry and problems solved, however, differ. As emphasised by Joy Damousi and Mariano Ben Blotkin, the concept of 'transnational' addresses both the qualitative nature of a subject and a particular historical approach. It focuses on the movement, flow, circulation, and intersection of people, ideas, and goods across political and cultural borders. Waltraud Ernst and Thomas Mueller attempt to define their transnational approaches as systemic comparison, transfer, shared history, connected history and historie croisée of psychiatric themes. Inspired by the initiatives made by Akira Iriye, Glenda Sluga and Sunil Amrith and other historians, who have called attention to the importance of studying international institutions, my research analyses a disparate collection of evidence at the level of international organisations and from local aspects, allowing not only a critical reconsideration of trauma in the trend of global medicine, but also its reception, contestation and appropriation in the non-Western contexts.

Guided by the works of medical historians, literary critics and cultural anthropologists, this project combines archival research with oral history interviews across the UK, Switzerland and Taiwan, to challenge the existing historical accounts of trauma, and provide evidence of the limited capacity of globalised psychiatric

norms and their reception and appropriation beyond the imagination of world citizenship.

Regarding the WHO, in this thesis I scrutinise the following aspects: the organisation's historical origin; the ancestry of its mental health projects; bureaucratic structures and international relations that obstructed its development; and the flowed imagination of early mental health experts as they devised theories and assumptions on the workings of the human mind. Concerning the development of psychiatry in Taiwan, the 'Free China' that was targeted by the WHO to develop a template for engineering its rationale in the times of Cold War, I discuss the following themes: the benefit of WHO efforts in Taiwan; historical grounds for the works of international organisations in developing Taiwan, the reasons Taiwan actively participated in international medical research; and the problems cause by Taiwan's zeal in following global standards.

The key findings of my thesis suggest that trauma, a much-debated concept in the history of medicine, was globally diffused by at least three trends. First, mental health experts who witnessed the price paid by human beings in World War II, and the postwar socio-cultural changes, were prompted to investigate the aetiology of mental illnesses. Based on the aspiration of world citizenship, these professionals envisaged international collaboration in psychiatric research. In this phase, trauma was still a vague concept. Second, the emerging international organisations, such as the World Health Organization analysed in my thesis, provided a platform for international collaboration and mobilised a unique form of knowledge production. The common language programme and the attempt to unify psychiatric disease

profiles laid an important foundation for diseases to be recognised, classified, and treated worldwide. Third, although the paradigm of modern psychiatry had been established, the world standards or psychiatric norms were unable to fully account for extreme forms of social suffering in local contexts such as that of Taiwan. How Taiwanese psychiatrists adopted various non-medical approaches in their own idiosyncratic ways to address the suffering among Taiwanese people due to political violence stands out as a unique example of the limited globalised scientific standards and specific articulations developed between national citizenship and transnational norms.

Part I of this thesis examines the existing historical themes and connotations of what I term the transnational trauma in the re-oriented world order after the WWII, and the specific context of its emergence.

Chapter 1 introduces the methodology employed in the thesis and in previous works that culminated in the current study. I first answer a set of questions: What is transnational history? Why should one analyse trauma and psychiatry using the approach of transnational history? I refer to the words of proponents of this historical inquiry, and present working definitions and elements that compose transnational history. I also introduce the characteristics of transnational history, especially the advantages of this method for portraying a global notion of medical practice. In the literature review, I first introduce important trauma studies, analysing their impact on historical studies and on how trauma has been accounted for in history. Second, I narrow the scope of my focus to psychiatry. I introduce previous historical research on trauma as a psychiatric subject and on other transnational accounts of modern

psychiatry, explaining their contributions and shortcomings. Finally, I justify the choice of the WHO in Geneva and the Psychiatric Department of National Taiwan University Hospital as the main foci of my research.

In Chapter 2, I delineate the context of the 'glocalisation' of modern psychiatry in Taiwan. The focus is on studies of postwar mental health issues in Taiwan and on theoretical reconstruction of the Department of Psychiatry at National Taiwan University under the first ethnic Taiwanese psychiatrist, Tsung-Yi Lin. I review the re-institutionalisation of psychiatry in the context of the termination of Japanese colonisation. This is followed by a review of the construction of modern psychiatry by ethnic Taiwanese psychiatrists, without government support; in this section I employ comparative psychiatry to analyse the early studies produced by Taiwanese psychiatrists. I then propose three focal points of the 'mind reconstruction' processes in postwar Taiwan. First, I discuss the characteristics of decolonisation and the attempt to construct an autonomous Taiwanese psychiatry. Second, I argue that prior research using comparative psychiatry in Taiwan has been based on the tension between the recognition of self and others in the milieu of the government handover. During that period, massive immigration and the legacy of political violence formed the historical context for the surfacing of so-called traumatic narratives from events such as the 2.28 Incident and the White Terror. These narratives were later embodied in medical terms. Third, although the paradigm of 'Taiwanese psychiatry' had not yet been constructed, the epidemiological methods applied by the early psychiatrists created the foundation of a new methodology. This new psychiatric methodology pushed Taiwan onto the international stage, catalysing the development of psychiatric instruments by the WHO from the 1960s onwards.

The Part II of the thesis marks out the globalization of psychiatric norms in the context of the WHO, including the early initiatives of the Mental Health Section regarding its objectives of world citizenship, and the 'manageable programme' of international scientific collaboration realized in the 1960s and 1970s.

Chapter 3 examines the role of the WHO in promoting international mental health. This initiative was intended as a rehabilitative endeavour to help people face the psychological devastation of the postwar period. In the first chapter, I explain the framework within which the globalisation of psychiatric subjects occurred through the joint effort of various international agencies, both organisations and people. In the third chapter, I regard the WHO as a specific framework for the globalisation of mental health issues. Topics in this section include the global awareness of mental rehabilitation; the strengthening of the link between psychiatry and public health; and the era of large-scale, cross-cultural studies of mental health. These attempts, I argue, closely relate to the central idea of 'world citizenship' coined by Brock Chisholm, the first director of the WHO. World citizenship presumes the universality of humanity and the hidden aspiration of promoting peace. These concepts shaped the basis of the WHO's scientific practice.

My analysis reviews the manner in which psychiatric professionals addressed war-related trauma among soldiers before and during the war, before reaching out to civilians. Second, I suggest that the World Congress on Mental Health held in 1948 in London was the turning point of international mental health. This particular event transformed psychiatry from a science regulating social deviants into a discipline

concerned with all members of society. Moreover, I demonstrate the concatenation of psychiatry and public health, which gave birth to a new paradigm of psychiatry: *psychiatric epidemiology*. Finally, I describe the early projects conducted at the Mental Health Section of the WHO. This section of my thesis examines the meanings and functions of these projects and the extensive preparation behind the 1965 cross-cultural study, which provided the skeleton for mental health awareness in non-Western 'developing' countries.

Chapter 4 comments on the first large-scale international study of mental health conducted by the WHO. Proposed by Tsung-Yi Lin and his colleagues, this 10-year project established the foundation of international mental health research. The chapter includes three parts: the background of the project, its content, and its aftermath. By reviewing relevant international work, I illustrate both the accomplishments and the limitations of the WHO's ideology.

Firstly, I examine the cultural milieu of the psychiatric field in the early 1960s, when the international research was undertaken. In the second part of the chapter, I analyse the actual content of the WHO's 10-year project, including the renowned classification and standardisation of psychiatric diseases, and pilot studies in cross-cultural methods of assessment and diagnosis. These two aspects of the project created not only a common global language but also useful instruments for future research, such as diagnostic methods and statistical procedures. The results of the International Pilot Study of Schizophrenia convinced many people of the viability of international and cross-cultural research. They also seemed to confirm the presumptions on the 'universal mind' made by the founders of the WHO.

Unfortunately, the 10-year project was left unfinished, and the achievement of the WHO was later challenged as flawed by psychiatric anthropologists who conducted the field work for the project. The so-called 'category fallacy', for example, was reflected in the work of Arthur Kleinman, who studied 'depression' and 'neurasthenia' in Taiwan and China. My interviews with people involved in such initiatives clarified the pros and cons of these international efforts in the field of psychiatry. This thesis reviews some of the achievements made by these people as well as the setbacks they had faced.

Part III of the thesis returns the focus of this transnational history to Taiwan. Throughout both chapters, I demonstrate the historical background concerning Taiwanese psychiatrists' independent professionalism, and how it helped transforming trauma regarding its roles and functions in and outside of medical fields.

In Chapter 5, I first briefly introduce several sociological and historical analyses of the role of Taiwanese doctors under Japanese colonial rule, arguing that they were not only physicians who resolved patients' ailments, but also social activists who attempted to diagnose society. Other scholars have analysed the character of Taiwanese elites and have concluded that such elites acted as agents in the production of colonial modernity during Japanese colonial times. In my opinion, these phenomena continued into the postwar period. I argue that during the 'silent' period of the Taiwanese postwar social and cultural crackdown, and with the special background of the medico-political relationship, the discourse of trauma served the purpose of cultural production. Psychiatrists practicing outside of their field 'produced' this culture by their opinions, which were influenced by the responsibility

that psychiatrists felt towards society and to their sense of professional ethics. In addition, their literary practice can be considered a strategy to bypass the environment of censorship and to sublimate their desire to comment directly on society.

In Chapter 6, I present three cases to analyse the nature, characteristics, and purposes of different concepts of traumas, and to highlight the meaning and function of psychiatric language before and after the globalisation of modern psychiatry. My discussion includes a look at the limitations that psychiatry faces in a local context. In the first part, I analyse the research by Naka et al. conducted during the WWII era. Naka et al. examined the psychoneurological symptoms among 389 Taiwanese patients after an earthquake in 1935. Their argument supports the discourse of tropical neurasthenia used by the Japanese colonists to justify their attitude of racial superiority.

In the second part, I examine how 'psychological trauma', broadly defined, was documented in the case registries that were kept untouched by the Department of Psychiatry at National Taiwan University Hospital in the early postwar period. These patient registries show the complexity of psychological trauma as it was conceived during the conflicting cultural context of post-colonial Taiwan. They also illustrate the transformation of the concept of trauma during shifts in psychiatric paradigms, and the controversial and subjective nature of related medical diagnoses. These cases not only emphasise the multiple factors that shape 'trauma-related' disorders, such as language capacity, extreme experiences, changing social structure, and so forth; they also illustrate the lack of clarity confronted by a psychiatrist in attempting to explain the nature of trauma.

In the third part, I describe the social practice of psychiatrists concerning the 2.28 Incident. This section examines how Taiwanese psychiatrists applied their professional theories to their political aspirations, facilitating a movement of peace and justice against state violence, and implementing social campaigns after the lifting of martial law in the 1980s. I demonstrate how these psychiatrists surpassed the boundaries of 'diagnostic psychiatry' and opened a dialogue between the psychiatric profession and the public domain. This analysis explains how the 'trauma' theme functioned outside the field of clinical medicine. By portraying these three cases, I illustrate how trauma was represented in a cross-cultural context during the postwar 'traumatic era'. During the same period, international psychiatry began to develop useful tools in response to industrialisation, urbanisation, immigration, and other global phenomena. I argue that the 'styles' and even 'genre' of trauma varied according to circumstance, with the greatest diversity being evident in non-Western social, economic, and political settings.

Finally, the conclusion to this thesis reviews the main themes presented, and considers the 'afterlife' of trauma during the ongoing work of reclassification in modern psychiatry.

TRANSNATIONAL TRAUMA:
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Thesis submitted to the Faculty of Modern History, University of Oxford, for the Degree of Doctor of Philosophy.

TRINITY TERM 2012.

To my parents, for your inspiration and support.

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List of Abbreviations and Acronyms

APA – American Psychiatric Association
ABMAC – American Bureau for Medical Advancement in China
CMB- China Medical Board
DHSS – Department of Health and Social Security (UK)
DOSMED - The Determinants of Outcome of Severe Mental Disorders
DSM – Diagnostic and Statistical Manual of Mental Disorders
FAPA – Formosan Association of Public Affairs
FRCs – Field Research Centres
IAEA – International Atomic Energy Association
ICD – International Classification of Diseases
IOP – Institute of Psychiatry
IPSS – International Pilot Study of Schizophrenia
JFMA –Journal of Formosan Medical Association
KIMG - Kuomintang, Intelligence, Military and Government Complex
KMT – Kuomintang, a.k.a Guomindang, Chinese Nationalist Party
LSTHM – London School of Tropical Hygiene and Medicine
MOFA – Ministry of Foreign Affairs
NATO – North Atlantic Treaty Organization
NATPA – North American Taiwanese Professors' Association
NATWA – North American Taiwanese Women's Association
NIMH – National Institute of Mental Health
NTUH – National Taiwan University Hospital
OIHP – L'Office International d'Hygiène Publique
PAHO – Pan American Health Organization
PASO – Pan American Sanitary Organization
PSE – The Present-state Diagnostic Tool
PTSD – Post-traumatic Stress Disorder
PUMCH – Peking Union Medical College Hospital
ROC – Republic of China
SVFs – Surviving Victims and Families
TPPA – Taiwan Province Physician Association
UN – United Nations
UNRRA – United Nations Relief and Rehabilitation Administration
USAID – United States Agency for International Development
WFMH – World Federation for Mental Health
WHO – World Health Organization

'What does a psychologist report? What does he observe? Isn't it the behaviour of people, in particular their utterances? But these are not about their behaviour.'[1]

-- Ludwig Wittgenstein

[1] Ludwig Wittgenstein and G. E. M. Anscombe, *Philosophical Investigations* (New York: Macmillan, 1953) p. 133.

Introduction

This thesis considers the history of trauma, both as a globalised psychiatric concept and as a diagnosis, and its social and cultural representation from a transnational perspective after World War II. The history of trauma not only illustrates the transformation of a disease concept, but also highlights the multiple influences acting to shape that concept. The intellectual evolution of the concept of trauma was determined by various medical, social, and cultural variables, institutions, and people who wielded strong influence in the postwar environment.

Early postwar Taiwan experienced drastic social and cultural changes during the era of decolonisation and the handover between two political regimes and wider social contexts regarding the newly oriented international relations. Soon after the defeat of Imperial Japan in September 1945, Taiwan was placed under the control of the Republic of China (ROC), led by the Chinese Nationalist Party. Before the central government of the ROC was relocated to Taiwan in 1949, an interregnum was established as the highest administrative government, namely, the Office of the Chief Executive of Taiwan Province (台灣省行政長官公署). Chen Yi's corrupt administration and a lack of discipline in the military police severely undermined the chain of command. and this poor governance led to economic hardship and social unrest. In addition, cultural estrangement occurred between the growing population of migrants from the mainland and the residents of the island whose families had resided there since before the war. These tensions resulted in the rapid spread of social

upheaval across the entire island, not only against Chen Yi, but also between different ethnic groups.

On February 28, 1947, the arrest of a cigarette vendor by government agents during an anti-government uprising led to the death of a bystander and a subsequent civilian massacre. This event became known as the 2.28 Incident. Weeks later, government troops were sent from the mainland to manage the crisis and suppress opposition or resistance to the government in Taiwan. The 2.28 Incident was a prelude to an era of heavy-handed governing, which included a policy of clearing villages (qingxiang, 清鄉), the introduction of Martial Law (as of May 19, 1949), and the long-lasting White Terror period that began in the 1950s. These measures, which were enforced for four decades, resulted in enormous anxiety in the civilian population and left a legacy, the impact of which is difficult to estimate.

In the closing remark of a paper reflecting on the optimal method for managing the suffering among victims of the 2.28 Incident,[2] Tsung-Yi Lin (1998) wrote the following:

> One of the most important problems remaining to be resolved is that of finding a proper place for 2.28 in Taiwanese history. […T]he society as a whole should find ways, preferably through consensus, for dealing with this unique and painful experience and the manner in which it should be remembered. For such a difficult transition from dictatorship to democracy in

[2] The 2.28 Incident (Chinese: 二二八事件) was an uprising in Taiwan that began on February 28, 1947, and was brutally suppressed by the Kuomintang (Nationalist Party) government, resulting in more than 20,000 civilian deaths. Official government policy repressed education on the events until recently, for various reasons. Many of the details of the incident are still highly controversial and are hotly debated today.

> Taiwan, the German experience with dictatorships in this century would be of interest when in search of possible clues to help Taiwan learn about "dealing with the past."[3]

Lin (1920-2010) was the first ethnic Taiwanese psychiatrist. In this passage, Lin was referring to both the Nazi regime of World War II and the Communist Government of East Germany, which persisted for four decades until the fall of the Berlin Wall in 1989. The Soviet Union, which had attempted to maintain eastern satellite states as a buffer against the United States and NATO, collapsed shortly thereafter in 1991. In 1987, close to the end of the Cold War, Lin—who had been blacklisted and was living in Japan— seized the opportunity to return to his homeland when martial law was lifted in Taiwan. During his short stay, he extensively interviewed survivors and families of the victims of the 2.28 Incident and the consequent White Terror period. Lin had been inspired by the grief research conducted by the Boston psychiatrist Erich Lindermann, with who he had worked while studying abroad in 1951 and 1952. Lin thus identified the five-stage pathological manifestations of suppressed or delayed grief among his interviewees.[4]

Lin assumed that the surviving victims and their families (SVFs) suffered from psychological distress similar to that of post-traumatic stress disorder (PTSD). To treat their suffering, however, Lin did not propose a medical or psychiatric

[3] Tsung-Yi Lin, 'Confrontation or Reconciliation? Violent Oppressors Vs. Miserable Survivors', in Tsung-Yi Lin (ed.), *An Introduction to 2-28 Tragedy in Taiwan: For World Citizens* (Taipei: Taiwan Renaissance Foundation Press, 1998), 135-75. p. 165.

[4] The paper Lin consulted in drafting his own was Erich Lindermann's 'Symptomatology and Management of Acute Grief', *American Journal of Psychiatry,* 151/2 (1944), pp. 155-60. Lindermann studied the families and relatives of victims who died in the 1942 fire at Coconut Grove, the renowned nightclub during the post-Prohibition period in Boston. Lindermann read this paper at the Centenary Meeting of the American Psychiatry Association in May 1944 and published it in September of the same year. This paper is considered pioneering research on post-traumatic stress disorder.

prescription. Instead, he endorsed a political intervention. This story is significant for several reasons. First, Lin recommended using the method that the German government had devised to compensate the victims of dictatorships; he believed this method would provide appropriate measures to compensate the 2.28 victims. Lin's choice highlights the nature of collective trauma. In other words, such suffering does not "belong" to a single population, whether that of a country, nation, or ethnic group. It is, instead, *transnational*. Second, as a psychiatrist, Lin observed the intricate mechanisms of suffering that had developed among victims. He found that their suffering resembled that of patients experiencing PTSD, yet could not be fully accounted for by that specific diagnosis, and could not be treated by simply using the theoretical frameworks and recommendations of modern psychiatry. Thus, Lin approached the problem with a radical political stance that was informed by projects of transitional justice in other post-conflict states, rather than attempting to treat the symptoms of individual victims. Lin's approach illustrates the limitations of the diagnosis of PTSD and modern psychiatry in general in addressing events such as the 2.28 Incident.

The diagnosis of PTSD is a feature of modern diagnostic psychiatry. It appeared for the first time in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) published by the American Psychiatric Association in 1980. It was also included in the tenth edition of the International Classification of Diseases (ICD-10), compiled by the World Health Organisation in 1992. These diagnostic systems emerged after World War II to facilitate communication between psychiatrists in different countries. The aim was to provide a baseline to classify challenging cases among people with severe personal disturbances caused by trauma.

The consistency in classification was theoretically convenient. It enabled mental illness to be identified and treated in a wide range of settings, using a set of diagnostic characteristics that would be applicable across various cultures and different personal experiences. In brief, anyone anywhere in the world could have been diagnosed with a certain mental disorder if they met the diagnostic criteria. Whether specific diseases actually exist would be subject to the development of these diagnostic standards over the course of history. This thesis assumes that the transnational applicability of the PTSD diagnosis is due not only to the universality of trauma-related suffering, but also to the global standardisation of disease classification.

The standardised classification of psychiatric diagnoses was one of the projects undertaken by the World Health Organisation after World War II for postwar rehabilitation of people's mental health. The total devastation wreaked by the "ultimate war"—the Holocaust in Europe, the atomic bombs dropped on Hiroshima and Nagasaki, and the extensive firebombing of German and Japanese cities—meant that the victims of World War II were both civilian and military. In the early postwar period, people were confronted not only by the destruction of war and the ruins of its aftermath, but also by the great changes caused by rapid industrialisation and urbanisation.

In this environment, mental health experts undertook a large-scale, cross-cultural study to understand the aetiology of mental illness. They attempted to identify stressors that would trigger specific mental illnesses over a person's life. During this period, when the pathology of psychiatric diseases was still unclear, the WHO provided assistance by tracking experts worldwide and offering them the opportunity

to participate in mental health projects in developing countries. Psychiatrists also sought a common language to communicate with each other, catalysing the standardised classification of psychiatric diseases. The phase-based projects of the WHO provided an optimistic picture of global mental health because they expressed an intrinsic optimism as to how mental health could be managed and improved. The WHO policy ultimately implied that international collaboration is feasible, and that the profiles of psychiatric diseases might be universal.

Each chapter of this thesis examines a different aspect of the historical process of globalisation and localisation (occasionally referred to as 'glocalisation') of psychiatric diagnoses, emphasizing the issue of trauma. Analysis of the intellectual history in this thesis was conducted mainly at two institutions: the Mental Health Unit of the WHO and the Psychiatric Department of National Taiwan University Hospital. The discussion also details the examination of the broader roles these two central institutions played in the course of psychiatric history. Regarding the WHO, in this thesis I scrutinize the following aspects: the organisation's historical origin; the ancestry of its mental health projects; bureaucratic structures and international relations that obstructed its development; and the flawed imagination of early mental health experts as they devised theories and assumptions on the workings of the human mind. Regarding the development of psychiatry in Taiwan, I discuss the following themes: the benefit of WHO efforts in Taiwan; historical grounds for the works of international organisations in developing Taiwan; the reasons Taiwan actively participated in international medical research; and the problems caused by Taiwan's zeal in following global standards. Furthermore, I provide case studies in which

Taiwanese psychiatrists appropriated the discourse of trauma outside of hospitals to account for the social suffering of Taiwanese people.

Objectives of the research

This thesis proposes a transnational method of inquiry into the history of psychiatry. Among the proliferating research into transnational histories of medicine, mental health issues are gradually garnering more attention. Traditionally, the focus has been on other topics, such as the impact on infectious diseases through imperial expansion, colonisation, war, travel, and commerce. The transnational histories of psychological or psychiatric topics, however, remain predominantly Eurocentric or are typically focused on the colonial context. This thesis breaks from this pattern by providing a historical analysis of globalised mental health issues. In addition, it provides an alternative approach to what has been construed as trauma in the history of medicine. Historians have searched for sources that provide a reliable account of trauma, including the concept of trauma in medical science, hospital records and case histories in specific institutional settings, and even in literature and art.[5]

This thesis regards trauma not only as the alteration of mental status by external reality, but also as an actual disease that has the potential to be insidiously and paradoxically entrenched by the practice of mental health professionals. For the first definition of trauma, namely, an alteration of mental status by external reality, mental health professionals were aware of the existence of a problem but were unable to

[5] See Mark S. Micale and Paul Frederick Lerner, 'Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction', in Mark S. Micale and Paul Frederick Lerner (eds.), *Traumatic Pasts : History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge Studies in the History of Medicine; Cambridge: Cambridge University Press, 2001b), pp. 1-30.

define its nature. Later, diseases related to trauma emerged and became institutionalised and globalised through the practices of mental health professionals. Moreover, this thesis supplements the current studies of trauma in East Asia. Previous studies have tended to graft Western theories onto a non-Western context, rendering the concept of trauma and its application a fairly crude cultural import. Any research that hopes to provide additional insight would necessarily have to work more precisely and definitively from within the Eastern context.

Most historical writings on scientific or medical subjects in non-Western contexts focus on the diffusion or exchange of ideas between the East and the West. This thesis, however, concentrates on a substantially more extensive context by examining the same paradigm through the lens of Global North and South. Through this and other methods, a persuasive argument can be propounded, that psychiatric diagnoses are not only scientific artefacts produced through mutual reference between Eastern and Western experiences; such diagnoses are also measures of instrumental rationality employed by postwar internationalists to engineer their modernity in the Global South. My research revealed that Taiwan, which sat the membership of China in the United Nations and its specialised agencies from 1948 to 1971, was a developing country that was actively collaborated with and simultaneously imposed upon. The exchange of information between the WHO and Taiwan was not a diffusion of knowledge from developed countries to a latecomer, but rather a process mutually constructed by various contributors with their own interests and purposes. I will demonstrate why Taiwan enjoyed the opportunity to play such a central role in international, collaborative mental health research after World War II. The WHO expressed a desire for Taiwan to become one of its research outposts; in addition, the

WHO was experiencing a shortage of resources and was hindered by the postwar international relations environment. Taiwan thus became a local outpost to which the WHO could outsource research. The mental health programme envisioned by the WHO had different objectives from those of Tsung-Yi Lin's survey of psychiatric diseases in Taiwan. However, the WHO took great interest in Lin's statistical methodology, which was inspired by public health research. This interest was one of the contingent links between the WHO and Taiwan, and fuelled the internationally collaborative process of knowledge production.

Finally, this thesis also analyses the range of factors that facilitated Taiwan's vigorous participation in international research from a local perspective. In the process I attempt to move beyond a simple analysis of Taiwan's shared aspirations with other countries taking part in the enterprise of global postwar rehabilitation. This thesis is not merely concerned with the actions of countries and individual players in shaping the postwar diagnosis of mental illnesses, or the efforts of such players to maximize their own influence in the psychiatric field. It is on the broader topic of trauma, and how the discourse related to trauma was appropriated during the historical process. Accordingly, a historical analysis is offered of the internal factors that allowed appropriation of the concept and discourse of trauma in a non-Western setting. Interpretation that is additive to the extant studies concerning the 2.28 Incident, which has been extensively researched during the last two decades, is also presented.

Several scholars have discussed the traumatic and catastrophic nature of Chinese history.[6] In Taiwan, the legacy of the 2.28 Incident and the consequent vicissitudes of political violence are widely regarded as traumatic experiences that have been (and continue to be) retrospectively diagnosed by historians. For example, with reference to the collective memory of 2.28, historian John Cooper notes that 'Many Taiwanese recall the incident with ill-feeling.'[7] One of Taiwan's leading historians, Yen-Hsien Chang (張炎憲), responsible for establishing an oral history database, used personification to describe the 2.28 Incident and the White Terror as the darkest events in Taiwan's history. He stated, 'In the past, the horror and sorrows of this period of history could only weep at night, being invisible in the society. Thus, many historical facts had been forgotten, subject to the withering of political prisoners.'[8]

Another historian, Xiaofeng Li (李筱峰), published a commentary on the 2.28 Incident, in which he described the tragic impact it had on the residents of Taiwan. Li postulated that the event left Taiwanese citizens more submissive than they had been previously, with a new fear of politics. Without directly employing the word 'trauma', Li elucidated the psychopathology and psychological impact of the 2.28 Incident on the Taiwanese population.[9]

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[6] Ban Wang, 'Postrevolutionary History in a Traumatic Key', in Ban Wang (ed.), *Illuminations from the Past: Trauma, Memory and History in Modern China* (Stanford: Stanford University Press, 2004a), pp. 93-178.

[7] John Franklin Copper, *Historical Dictionary of Taiwan (Republic of China)* (3rd ed.) (Historical Dictionaries of Asia, Oceania, and the Middle East; Lanham, Md.: Scarecrow Press, Inc., 2007) xliii, p. 337.

[8] Yen-Hsien Chang, 'Preface', in Ying-Tai Chen (ed.), *Memory and Testimony of the White Terror* (Taipei: Tangshan, 2005).

[9] Xiaofeng Li, *Intepretation on the 2.28 Incident* (Taipei: Yushan Publication Co., 1998b). p. 208.

The philosopher Xiaopo Wang, another pioneer of the 2.28 studies, explicitly visualised the legacy of the Incident as an ailment: 'The wound cannot be cured if there is no therapy. Those Taiwanese people who could not bear the irony of history then walk on the track of "Taiwan for independence". How should we treat this historical wound and reconstitute the togetherness of the nation without making reparations for the 228 Incident?'[10]

Employing the concept of psychoanalysis, a poet voiced: 'The memory and discovery of the 2.28 Incident is an important lesson of Taiwanese *Geistesgeschichte*, because this evanescent experience of history, which resembles a nightmare, represses the psyche of Taiwanese people, and distorts their citizen personality.'[11]

Amid writings on the 2.28 Incident and the White Terror, both artistic and scientific disciplines reached a consensus on the psychiatric terminology of trauma. In the opinion of poet Ming-Yung Li (李敏勇), literature written on these events reflects the poverty of memory and the particular challenges of attempting to recall something traumatic. His title "The Physiology and Pathology of Postwar Taiwanese Literature" emphasised the general neglect of postwar *Geistesgeschichte* amongst the Taiwanese people.[12]

The use of terms such as 'pathology' and 'trauma' was not unique to poets, but was also evident in the words of a celebrated novelist, Qiao Li (李喬), who stated:

[10] Xiaopo Wang, 'The Healing of Historical Wound', in Xiaopo Wang (ed.), *The Facts of the 2.28* (Taipei: Strait Academics, 2003). p. 397.
[11] Ming-Yung Li, *Memory and Discovery in Flowers Blossoming on the Wound: 228 Poetry Collection* (Taipei: Yushan Publication Co., 1997). p. 6.
[12] Ibid.

'Would "2.28" not affect people who did not experience the 228 Incident? It touches [on] the point whether the trauma brought about by "228" will be "inherited" or "remained" [sic] to the next generation?'[13] He mentions that 'inherit' refers to human physiology, whereas 'remained' (or 'passed on') implicates myths, arts, literature, and other creative works that keep the memory of the incident culturally alive. In the same paper, Li employed the term 'post-2.28 syndrome' to describe the sense of heaviness that persists a half-century after the event.[14] Overall, these various opinions expressed by both the medical and artistic communities show the degree of consensus on the past and current mental states birthed by the 2.28 Incident.

Health professionals began studying the psychology of the 2.28 Incident two decades ago, thus, almost forty years after the actual event. The most recent report on the attribution of responsibility for the 2.28 Incident notes the injury caused to the collective Taiwanese psyche, stating that this event 'shocks Taiwanese people's psyche, leading up to their chronic fear and indifference about politics.'[15] Thus, regarding interpretations of the 2.28 Incident, trauma is viewed both as a literary hyperbole and as a psychiatric diagnosis by mental health workers and humanities scholars alike. However, few people from either of those two camps have reflected on the historical process by which the concept of trauma was branded onto non-Westerners. To remedy this gap from both a global and a local perspective, I inspect the relationship between historical events recognised as 'traumatic' and the manner in which psychiatric professionals and their collaborators have accounted for the

[13] Qiao Li, 'The Meaning of '228' Regarding Taiwanese Geistesgeschichte', in Yen-Hsien Chang, Mei-Jung Chen, and Ya-Hui Yang (eds.), *Anthology of the 228 Incident Studies* (Taipei: Wu San-lian Foundation For Taiwan Historical Materials, 1998a), pp. 397-408, p. 398
[14] Ibid. p. 401
[15] Chin-Huang Chen, *The Responsibility Attribution of the 228 Incident Investigation Report* (Taipei: The 2.28 Incident Foundation, 2005). p. 77

sufferers in these events. This approach helps clarify the relationship between the psychiatric language used to describe an individual's suffering and that which is appropriated as historical witness.

Notes on Sources

This thesis draws on the works of medical historians and scholars of trauma studies, combining archival research with supplemental oral histories. It examines the preceding historical accounts, which (as noted earlier) were mostly constrained in scope to the approaches espoused by Western-oriented theorists. The primary sites examined in this transnational history are the WHO and the Psychiatric Department of National Taiwan University Hospital; the dynamics between these two institutions are also reviewed at length. Therefore, most of the historical material was gathered in Geneva and Taipei. Relevant documents included official records, correspondence between headquarters and mental health experts identified worldwide, and the personal papers of core personnel in the WHO mental health programmes. Beyond the two main institutions, source material was obtained from the National Archives at Kew; from the archival services of the University of London, Queen Mary, and the Institute of Psychiatry, King's College London; and from the Head Hospital Archives at St Hugh's College, Oxford. Material collected in Taiwan included documents from the archives at the Institute of Modern History, Academia Sinica (中央研究院近史所), Archives of Academia Historica (國史館), and Taiwan Historica (台灣文獻館).

One of my interviewees, Professor Hsien Rin, kindly granted me access to the patient registries kept by the Psychiatric Department at National Taiwan University

Hospital. The final chapter of this thesis includes a review of the material, and as far as I am aware, to date no other studies have used this particular source. In addition, oral interviews were conducted with people who participated in the early international mental health projects, such as the International Pilot Study of Schizophrenia and the International Classification of Psychiatric Diagnoses. I also interviewed members of the first generation of Taiwanese psychiatrists, most of who had had direct contact with the key subject of my thesis Tsung-Yi Lin (林宗義). Lin was an advisory expert and later Medical Officer at the Mental Health Unit of the WHO. The degree of Lin's accomplishment is considerable when one reflects on his status as the first ethnic Taiwanese psychiatrist; he was also the first head of the Psychiatric Department at National Taiwan University Hospital.

This thesis focuses on the globalisation and localisation of psychiatric diagnoses shaped by international and local mental health professionals. It does not examine the voices of the mental health patients or trauma victims themselves, which are seen squarely in today's history of psychiatry. This point constitutes the main limitation of my enquiry.

Thesis Structure

The first chapter is entitled "The Scope of Enquiry: Why Transnational, Why Trauma, Why Postwar World Psychiatry, and Why Taiwan?" This chapter introduces the methodology employed in the thesis and in previous works that culminated in the current study. I first answer a set of questions: What is transnational history? Why should one analyse trauma and psychiatry using the approach of transnational history?

I refer to the words of proponents of this historical inquiry, and present working definitions and elements that compose transnational history. I also introduce the characteristics of transnational history, especially the advantages of this method for portraying a global notion of medical practice. In addition, I explain the manners in which transnational history differs from world or global history.

In the literature review, I first introduce important trauma studies, analysing their impact on historical studies and on how trauma has been accounted for in history. Second, I narrow the scope of my focus to psychiatry. I introduce previous historical research on trauma as a psychiatric subject and on other transnational accounts of modern psychiatry, explaining their contributions and shortcomings. Finally, I justify the choice of the WHO in Geneva and the Psychiatric Department of National Taiwan University Hospital as the main foci of my research.

The second chapter is entitled 'From Cultural Psychiatry to Psychiatric Epidemiology: the Re-Institutionalisation of the Psychiatric Department at National Taiwan University Hospital'. In this chapter I delineate the context of the 'glocalisation' of modern psychiatry in Taiwan; in other words, the globalisation of certain ideas made local. The focus is on studies of postwar mental health issues in Taiwan and on theoretical reconstruction of the Department of Psychiatry at National Taiwan University. In the opening pages I review the re-institutionalisation of psychiatry in the context of the termination of Japanese colonisation. This is followed by a review of the construction of modern psychiatry by ethnic Taiwanese psychiatrists, without government support; in this section I employ comparative psychiatry to analyse the early studies produced by Taiwanese psychiatrists. I then

propose three focal points of the 'mind reconstruction process' in postwar Taiwan. First, I discuss the characteristics of decolonisation and the attempt to construct an autonomous Taiwanese psychiatry, with reference to my primary sources. Second, I argue that prior research using comparative psychiatry in Taiwan has been based on the tension between the recognition of self and others in the milieu of the government handover. During that period, massive immigration and the legacy of political violence formed the historical context for the surfacing of so-called traumatic narratives from events such as the 2.28 Incident and the White Terror. These narratives were later embodied in medical terms. Some of these studies characterised the inner-Asian identity struggle of the Taiwanese people. Third, although the paradigm of 'Taiwanese psychiatry' had not yet been constructed, the epidemiological methods applied by the early psychiatrists created the foundation of a new methodology. This new psychiatric methodology pushed Taiwan onto the international stage, catalysing the development of psychiatric instruments by WHO from the 1960s onwards.

The third chapter, entitled, 'The WHO's New Paradigm in Psychiatric Science after World War II, 1948–c.1961', examines the role of the WHO in promoting international mental health. This initiative was intended as a rehabilitative endeavour to help people face the psychological devastation of the postwar period. In the first chapter, I explain the framework within which the globalisation of psychiatric subjects occurred through the joint effort of various international agencies, both organisations and people. In the third chapter, I regard the WHO as a specific framework for the globalisation of mental health issues. Topics in this section include the global awareness of mental rehabilitation; the strengthening of the link between

psychiatry and public health; and the era of large-scale, cross-cultural studies of mental health. These attempts, I argue, closely relate to the central idea of 'world citizenship' coined by Brock Chisholm, the first director of the WHO. World citizenship presumes the universality of humanity and the hidden aspiration of promoting peace. These concepts shaped the basis of the WHO's scientific practice.

My analysis reviews the manner in which psychiatric professionals addressed war-related trauma among soldiers before and during the war, before reaching out to civilians. Second, I suggest that the World Congress on Mental Health held in 1948 in London was the turning point of international mental health. This particular event transformed psychiatry from a science regulating social deviants into a discipline concerned with all members of society. Moreover, I demonstrate the concatenation of psychiatry and public health, which gave birth to a new paradigm of psychiatry: *psychiatric epidemiology*. Finally, I describe the early projects conducted at the Mental Health Section of the WHO. This section of my thesis examines the meanings and functions of these projects and the extensive preparation behind the 1965 cross-cultural study, which provided the skeleton for mental health awareness in non-Western 'developing' countries. The transformation of psychiatry in international health organisations can be viewed as a collective response among psychiatric professionals to postwar trauma. Not only organisations but also people were involved in the 'transnational' activities that facilitated the globalisation of mental health content. This transformation affected the spirit, philosophy, and attitude of the new psychiatric paradigm, as well as terminologies, instruments for research, and other factors related to the practice of the new science.

The fourth chapter, entitled, 'International Mental Health and Its Discontents: WHO's 10-year Project and its Challenges', comments on the first large-scale international study of mental health conducted by the WHO. Proposed by Tsung-Yi Lin and his colleagues, this 10-year project established the foundation of international mental health research. The chapter includes three parts: the background of the project, its content, and its aftermath. By reviewing relevant international work, I illustrate both the accomplishments and the limitations of the WHO's ideology.

In the first part of Chapter 4 (continuing from the conclusion of Chapter 3) I examine the cultural milieu of the psychiatric field in the early 1960s, when the international research was undertaken. In the second part of the chapter, I analyse the actual content of the WHO's 10-year project, including the renowned classification and standardisation of psychiatric diseases, and pilot studies in cross-cultural methods of assessment and diagnosis. These two aspects of the project created not only a common global language but also useful instruments for future research, such as diagnostic methods and statistical procedures. The results of the International Pilot Study of Schizophrenia (IPSS) convinced many people of the viability of international and cross-cultural research. Furthermore, the optimistic outcome of IPSS seemed to confirm the presumptions on the 'universal mind' made by the founders of the WHO.

Unfortunately, the 10-year project was left unfinished, and the achievement of the WHO was later challenged as flawed by psychiatric anthropologists who conducted the field work for the project. The so-called 'category fallacy' was reflected in the work of Arthur Kleinman, who studied 'depression' and 'neurasthenia' in Taiwan and China. In addition, a group of psychologists from

Chinese-speaking countries and municipalities (including Taiwan and China) attempted to establish a paradigm of 'Chinese native psychology'. These professionals emphasised the fundamental differences between the Chinese population and Westerners, and explained the inappropriateness of a Western hegemony in the psychological sciences. My interviews with people involved in such initiatives clarified the pros and cons of these international efforts in the field of psychiatry. This thesis reviews some of the achievements made by these people as well as the setbacks they had faced.

The fifth chapter, entitled, 'Social Practice of Taiwanese Psychiatrists', returns the focus of this transnational history to Taiwan. Following the argument made in the previous chapter on the discontent with international mental health, this chapter examines the roles and functions of trauma outside the medical field. By this stage in history, trauma was already an institutionalised official diagnosis in modern psychiatry, and its discourse was appropriated by Taiwanese physicians outside of medicine. The concept echoed that of 'social suffering', which influenced Taiwanese psychiatrists' activities beyond the scope of psychiatry. I first briefly introduce several sociological and historical analyses of the role of Taiwanese doctors under Japanese colonial rule, arguing that they were not only physicians who resolved patients' ailments, but also social activists who attempted to diagnose society. Other scholars have analysed the character of Taiwanese elites and have concluded that such elites acted as agents in the production of colonial modernity during Japanese colonial times. In my opinion, these phenomena continued into the postwar period.

In Chapter 5, I argue that during the 'silent' period of the Taiwanese postwar social and cultural crackdown, and with the special background of the medico-political relationship, the discourse of trauma served the purpose of cultural production. Psychiatrists practicing outside of their field 'produced' this culture by their opinions, which were influenced by the responsibility that psychiatrists felt towards society and to their sense of professional ethics. In addition, their literary practice can be considered a strategy to bypass the environment of censorship and to sublimate their desire to comment directly on society. In 1989, when martial law was lifted, the language of trauma became a touchstone for Tsung-Yi Lin and his psychiatrist colleagues to redress the 2.28 Incident. This scenario provided a linguistic background for the public to embark on other political rehabilitations.

The sixth chapter is entitled 'Vicissitudes of Trauma: Mental Consequences in Three Time Periods in Taiwan'. In this chapter I argue that the essence of trauma is the imposition of an emotional change wrought by an external reality that affects individuals or communities. This description echoes the working definition I set out in the introductory chapter. My primary aim is to illustrate discourse in trauma psychology during three distinct periods in twentieth-century Taiwan. I present these three cases (or periods) to analyse the nature, characteristics, and purposes of different concepts of traumas, and to highlight the meaning and function of psychiatric language before and after the globalisation of modern psychiatry. My discussion includes a look at the limitations that psychiatry faces in a local context.

In the first part of Chapter 6, I analyse the research by Naka et al. conducted during the WWII era. Naka et al. examined the psychoneurological symptoms among

389 Taiwanese patients after an earthquake in 1935, during the late phase of Japanese colonialism. By comparing these cases to others described in German medical literature, Naka et al. concluded that the suffering of the Taiwanese patients was neurological rather than psychogenic in nature. Symptom manifestation in these victims resembled what the German physician and anthropologist Erwin Bälz had defined as *Emotionslähmung*, a type of psychogenic acute psychosis. Naka et al. further compared this disorder with shell shock, and argued that the symptoms of *Emotionslähmung* in Taiwanese people were associated with altered autonomic nervous systems, influenced by the tropical weather. This argument supports the discourse of tropical neurasthenia used by the Japanese colonists to justify their attitude of racial superiority.

In the second part of Chapter 6, I examine how 'psychological trauma', broadly defined, was documented in the case registries that were kept by the Department of Psychiatry at National Taiwan University Hospital in the early postwar period. Before my study, these cases had been untouched by historians. In 1946, psychiatric science in Taiwan was undergoing a process of decolonisation and re-institutionalisation. The content of psychiatric education was evolving from the Japanese-German model to an Anglo-American system. Tsung-Yi Lin, having returned to Taiwan from Japan, dominated the establishment of the new psychiatric paradigm. After he arrived at what many considered the 'barren land of psychiatry', the department confronted a series of language and cultural conflicts. Their patients were mainly those who suffered from experiences related to immigration and ethnic conflicts. The patient population included Chinese public servants who had recently relocated from mainland China to Taiwan, Japanese men (descendants of colonists) who worked for

a salary and remained on the island, and local Taiwanese people who were increasingly anxious by the drastic social changes. The patient registries show the complexity of psychological trauma as it was conceived during the conflicting cultural context of post-colonial Taiwan. They also illustrate the transformation of the concept of trauma during shifts in psychiatric paradigms, and the controversial and subjective nature of related medical diagnoses. These cases not only emphasise the multiple factors that shape 'trauma-related' disorders, such as language capacity, extreme experiences, changing social structure, and so forth; they also illustrate the lack of clarity confronted by a psychiatrist in attempting to explain the nature of trauma.

In the third part of Chapter 6, I describe the social practice of psychiatrists concerning the 2.28 Incident. This section examines how Taiwanese psychiatrists applied their professional theories to their political aspirations, facilitating a movement of peace and justice against state violence, and implementing social campaigns after the lifting of martial law in the 1980s. I demonstrate how these psychiatrists surpassed the boundaries of 'diagnostic psychiatry'—the paradigm of which was established, ironically, through their social practice—and opened a dialogue between the psychiatric profession and the public domain. This analysis explains how the 'trauma' theme functioned outside the field of clinical medicine.

By portraying these three cases, I attempt to illustrate how trauma was represented in a cross-cultural context during the postwar 'traumatic era'. During the same period, international psychiatry began to develop useful tools in response to industrialisation, urbanisation, immigration, and other global phenomena. I argue that

the ‘styles’ and even ‘genre’ of trauma varied according to circumstance, with the greatest diversity being evident in non-Western social, economic, and political settings. Finally, I discuss one of the major disadvantages of modern psychiatry, namely that the effort at all-encompassing standardisation restricts the attempt by psychiatric experts to truly cover all possible manifestations of the human psyche.

Finally, the conclusion to this thesis reviews the main themes presented, and considers the ‘afterlife’ of trauma during the ongoing work of reclassification in modern psychiatry.

PART I: RE-ORIENTING TAIWAN IN THE POSTWAR ORDER

Chapter 1

The Scope of Enquiry:
Why Transnational, Why Trauma, Why Postwar World Psychiatry, and Why Taiwan?

In a historiographical essay comparing 'world history' and 'global history', Bruce Mazlish carefully defines these two approaches regarding their etymology, methodology, themes, and possible timeframes. In particular, Mazlish discusses the approach of writing the 'history of globalisation' as a possible venture in historical research.[16] I believe this suggestion stems from the notion that the globalised subjects of world history should reflect the concept of a global history. Moreover, the routes and factors of globalisation are transnational rather than spreading outwards from a single centre. In other words, globalisation is not simply a one-dimensional transfer between two geographical areas.

In their introduction to *The Global History Reader*, the editors, Bruce Mazlish and Akira Iriye, argue that the decades after the end of World War II constitute the main period for the study of current global history.[17] During the course of World War II, technological predecessors of the space/time compression began surfacing. The world became flat because of advances in communication and transportation: 'Rockets were developed, the nuclear bomb exploded, and the early elements of the computer revolution threw their flickers across the future.'[18] The decades after World War II also marked the emergence of a global society, in tandem with the end of

[16] Bruce Mazlish, 'Comparing Global History to World History', *Journal of Interdisciplinary History,* 28/3 (1998), p. 385-91, p. 92-3.
[17] Bruce Mazlish and Akira Iriye, *The Global History Reader* (New York ; London: Routledge, 2005) x, p. 302.
[18] Ibid. p. 7.

colonialism and the start of the Cold War. This period was marked by the division of the world into new spheres of influence, the surfacing of new migration patterns, alterations effectuated by consumerism and the increase of the middle class, the establishment of new international relations and alliances, and the acceleration of scientific theories. This new historical background in which the WHO (and the developing 'world psychiatry') would act requires commenting on.

Akira Iriye, one of the leading theorists of global/transnational history, examines the role of international organisations in the enterprise of globalisation. Iriye cites James Mittelman's statement, globalisation is a coalescence of varied transnational processes and domestic structures, allowing the economy, politics, culture, and ideology of one country to penetrate another. Iriye emphasises the proliferation of international organisations after the end of World War II. The end of the war opened boundaries among nation states, providing a platform for issues that attracted international attention, including humanitarian relief, development, human rights, and the environment. These elements were eventually recognised as embodying a set of universal values, although the exact nature of such values was—and still remains—the source of numerous disagreements. The various postwar issues were often codified through the United Nations. International organisations have arisen around all these topics, with the hope of creating a better world, irrespective of the country a person happens to live in—a true cosmopolitan ideal.

International organisations, although not the only players in creating transnational history, become more significant during processes that transcend the

interests of individual nations.[19] Scholars of transnational history, therefore, consider the voices of people or collectives that are otherwise marginalised by historical writings, and transmits these narratives to other areas of the world to build awareness and engender empathy. The universality of many of the world's most harrowing experiences becomes clearer with this type of transmission.

American historian Ian Tyrell provides a working definition of transnational history and clarifies the characteristics and functions of this field of study. He further contrasts transnational history with globalisation, world history, and comparative history.[20] The efficacy of the transnational approach is closely related to wider developments in politics and society that are concerned with these traditional approaches. Transnational history is not merely concerned with the globalisation commonly considered by global history because globalisation is linked to modernisation theory and focuses on unidirectional activity, on the homogenisation of the world, and so forth. It is not merely of world history either. Transnational history is a broader approach that encompasses world history but addresses cross-cultural issues at a level far higher than that of nation states. The concept of transnational history has enabled scholars to recognise the importance of nations while contextualising their growth. The same analytical perspective can be applied to international organisations. Furthermore, advocates of transnational history generally distinguish their field from comparative history because the latter tends to treat national borders as a 'given'. By contrast, transnational history addresses issues that cross the boundaries between states, nations, languages, or other groupings.

[19] Akira Iriye and American Council of Learned Societies., 'Global Community the Role of International Organizations in the Making of the Contemporary World', *ACLS humanities e-book* (Berkeley; Los Angeles: University of California Press, 2002).
[20] Ian Tyrrell, 'What Is Transnational History', in Ian Tyrrell (ed.), *Ian Tyrrell* (2011: wordpress, 2007).

The transnationalisation of a psychiatric subject

One of the first attempts to address the transnationalisation of psychiatric or psychological topics was a collection of essays entitled 'The Transnational Unconscious', edited by Joy Damousi and Mariano Ben Plotkin.[21] The book does not consider psychoanalysis a scientific theory, but rather as a cultural artefact that was broadly disseminated through countries and cultures during the twentieth century. Historian Carl Schorske argues that psychoanalysis is the child of a specific time and place. However, the fact remains that psychiatry soon became a transnational system of beliefs and thoughts that rapidly expanded its parameters beyond national boundaries.[22] Moreover, as argued by John Forrester, the presence of psychoanalysis in the West, as well as in other countries, is 'so constant and pervasive that escaping its influence is out of the question.' [23] According to Forrester, reverting to pre-Freudian beliefs today would be as unlikely as 'going back to pre-Copernican beliefs' on the universe. [24] As emphasised by Damousi and Plotkin, the concept of 'transnational' addresses both the qualitative nature of a subject and a particular historical approach; that is, the transnational approach focuses on the movement, flow, circulation, and intersection of people, ideas, and goods across political and cultural borders. Thus, in the anthology *The Transnational Unconscious*, scholars address the theme of transnationalisation from various perspectives. These include

[21] Joy Damousi and Mariano Ben Plotkin, *The Transnational Unconscious : Essays in the History of Psychoanalysis and Transnationalism* (The Palgrave Macmillan Transnational History Series; Basingstoke: Palgrave Macmillan, 2009) xii, p. 264.
[22] Carl Schorske, *Fin-De-Si`Ecle Vienna: Politics and Culture* (New York: Vintage Books, 1981).
[23] John Forrester, 'A Whole Climate of Opinion: Rewriting the History of Psychoanalysis', in Mark S. Micale and Roy Porter (eds.), *Discovering the History of Psychiatry* (New York: Oxford University Press, 1994). p. 174.
[24] Ibid.

movements that accelerated the transnational access to psychoanalysis; the role of individual actors who assisted in the diffusion of psychoanalytic concepts; colonial versus liberating influences of psychoanalytic theories and practices; and examples that stand in opposition to the diffusion theories, illustrating that at times psychoanalytic concepts have radiated from a peripheral node to a central area of influence. Such accounts not only enrich the history of psychoanalysis, but also attest to the possibility of writing transnational intellectual histories.

In another recent book, edited by Waltraud Ernst and Thomas Mueller, the word 'transnational' was used for the first time in the history of psychiatry. The editors selected accounts that employ various methodologies to describe, interpret, and analyse psychiatric themes in Anglo-Saxon, Germanic, and Francophone countries in Europe during the course of history. Without following any standardised rule, these approaches, in the editors' own words, include 'systemic comparison, transfer, shared history, connected history and historie croisée'.[25] Such attempts traverse and challenge 'ideologically and conceptually fraught terms [such] as medical "system", "centre" versus "periphery", "eastern" versus "western', "traditional" versus "modern" and even "global versus "local".'[26] According to Ernst and Mueller, the transnational approach not only attempts to 'reach beyond the conceptual and thematic confines of the single-country case studies […] prevalent in most histories of psychiatry and mental health', but also 'takes issues with an a priori spatial focus on nation states, […] with histories that take the boundaries of modern nations as their main reference point and framework of analysis and thereby reify politically imposed

[25] Waltraud Ernst and Thomas Mueller, *Transnational Psychiatries: Social and Cultural Histories of Psychiatry in Comparative Perspective, C.1800-2000* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2010). p. xi.
[26] Ibid. p. xi.

borders and, in Benedict Anderson's sense, "imagined communities".'[27] These accounts, which compare psychiatric systems across Europe, are able to trace and examine the significant connections and scientific networks from which mental health practitioners of various nations (or nation states) took their inspiration. However, the chapters on the history of psychiatry in non-Western countries are unfinished. For example, one chapter describes how a research team compared the medico-conceptual developments in post-Communist Eastern Bloc states with those of Great Britain and West Germany, by scrutinising the international transfer of knowledge within the context of the globalisation of psychiatric knowledge. In another chapter, the historian focuses on the translation of the concept of depression from the West to Japan, including susceptibility or resistance to depression. Both of these accounts use a transnational approach, but the questions asked and the problems solved differ. Indeed, one of the main challenges of the transnational field is confusion arising from diverse applications of the approach.

This thesis also employs the transnational approach by examining the notion of 'psychological trauma', a concept that has drawn much attention in East Asia since the 1990s. Instead of interpreting 'trauma' as a cultural subject, in the manner of Damousi and colleagues, I focus on the transformation of psychiatry that incidentally facilitated the transnationalisation of 'trauma' in the context of the WHO and Taiwan.

As persuasively argued by Chinese literature scholar Ban Wang, trauma is now a global phenomenon, notably associated with post-colonial narratives, and not only

[27] Ibid. p. xiii.

within the framework of psychiatry, but also within other scholarly fields.[28] The language of trauma is evident in accounts of memory studies conducted in East Asia in the 1990s.[29] In the context examined by this thesis, the concept of trauma, combined with other features of modern psychiatry, gained popularity in Taiwan through several trajectories of modernisation. These trajectories included the institutionalisation of psychiatry as a medical discipline and the maturation of psychiatric discourse among professionals and laymen; they also included cultural forces that mobilised Taiwan to participate in international society. However, as argued by Akira Iriye and Rana Mitter, 'transnationalisation' is not 'universalisation'.[30] My thesis focuses on the background of the period after World War II, and examines the transmission and rapid expansion of knowledge outside of Europe. Knowledge transfer cannot be mapped simply as a single trajectory between two geographical spots. Because of the unique postwar political and social circumstances, particularly the establishment of international organisations and the implications of that development, transnational history has been written by analysing the international attempt to remove the boundaries of nation states. Such boundaries include frontiers that were newly formed in the context of the Cold War, and those of developing countries that were freeing themselves from the worldwide, systematic colonial rule that had defined the geopolitical arena in the eighteenth and nineteenth centuries.

[28] Ban Wang, *Illuminations from the Past : Trauma, Memory, and History in Modern China* (Cultural Memory in the Present; Stanford, Calif.: Stanford University Press, 2004b) xii, p. 311.
[29] According to Jager and Mitter, memory studies appeared in the post-Cold War period as a new scholarly enterprise. See Sheila Miyoshi Jager and Rana Mitter, *Ruptured Histories: War, Memory, and the Post-Cold War in Asia* (Cambridge, Mass.: Harvard University Press, 2007) xii, p. 384.
[30] Akira Iriye and Rana Mitter, 'Forward', in Joy Damousi and Mariano Ben Plotkin (eds.), *The Transnational Unconscious : Essays in the History of Psychoanalysis and Transnationalism* (Basingstoke: Palgrave Macmillan, 2009), xii, 264 p.

Problems associated with Trauma Studies

Trauma has been studied extensively in the field of Western medical history. The studies published to date have largely investigated the response of Western psychiatry to wars, industrialisation, massacres and genocides, natural disasters, and other catastrophes. No comprehensive investigations into trauma in a non-Western context have been published. The current study examines how the concept of trauma (which is loaded with cultural meaning in the West) entered the psychiatric setting in the non-Western world after World War II. My analysis includes the avenues through which the notion of trauma was received, the establishment of the psychiatric discipline, and how the Taiwanese psychiatric profession countered extreme experiences. Whether considered a psychiatric diagnosis or literary rhetoric, trauma cannot be restricted to the domain of either medicine or literature. Therefore, I examine the multiple avenues through which the concept of trauma became globalised with the standardisation of psychiatric diagnoses. The term *trauma*, which began as an extremely Western psychiatric concept, was applied in Taiwan after World War II and was appropriated by local psychiatrists as an instrument for their political activism in response to the 2.28 Incident and the ensuing White Terror.

The term *trauma* originates from the ancient Greek *τιτρώσκω*, or piercing, meaning a physical injury. The definition provided by the Oxford Dictionary is 'a mental condition caused by severe shock, especially when the harmful effects last for a long time'.[31] This psychopathological meaning was elaborated by Jean-Martin

[31] H. W. Fowler et al., *The Concise Oxford Dictionary of Current English* (5th edn.; Oxford: Clarendon Press, 1967) xvi, 1558 p.

Charcot and Sigmund Freud and popularised by later psychoanalysts.[32] According to Jean Laplanche, trauma was first described by Charcot, who between 1880 and 1890 studied certain hysterical paralyses that followed physical injuries.[33] Thereafter, the notion of psychological trauma primarily fitted into the perspective of psychological economy, as Freud himself indicated. From this viewpoint, trauma is defined as an experience that presents the mind with a rapid increase in stimulus too powerful to be managed the normal way, resulting in permanent disturbances of the psyche. This scenario was first described in *Beyond the Pleasure Principle*, which envisioned trauma in terms of a primal relationship between an organism and its surroundings.[34] This notion of trauma thereafter insidiously became the aetiology of neurosis through many subsequent revisions of the concept. Unfortunately, these revisions did not include further definition of the nature of the traumatic stimulus. However, the initial definition had been informed by Freud's own life experiences and observations, such as those gleaned during the First World War.[35]

Although the definition and usage of the term *trauma* has a long history, dating back to the end of the nineteenth century, certain modern and contemporary psychiatrists do not fully embrace the term. German Berrios, a professor of psychiatry at Cambridge University in the United Kingdom, is one such professional. Berrios, who specialises in the history of mental symptoms from the perspective of descriptive psychiatry, does not offer a specific account of trauma. At the time Berrios was writing, trauma was not viewed as a description of mental symptoms, but constituted

[32] Cathy Caruth, *Unclaimed Experience: Trauma, Narrative, and History* (Baltimore: Johns Hopkins University Press, 1996) x, p. 154.
[33] Jean Laplanche and J. B. Pontalis, *The Language of Psychoanalysis* (New York: W. W. Norton, 1973). pp. 469-70.
[34] Sigmund Freud and C. J. M. Hubback, *Beyond the Pleasure Principle* (London ; Vienna: The International Psycho-Analytical Press, 1922) 90 p.
[35] Ibid. pp. 465-473.

a perspective shared by a handful of theorists to explain the aetiology of neuroses. However, Berrios describes 'nervous insensitivity', a type of consequential delusional madness caused by nervous overexcitation. Such overexcitation was described by the eighteenth-century physician William Battie in an early account of the causal relationship between external stimuli and mental symptoms.[36] Trauma, nonetheless, was not substantiated as an official psychiatric diagnosis until 1980, when the American Psychiatric Association included the diagnosis of post-traumatic stress disorder (PTSD) in its *Diagnostic and Statistical Manual of Mental Disorders.* Thus, PTSD became a new category of anxiety disorders; this was accomplished for soldiers returning from the Vietnamese War to receive financial compensation.[37]

At present, two traditions that commenced in the 1990s are clearly observable in writings on trauma. The first tradition is the call for testimonies and narratives of traumatic memories as a historical source; most of these narratives focus on crucial historical events such as those that occurred during the First or World War IIs, in Vietnam, during the Holocaust, or at Hiroshima and Nagasaki. The second tradition regards trauma as a mental illness and traces its sociohistorical roots across various cultures. Neither tradition, however, attempts to explore the psychological causes and effects of war and political violence.[38]

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[36] G. E Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1996). p. 89-90.

[37] Edgar Jones and Simon Wessely, *Shell Shock to PTSD : Military Psychiatry from 1900 to the Gulf War* (Maudsley Monographs,; Hove: Psychology Press, 2005) xvii, p. 300; Ben Shephard, *A War of Nerves* (London: Jonathan Cape, 2000) xxiii, p. 487, p. [8] of plates. Allan Young, *The Harmony of Illusions : Inventing Post-Traumatic Stress Disorder* (Princeton, N.J.: Princeton University Press, 1995) x, p. 327.

[38] One of the early proponents of psychohistory is Robert Jay Lifton (born 1926). He is an American psychiatrist renowned for his studies on the survivors of the Holocaust, Hiroshima bombing, and various forms of political violence. He lobbied for the inclusion of PTSD in the DSM system of psychiatric diagnoses. See Robert Jay Lifton, *Death in Life; Survivors of Hiroshima* (New York: Random House, 1967) viii, p. 594; Robert Jay Lifton, *Revolutionary Immortality: Mao Tse-Tung and the Chinese Cultural Revolution* (London: Weidenfeld & Nicolson, 1969) xiv, p. 178; Robert Jay

The work of Cathy Caruth provides an example of the call for narratives. Caruth, a scholar of comparative literature, links historical forces, psychic experiences, and literary expressions in her *Unclaimed Experience.* This book provides one of the first theoretical accounts of the production process of traumatic narratives.[39] Caruth's work approaches the proliferation of historical writing that incorporates trauma narratives with an attitude of commemoration and compassion.[40] Concerning the relationship between history and trauma-induced experiences, Caruth writes that if trauma 'must be understood as a pathological symptom, then it is not so much a symptom of the unconscious, as it is a symptom of history. The Traumatised, we might say, carry an impossible history within them, or they become themselves the symptom of a history that they cannot entirely possess.'[41]

Caruth frequently cites the work of clinician Bessel Van der Kolk in her accounts. Other humanities scholars and mental health professionals have similarly adopted a range of collaborative approaches when discussing the subject of trauma. This sometimes consists of coauthoring monographs, or citing each other's work without providing adequate reasons for these citations.[42] Certain research has been criticised for lacking scientific verification and creating pragmatic problems.[43]

Lifton, *The Nazi Doctors : Medical Killing and the Psychology of Genocide* (London: Macmillan, 1986) xiii, p. 561.

[39] Caruth, *Unclaimed Experience : Trauma, Narrative, and History*.

[40] For example, in Klaus Hentschel, *The Mental Aftermath : The Mentality of German Physicists 1945-1949* (Oxford: Oxford University Press, 2007) p. 205, employing tools from the history of mentality, such as representative serial publication, correspondence, and contemporary observations by visiting emigré scientists, the author identifies and discusses the uniform behaviour and mentality of German physicists in the immediate aftermath of World War II.

[41] Caruth, *Unclaimed Experience : Trauma, Narrative, and History*. p. 5

[42] Such as Shoshana Felman and Dori Laub, *Testimony : Crises of Witnessing in Literature, Psychoanalysis, and History* (New York: Routledge, 1992) xx, p. 294

[43] For example, See Susanne Vees-Gulani, *Trauma and Guilt : Literature of Wartime Bombing in Germany* (Berlin: W. de Gruyter, 2003) p. 217

However, historian Dominick LaCapra disputes the traditional critiques provided by objectivist history. LaCapra argues that trauma constructs the subjective perceptions of the survivors of historical events, such as the Holocaust, and that this situation calls for the deliberate construction of a particular subjectivity when producing accounts for secondary witnesses. LaCapra appeals to historians to deploy the technique of 'empathetic unsettlement', a type of sensitivity that entails responsiveness to the traumatic experience of others, to make the history of the experience more accessible.[44]

The second approach to trauma falls under the scope of the history of medicine. In *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, historians Mark Micale and Paul Lerner present a collection of essays on trauma-related psychiatric disorders from the Victorian era to the period between the First and World War IIs. Instead of following other scholars' obsessions with catastrophe, victimisation, and memorialisation, the authors collected evidence at the actual sites of trauma and examined how the medico-cultural milieu shaped and was shaped by traumatic events. Their material includes medical writings, case histories, and art forms. Thus, a central theme of their work was how the medico-cultural context facilitated the construction of psychological trauma historically.[45] Similarly, British historian Ben Shephard dedicated his research to the history of psychiatry in the military. In *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century*, Shephard presents a record of the transformation of soldiers' trauma from a moral to a

[44] See Dominick Lacapra, *Representing the Holocaust : History, Theory, Trauma* (Ithaca ; London: Cornell University Press, 1994) xiii, p. 230; Dominick Lacapra, *History and Memory after Auschwitz* (Ithaca, NY: Cornell University Press, 1998) ix, p. 214; Dominick Lacapra, *Writing History, Writing Trauma* (Parallax; Baltimore ; London: Johns Hopkins University Press, 2001) xvi, p. 226.
[45] Mark S. Micale and Paul Frederick Lerner, *Traumatic Pasts : History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge Studies in the History of Medicine; Cambridge: Cambridge University Press, 2001a) xiv, p. 316.

medical issue, especially during the First and World War IIs and in Vietnam.[46] Shephard's work is rich in historical detail and meticulously recreates the treatment of casualties of the First and World War IIs by military psychiatrists. However, it conspicuously does not provide a clear clinical picture of the suffering of the participants in these wars.

In contrast to Shephard's approach, anthropologist Allan Young examines the historical construction of the psychiatric disorder of Post-Traumatic Stress Disorder (PTSD) by providing actual transcripts of group therapy and diagnostic sessions. Young also reviews the lobbying processes through which the disorder was ultimately included in the DSM-III. He concludes that PTSD is a cultural product that was gradually assembled by the practices, technologies, and narratives through which it is diagnosed, studied, and treated. He furthermore unravels the various interests, institutions, and moral arguments mobilising these efforts.[47] Young's radical claim demonstrates the main problem clinicians are confronted by, which is that the diagnosis of trauma is complex and can be obscured by a bevy of external stressors—most of which are social, economic, or even political. In their recent book, historians Edgar Jones and Simon Wessley link discourses of shell shock, war neurosis, PTSD, and Gulf War syndrome, demonstrating the paradigm shifts around these trauma-related psychiatric disorders across the broad spectrum of the twentieth century.[48] Their focus, however, is constrained by the military context to which they restrict their research. Apart from stating that 'cultural changes are reflected in the incidence

[46] Shephard, *A War of Nerves*.
[47] Young, *The Harmony of Illusions : Inventing Post-Traumatic Stress Disorder*.
[48] Jones and Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*.

of psychological disorders as a result of combat',[49] the authors make little reference to the application of the concept of trauma in non-Western contexts.

Historian Ruth Leys pursues a more comprehensive, genealogical approach to trauma in her review of theorists from Freud's time to the age of neurobiology. Leys dedicates two chapters to the points of intersection between two different conceptions of trauma, namely the clinical approach (e.g., Bassel Van der Kolk) and the hermeneutic approach (e.g., Cathy Caruth). In the process, Leys discusses the pros and cons of these two rival models for determining whether people are suffering from trauma. She provides an opposing account to Caruth's approach, which arguably takes the occurrence of trauma for granted. Leys illustrates the difficulties encountered in various fields of trauma studies, including psychology, sociology, psychiatry, social work, and even literature. She suggests that it is necessary to comprehend the manner in which knowledge is produced and processed in certain sociohistorical structures.[50] As more historical materials were to be unearthed, echoing Ley's genealogical approach, historian Tracy Loughran proposes an attitude not as extreme as the divided approach of timeless truth and social construction of trauma. Instead, she suggests an approach to destablise the meanings trauma that had been respectively established in different disciplines, paying attention to the coverage of literary, psychological and historical methods.[51] The important analyses and debates provided by above scholars, however, remain focused on Western contexts.

[49] Ibid.
[50] Ruth Leys, *Trauma: A Genealogy* (Chicago: University of Chicago Press, 2000) x, p. 318.
[51] Tracy Loughran, 'Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories', *Journal of the History of Medicine and Allied Sciences,* 67/1 (2010), 94-119.

Globalised Trauma

In a recent monograph, anthropologists Didier Fassin and Richard Rechtman made the bold claim that trauma has become a 'major signifier of our age'.[52] Fassin and Rechtman are both physicians and humanitarian workers. Through their method of participatory observation, they presented a compelling analysis of the historical construction and political uses of trauma, a concept that 'profoundly transforms the moral framework of what constitutes humanity'.[53] Fassin and Rechtman discuss the daily practices of professional communities, mostly comprising mental health and humanitarian workers, and the internal standards of these disciplines and their interactions with their clients—including both the nation and the individual. The authors observe that there exists a double genealogy of 'medical' versus 'moral' that integrates the complex relationships between violence and suffering, politics and psychiatry, experience and care, and memory and truth. This analysis loosely corresponds with Ruth Ley's approach. However, Fassin and Rechtman fail to acknowledge that the acceptance of specific trauma-related suffering is not necessarily universal. The literature clearly shows that most authors focus on psychic reactions to major historical events such as wars, genocides, and other large-scale catastrophes. Most of these historical writings tend to leap over long periods between major events, to sustain momentum and to garner attention for people or collectives devastated by the events. Few works show an awareness of the minor variations or petty determining moments that facilitate the transformation of the concept of trauma during the plodding spectrum of history. Yet, it is these transformative moments that

[52] Didier Fassin and Richard Rechtman, *The Empire of Trauma : An Inquiry into the Condition of Victimhood* (Princeton ; Oxford: Princeton University Press, 2009) xii, p. 305.
[53] Ibid. p. 21.

have resulted in the globalisation, popularisation, and reorientation of the concept of trauma in a wider range of contexts.

In the past two decades, a flood of 'traumatic' discourses has appeared concerning traumatic events such as wars, massacres, and other devastating experiences in East Asian history. These discourses dominated the burgeoning new—and in many cases nationalistic—historical narratives in Japan, China, South Korea, and Taiwan, where the term has gained different ways of translation. For example, as noted by Sheila Miyoshi Jager and Rana Mitter, the surge of memory in the 1990s brought World War II to the centre of Japanese public debate and generated a 'transnational memory' of the war.[54] This discourse was not confined to a single national narrative, but included interactions across Asia. Jager and Mitter further state that certain turning points, such as 9/11 and the global war launched by the United States on terrorism, have played a pivotal role in transforming memories of war of Asia (the 'Asian narrative') into a global narrative. Although most published research on these events has not directly labelled the events as traumatic, it is the destructive, disturbing, distressing—in short, the traumatic—effects of such episodes that draw the attention of historians.

Ban Wang further comments on 'globalised' traumatic memory by identifying other themes in a wide range of materials from the fields of history and literature. He argues that two main categories of trauma exist in modern China. One is associated with historical catastrophes, such as the encroachment of imperialism, colonisation, wars, and dictatorships. The other has been caused by the shock of the current

[54] See Jager and Mitter, *Ruptured Histories: War, Memory, and the Post-Cold War in Asia*.

worldwide capitalist system, and the collapse of earlier styles of interpersonal relationships catalysed by mass commercialisation.[55] Some contemporary authors have attempted explicitly to use concepts of trauma, even those as specific as PTSD, to analyse memory texts from different periods of Chinese history.[56]

In East Asian and especially Chinese contexts, trauma remains hyperbolic as employed by creative writers and literary critics The texts that use this exaggerated and unreal vision of trauma are designated *shanghen wenxue* (scar literature, 傷痕文學) or *chuangshang wenxue* (trauma literature, 創傷文學).[57] In these accounts, the techniques writers employ are similar to those used in the production of historical memory studies. However, the literary narratives denote particular genres produced as a consequence of specific sociohistorical circumstances, such as the Chinese immigration to Taiwan after World War II or the cultural revolution in Communist China. In these literary accounts, the so-called scars or trauma are transplanted using the concepts of modernist literary theory, which has its root in Freudian and Western psychology. The manifestation of collective scars and trauma in Chinese contexts, however, is sensitive to local culture. For instance, David Der-wei Wang identifies two distinct traditions of scar writing that resulted from the split of China during the middle of the twentieth century.[58] Efforts have recently been made to explore the manner in which the language of modern psychology was introduced into Chinese

[55] Wang, *Illuminations from the Past: Trauma, Memory, and History in Modern China*.
[56] For example, see Lynn A. Struve, 'Confucian PTSD: Reading Trauma in a Chinese Younster's Memoir', *History & Memory,* 16/2 (2004), p. 14-31. Aaron William Moore, 'Problems of Changing Language Communities: Veterans and Memory Writing in China, Taiwan, and Japan', *Modern Asian Studies,* 45/2 (2011), p. 399-429.
[57] For scar literature, see Henry Yuhuai He, *Dictionary of the Political Thought of the People's Republic of China* (Armonk, N.Y. ; London: M.E. Sharpe, 2001) xiv, p. 727, pp. 377-78. Dewei Wang, 'On Scars and National Memory', *The Monster That Is History : History, Violence, and Fictional Writing in Twentieth-Century China* (Berkeley ; London: University of California Press, 2004c), p. 148-82.
[58] Wang, 'On Scars and National Memory'.

literature through the diffusion of modernism during the early twentieth century.[59] However, studies of trauma or psychological terminology as a thematic or medical subject in Chinese history are lacking.

The main issues I address in this thesis have been confronted by other scholars of the history of trauma during the past two decades. Thus, the same issues tend to be raised repeatedly in the discussion and epilogue sections of numerous scholarly texts. According to Cathy Caruth, a relationship certainly exists between psychological trauma and important historical events, but this relationship needs further exploration. Do issues related to trauma reach their pinnacle only when instigated by life-threatening events? This question has been neglected by most scholars.

As emphasised by Jager and Mitter, traumatic historical memories earn transnational concern at certain turning points. Did the concept of trauma, however, appear far earlier than these critical moments, during which it could be used without questioning? Amid the ruptured and discontinuous writings on trauma, can we pursue an alternative inquiry that probes the continuity of this psychological or psychiatric language as it appears in global history? To answer these questions, I set a transnational 'skeleton' on which the history of psychological trauma unfolds. As a starting point, I regard trauma as a psychiatric concept. From the literature reviewed, its definition is vague and disputed. However, trauma clearly concerns not only the nature of a verifiable external reality but also the psychological responses to that reality. Furthermore, trauma is often subject to the compassionate approval of

[59] For example, see See Lydia He Liu, *Translingual Practice : Literature, National Culture, and Trnslated Modernity--China, 1900-1937* (Stanford, Calif.: Stanford University Press, 1995) xx, p. 474. Hsiao-Yen Peng, 'A Traveling Malady: The "Malady of the Heart", Scientific Terminology, and the Neo-Sensation School', *Bulletin of the Institute of Chinese Literature and Philosophy [Zhong Guo Wen Zhe Yan Jiu Ji Kan],* 34 (2009), pp. 205-48.

'victimhood' by a professional diagnosing the psychiatric ailment. The globalisation of trauma is closely associated with the international standardisation of psychiatric diagnostic classification that took place after World War II. Scholars of trauma have shown that the definition of trauma has experienced paradigm shifts, and that the treatment of trauma requires a sensitive response, which LaCapra calls *empathetic unsettlement*. Ultimately, the study of trauma requires a certain reprieve from the concrete diagnostic criteria of PTSD. Instead, I respond to the call of international mental health experts to study the causation of mental illness as a response by the medical profession to post-conflict devastation and dislocation.

The World Health Organisation (WHO) as the Site for the Globalisation of Traumatic Psychiatry

In this thesis, I regard the WHO as one of the main conduits through which the transnational history of trauma can be defined. Historians have paid particular attention to the role of international organisations in disseminating ideas in a global fashion (the globalisation of ideas) since World War II. International organisations, both governmental and non-governmental, were central in shaping a global community during the Cold War.[60] According to Iriye, during the Cold War, states were preoccupied with domestic interests. International organisations acted counter to these provincial interests by promoting cultural exchange, offering humanitarian assistance, extending developmental aid, protecting the environment, and championing human rights to increase global interdependence and peace. Furthering

[60] Akira Iriye, *Global Community : The Role of International Organizations in the Making of the Contemporary World* (Berkeley, Calif. ; London: University of California Press, 2002) ix, p. 246

this line of thought, Sunil Amrith argues that international institutions provide the ideal case study for analysing transnational connections, flows, journeys, and identities.[61] In Amrith's words, international organisations have acted as 'a site and a resource: a place to stake claims on the world stage … as the source of symbolic tools—languages, images, norms, standards—which can be turned into claims of entitlement.'[62] Similarly, Glenda Sluga notes that promoting the transnational history of international institutions favourably illustrates the intersection of international institutions into thick traversing histories of social and political influences across geopolitical spaces. Sluga also writes that transnational history recontextualises international institutions and ideas in the social history of twentieth-century internationalism.[63]

The WHO was developed as a specialised agency of the United Nations (UN) and is concerned, inter alia, with issues of public health. The WHO was partly developed in response to the surge in worldwide infectious disease epidemics and postwar chaos in the aftermath of World War II, as well as massive immigration and rapid socioeconomic changes.[64] The design of the WHO reflected the sentiments of delegates from China, Brazil, and Norway at the conference of the United Nations Relief and Rehabilitation Administration (UNRRA), namely that 'medicine is one of the pillars of peace'.[65] These delegates challenged the neglect of public health and responded to the 'spillover' theory proposed by functionalist economists such as

[61] Sunil S. Amrith and Genda Sluga, 'New Histories of the Un', *Journal of World History,* 19/3 (2008), pp. 251-74.
[62] Sunil Amrith, closing remarks at 'Transnational History of International Organizations: Methodology/Epistemology' conference, King's College, Cambridge, April 2009. See also Genda Sluga, 'Editorial - the Transnational History of International Institutions', *Journal of Global History,* 2011/6 (2011), pp. 219-22.
[63] Ibid.
[64] Kelley Lee, *The World Health Organization (WHO)* (Global Institutions Series.; Abingdon, Oxon ; New York, N.Y.: Routledge, 2009) xx, p. 157.
[65] *Official Records of the World Health Organization*, 1(1948): p. 39.

David Mitrany. Spillover economists had argued that cooperation in one technical area, such as medicine, would spill over into other areas, thus stimulating economic growth in postwar states and preventing the plunder of resources that could possibly cause further atrocities.[66]

Although a long history of international cooperation on health issues existed before the creation of the WHO, after its creation the concept of international sanitary collaboration was expanded across the Atlantic Ocean and diffused to underdeveloped countries.[67] This was also the first time mental health gained international attention as an emergent health issue. Under the auspices of the WHO, the first central administrative body for the development of international mental health was created. The Mental Health Unit of the WHO and the World Federation for Mental Health were established according to suggestions made at the conclusion of the International Congress of Mental Health held in London in 1948.[68] From that point on, mental health was addressed with the rest of the public health agenda created within the WHO. Under WHO guidance, worldwide mental health experts attempted to detect, explain, and account for trauma in humans—while sovereign states tended to downplay the issue.[69] Visionary experts based at the WHO headquarters in Geneva attempted to study the pattern through which humans developed mental illness during traumatic times of great change. Such effort echoed the notion of 'world citizenship'

[66] Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (London: Hurst, 1995) xiv, p. 272.
[67] John Farley, *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: UBC Press, 2008) xvi, p. 254.
[68] J. C. Flugel et al., *International Congress on Mental Health, London, 1948*, 4 vols. (London New York: H.K. Lewis; Columbia University Press, 1948).
[69] For example, see Hans Pols, 'The Repression of War Trauma in American Psychiatry after WWII', in Roger Cooter, Mark Harrison, and Steve Sturdy (eds.), *Medicine and Modern Warfare* (London: Clio Medica/The Wellcome Series in the History of Medicine, 1999), pp. 251-76. Janice Matsumura, 'State Propaganda and Mental Disorders: The Issue of Psychiatric Casualties among Japanese Soldiers During the Asia-Pacific War', *Bulletin of the History of Medicine,* 78 (2004), pp. 804-35.

that was fashionable in intellectual circles at the time. The WHO experts first standardised the classification of psychiatric diagnoses to create a common language for mental health researchers and practitioners, and began establishing the disease profile of specific mental disorders. Through my research, I found that their endeavour had both positive and negative consequences. On the one hand, they proved that international collaboration on mental health research was feasible. They also provided norms, such as classifications of psychiatric diagnoses, in areas where standardised measures had not been well developed for mental illnesses. On the other hand, the applicability of the WHO's research outcomes are questionable. In the last part of my thesis I scrutinise this issue by examining case studies of psychological trauma in Taiwan.

Taiwan: A case study of the 'glocalisation' of ideas

Why does this study favour Taiwan as a site of transnational history? As argued by Glenda Sluga, histories of international institutions have tended to downplay or ignore the transnational setting and contexts of these institutions, and the implications thereof. Taiwan was a central player in the early phase of the WHO project, and thus provides a rich context regarding international relations and collaborations. Taiwan was targeted by the WHO to develop a 'template' for engineering its rationale on mental illnesses. The Nationalist Chinese government was one of the main proponents that promoted the establishment of the WHO. However, the WHO later withdrew from mainland China and instead continued its work in Taiwan after the defeat of the Chinese Communist Party in the Chinese Civil War. The Nationalist Chinese government, backed by the Western blocs in the Cold War, continued to represent

China in the United Nations and its specialised agencies. However, Taiwan seized the opportunity to join the collaborative work then taking place in international public health. Taiwan later represented the seat of China, a fact Brock Chisholm described as 'an absurdity which is outstanding even in this era of absurdities'.[70] Among numerous different agendas, Taiwan became a model student for the ideology of the WHO. The relationship between the WHO and Taiwan cannot be overlooked when examining the history of international health.

Taiwan also provides a benchmark for students of international health to speculate on the rationale of the WHO. Although Taiwan's sociogeographic characteristics were ideal for most WHO public health projects, Taiwan had its own motives for wanting to join the work of the WHO. Despite Taiwan being used as a template for the WHO to test its rationale in underdeveloped countries, Taiwanese professionals were confident enough and aspired to be a part of international society. Elaborating from Ian Tyrell's definition of transnational history, Anne Leylen calls for research into Taiwan as a laboratory of the 'transnational'.[71] Apart from arguing the feasibility of such approach to Taiwan history from perspectives of geopolitical circumstances, she further emphasises that such approach can transcend current historiography of Taiwan as limited in the scope of 'Sino-centrism' and the emerging call of 'Taiwan Island history (Taiwan daoshi, 台灣島史), surpassing the current scholarly discourses of decolonisation or postcolonisation. 'Shelly Riggers argues that after World War II, Taiwan developed its own identity and aspirations. The Taiwanese people had resisted outsiders' efforts to absorb, subjugate, and marginalise

[70] Farley, *Brock Chisholm, the World Health Organization, and the Cold War*. p. 90.
[71] Anne Heylen, 'The Transnational in Taiwan History: A Preliminary Exploration', *Concentric: Literary and Cultural Studies,* 36/1 (March 2010), 9-33.

their homeland. Keeping Taiwan alive as an autonomous actor in international politics and economics required determination and energy.[72] The same qualities were reflected in the participation of medical professionals in the field of international health. However, many successful achievements of WHO projects in Taiwan were not necessarily due to local representation of its *raison d'être*, but to state coercion moulding the wills of Taiwanese professionals.[73] This mindset was evident not only in the battle of mental health professionals against epidemic infectious diseases, but also in research into psychiatric epidemics. Later in this thesis I elaborate on these points .

In addition to international relations, social and cultural factors played a role in Taiwan and must be included in this analysis of transnational history. With its unique identity and aspirations, how did Taiwan receive and appropriate globalised mental health concepts? How did Taiwanese mental health professionals retrospectively account for people's individual and collective trauma? The final two chapters of this thesis provide case studies of Taiwan's traumatic experiences, which illustrate the challenges facing the so-called international standards produced by the works of the WHO. I analyse how Taiwanese psychiatrists interpreted and struggled with the social suffering of Taiwanese people beyond the standardised classification of psychiatric diagnoses and institutionalised practice. Such an analysis concretely depicts how local

[72] Shelley Rigger, *Why Taiwan Matters: Small Island, Global Powerhouse* (Lanham, Md.: Rowman & Littlefield, 2011) ix, p. 211, p. [10] of plates.
[73] Yi-Ping Lin, 'War against Mosquitoes: Science, Technology and Society Study of Post-War Malaria Eradication in Taiwan', *Taiwan: A Radical Quarterly in Social Studies,* /81 (2011), pp. 187-236. Yi-Ping Lin and Shiyng Liu, 'A Forgotten War: Malaria Eradication in Taiwan, 1905-65', in Angela Ki Che Leung and Charlotte Furth (eds.), *Health and Hygiene in Chinese East Asia* (Durham London: Duke University Press, 2010), pp. 183-203. Du-Jian Tsai and Fei-Yi Liang, 'The Significance of Medical Ethics Presented by Malaria Research in Taiwan', in Yu-Mei Yu and Du-Jian Tsai (eds.), *The Transformation of Medical Morals in Taiwan: Case Studies* (Taipei: National Institute of Health Research, 2003), 101-32. Harry Yi-Jui Wu, 'Beyond the Scope of the State: Anti-Malaria Campaigns in and out of Taiwan ', *Taiwan, A Radical Quarterly in Social Studies,* Vol. 88 (2012).

professionals adapted and embezzled what Isaiah Berlin called the ‘crooked timber of humanity’ that was manufactured according to the postwar humanitarian rationale.

Chapter 2

From Cultural Psychiatry to Psychiatric Epidemiology: the Re-Institutionalisation of the Psychiatric Department at National Taiwan University Hospital

Introduction

In a special edition of the Chinese Society Bulletin of Neurology and Psychiatry, published in 1981, retired superintendent of National Taiwan University Hospital (NTUH) Wei Huoyao (魏火曜) acknowledged the role of psychiatrists in preventing heart disease. Huoyao wrote that these professionals had been 'contributing to the prevention of heart diseases in the time of rapid changes' since World War II, and particularly after the establishment of psychiatric society in 1961. In this context, heart disease (*xinbing*, 心病) does not mean ailments affecting the heart as understood in cardiology. It instead denotes mental illnesses recognised by traditional Chinese medicine. In the classics of ancient Chinese medicine, the heart is considered to rule the five major organ networks. The heart commands the movement of the four extremities, circulates vital energy (*qi*, 氣), and roams the realms of both the material and immaterial world—including mental activities. This summary illustrates the traditional Chinese understanding of mental problems that were common among the Chinese, and indeed the rest of the world, during great changes in the postwar period. It highlights the historical significance and paradox of the development of modern psychiatry in immediate postwar Taiwan, or what is more frequently referred to as Free China.

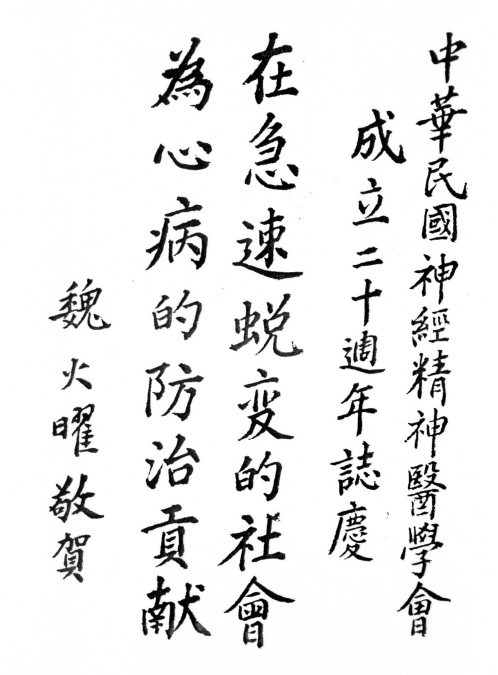

Figure 1 The superscription in Chinese language reads, 'Contributing to the prevention of heart diseases in the time of rapid changes'.

Modern psychiatry in Taiwan did not commence only after the end of World War II. It was reborn in the shadow of the postwar devastation of various social, cultural, and historical determinants. The re-institutionalisation of the psychiatric department at NTUH, however, provided the momentum to connect Taiwanese psychiatry to the rest of the world. In this chapter, I analyse the efforts made by the first native Taiwanese psychiatrist Tsung-Yi Lin (林宗義) and his team. My analysis consists of examining the three aspects of modernity represented by transnational characteristics of modern psychiatry; this framework provides the context for discussing key issues in the following chapters. Issues I explore include the legacy of Japanese colonisation, the establishment of the postwar nation-state, and globalisation. Through an exploration of the academic papers, memoirs, and oral history accounts of the first-generation psychiatrists at NTUH, I illustrate how Tsung-Yi Lin endeavoured to construct an autonomous Chinese psychiatry, in contrast to Japanese colonial

medicine. Later, immediately after the war, Lin and his team developed innovative inquiries into problems they encountered, which concerned mainly personality types and psychological patterns among various Chinese populations in Taiwan. Through their efforts, psychiatric epidemiology gradually became the paradigm for research among Taiwanese psychiatrists.

In addition, I demonstrate the relationship between the postwar world order and Taiwan regarding the significance of psychiatric research. In the context of internationalism and the Cold War, Taiwan was considered a part of the Global South, a site for developers to engineer their scientific modernity. Under these circumstances, Taiwan was exploited as a preeminent laboratory in which 'the world' could contrive its scientific rationale. The huge amount of funding offered by U.S. bodies and the WHO for Taiwan to develop mental health projects signified a reorientation of the world order, in which Taiwan was absorbed into the reshaped Western world. The new human bodies and psyche acquired by the Taiwanese during decolonisation were, in fact, ruled by the skeleton of globalisation, closely linked to Western dominance. A theme of this chapter is thus the context of postwar history in Taiwan and the development of the general medical field in Taiwan.

Chinese Psychiatry Before the End of WWII

Psychiatry is a young medical speciality in the Chinese-speaking world, and was not well developed until the second half of the twentieth century. Between the mid-nineteenth and early twentieth century, missionaries and colonial enterprises introduced psychiatry to Chinese cities, either as part of the modernization process or

as benevolent charity work. In 1898 John Kerr (1821-1901) established a hospital in Canton for mentally ill patients; this was the first psychiatric hospital in China.[74] In Hong Kong, Victoria Mental Hospital was built with a 130-bed capacity.[75] In Beijing, a specialised institution for the mentally ill was built with the aid of the Rockefeller Foundation.[76] Regardless of the theories and practices around mental illness in traditional Chinese medicine, these institutions reflected the sporadic diffusion of Western medicine in Chinese-speaking areas.

The development of psychiatric science at national levels in East Asia should be examined in light of the modernisation of nation states and their colonial expansion. The most prominent example is Japan. In the late 1860s, the regime of the Meiji emperor attempted to reform Japan, introducing Western culture, technology, and legal and medical practices to catch up with the more powerful countries in the West. German psychiatry was introduced to Japan, and the University of Tokyo was the first hub to accommodate this newly launched medical discipline. Psychiatry was included in syllabi taught in Japan and was largely shaped by the descriptive school of Emil Kraepelin.[77] Psychiatry in Japanese colonies, such as Taiwan and Manchuria,was mainly a service for emigrants from Japan. As in most colonies during the pre-World War II period, a range of psychiatric diagnoses was derived to foster the health and power of the colonisers. In colonial Taiwan, classic examples were the epidemic of tropical neurasthenia, hypochondriasis, and hypotheses on the personalities of

[74] Peter Paul Szto, The Accommodation of Insanity in Canton, China, 1857-1935', Thesis (Ph.D.) (UMI, University of Pennsylvania, 2002).
[75] Kam-Shing Yip, 'A Historical Review of Mental Health Services in Hong Kong (1841 to 1995)', *Journal of Social Psychiatry,* 44/1 (1998), pp. 46-55.
[76] Hugh L. Shapiro, 'The View from a Chinese Asylum: Defining Madness in 1930s Peking', Thesis (Ph. D.) (Harvard University, 1995).
[77] John L. Cox, *Transcultural Psychiatry* (London; Dover, N.H: Croom Helm, 1986), p. 337

indigenous people.[78] By the end of World War II, no East Asian countries other than Japan had developed their own national version of psychiatry.

Mental health issues attracted attention after World War II at both international and local levels. In China, the renowned demographer Ta Chen (陳達) emphasized the need to assess the population with mental and physical deficiencies.[79] Ta Chen argued the need for such population studies in China not only because of incomplete and inaccurate data left behind by a series of wars, but also to enhance mutual understanding and attain 'international peace of a permanent order'.[80] Because of continual instability in mainland China, Ta Chen's appeal was not realised until the late 1950s when an epidemiological survey was attempted.[81] In the mid-1960s, however, all psychiatric activities were suspended.

In the Black Heaven and Dark Earth

By contrast with China, where psychiatric activities were suspended after the end of World War II, in Taiwan psychiatry was reinstituted and underwent continual development, becoming a new discipline referred to as Chinese psychiatry. In August 1945, after Japan's defeat, Taiwan broke away from a half century of colonisation. Under the authorisation of Douglas MacArthur's General Order, Chen Yi (陳儀), the Chinese delegate, was escorted by George Kerr to Taiwan to accept the surrender of

[78] Yu-Chuan Wu and Hui-Wen Teng, 'Tropics, Neurasthenia, and Japanese Colonizers: The Psychiatric Discourses in Late Colonial Taiwan', *Taiwan, A Radical Quarterly in Social Studies,* 54 (2004), pp. 61-103.
[79] Ta Chen, 'The Need of Population Research in China', *Population Studies,* 1/4 (1948), pp. 342-52.
[80] Ibid.
[81] Peter Cheung, 'Adult Psychiatric Epidemiology in China in the 80s', *Culture, Medicine and Psychiatry,* 15/4 (1991), pp. 479-96.

the Japanese government. Chen Yi was commissioned to organise an interregnum to govern Taiwan as a province of what was then the Republic of China. Most public institutions established during colonisation were handed over to the Nationalist Chinese government, including governor offices, banks, the tobacco and alcohol monopoly bureau, railway systems, educational institutions, hospitals, and other infrastructure systems.[82] For the medical system, the handing over of Imperial Taihoku University and its affiliated hospitals was most important.[83]

The Chinese Nationalist government assumed control of the properties previously administered by Japanese institutions, despite a shortage of labor and financial resources. To facilitate communication with the Japanese, the Chinese Nationalist government employed the only native Taiwanese professor at the Medical School at the time, Tu Congming (杜聰明), and the only native Taiwanese lecturer, Bosei Lim (林茂生). These two people were the only academic staff members at the College of Humanities at Imperial Taihoku University who had been familiar with the Japanese administration. Tu Congming had been the first Taiwanese person to receive a Doctorate of Medical Science from Kyoto Imperial University during Japanese colonisation. He became the first Taiwanese professor under Japan's imperial university system. Lim had similarly been the first Taiwanese person to receive a Doctorate in Philosophy, which he had completed in the United States; he studied with John Dewey at Columbia University in New York in the 1920s. In his dissertation, Lim criticised the Japanese educational policy of assimilating the

[82] Overviews on the handing over of Japanese institutions can be found in Chun-Kit Joseph Wong, *Postwar Taiwan in Historical Perspective* (Studies in Global Chinese Affairs; Bethesda: University Press of Maryland, 1998) vi, p. 344; and Zi Zheng, *Hand-over and Reconstruction of Postwar Taiwan: An Anthology of Contemporary Taiwanese History* (29; Taipei: Hsinhua, 1994).
[83] Shu-Fen Chen, *Post-War Epidemics: Issues and Institutionalisation of Public Health in Taiwan, 1945-1954* (Taipei: Daw Shiang Publishing, 2000).

colonised Taiwanese people, and emphasised the need for students to develop individual autonomy based on liberalism.[84]

Tu and Lim were the only two Taiwanese members of the adoption committee of the university. Congming was appointed a professor because he had a medical degree, but Lim was appointed a lecturer, although he held an equivalent degree in a non-medical field.[85] Medical sciences at Imperial Taihoku University were substantially better developed than other disciplines, and the new Chinese Nationalist government was keenly aware of this. This scenario was historically attributable to the educational restrictions placed on native Taiwanese people. During the Japanese colonial era, Taiwanese intellectuals had been prevented from taking advantage of higher education and tended to enter the public administration system instead. Taiwanese students who excelled academically tended to study medicine and become freelancers to exempt themselves from regulation by the Japanese government. A career as a physician thus became the most popular aspiration among the Taiwanese.[86] According to statistics, among personnel still working for Imperial Taihoku University by the end of World War II, more than 2,000 were medical school graduates, including 140 people who had been awarded doctorate degrees, mostly from universities in Japan. In contrast, only 64 scholars were registered in the domains of humanities, legal studies, agriculture, and engineering.[87]

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[84] Mosei Lin, *Public Education in Formosa under the Japanese Administration: Historical and Analytical Study of the Development and the Cultural Problems* (New York: [s.n.], 1929) xiv, p. 160

[85] University, 'The Adoption of the Taihoku Imperial University'.

[86] For career choice among Taiwanese students, see Chun-Kai Chen, *Studies on the Social Status of Taiwanese Doctors under Japanese Rule* (Graduate Institute of History Series; Taipei City: National Taiwan Normal University, 1992); Ming-Cheng Miriam Lo, *Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan* (Colonialisms; Berkeley, California.; London: University of California Press, 2002) xii, p. 236; Yun-Wen Yeh, *History of Taiwanese Medical Services: Medico-Political Relationships* (Taipei: Hung Yeh, 2006).

[87] To diminish the influence of Taiwanese intellectuals, the Japanese colonial government either prevented Taiwanese from working or minimised the number of Taiwanese staff in most public sectors,

Mental health issues in Taiwan had long been downplayed or presumed unimportant by the Chinese, including the Chinese Nationalist government. Because the Chinese ethnicity is of such an ancient origin, it had attained an unusual degree of stability and the incidence of mental and physical deficiency among the Chinese was relatively low.[88] During the prewar period, controversy arose as to whether mental illnesses existed among the Chinese. Whereas some missionary doctors believed that insanity prevailed to a considerably lesser extent in China than in Europe, others affirmed the very real existence of Chinese mental illness, although it was thought to take different forms from Western malaise.[89] Even after modern psychiatry had been popularised in the Chinese-speaking world, traditional Chinese health beliefs and practices continued to strongly influence symptom manifestations and health-related behaviours of Chinese patients.[90]

Tsung-Yi Lin (林宗義), son of Bosei Lim, was the first native Taiwanese physician to pursue the study of psychiatry before World War II. One of Tsung-Yi Lin's main motives was his understanding of the Han Chinese (漢民族), an ethnic group native to China and also the main population in Taiwan. Lin discussed furthering his specialty training with his father.[91] Like other distinguished Taiwanese

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including educational institutions. According to the statistics calculated by the adoption committee, of 600 Taiwanese working at Imperial Taihoku University, only one was a professor, namely, Congming Tu at the Medical School; one lecturer held a high rank, namely, Bosei Lim at the School of Humanities. Other Taiwanese were mostly administration staff. In the affiliated hospital, no Taiwanese were employed as operating officers. All 39 of the Taiwanese clinicians were employed as assistants (副手). See University, 'The Adoption of the Taihoku Imperial University'.

[88] Chen, 'The Need of Population Research in China',

[89] Martha Li Chiu, *Mind, Body, and Illness in a Chinese Medical Tradition* (Harvard University, 1986).

[90] Keh-Ming Lin, 'Traditional Chinese Medical Beliefs and Their Relevance for Mental Illness and Psychiatry', in Arthur Kleinman and Tsung-Yi Lin (eds.), *Normal and Abnormal Behavior in Chinese Culture* (Dordrecht, Boston, London: D. Reidel Publishing Company, 1981), pp. 95-111.

[91] Tsung-Yi Lin, 'My Father Bosei Lim', in Hui-Ling Hu (ed.), *Daoyu Ailian (Love Stories on the Island)* (Taipei: Yu-Shan Books, 1995), pp. 1-23.

students under Japanese colonisation, Lin pursued his higher education in Japan after graduating from Taihoku High School (台北高等學校). One reason for this choice was that no systematic psychiatric training was offered in Taiwan. While in Japan, between 1939 and 1946, Lin spent three years studying medicine, receiving two years of specialty training in general psychiatric medicine at Imperial Tokyo University, and another year at Matsuzawa Hospital (松澤病院).[92]

For most Taiwanese intellectuals, the blows of the postwar situation on the island shattered their visions of China. On October 25, 1945, Tsung-Yi Lin saw his father in a photograph sent to Tokyo, in which Bosei Lim was wearing a *magua* (馬褂), a kind of a long coat that represented Chinese culture, during the retrocession of

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[92] Matsuzawa Hospital (currently Tokyo Metropolitan Matsuzawa Hospital) is the largest and oldest mental hospital in Japan, having been founded in 1879. It is currently regarded as Japan's foremost psychiatric authority.
Before Tsung-Yi Lin's departure for the entrance examination at Tokyo University, Bosei Lim gave him a calligraphic rendering of a poem written by Wang Yang-ming (王陽明, 1471-1529), a Neo-Confucian philosopher in Ming China.

> *I know you search for Utopia.*
> *Where may it be found?*
> *Far away in the deep ravines of the Western Mountains.*
> *The Ancients say the fisherman knows the way.*
> *Ask not.*
> *Follow the river,*
> *Gather flowers as you climb.*

According to Lin's memoir, the cultural foundation embedded in Chinese thought provided him with fertile soil for his studies to take root. See Tsung-Yi Lin, *Road to Psychiatry: Across the East and the West* (Taipei: Daw Shiang Publishing, 1994).
Wang Yang-ming's poem reflects how difficult it is to pursue a narrow road seldom traveled. According to Komagome Takeshi, who studied the intellectual history of Bosei Lim, the "deepest place in the mountains of the West" reflects the experience of the Taiwanese elite, represented by Lin, who was driven to study in the West in search of the possibility of modernity. See Komagome Takeshi, 'Colonial Modernity for an Elite Taiwanese, Lim Bo-Seng: The Labyrinth of Cosmopolitanism', in Ping-Hui Liao and David Der-Wei Wang (eds.), *Taiwan under Japanese Colonial Rule, 1895-1945* (New York: Columbia University Press, 2006), 141-59.
In 1984, when Lin published his memoir, he entitled the book 'The Road to Psychiatry: Across East and West'. Some of the material was collected from lecture handouts he wrote for a series of talks he was invited to give at his alma mater, the University of Tokyo, in September 1979, on his international experience. To a considerable degree this material summarised the content and structure of Lin's cross-cultural knowledge.

the Chinese Nationalist government. In the photo, Lin's father displayed an 'excited, confident, and robust' facial expression.[93] This cheerful, hopeful atmosphere did not last long. In the communications between father and son, Lin discerned the disillusionment of his father, and gradually realised that the situation in Taiwan was worsening. Problems included the ill treatment of and discrimination against Taiwanese people by the Chinese, a lack of constructive plans, and cultural discontinuity caused by banning the Japanese language.[94]

Tsung-Yi Lin returned to Taiwan on May 30, 1946. On the day of his arrival, using the metaphor of 'black heaven and dark earth' (黑天暗地), Bosei Lim described the current situation in Taiwan. The contrast with his excitement of only a few months earlier was stark.[95] 'Has the quality of Chinese people deteriorated?' was the first question Tsung-Yi Lin asked his father. This question represents the gap between how the Chinese were imagined by most Taiwanese, and how they were in reality. These anticipatory remarks remained in Lin's mind for later inquiry. On the same day, he received three suggestions from his father on how to conduct psychiatric research in Taiwan: 'First, take the approach from social and cultural perspectives; second, integrate with other disciplines; third, consolidate connections with international academics.'[96] Bosei Lim's suggestions not only reiterated his concerns with his son's career choice, but also revealed his anxiety on the isolation of Taiwan in the context of postwar international relations.

[93] Lin, 'My Father Bosei Lim'. p. 8.
[94] Ibid.
[95] Ibid. p. 17.
[96] Ibid. p. 23.

The aftermath of war provided fertile conditions for psychological trauma to emerge among both clinicians and the public. The blows perceived by young psychiatrists were crucial for them to recount their own trauma and that of people who sought help from them. However, no one could come to terms with such trauma until clinicians had acquired and became familiar with the language and diagnostic tools of modern psychiatry. After Tsung-Yi Lin returned to Taiwan, he observed that the Taiwanese had difficulty accepting that the Chinese, who had completely different language habits, held most of the power in government. He was reminded of his father's experience of disillusionment some years before. He also found it difficult to communicate with colleagues and patients without learning Mandarin, as during the Japanese colonial times, ordinary people were used to communicate in their mother tongues and the official language, Japanese. Tsung-Yi Lin was confronted by his own identity crisis because he was not treated as well as new Chinese immigrants who had recently arrived in Taiwan.[97] His experience was shared among the Taiwanese and could be found in various personal accounts. The war, the change in language policy, and the shift in culture, had all affected the psyche of the Taiwanese people. Wen-Shing Tseng (曾文星), one of Lin's students, found the Taiwanese people to be confronted with the effects of economic collapse and social turmoil immediately after the war. However, Tseng was reluctant to transform his national identity and to adjust to the Chinese language and culture.[98] Similarly, Hsin-Hsin Chung (鍾信心), a nurse who had just graduated from St Luke's College of Nursing in Tokyo, was likewise struck by the 'blow of reality' after returning to Taiwan.[99]

[97] Lin, *Road to Psychiatry: Across the East and the West*. p. 5.
[98] Wen-Shing Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America* (Taipei: Psychology, 2010). pp. 56-57.
[99] 鍾信心 personal communication

Seeing the Difference

The postwar development of modern psychiatry in Taiwan was based on the desire to construct a psychiatric science that would belong to the Chinese. Most Taiwanese medical personnel after World War II identified themselves as Chinese, including Tsung-Yi Lin. This assumption resulted from their yearning for decolonisation, long suppressed during the Japanese colonial times. The questions asked by Tsung-Yi Lin, however, were based on the glaring discrepancy between his visions of the Chinese before the end of World War II and the reality he perceived on returning home. Shocked by the intensity of his father's disillusionment, Lin inquired into the Han Chinese culture to try and comprehend their psychology. 'Why are they so cruel to us?' Lin asked his father. 'Taiwanese intellectuals, including myself,' said Bosei Lim, 'have difficulty understanding the principles of living and the [Chinese] styles of doing.'[100] Bosei Lim proposed research into the qualitative changes in the Han Chinese applying Hegel's dialectic principle. Tsung-Yi Lin pursued scientific methods and conducted actual field work.[101]

Like many psychiatrists in the West who fathomed their scope of cultural psychiatry and comparative psychiatry, this 'bicultural experience' mobilised Tsung-Yi Lin's pursuit of psychiatric research.[102] According to Lin, as a student from the colony, he had already perceived the innate differences between Taiwanese and Japanese people during his studies in Japan. The feeling of 'seeing the difference' was reinforced when he witnessed how the Chinese treated Taiwan after Japan's handover.

[100] Lin, 'My Father Bosei Lim'. p. 14.
[101] Lin, *Road to Psychiatry: Across the East and the West*. p. 10.
[102] Ibid. p. 89.

As discussed, the blow of postwar devastation was a shared experience among Taiwanese intellectuals, as was the realisation of the difference between themselves as 'Taiwanese Chinese' and the Chinese newcomers from the mainland.

Tsung-Yi Lin adopted three principles during the re-institutionalisation of the psychiatric department at NTUH. The first was a focus on clinical work; the second, substantiation of epidemiological field works in Taiwan; the third, an effort to strengthen psychiatric education and training systems.[103] When Lin assumed his new post, Taipei had 140 psychiatric hospital beds, and only one other qualified psychiatrist—who was waiting to be repatriated to Japan. The government estimated nine institutions and 819 psychiatric patients, whether under care or not, in all of Taiwan. While developing a five-year survey project, Lin was told by a governmental official that 'Chinese would not acquire psychiatric diseases'.[104]

Advised by Ryosuke Kurosawa (黑澤良介), the Japanese psychiatrist hired by Tu Congming for the handover administration, Lin and his students completed the first survey of psychiatric diseases before Kurosawa returned to Japan. As with other developing medical specialities, Lin's first psychiatric epidemiology study was accomplished thanks to previous research conducted by the Japanese. During the handover of National Taiwan University, the adoption committee suggested that the re-institutionalised university should, to a degree, respect the old system because of financial and personnel shortages.[105]

[103] Ibid. p. 10.
[104] Ibid. p. 10.
[105] University, 'The Adoption of the Taihoku Imperial University'.

Beginning in 1946, Lin mobilised local gentry, elders, and the police to help him investigate the distribution of psychiatric diseases in Baksa (木柵), a town located in northern Taipei.[106] He appropriated the *hōko* system (保甲制度), a community-based law enforcement and civil control system endorsed by the Japanese colonial government. Over the next two years, two more townships were also surveyed by Lin's team, namely Xinpu (新埔), a Hakka township in northern Taiwan, and Anping (安平), a fishing village in the south. These three areas represented three diverse regions of social and economic development. Across the three surveys, 19,931 'Chinese' were examined by the census method. The research results were later published as 'A study of the incidence of mental disorder in Chinese and other cultures' in the journal *Psychiatry*.[107]

Before commencing their research, Lin et al. had collected similar data obtained from worldwide surveys between 1929 and 1944, on the prevalence and incidence of psychiatric diseases. The team compared their statistical findings with these global data. Thus, in addition to constructing the first epidemiological profile of psychiatric diseases among Chinese populations, Lin et al. were able to report on the methodological difficulties inherent in comparing such diverse data. These difficulties later became the foundation for further studies. The methodological challenges arose

[106] *hōko* system, also known as *baojia* system in the Chinese context, was initially an invention of Wang Anshi of the Song Dynasty in the eleventh century. Taiwan, under Japanese colonial rule, implemented the *hōko* system, an adapted form of *baojia*, under which the bureaucratic system was operated primarily by civilian officials in the order of command, involving the authorization of power. For details, see Huiyu Cai, 'One Kind of Control: The *hōko* System in Taiwan under Japanese Rule, 1895-1945', Ph.D. thesis (Columbia University, 1990); Huiyu Cai, 'Shaping Administration in Colonial Taiwan', in Ping-Hui Laio and David Der-Wei Wang (eds.), *Taiwan under Japanese Colonial Rule, 1895-1945* (New York: Columbia University Press, 2006), pp. 97-121.

[107] Tsung-Yi Lin, 'A Study of the Incidence of Mental Disorder in Chinese and Other Cultures', *Psychiatry,* 15 (1953), pp. 313-36. This paper was later spotted by the Chief of Mental Health Unit at the World Health Organization, Ranold Hargreaves and became the key document that supported his recruitment member of the advisory expert committee in 1955. Details will be given in Chapter 3.

from the divergent ways in which research participants or subjects had been sampled, surveyed, and assessed; the questionable reliability of data concerning the sources they were obtained from; and, most important, disparities in diagnostic standards.[108]

Starting from Lin's survey, several culture-bound syndromes were identified. Lin's team first found a culture-bound syndrome prevalent specifically in Chinese populations, namely *Hsieh-Ping* (邪病), which means 'devil's sickness'. The syndrome was characterised by a trance state in which the patient identified with a dead person for a period of between half an hour and many hours. The patient would speak in a strange tone of voice, the content being mostly ancestor worship.[109] The syndrome often appeared among highly religious people. Symptoms included tremors, disorientation and delirium, and occasionally visual or auditory hallucinations. The team's findings constituted one of the main reports of culture-bound syndromes identified by the research efforts of East Asian psychiatrists. Other examples included 'Utox reaction' among the Atayal in Taiwan, 'Imu'[110] among the Ainus in Japan, and 'Koro'[111] in various Southeast Asian countries.

In the 1970s, cases of 'frigophobia' were reported by Hsien Rin et al., who later pursued cultural psychiatry rather than epidemiology. In these observations, patients suffered from an extreme morbid fear of cold. When these patients were brought to hospital, they arrived in heavy clothing, usually having covered specific parts of their

[108] Ibid.
[109] Julian P. Leff, 'Knocking on Doors in Asia', in Julian P. Leff (ed.), *Psychiatry around the Globe: A Transcultural View* (London: Gaskell psychiatry series, 1988), pp. 92-100.
[110] Y. Uchimera, 'Imu in the Ainu Race', *Japanese Journal of Psychiatry and Neurology,* January (1938).
[111] P. M. Yap, 'Koro—a Culture-Bound Depersonalization Syndrome', *The British Journal of Psychiatry,* 111 (1965), pp. 43-50. Hsien Rin, 'A Study of the Etiology of Koro in Respect to the Chinese Concept of Illness', *Journal of Psychiatry,* 11 (1965), pp. 7-13.

bodies that were considered weak in classic Chinese thought on health. Patients were characterised by overprotective mothers and they had dependent personalities. Rin et al. explained that their symptoms were closely related to the traditional Chinese concepts of vitality and the yin-yang (陰陽) principle. In addition, the symptom might have developed as a regressive psychopathological feature, with a displaced and symbolic manifestation of fear caused by threats to the patient's security, and resultant imaginings of death.[112]



Figure 2 Photographic images of patients suffering from frigophobia

Other than analyzing the dominant Han Chinese, the NTUH team also wished to survey other ethnic groups in Taiwan. To obtain data for comparative research, Lin's student Hsien Rin conducted another survey using similar methods between 1949 and 1953. This study surveyed 11,442 people in four indigenous groups with 'differing degrees of acculturation', namely, the Ami, Saisiat, Paiwan, and Atayal

[112] Yen-Huei Chang, Hsien Rin, and Chu-Chang Chen, 'Frigophobia: A Report of Five Cases', *Bulletin Chinese Society of Neurology and Psychiatry,* 1/2 (1975), pp. 9-13.

populations.[113] Investigative reports published by the Japanese in the early twentieth century provided the team with useful information on Taiwan's indigenous tribes.[114] These reports were published as the *Report on Investigations into the Customs of Aboriginal Peoples* (番族慣習調查報告書) and addressed Taiwanese traditions. The five volumes and eight issues of the report included descriptions of psychiatric diseases in the four tribes the committee had surveyed ethnographically. The ideology of 'four degrees of acculturation' was also taken from this report.

Using the same basic research framework employed in the Chinese study by Lin et al. between 1946 and 1948, Hsien Rin et al. conducted similar door-to-door surveys of four indigenous tribes. They had the support of 'influential community leaders' who assisted them in identifying case studies in local communities.[115] Household visits were made by two teams of field investigators, including psychiatrists, students, and nurses, accompanied by one community leader. The community leaders paved the way for an interview by explaining the purpose of the visits and acting as interpreters. To the surprise of the investigators, mental illness was 'well recognised by the tribesmen'.[116] Their report included a summary of three main factors that contributed to identifying cases among the aboriginal peoples. First, the intimate knowledge

[113] Hsien Rin, 'An Investigation into the Incidence and Clinical Symptoms of Mental Disorders among Formosan Aborigines', *Psychiatria et Neurologia Japonca,* 63/5 (1961), pp. 480-500.
[114] Various investigative activities were conducted to examine the customs and cultural habits of Taiwanese people during the Japanese colonial period. Numerous differences existed between Japanese and Taiwanese people in the areas of law, customs, language, and culture, which led to frequent problems in administrative and legal proceedings. The government and civic groups established numerous organisations in the hopes of quickly resolving such problems, but the results were poor. On the order of the Civilian Affairs executive Goto Shinpei (後藤新平), the Taiwan Governor-General's Office established a 'Temporary Committee for the Investigation of Taiwan Traditional Customs' (臨時臺灣舊慣調查會) in April 1901 (34th year of Meiji Emperor). The investigations into traditional customs not only led to a greater respect among the Japanese for the study of place and folklore, but their methods and results were transplanted and used in all areas of China that were occupied by Japan.
[115] Hsien Rin, 'Mental Illness among Formosan Aborigines as Compared with the Chinese in Taiwan', *The Journal of Mental Science,* 108/453 (1962), pp. 134-46.
[116] Ibid.

residents (and particularly community leaders) had of each other's personal lives facilitated the task; villages were small and village life was cohesive and intimate. Second, the team found a complete absence of stigma attached to mental illness. Third, villagers possessed relatively uniform concepts on mental illness versus normal behaviour.[117]

Similarities among the Differences

Lin et al. began their research with the hypothesis that various ethnic groups would display different patterns related to mental health problems. However, their statistical results indicated numerous similarities between the groups. Lin's team found similar lifetime prevalence rates for total mental disorders among the Chinese (9.4 per 1,000) and indigenous populations (9.5 per 1,000). The rates for psychotic disorders were also almost identical (3.9 per 1,000 for Chinese and 3.8 per 1,000 for indigenous Taiwanese). The team thus concluded that 'primitive' people were not necessarily mentally healthier than 'civilised' ones, at least for the prevalence of mental disorders.[118] However, the researchers found a significantly lower rate of 'schizophrenic reaction' among the indigenous groups, compared with the Chinese. They reasoned that this was because of the proportionally larger number of deaths among indigenous schizophrenics because of their limited capacity for adjustment to stress and deprivation during World War II.[119]

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[117] Ibid.
[118] Ibid.
[119] Ibid. Popper introduced the concept of schizophrenic reaction in 1920, to refer to single schizophrenic episodes of short duration with full recovery, occurring after a traumatic experience. It was also a diagnosis included in the sixth revision of the International Classification of Diseases (ICD-6), published by the WHO in 1948. It was, however, abandoned in the Seventh Revision (ICD-7) in 1955.

Cases of convulsive hysteria were found to be rare among Chinese populations. Similarly, Lin et al. found an extremely small number of cases among indigenous people that could be classified as 'psychoneurosis', apart from the 'Utox reaction' found among the Atayal tribe.[120] The research team concluded that culturally bound syndromes such as *Hsieh-Ping* among the Chinese, 'Utox reaction' among the Atayal, and 'Imu' among the Ainu in Japan (Uchimura et al., 1938) all shared a similar underlying psychopathology.[121] They are all psychological reactions triggered by stress and particularly fear. The dissimilarities appear at the levels of consciousness at which the fear complex operates, and the levels of the organisation of symptoms.

These studies not only laid the foundation for Lin's team to conduct follow-up epidemiological surveys of mental disorders in Taiwan, but also paved the way for the team to join international collaborative research. These two large-scale population surveys in Taiwan, conducted by the same researchers, became important pioneering ventures in psychiatric epidemiology. The prevalence rate for psychoses during the two study periods could be compared. Fifteen years after the original survey of the Chinese population, Lin's students returned to the same three areas and repeated the study using the same techniques. In the period between the two surveys, the total number of Chinese inhabitants in the three communities had risen from 20,000 to 29,000. From the first to the second survey, no significant change was present in the

[120] Ibid.
[121] Y. Uchimura, 'Imu in the Ainu Race', *Japanese Journal of Psychiatry and Neurology,* January (1938). Also see Tsung-Yi Lin and C. C. Stanley, 'The Scope of Epidemiology in Psychiatry', *Public Health Papers* (16; Geneva: World Health Organization, 1962).

prevalence of psychoses for the group as a whole.[122] The follow-up population surveys in Chinese communities were later recognised as the 'Formosan model'[123] in psychiatric epidemiology, despite flaws in the research design. However, according to Julian Leff, the lack of standardised techniques for the clinical examination and diagnosis of patients render comparisons with other studies dubious.[124] This shortcoming later became an issue that psychiatrists in Taiwan and worldwide have endeavoured to overcome.

Psychiatrists who participated in the studies by Lin et al. developed relatively divergent attitudes towards the universality of mental disorders. However, during the immediate postwar period a common belief arose among these new professionals; that is, they ought to employ ratified standards for methodology.[125] For example, in the indigenous survey of Rin et al., the researchers did not find 'completely common resemblances' among the clinical pictures of mental ill aboriginal people. However, they were able to make descriptive classifications through careful case studies and evaluations based on 'Euro-American standards of the diagnostic method' as applied to the surveyed communities.[126] Such claim later developed dissimilar insights and approaches into other cross-cultural studies even within the same institution.

Catching Up with the World

[122] Tsung-Yi Lin et al., 'Mental Disorders in Taiwan Fifteen Years Later: A Preliminary Report', in William A. Caudill and Tsung-Yi Lin (eds.), *Mental Health Research in Asia and the Pacific* (Hawaii: East-West Center Press, 1969).
[123] See Jiashuan Wu, *The Pioneer of Taiwanese Psychiatric Care: Biography of Ying-Kun Yeh* (Taipei: Psygarden, 2005).
[124] Leff, 'Knocking on Doors in Asia'.
[125] Cheng-Ching Hsu, 'Personal Communication', (Xindian City, 2012).
[126] Rin, 'An Investigation into the Incidence and Clinical Symptoms of Mental Disorders among Formosan Aborigines'.

The early Taiwanese psychiatrists aspired to connect with the world, a desire that accelerated the development of modern psychiatric science. Initially, however, despite the development of methods of enquiry born within their own uncertain context, Taiwanese psychiatrists could only graft knowledge by implementing foreign standards or translating theories. The newly launched psychiatry department at NTUH had not yet established a scholarly system for students to follow. Under these circumstances, Tokyo became regarded as the source of referential knowledge. The work of theorists such as Karl Jaspers, Ernst Kretschmer, Emil Kraepelin, and Kurt Schneider were included in the Japanese syllabus of psychiatric education. Their theories were often mentioned in the early syllabi of psychiatry, despite the difficulty students had in understanding them.[127] Students committed to reading psychiatry were, to an extent, influenced by the teachings of Ryosuke Kurosawa and Tsung-Yi Lin, as well as literature on psychology or philosophy available outside of medical school; the latter included Sigmund Freud's *Psychoanalysis*.[128] The first psychiatric paper presented to the general assembly of the Taiwan Medical Association was an introductory article on four cases of war neurosis.[129]

Although psychiatry was a young speciality at the NTUH, after its inauguration the director encouraged new doctors to conduct innovative research.[130] During the first 10 years of the department, 22 medical students chose to graduate with a dissertation in psychiatry, supervised by Tsung-Yi Lin. Their dissertations covered

[127] Lin, *Road to Psychiatry: Across the East and the West*. p. 21.
[128] See Hsien Rin, 'Dedicated to Late Professor Ryosuke Kurosawa', in Hsien Rin (ed.), *The 25th Anniversary of the Department of Psychiatry and Neurology* (Taipei: National Taiwan University Hospital, 1972a), pp. 167-69; Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America*.
[129] Jung-Ji Chen and Chu-Chang Chen, 'Analysis of Academic Presentation Titles within the Past Twenty Years', *Bulletin Chinese Society of Neurology and Psychiatry,* 7/2 (1981), pp. 46-48.
[130] Chu-Chang Chen, Personal Communication (Taipei, 2011).

various aspects of psychiatry, many of which represented then-fashionable or emerging approaches to psychological subjects. Bearing pioneering knowledge and advanced techniques, Taiwanese medical scientists—including the new psychiatrists—shared the worldwide zeal for turning medical practices into scientific interventions. The influence of postwar rehabilitative ideals was strong. According to Japanese intellectual historian Shunsuke Tsurumi, certain civilians in postwar Japan attempted to instill 'principles of science' to replace existing myths and fables in Japanese society, to provide a foundation for cultural reconstruction.[131] In Taiwan, although the colonial era of occupation had just ended, science offered a neutral, impartial, and compelling instrument for Taiwanese people to understand themselves better. At the first assembly of the first Taiwan Provincial Medical Association in 1947, a journalist raised a motion to employ 'scientific methods' to enquire into the 'invisible [psychiatric] disease' and to 'diagnose the ailment of the society' and 'compete in the world'.[132] This scientific zeal, in the end, reframed the fundamental enquiry into the psychopathology of psychiatric diseases in Taiwan. This point is discussed further in the next chapter.

For their graduate dissertations, most doctors chose epidemiological surveys as their research method. This preference arose because many of these doctors were recruited in the department's epidemiology research projects. To familiarise themselves with survey methods, the young doctors conducted their pilot research on blood, a tangible measure of humans. Thereafter, they plunged into the bedlam of research on psychiatric symptoms. The research of Tsung-Yi Lin and his student Ke-Hsiao Chen on sporadic hypoglycaemia became the first academic paper published by

[131] Shunsuke Tsurumi, *An Intellectual History of Wartime Japan, 1931-1945* (Japanese Studies.; London; New York: KPI: Distributed by Routledge & K. Paul, 1986) viii, p. 136.
[132] *Taiwan Medical World,* No. 4, 1948, p. 5.

the psychiatry department.[133] Among Lin's students, many chose to study the statistics of blood pressure among different Chinese populations, or the relationship between blood pressure and psychiatric symptoms, for their graduate dissertations.[134]

It is worth mentioning a type of research that was once popular but short-lived in the history of Taiwanese psychiatry. Before the development of biological psychiatry, the psychiatric study of historical figures (*bingji xhijixue*, 病跡史跡學) was a popular approach. One of the first proponents of comparative psychiatry, Pao-Meng Yap, conducted a famous study on the mental illness of Hung Hsiu-Ch'uan (a.k.a. Hong Xiuquan, 洪秀全), the leader of the Taiping Rebellion.[135] In 1948, three of Lin's students graduated after completing psychiatric research into the persons of Johann Wolfgang von Goethe, Jean-Jacques Rousseau, and Friedrich Nietzsche. Among these three authors, Hsien Rin, who had studied Goethe, became a prominent cultural psychiatrist. Yeh Shengji (葉盛吉), who had studied Nietzsche, later became bored with hospital life and devoted himself to the approach of social medicine, which suited his political aspirations. He contributed to public health research on malaria in Chowchou (潮州), a township in southern Taiwan, where the Rockefeller Foundation was infusing its scientific methods towards eradicating malaria. This was one of the main sites (or 'laboratories') for postwar public health experts to test their developmentalist ideals in the Global South. Unfortunately, the Nationalist Chinese

[133] Chen and Chen, 'Analysis of Academic Presentation Titles within the Past Twenty Years',
[134] Hsien Rin, *The 25th Anniversary of the Department of Psychiatry and Neurology*, ed. Hsien Rin (Taipei: National Taiwan University Hospital, 1972b) pp. 5-12.
[135] Pow-Meng Yap, 'The Mental Illness of Hung Hsiu-Ch'uan, Leader of the Taiping Rebellion', *The Far Eastern Quarterly,* 13/3 (1954), pp. 287-304.

government eventually executed Yeh Shengji because of his socialist intellectual tendency.[136]

Reintroduction of Psychoanalysis and the Basis of Psychiatric Epidemiology

In the early 1950s, a surge of Taiwanese psychiatrists interested in psychoanalysis occurred. It was not, however, conventional Freudian psychoanalysis that inspired medical students to acquire psychiatric speciality training.[137] It was instead the neo-Freudian approach, which emphasised the social and cultural determinants of the psychodynamic self, rather than sexual drives. Neo-Freudian psychoanalysis had been introduced in Taiwan.

In 1951 and 1952, sponsored by the American Bureau for Medical Aid to China (ABMAC), Tsung-Yi Lin left Asia for the first time in his life to study psychiatry in Boston. In the third quarter of the twentieth century, the intertwined development of psychiatry and psychology saw the dominance of psychoanalysis. Medical historians argued that wartime experiences had profoundly transformed American psychiatry.[138] One reason was that a large number of psychoanalysts flowed into the United States after World War II. In addition, a growing number of patients with war neurosis or

[136] Weili Yang, *Double Nostalgia: Yeh Shengji, a Taiwanese Intellectual's Youth, Wandering, Exploration and Tragedy* (Taipei: Renjian, 1995).
[137] For example, Wen-Hsing Tseng wrote in his memoir that three factors prompted him to choose psychiatry as a speciality. First, Freud's interpretation of dreams had intrigued him before his entry into medical school. Second, he found that psychiatry helped him communicate with his patients and understand their thoughts and behaviours. Third, Tsung-Yi Lin's appreciation and encouragement played a critical role in his decision. See Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America*. p. 48.
[138] See Andrew Scull, 'The Mental Health Sector and the Social Sciences in Post-World War II. USA. Part 1: Total War and Its Aftermath', *History of Psychiatry,* 22/1 (2011), pp. 3-19. Ben Shephard, *A War of Nerves* (London: Jonathan Cape, 2000) xxiii, p. 487, p. [8] of plates.

battle exhaustion sought treatment with leading American psychiatrists. These trend gave the psychiatrists, who were mostly from military backgrounds, the confidence to persuade U.S. politicians, the public, and their colleagues that their modern techniques were powerful and had the potential to cure mental disorders not only among war casualties, but also among civilians.

When Lin returned to Taiwan, he immediately published his observations of this phenomenon in the *Journal of Formosan Medical Association*, the first (and at the time the only) medical journal in Taiwan.[139] After briefly introducing the early development of psychoanalysis, Lin focused on the importance of 'interpersonal relationship' in shaping the personality, and its potential role in the formation of mental illness. The interpersonal approach was endorsed not only by the American Psychiatric Association but also later by experts in the WHO. Based on this theory, in the late 1950s the Mental Health Unit of the WHO began sketching a cross-cultural study of the range of social and cultural determinants that could trigger or contribute to mental illnesses. This approach, which I examine in the next two chapters, was the prototype for international psychiatric epidemiology.[140] Back in Taiwan, Lin's pioneering field research convinced him of the variables determining mental illnesses and consolidated his enquiry into psychiatric epidemiology, which became a key paradigm for psychiatry in Taiwan. In contrast, traditional psychoanalysis was seldom pursued in Taiwan, despite occasional attempts among interested people.

[139] Hao-Wei Wang, 'The Development of Psychoanalysis in Taiwan after 1945', (Taipei: Taiwan Institute of Psychotherapy, 2004).
[140] See Chapters 3 and 4.

The Quest for Standardisation

The practice of standardisation figured prominently in the aspirations of psychiatrists as members of a modern, advanced, and scientific international society. Infusing scientific modes into their studies of 'differences', these professionals employed standardised instruments that had been newly introduced to Taiwan. The transplanted measures tended to have been taught in institutions where most of the staff in a psychiatric department had been trained, or were golden standards introduced in textbooks. For example, the Kraepelin-Bourdon Test, a questionnaire to assess patients' personality and concentration, was introduced to the NTUH psychiatric department in 1947. The Rorschach Test, a projective test for assessing patients' psychological functions by analysing their interpretation of inkblots, was employed in 1949; it was used to investigate the intelligence and cognitive functioning of indigenous people.[141] The Thematic Apperception Test (TAT), another projective measure for evaluating patients' thoughts, attitudes, observational capacity, and emotional responses to ambiguous test materials, was also used. These tests were employed not only to assess patients' mental functions, but also as a reference to screen the intelligence of people who desired entry into medical schools.[142]

In 1950, one year after the establishment of the Chinese National government in Taiwan, the official language of NTUH was switched from Japanese-German to a Chinese-English system. This change was most overtly substantiated in the recording

[141] Fayu Cheng et al., 'A Comparative Investigation of Taiwanese and Urbans by Rorschach Test', in Shih-Liang Chien (ed.), *Essays and Papers in Memory of Late President Fu Ssu-Nien* (Taipei: National Taiwan University, 1952), pp. 257-72.
[142] Hsien Rin, 'Table of the History of Department of Psychiatry and Neurology', in Hsien Rin (ed.), *The 25th Anniversary of the Department of Psychiatry and Neurology* (Taipei: National Taiwan University Hospital, 1972c), pp. 5-12.

of patient registries. However, psychiatrists were not used to the new system and were suddenly required to combine five languages (Mandarin Chinese, English, Japanese, German, and Romanised Taiwanese) to note patients' self-reports or their own impressions, diagnoses, and prescriptions.[143]

The residency system of medical training that had originated in American hospitals was also introduced to the psychiatric department of NTUH in 1950. By 1954, one year before the director Tsung-Yi Lin was recruited by the WHO as an advisory expert for its Mental Health Unit, a range of psychological tests and therapies had become routine in NTUH outpatient clinics and wards. The psychiatric department also assisted the Defence Medical School with training military psychiatrists, on demand, for government service. Within a space of less than ten years, the psychiatric department at NTUH had introduced a range of standard operation procedures, and had become an almost full-fledged specialised medical institution.[144] With its lively research activity and large number of publications, it had also become a training centre—which not only produced its own young psychiatrists but was also a model imitated by other institutions.[145]

In 1961, the Chinese Society of Neurology and Psychiatry was established in Taipei. The following year it became a member of the World Psychiatry Association, seeking a synchronous development between Taiwan and the world.[146] This quest had

[143] The case registries kept during this period reveal the characteristics of linguistic mixture and the chaos of disease classification, which I will examine in Chapter 5.
[144] Ibid.
[145] Jung-Ji Chen and Hsien Rin, 'Statistics of Academic Presentations and Journal Publications of the Chinese Society of Neurology and Psychiatry in the Past 25 Years', *Bulletin Chinese Society of Neurology and Psychiatry,* 1/1 (1975), pp. 2-5.
[146] Chu-Chang Chen, 'Twenty Years since the Establishment of the Chinese Society of Neurology and Psychiatry', Ibid.7/2 (1981), pp. 33-46.

also been reflected in the themes and topics of research within the psychiatric department at NTUH, such as an increasing number of studies in psychiatric epidemiology and psychopharmacology, and decreasing interest in electroshock or insulin shock therapy.[147] In 1965, the director of the department, Tsung-Yi Lin, was recruited to direct the international programme in social psychiatry at the WHO. This project gave birth to standardised disease classifications and an optimistic, quasi-universal disease profile of schizophrenia approved by nine field research centres worldwide. The brief six-year period before the People's Republic of China replaced Taiwan as the official Chinese representation saw the pinnacle of interaction between Taiwan and the WHO.[148] Although Taiwan was evicted from the United Nations in 1971, the pursuit of internationally approved standards for survey instruments did not cease. Psychiatrists continued to translate or modify standardised questionnaire manuals from English to Chinese, and endorsed their validity by testing them on Taiwanese patients.[149]

Despite the optimism, there were also voices of introspection. For example, in reviewing the development of Taiwanese psychiatry, Hsien Rin observed that a need arose to choose between adopting the diagnostic system of the United States and the WHO or creating a system solely belonging to Taiwan.[150] In addition, while analysing the prospect of psychiatric research in Taiwan, Ke-Ming Lin noted that although the reliability of standardised survey instruments was approved by psychiatrists and

[147] Jung-Ji Chen and Chu-Chang Chen, 'Analysis of Academic Presentation Titles within the Past Twenty Years', Ibid. pp. 46-48.
[148] Details are presented in Chapter 4.
[149] Such as Y. S. Shieh et al., 'The Applicability of the Diagnostic Criteria Dsm-Iii in the Psychiatric Inpatients', *Bulletin Chinese Society of Neurology and Psychiatry,* 8/1 (1982), pp. 37-38; Eng-Kun Yeh and Hai-Gwo Hu, 'Prevalence of Mental Disorders in Tapei City by Chinese Modified Diagnostic Interview Schedule: A Preliminary Report', *Bulletin Chinese Society of Neurology and Psychiatry,* 10/2 (1984), pp. 88-103.
[150] Hsien Rin, 'Reflections on the Past Twenty Years', *Bulletin Chinese Society of Neurology and Psychiatry,* 7/2 (1981), pp. 49-50.

considered a gold standard, this did not mean that such instruments were always suitable for local contexts. One can see that modern psychiatry in Taiwan progressed through both active creation of innovative methods and passive adoption of existing world standards. These two approaches represent the liminality of Taiwan in the pursuit of a scientific rationale in international postwar modernity.



Figure 3 Interviewing a patient with Rorschach Test at NTHU.[151]

[151] The photo was presented by the World Health Organization for the World Health Day in 1959. The theme chosen was 'Mental Illness and Mental Health in the World'. The caption reads, '"the passage from adolescence to the grownup world is often a stormy one and fraught with dangers to mental health… The failure of grownups to recognize and understand the basic needs of adolescents is usually the main single factor that prevents their sound development into adulthood. How are we to help adolescents to achieve a smooth and successful transition into adulthood? There is still no universal answer to this critical problem of our times. All the world over, societies are suffering more and more from the failure of this transition manifested in the form of mental ill-health among the young and juvenile delinquency in particular." So says Dr Tsung-yi Lin, Professor of Psychiatry at the National Taiwan University, in one of a series of articles edited by WHO's division of Public Information on the occasion of World Health Day.' Tsung-Yi Lin's appointment at the WHO will be discussed in Chapter 3 and 4. Source: WHO photographs archives PHOTO 6801. Credit: WHO/Eric Schwab, 1958

New Taiwanese Bodies under US Aid: Funding Matters

Despite the hunger of Taiwanese psychiatrists to connect with the world, Taiwanese psychiatry could not have progressed as it did without financial aid from the international community. Such aid came mostly from the US. Among the flow of financial support, four streams of funding were significant in furthering the development of modern medicine in Taiwan.[152] The first came from the China Medical Board (CMB) of the Rockefeller Foundation. Before the end of World War II, this fund had supported the Peking Union Medical College Hospital (PUMCH, 北京協和醫院) in Beijing. After the war, the money was distributed among Southeast Asian countries, including the Philippines, Hong Kong, Malaysia, Japan, Korea, and the Republic of China (ROC, or Taiwan). The second stream was the China Foundation for the Promotion of Education and Culture. This was an incarnation of the Boxer Indemnity Scholarship Programme (*genzi peikuan*, 庚子賠款), through which the Qing Empire paid the US to allow Chinese students to study in the US. The third and most important funding stream came from American Bureau of Medical Association in China (ABMAC). The ABMAC consisted of people friendly with the Chinese Nationalist government during World War II, when the Chinese Red Cross no longer provided aid to China.[153] The fourth stream was aid offered by US Naval

[152] Hou-Yao Wei, *The Reminiscences of Mr. Hou-Yao Wei*, ed. Academia Sinica Institute of Modern History (Oral History Series, 24; Taipei: Institute of Modern History, Academia Sinica, 1997).
[153] See Meng-Chih Lee, *ABMAC and Taiwan* (Taichung City: Lee Fund, 2007). John R. Watt, *A Friend in Deed: ABMAC and the Republic of China, 1937-1987* (New York: ABMAC, 1992). Three Chinese-Americans, Frank Co Tui, Earn B. Chu and Joseph Wei, founded the board of ABMAC in New York, November 1937. The Bureau was established to provide medical assistance to the Chinese military during the Sino-Japanese War. The patrons of the Bureau comprised former teaching staff at PUMCH, Christian missionaries, and other Westerners who had befriended the Chinese. ABMAC helped to establish a blood bank during the war, supplied collections to libraries at medical schools, and provided training fellowships for qualified Chinese doctors. During the Chinese Civil War, ABMAC kept a close relationship with Nationalist troops because of its anti-Communist attitude. In 1949, the Bureau's Chinese office was relocated to Taiwan, together with the Nationalist government. In the initial post-

Medical Research Unit, No. 2 (NAMRU-2); this unit supported American interests in the Pacific theatre and advanced US diplomacy in the region by studying infectious diseases of critical importance to public health and the US government. According to economist Chin-Ching Liu (劉進慶), aid from the US was legally facilitated by the China Aid Act, which had been created in 1948 and revived in 1950 because of the Korean War.[154] The STS scholar Wen-Hua Kuo explicitly states that public health development in Taiwan was 'powered by the U.S.'.[155]

There is thus no doubt that US aid contributed to the development of Taiwanese psychiatry. Much of the assistance went into the training of personnel.[156] For example, with the scholarship offered by AMBAC, Tsung-Yi Lin was able to further his postgraduate training at Harvard University. While in Boston, Lin organised the data from the field surveys he had collected with his students in Taiwan between 1946 and 1952. He published his research case studies together with his supervisors, Milton Greenblatt and Harry Solomon, and also published the first epidemiological research outcomes from his own department. These reports were published in the international journal *Psychiatry: Interpersonal Processes*, founded by Harry Stack Sullivan.[157]

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war period, under the management of Jui-Heng Liu (劉瑞恆) and the Bureau's representative and the head of Defence Medical School, Chi-Te Lu (盧致德), ABMAC offered scholarships to clinicians to study in the United States. In addition, it helped coordinate malaria and tuberculosis control programmes with the military, established cooperative programmes with medical schools, and promoted school health programmes and nursing education.

[154] Chin-Ching Liu, *Tai Wan Chan Hou Ching Chi Fen Hsi [an Analysis of Postwar Taiwan Economy]* (Taipei: Jen Chien Chu Pan She, 1992). Under the Mutual Security Act (AMA) and seeing Taiwan as one of its protectorates, the United States began to support Taiwan's military and economic development. The US provided Taiwan with military weapons against the growing Communist power while also paving the way for American private capital to enter Taiwan.

[155] Wen-Hua Kuo, 'How to Write a History of Public Health under U.S. Aid in Taiwan: A Critical Review', *Taiwan Historical Research,* 17/1 (2010), pp. 175-210.

[156] Timothy D. Baker and Mark Perlman, *Health Manpower in a Developing Economy: Taiwan. A Case Study in Planning* (The Johns Hopkins Monographs in International Health.; Baltimore: Johns Hopkins Press, 1967) xi, p. 203

[157] Lin, *Road to Psychiatry: Across the East and the West*. Lin, 'A Study of the Incidence of Mental Disorder in Chinese and Other Cultures'

After Lin's return to Taiwan, with support offered by the Agency for International Development (based in the US), the psychiatric department of NTHU was able to expand. It became one of five main specialities in the hospital and the medical school.[158]

In addition to aid from the US, the newly established WHO played an essential role. It mainly sponsored personnel training and academic research. Taiwan, as part of the Global South conceived by the postwar world order, was a state representing China at a time when the United Nations was actively investing in concerns of economic, agricultural, health, and other types of infrastructure development. Driven off the mainland by the Chinese Communists, Nationalist China relocated its government to Taiwan and became a rump state on the island. Taiwan had to withdraw from the WHO because it could not afford the vast costs of membership. In 1951, the Chinese Nationalist government expressed its interest in the organisation. Upon negotiation, Nationalist China was allowed in with a token payment to a maximum of $10,000 per year.[159] As a member of the WHO, Nationalist China (now vanquished to Taiwan) promised to adhere to the organisation's purposes and principles and to cooperate fully with its work.[160] The WHO began to use Taiwan—which had certain advantages associated with being an island—as one of its laboratories for large-scale thematic public health research projects. These projects experimented with malaria, trachoma, venereal diseases, and other problems.[161]

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[158] Lin, *Road to Psychiatry: Across the East and the West*. pp. 27-28
[159] John Farley, 'Money Matters', in John Farley (ed.), *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: UBC Press, 2008), pp. 76-90.
[160] Ibid.
[161] For islands used in WHO research, see Randall M. Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Johns Hopkins Biographies of Disease.; Baltimore, Md.: Johns Hopkins University Press, 2007) xvii, p. 296

Regarding mental health, Taiwan was considered one of the five prioritised countries whose participation in the WHO's social psychiatry programme was assumed.[162] In 1955, during the visit of Ronald Hargreaves, Tsung-Yi Lin (head of the Mental Health Unit of the WHO) was invited to become an advisory consultant to the expert committee at the WHO. He agreed, and the WHO offered not only to sponsor Taiwanese doctors to further their postgraduate speciality training, but also to send consultants to observe and supervise work in the psychiatric department of NTUH.[163] In 1965, when Taiwan was certified as having successfully eradicated malaria, the Mental Health Unit of the WHO recruited Tsung-Yi Lin as the medical officer to direct its ten-year programme in social psychiatry.[164]

The internal achievements of NTUH and its Formosan model are notable. However, the frequent contact between 'world' and 'Taiwanese' mental health systems should be considered from a wider transnational sociohistorical perspective. Case studies and analyses will be presented in the following chapters.

Building the Satellite System of Taiwanese Psychiatry

As well as receiving foreign support, Taiwan also vigorously stretched its own roots worldwide. In the early postwar years, when the burgeoning of science gave rise to fear and diseases of change, new scientific artefacts were often interpreted in magical rather than rational terms.[165] Inspired by the world scenario and the first satellite in space, Sputnik-1 (launched by the USSR in 1957), Tsung-Yi Lin began to

[162] Details are discussed in Chapters 3 and 4.
[163] Rin, 'Table of the History of Department of Psychiatry and Neurology'.
[164] See Chapter 4
[165] WHO PHOTO ARCHIVES/ Eric Scwab, 1958 Caption

create an information hub at NTUH. He planned to send his disciples all over the world to further their sub-speciality trainings in various centres of psychiatry.[166] He also expected to establish a team with a number of focus points. The capacity of the team, Lin said, 'should reach a "critical mass" in order to produce the blast'.[167] He sent three of his erstwhile students to North America: Hsien Rin, to read with Eric Lindermann at Harvard; Ying-Kun Yeh (葉英堃), to read with Eric Wittkower at McGill; and Chu-Chang Chen, to Boston for training in group psychotherapy. Lin also sent Huan-Ming Chu (朱桓銘) to London to read psychiatric epidemiology with statistician Donald Reid. Chin-Piao Chien (簡錦標) was sent to Boston to study psychopharmacology with Milton Greenblatt. Ming-Tse Tsuang (莊明哲) was sent to read genetics with Elliot Slater at Maudsley Hospital in London. Wen-Hsing Tseng (曾文星) was sent to Boston for training in individual psychotherapy. Cheng-Ching Hsu (徐澄清) was sent to Judge Baker Centre at Harvard University to further his sub-speciality in child psychiatry. Tsu-Pei Hung (洪祖培) was sent to the Queen's Square in London for training in neurology.[168]

Most of these young psychiatrists returned to Taiwan after their training abroad. Some of them were contracted in 'braindrains' and remained overseas. Nevertheless, interdisciplinary teamwork became a tradition in the psychiatric department of NTUH.[169] Between 1950 and 1968, an additional twenty members of the department were sent overseas to further their studies. They represented 22 different scholarships,

[166] W. T. Soong, Personal Communication (Taipei, 2011).
[167] Ibid.
[168] Lin, *Road to Psychiatry: Across the East and the West*.
[169] Soong, Personal Communication.

15 of which had been offered by the WHO. Table 1 below provides details about the funding bodies, trainees' destinations, degrees, and the duration of their stays.

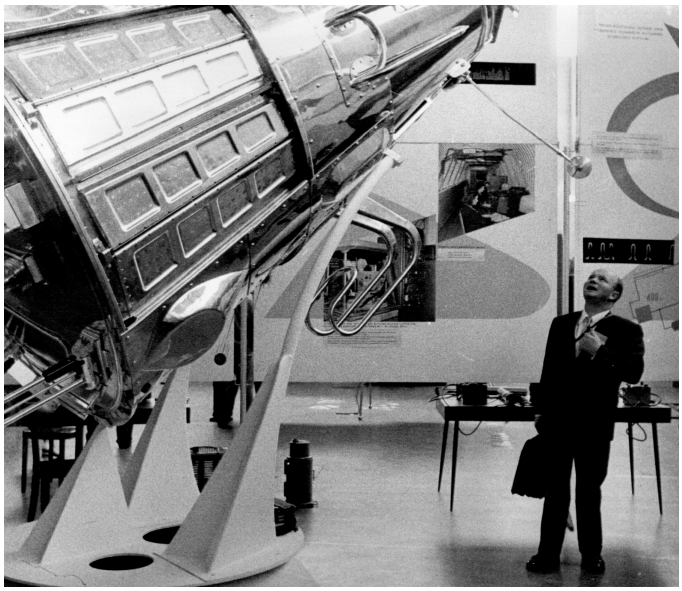

Figure 4 This photo shows a visitor to the exhibition on the Peaceful Uses of Atomic Energy organised by the United Nations in Geneva in September 1958. In 1959 the photo was chosen for the thematic showcase of World Health Day, representing 'Mental Illness and Mental Health in the World of Today'. Credit: WHO/Eric Schwab, 1958

Table 1 NTUH Psychiatric Department Staff on foreign scholarships for overseas further studies. [170]

Year	Name	Funding body	Destination	Degree	Duration
1950	Tsung-Yi Lin	ABMAC	Boston, USA		2 years
1955	Hsien Rin	WHO	Boston, USA		1 year
1956	Tsung-Yi Lin	WHO	Europe		1 year
1958	Chen-Chin Hsu	WHO	Boston, USA		2 years
1958	Yung-He Ke	WHO	Ann Arbor, USA	M.S.	2 years
1959	Hsiu-Hsin Wang	WHO	UK, USA		2 years
1959	Wen-Wen Chang	AID	UK, USA, Canada	B.S.	2 years
1959	Hsin-Hsin Chung	WHO	Detroit, USA	B.S.	2 years
1960	Tsu-Pei Hung	WHO	London, UK		1 year
1961	Ying-Kun Yeh	WHO	Europe		1 year
1962	Mei-Jung Chou	WHO	Boston, USA	M.S.	2 years
1962	Yue-Hsiu Chen	AID	Boston, USA	B.S.	2 years
1962	A-Mei Lin	AID	Boston, USA	M.S.	2 years
1963	Ming-Tse Tsuang	Sino-British	London, UK	PhD	2 years
1963	Ya-Mei Chang	WHO	Berkeley, USA	M.S.	2 years
1964	Kuang-Ming Chen	NINDB	Guam, USA		2 years
1964	Huan-Ming Chu	WHO	London, UK		2 years

[170] Rin, *The 25th Anniversary of the Department of Psychiatry and Neurology*.

1964	Su-Ken Yang	WHO	Edinburgh, UK	D.C.P	2 years
1965	Wen-Hsing Tseng	WHO	Boston, USA		3 years
1966	Yung-He Ke	East-West Centre	Ann Arbor, USA	PhD	3 years
1966	Hsin-Hui Liang	WHO	Tennessee, USA		no return
1968	Hsin-Chang Yu	WHO	Boston, USA	M.S.	2 years

In addition to sending young psychiatrists overseas for sub-speciality training, NTUH was able to provide assistance to other institutions, such as military hospitals and new convalescent hospitals.[171] This assistance was provided from the mid-1960s onwards. The skeleton of new Taiwanese psychiatry, led by Tsung-Yi Lin, was constructed of neither established templates nor eminent theories.[172] Lin was able to absorb diverse schools of theories in a prompt manner, transforming the focal points summarised from the reports made to him into his own problematics and hypotheses.[173] One of Lin's students, Wei-Tsung Soong, considered Lin's methods innovative. A political activist with whom Lin collaborated in the 1980s, Nan-Chou Su, believes that Lin's approach was based on the practical needs of his time. Thus, if not a product of Lin's creativity and that of his team, the psychiatric tradition of NTUH was a strategic product or service born out of the confrontation with immediate postwar *realpolitik*, rather than of wisdom brewed for long time. The challenges facing this body of knowledge as time unfolded are discussed in the following chapters. I examine the globalisation of mental health issues, and the incongruity between standardised psychiatric diagnoses and the specific contents and forms of mental suffering in local contexts.

[171] Rin, 'Table of the History of Department of Psychiatry and Neurology'. Soong, Personal Communication.
[172] Lin, *Road to Psychiatry: Across the East and the West*. Nan-Chou Su, Personal Communication (Taipei, 2010).
[173] Soong, Personal Communication.

Conclusion: *Cultiver notre jardin*

In this chapter, I have illustrated the construction process of Taiwanese psychiatry during the early postwar period. I conclude that the process was characterised by several features, which are discussed in this section. First, the re-institutionalisation of the psychiatric department of NTUH involved a process of decolonisation and subsequent construction of indigenous autonomy. For the first time, the institution was staffed and managed by Taiwanese people, despite the shortage of financial resources. In addition, Tsung-Yi Lin felt drawn to study the differences among the multi-ethnic residents of the island, in the process facilitating the department's research interests. Second, the contents of psychiatric education and services were transformed from the German-Japanese to the English-Chinese system. The transformation was reflected in the implementation of educational syllabi, recording of patient registries, and the appropriation of psychiatric theories. In addition to the transformation, the department transplanted a substantial number of foreign theories at different times. This phenomenon commonly occurs in places where resources are constrained.

Regarding methodology, Lin and his team were innovative. To answer their research questions, they made substantial efforts to obtain the information they needed before carrying out actual field surveys. To this end, they made good use of the ethnological reports produced by the Japanese colonial government. Furthermore, they conducted door-to-door sampling of research subjects across different levels of urbanisation and acculturation, a feat that was unattainable for later researchers.[174]

[174] Leff, 'Knocking on Doors in Asia'.

Their efforts yielded useful data for follow-up studies, and paved the way for the researchers to collaborate in international research in social psychiatry (which I discuss in Chapters 3 and 4). In tandem with the epidemiological surveys, Lin et al. also discovered several culture-bound syndromes; the resulting case studies and reports constituted the origins of postwar transcultural psychiatry. For example, Hsien Rin's research was favoured by Eric Wittkower when he was attempting to obstruct a later international project by the WHO.[175] However, these early approaches of transcultural or pan-cultural psychiatry were no longer in vogue after psychiatric epidemiology took the lead in the psychiatric field in Taiwan.[176]

Tsung-Yi Lin's life motto was 'Il cultiver notre jardin' (To cultivate our garden), taken from Voltaire's novel *Candide*.[177] The swift transformation of Taiwanese psychiatry from a barren land to a leafy garden was a realisation of this ideal. Figure 4 below shows a tree sketched by Tsung-Yi Lin, illustrating the organic nature of his studies and thoughts. Lin's knowledge system can be seen as an illustration of the early development of the psychiatric department of NTUH, because in its early phase the department developed entirely through this one man's voice. The teamwork in the department also reflected Lin's own work.[178] This situation made the presentation of diagnostic classifications, board training systems, and other standardised programmes relatively easy.[179] Whether this unique scenario ultimately facilitated or hampered the scope and scale of the development of Taiwanese psychiatry requires further analysis.

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[175] See Chapter 3
[176] Hsien Rin, Personal Communication (Taipei, 2009).
[177] Marnie Copland, *A Lin Odyssey* (Orlean, Mass.: Paraclete, 1987) p. 287.
[178] Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America*.
[179] Soong, Personal Communication.

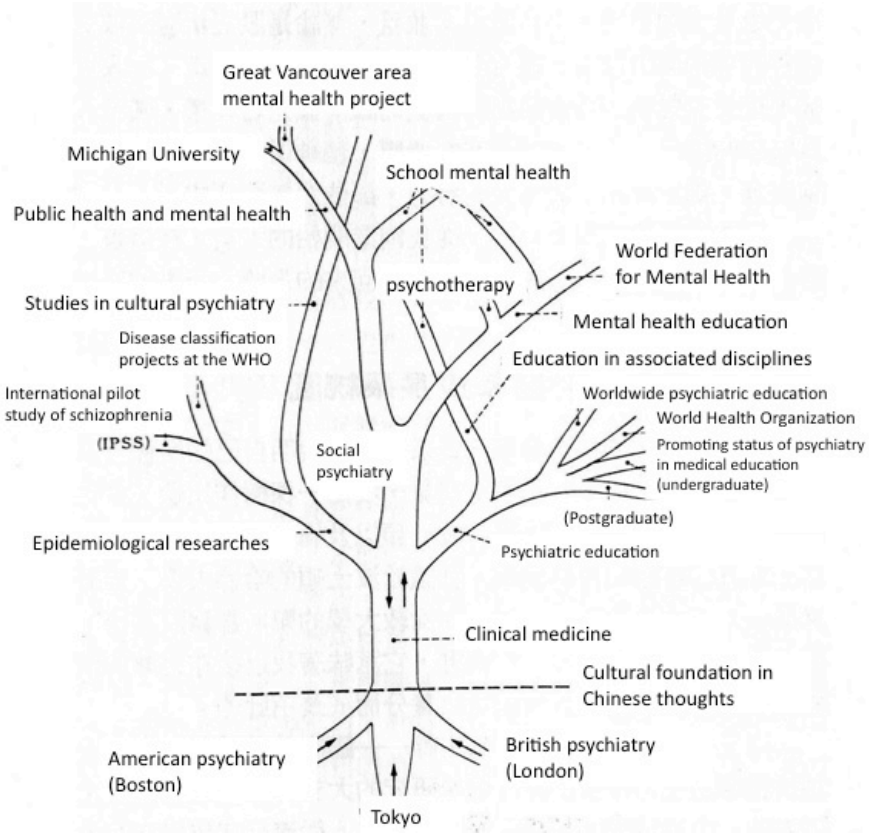

Figure 5 The tree sketched by Tsung-Yi Lin, illustrating the development of his studies and thoughts

In this chapter, I have considered the social and historical determinants of the rendezvous between world psychiatry and Taiwanese psychiatry. In addition to the globally shared fervour for scientific rationale, which is outlined in Chapter 3, several factors affected health issues at all sites of postwar globalisation. On the one hand, Taiwan wanted to escape the isolation of the closing decade of Japanese colonisation and the early postwar period. Intellectuals made every effort to embrace as many schools of scientific thought as possible, and to attain world standards in all types of measurements. On the other hand, the newly constituted Western world—including agents from the US and United Nations—regarded Taiwan as a blank template of the Global South, where they could impose development. No matter how absurd it was for Taiwan to represent the whole of China at the UN, the unique conditions in

Taiwan made it an excellent laboratory where developmentalists such as the WHO could experiment and engineer their thematic projects. The mutual regard between the North and South, as well as the East and West, facilitated frequent contact between the WHO and Taiwan. Concerning the development of medical research, during the years of decolonisation Taiwan was clearly incorporated into the territory of the Western bloc in the Cold War. Taiwanese people's psyche, moulded together with their bodies nurtured by the U.S., the WHO and other political powers, reflects the re-oriented position of Taiwan in the world order mapped out by various postwar geopolitical, social and cultural determinants.

PART II: THE GLOBALISATION OF MODERN PSYCHIATRY IN THE SHADOW OF TRAUMATIC TIMES

Chapter 3

The New WHO Paradigm in Psychiatric Science after World War II, 1948–c.1961

This chapter examines the role of international health organisations, especially the World Health Organization (WHO), in promoting mental health after World War II. Health professionals were calling for rehabilitation initiatives to address the devastation after the war. In Chapter 1, I set out the framework within which 'transnational' activities emerge during the joint effort of various international agencies, both organisations and individuals. In this chapter, I examine postwar international organisations as the backdrop against which discussions about the globalisation of mental health took place. Themes which I explore include the global awareness of mental rehabilitation, early ventures to prevent further catastrophes, the augmentation between psychiatry and public health, and the attempt by the WHO to conduct large-scale, cross-cultural studies relevant to mental health.

These attempts to globalise mental health studies hinged on the idea of 'world citizenship', coined by the first director-general of WHO, Brock Chisholm. World citizenship presumes a universality of human minds and the hidden aspiration of promoting peace; this ethos helped to shape scientific practices associated with WHO. I first illustrate in detail the endeavour of psychiatric professionals to deal with war trauma among soldiers before and during World War II, and then to extend their care to civilians. Thereafter I examine the World Congress on Mental Health in 1948 in London as the turning point of international mental health. After this event psychiatry began to transform itself from a science regulating social deviants into a discipline

concerned about the wider community, including civilians, with a greater range in the age distribution of recipient populations. Moreover, I demonstrate the augmentation of psychiatry and public health, which gave birth to a new paradigm of research into mental health, namely psychiatric epidemiology. Finally, I describe the early projects carried out at the Mental Health Section of the WHO, examining the meanings and functions of the awareness of mental health as these have grown in non-Western developing countries.

The transformation of the psychiatric discipline in international health organisations corresponds with the concept of 'thought collective' promoted by historian of science Ludwik Fleck. I argue that this transformation arose as a collective response among psychiatric professionals to the traumatic period following the war and to the need for rehabilitation.[180] Individuals as well as organisations were involved in transnational activities that facilitated the globalisation of mental health research. This globalisation was catalysed by the ethos of internationalism among scientists and their collaborators, particularly in WHO, encouraging them to develop new terminologies and instruments of research. The ultimate aim was to establish a new paradigm for understanding the human mind on a transnational basis. This chapter analyses social and historical factors that affected the emergence of the new science of international psychiatric epidemiology within the first ten years of the existence of WHO.

Lessons of War

[180] Ludwik Fleck, *Genesis and Development of a Scientific Fact* (Chicago: University of Chicago Press, 1979) xxviii, 203 p.

Warfare has had an immense impact on the development of modern psychiatry. Historians have written a broad range of theoretical accounts regarding the origination and transformation of traumatic psychologies, many of which were associated with 'shell shock', 'combat exhaustion', and 'war neurosis'. These military psychiatric categories stemmed mainly from the World Wars and Vietnam. Chapter 1 of this thesis provides some speculations on the progression from 'shell shock' to 'post-traumatic stress disorder' (PTSD) as a single-strand paradigm shift. Most historical enquiries focus on the alteration of disease terminology in the wake of battles rather than on the influence of warfare *per se* on the psychiatric disciplines. Ben Shephard exclusively discusses this neglected aspect in his history of traumatic psychiatry and psychology, showing that from the interwar period onward more attention was paid to preventing mental suffering among soldiers than to reparatory treatment.

According to Shephard, in Britain in the 1930s, voluntary hospitals gradually replaced asylums. Novel treatments for shell shock began to be endorsed by new institutions such as Cassel Hospital and Tavistock Clinic. Innovative theories were developed to negotiate between behaviourism and Freudian psychoanalysis. As the lessons of war were forgotten during peacetime, a number of individuals continued to probe the lessons of the Great War, with diverse opinions.[181] During World War II there seemed to be a tacit agreement between British and American psychiatrists, with both camps embracing preventive psychiatry in the form of screening soldiers' intelligence and personality. The screening ensured that only soldiers who were both physically strong and mentally robust were sent to the front line. For example, Ronald Hargreaves, a Tavistock-trained British psychiatrist, established 'Progressive

[181] Ben Shephard, 'The Lessons of Shell-Shock', *A War of Nerves : Soldiers and Psychiatrists, 1914-1994* (London: Pimlico, 2002b), pp. 161-68.

Matrices' as a kit for rapidly testing soldiers' intelligence. Harry Stack Sullivan, an American psychoanalyst who became renowned for his 'self system', investigated the personality types of military recruits.[182] Nevertheless, these preventive methods emphasised personnel selection, through which weaker individuals were spared front line duty, rather than establishing ways of protecting healthy minds from mental breakdowns.

Mental Health as an Issue of Public Health

Mental health professionals expressed specific concerns during the postwar period, as distinct from either before or during the actual war. As mentioned earlier in this chapter, the concept of world citizenship provided the core philosophy for all health initiatives. With regard to mental health, psychiatry no longer served as an instrument to control the social order. Rather, it viewed mental illness as a heavy burden on human beings in postwar society and attempted to understand why certain people were particularly at risk for mental symptoms. Psychiatric research attempted to identify the stressors and risk factors and whether other psycho-social factors played a role in mental illness.

The impetus to study the causes of mental illness from an international perspective was also derived from the concept of world citizenship coined by Brock Chisholm. Chisholm was a Canadian military psychiatrist and later the first Director-General of WHO; he was renowned for his pioneering ideas about preventive medicine and children's education, and was also known for his controversial

[182] Ben Shephard, 'We Can Save Those Boys from Horror', *A War of Nerves : Soldiers and Psychiatrists, 1914-1994* (London: Pimlico, 2002a), pp. 186-208.

endorsement of birth control, sterilisation, eugenics, and euthanasia in the 1930s. Before his epoch-making contribution to scientific practice, Chisholm's central concern was human conflict. He pondered why human conflicts occurred, how they affected people, and what psychiatrists could do to help people avoid further devastation. In 1945, he commented on the effect of the war on returning soldiers in the Journal *Psychiatry*.[183]

In the same year, Harry Stack Sullivan invited Chisholm to lecture on 'The Psychiatry of Enduring Peace and Social Progress' at the William Alanson White Foundation. The lecture was later published by Sullivan in *Psychiatry* and attracted feedback from numerous individuals and societies (such as the Unitarian Society, and the Institute for Semantography).[184] Realising his own popularity, Chisholm extended his focus from the military to the wider population. Some readers even sent their own proposals to Chisholm in response to his appeal. Thereafter, either by invitation or spontaneously, Chisholm contributed a number of articles not only to academic journals but also to popular magazines. For example, he wrote 'What Can I Do at Home about War or Peace?' for the magazine *Better Homes and Gardens.*[185] Chisholm's prescription for the world community conjured up both appreciation and controversy among his readers. His concept of human beings sharing a common destiny became a magnet for like minds. In contrast, his views criticising superstition and traditional morality irritated a number of religious groups. However, the world-peace proposal buried deep in Chisholm's heart did not surface in practical terms until

[183] See Brock Chisholm's publication on the journal *Psychiatry*, in WHO4: Records of the Director General's Office.
[184] See Eugene B. Brody, 'The World Federation for Mental Health: Its Origins and Contemporary Relevnce to WHO and WPA Policies', *World Psychiatry,* 3/1 (2004), pp. 54-55, George Brock Chisholm, 'The Psychiatry of Enduring Peace and Social Progress', *Psychiatry,* 9 (1946), pp. 1-44.
[185] See Brock Chisholm, 'What Can I Do at Home about War or Peace?' in *Better Homes and Gardens*. WHO4: Records of the Director General's Office.

he stepped down as the Director-General of the WHO in 1953. During his tenure, he had managed several epidemics successfully, such outbreaks of cholera in Egypt and malaria in Greece and Sardinia. Regarding psychiatry, however, he had remained relatively quiescent.

The project that made 'world citizenship' a feasible psychiatric premise began in 1953. At the end of that year, at the Seminar on the Mental Health of the Eastern Mediterranean Region, Ronald Hargreaves (then Chief of the Mental Health Section of WHO) delivered a paper entitled *Mental Hygiene and the Epidemiology of Psychiatric Disorders.* His paper emphasised the need to develop psychiatric care outside of asylums, and the need for cooperation between public health and psychiatry personnel. Regarding preventive work, and recognising that psychiatric disorders might include genetic factors (e.g. schizophrenia), he posited that full-blown disorder might only develop in the presence of various stressors. About the stressors themselves Hargreaves suggested, 'These stressful experiences […] are not those which are unusual or exceptionally catastrophic, they are, on the contrary, those which are usual and which are the common lot of all human beings'. Thus Hargreaves was referring not to the devastation caused by human atrocities and natural disasters, but to everyday stresses such as work, parenting, schooling, and even the weaning of infants.[186] His words acknowledged the universality of all human beings and the need for mental health professionals to probe the causality of mental health issues.

After the 1953 seminar, the core spirit of psychiatry shifted and new research methods began to take shape. While in Buenos Aires in 1953, Hargreaves wrote

[186] See Ronald Hargreaves, *Mental Hygiene and the Epidemiology of Psychiatric Disorders.* WHO ARCHIVE M4/445/2/ J1.

another paper titled *Preliminary Statement on a Research Project Dealing with Mental Health and Disease from a Comparative Point of View*. In this paper Hargreaves stated that

> It is [a] well-recognised principle of medical research that the comparative study of groups that are similar in most respects but dissimilar in one or two specific ways allows for a study of etiological factors which has nearly all the qualities of an experimental investigation. It is also a fact that psychiatrists have tried to use this technique here and there for the last 50 years: Kraepelin's paper on comparative psychiatry formulated the problem at the beginning of the century, and the Milbank Memorial Fund's Symposium on the Epidemiology of Mental Disorder gives us an example of the current application of the method. It must be said, however, that the subject has so far not been dealt with in a truly systematic way, the reason for this being in all likelihood that it was until now practically impossible to carry it out in sufficient scope.[187]

Hargreaves referred to the 'urgency' of pursuing this project 'in the near future'; he further proposed '[the] initial task of assembling the available evidence, collecting such additional facts as seem necessary for securing the over-all usefulness of the existing material and of organizing the sum of our present knowledge with a view towards making truly systematic research possible'.[188] According to Hargreaves a 'manageable project' was necessary, such as Emil Kraepelin's research in

[187] Ronald Hargreaves, *Preliminary Statement on a Research Project Dealing with Mental Health and Disease from a Comparative Point of View*. WHO ARCHIVE M4/445/2. J1. p. 1.
[188] Ronald Hargreaves, *Preliminary Statement on a Research Project Dealing with Mental Health and Disease from a Comparative Point of View*. WHO ARCHIVE M4/445/2. J1, p. 2.

comparative psychiatry. Hargreaves' words implied that a manageable project, based on the universality of human beings, would be an international effort and would lend itself to epidemiology and would benefit future research. One can further understand the *zeitgeist* of his project by referring to his book published in 1958, in which he saw psychiatric illnesses as actual diseases, such as cholera. The project became a cornerstone of public health.[189] Nevertheless, Hargreaves had to wait a long time before his visionary project was carried out. To explain this delay, I examine the broader context in which the project took place and discuss the history of WHO.

The WHO Model and Early Efforts in the Mental Health Field

The globalisation of modern psychiatry in the postwar period occurred in tandem with the development of international organisations, of which the WHO was a main player. According to the constitution agreed at the International Health Conference in New York in 1946, the WHO was one of the special agencies established immediately after the founding of the United Nations. Although a postwar organisation, it had seen several previous incarnations—such as *L'Office International d'Hygiène Publique* (OIHP) before the First World War, and the Health Organization of the League of Nations during the inter-war period. In contrast to its predecessors, the WHO did not limit its scope to Europe but covered six regions of the world. According to Javed Siddiqi, the WHO and other UN special agencies were based on the 'spill-over' theory endorsed by functionalist economists such as David Mitrany. As mentioned in a previous chapter, spill-over theorists believed that

[189] G. R. Hargreaves, *Psychiatry and the Public Health* (University of London. Heath Clark Lectures,; London ; New York: Oxford Univiversity Press, 1958) p. 118.

alleviating health challenges in less-developed countries would decrease the conflict between states due to unequal resource distribution, thereby fostering stability at the economic level and facilitating world peace.[190] The WHO was inaugurated on 7 April 1946. The subsequent First World Health Assembly was held in Geneva; here, health issues requiring urgent postwar rehabilitative work were identified by health professionals. However, not until 1948 was mental health officially listed in the inaugural constitution of WHO. The constitution stated that '[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'; the objective was 'the attainment by all peoples of the highest possible level of health'.[191] The early projects of the WHO focused mostly on controlling epidemics during and after World War II, such as malaria, tuberculosis, treponematoses, viral diseases, and other communicable diseases.[192]

The WHO has a unique structure and *modus operandi*. One aspect of its design was the decentralisation of power to regional offices; another was ensuring that recommendations made by headquarters were distributed effectively. The decentralised design was intended to keep the WHO from becoming a 'supranational organisation' and to remain an 'instrument only', which would 'take its instructions from the governments of the world, and for its personnel to do exactly as they were told to do by the peoples of the world through their governments'.[193] To fulfil the needs of various regions of the world, the WHO is decentralised into six regions, each

[190] Javed Siddiqi, *World Health and World Politics : The World Health Organization and the UN System* (London: Hurst, 1995) xiv, p. 272.
[191] The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org*., **2**, 100), and entered into force on 7 April 1948. It has not been changed since its inauguration.
[192] World Health Organization., *The First Ten Years of the World Health Organization* (Geneva,, 1958) vii, p. 538
[193] George Brock Chisholm, *Prescription for Survival* (Bampton Lectures in America; [New York]: [Columbia University Press], 1957) p. 92.

consisting of a regional committee and office which are responsible for formulating policies of a regional character, and for monitoring regional activities.[194] To enable this huge organisation to function well, the WHO used to employ thematic projects or programmes of advisory services, with expert advisory panels and committees to facilitate the projects. The operational style of the advisory services has never been simple. To meet a request from a country, the regional director consults with national authorities to determine the type of international assistance needed. A suitable expert or team is then recruited by the WHO and briefed on the purpose of the project, the conditions in the region and country, and the general administrative and technical procedures that the organisation has found useful in similar circumstances. The regional office assists with the necessary liaison and co-ordination with national counterparts and local services appointed to work with the expert or team.[195] Although declaring itself to be 'decentralised', the operation of the WHO relies on a 'vertical model'.[196] In this model, all recruited experts from all over the world gather at the Geneva headquarters. They run study groups and technical meetings, either as large conferences or small seminars, and conclude their discussions with technical reports. The reports provide authoritative direction for WHO policies and programmes, and are referred to by member states when developing national policies.

The 1948 International Congress on Mental Health

In addition to the afore-mentioned activities, the WHO provides a hub for health professionals from all over the world to meet, exchange ideas, and promulgate their

[194] World Health Organization., *Facts About WHO* (Geneva: World Health Organization, 1990) p. 28
[195] World Health Organization., *The First Ten Years of the World Health Organization*.
[196] Siddiqi, *World Health and World Politics : The World Health Organization and the UN System*.

proposals. In 1948 the topic of mental health gained international attention in its own right. The International Congress on Mental Health played a pivotal role in corroborating international mental health research as an instrument for the postwar project of global rehabilitation. This led to the establishment of the Expert Committee of the Mental Health Unit (MHU) in the WHO, and the birth of another organisation, the World Federation for Mental Health (WFMH). These new organisations helped to promote the work of individual mental health professionals to the level of international collaboration.

The International Congress on Mental Health was organised by Michael Harvard of the National Association of Mental health in the UK and was chaired by Dr John Rees (also known as Jack Rees), who had been the head of psychiatric services in the British Army. The Congress was held in London from August 16 to 21, 1948. By the time the WHO was officially established in Geneva in 1948, its membership policy allowed only those countries that were members of the United Nations to join the organisation—a point which contradicted the idealism of the Constitution of WHO. Britain discouraged its own delegates from attending international conferences organised by bodies other than the WHO.[197] Nonetheless, Michael Harvard strategically attempted to gather delegates by issuing invitations to the Congress through the Foreign Office, and by accepting personal applications. His intention was to create a genuine assembly of world citizens that was not hampered by the membership policy of the WHO or hindered by world politics under the Cold War. For example, Germany, Japan, and Spain were initially banned by British national law from attending the Congress, as the gathering was regarded as a British

[197] National Archives FO 370/1411. Representation of His Majesty's Government at the International Congress on Mental Health to be held in London in 1948. Code 403 file 5577 J. Lindsey to Miss Murray, 17th Dec 1947

diplomatic mission.[198] These nations were eventually allowed to attend after making individual applications. Russia, however, could not send a representative according to its own national laws.

During the week of the Congress, psychiatrists, anthropologists, and sociologists gathered to search for 'a basis for common human aspiration'[199] regarding human mental health. The statement of the Congress provides a rare example of international organisations reflecting on the wrongdoing of modern science after World War II. It asserted: 'Few societies of which we have knowledge are wholly free from distortion of human impulse, sometimes on a large scale, such as racial oppression, or industrial conflict'.[200] Due to the 'profound disquiet following two world wars, and the fear of a third catastrophe', scientists were compelled to face the dreadful 'possibilities of biological and atomic warfare'. Instead of initiating social reforms, the Congress was determined to 'infuse a scientific spirit into the movements of reform and reconstruction' in those countries that had suffered in the most recent war.[201]The Congress concluded with three main objectives, related to recruiting specialists and making suggestions to the newly founded UN specialised agencies.[202]

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[198] National Archives FO 370/1525 International Congress on Mental Health, London, Aug 1948. Code 403 file 310

[199] J. C. Flugel et al., *International Congress on Mental Health, London, 1948*, 4 vols. (London New York: H.K. Lewis; Columbia University Press, 1948).

[200] Ibid.

[201] Ibid. pp. 285–286.

[202] These objectives are:

1. To bring together representatives of the professions to the promotion of human well-being, with the aim of defining those conditions which will enable every man, woman and child to develop his full worth and dignity.
2. To bring suggestions to the notice of the United Nations' specialised agencies, for example, the United Nations' Educational, Scientific and Cultural Organisation, whose objectives are relevant to our theme, and the World Health Organisation which already accepts social, mental and physical health as one and indivisible.
3. To encourage ever-widening activities of organisations concerned with mental health in many countries, having regard to the fact that different societies will show very different types of

Two new organisations related to mental health, namely the Mental Health Expert Committee at the WHO and the World Federation for Mental Health (WFMH), were founded in line with proposals from the Congress. The former was regarded as a centre to foster international mental health, and the latter replaced the International Committee for Mental Hygiene. Specifically, the WHO Mental Health Expert Committee was expected to handle forthcoming international surveys and develop international standards regarding research methodology. The WFMH would assess the universality of the Congress's statement from the standpoints of various nations and cultures, and suggest modifications for its improvement. The WFMH records, however, indicate that the various experts maintained close correspondence with one another and were actively involved in meetings and study groups organised by either official body.

Although the practical considerations of these new international organisations were complex, the core agenda of the 1948 International Congress was simple. It sought to treat the damaged minds of people devastated by the war and to find methods of peacemaking by enhancing mental health. At the beginning of the summary of *Mental Health and World Citizenship* several questions were asked: 'Can the catastrophe of the third war be averted? Can the peoples of the world learn to co-operate for the good of all? On what basis is there hope for enduring peace?'[203] One might say that the development of world psychiatry in the postwar period was based on these bold and rather naïve questions.

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readiness to understand and accept the new knowledge and that a variety of methods of communication, from the most concrete to the most general, will have to be used.

[203] World Federation for Mental Health., *Mental Health and World Citizenship : A Statement Prepared for the International Congress on Mental Health* ([London]: World Federation for Mental Health, 1948) p. 47

From the ‘collection of hunches’ to the practice of collaboration

Individuals involved in international activities around 1948 tended to have a fairly consistent level of awareness regarding mental health issues. In contrast, consensus was never reached about development priorities and know-how during the first ten years of WHO. Thus before the large-scale systematic approach was fully formulated, the concerns of early visionaries regarding mental health were akin and yet diverse. Nevertheless, theories and protocols were proposed to deal with the question of the aetiology of mental illnesses. The experts attempted to answer questions such as ‘Why do human beings develop psychiatric symptoms?’ This general concern shifted the direction of mental health beyond the desire to prevent individuals from deteriorating mentally under exposure to extreme experiences, to exploring the stressors that human beings encounter during their development. In addition, the focus shifted from removing mentally ill people from society towards a community-oriented preventive psychiatry.

Mental health professionals realised that before they could initiate preventive work they needed to understand the mental health problems among different nations, and this became their first concern. Despite their similar attitudes towards international collaboration, they lacked a useful methodology. They began to draw their own conclusions about the human condition resulting from postwar devastation. For example, Brock Chisholm considered the postwar human condition to constitute ‘a valid anxiety’; by this he meant a ‘free-floating’ anxiety that was part of everyone’s life, which was ‘not necessarily seen to belong to its real source, but maybe just felt as

a discomfort and unhappiness, a fear that "something is wrong".'[204] During World War II, as head of the Canadian Army Medical Services, Chisholm expressed his views on the negative psychological impacts of war.[205] Disillusioned by the activities of nation states, he turned to humanism and world government, believing that the only real hope lay with the people of the world. If individuals could come to their senses and learn to think and act globally, they would form a single human race, embodying his concept of 'world citizenship'.[206] As the director-general of the WHO, Chisolm promoted collaborative works among nations, regarding these as 'essential for the very survival of the race'. However, although he recognised the importance of 'learning from each other', Chisholm did not propose substantial practical methods to facilitate the international work on mental health. His contributions were limited to random observations of selected populations and the identification of characteristics of human emotions, such as anxiety and aggression.[207]

Among the priorities identified by the WHO after World War II, mental health was listed as the fifth most important. Several factors accounted for the delayed programming of mental health issues. First, the more urgent categories were attended to first, namely malaria, other endemo-epidemic diseases, and public health administration.[208] Another reason was that Chisholm, himself a psychiatrist, had to distance himself from privileging mental health issues so that he would be perceived

[204] Chisholm, *Prescription for Survival*.
[205] John Farley, *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: UBC Press, 2008) xvi, p. 254
[206] Ibid.
[207] George Brock Chisholm, *Can People Learn to Learn? How to Know Each Other* (London: Ruskin House, 1958) p. 144.
[208] World Health Organization., 'WHO and Mental Health 1949-1961', (Geneva: World Health Organization, 1962).

as neutral.[209] Although sluggish in its actions, the committee never stopped looking for urgent issues and assessing the immediate needs of society.

The mental health expert committee of the WHO was drawn from an advisory panel of nearly 100 members in 38 countries. It met for the first time in 1949 and carefully considered the principles that should govern the WHO's future activities in mental health.[210] The principles laid down by these experts clearly reflected the new imperatives of mental health in the postwar era. First, by encouraging training and specialisation in mental hygiene, the advisory experts hoped to build up the preventive aspects of mental health work. Second, they were concerned about developing psychiatric services for children, both therapeutic and preventive. Finally, they saw the need to integrate mental health with other activities being conducted by the WHO, such as public health administration, maternal and child health, and nursing. In the first decade of its existence, the WHO had assisted in the development of psychiatric services, notably by making available the services of qualified short-term consultants to help member states regarding law, hospital treatment, personnel training, and other issues. Apart from its own areas of focus, the Expert Committee also worked extensively with other international organisations such as United Nations Educational, Scientific and Cultural Organization (UNESCO) and International Labour Organization (ILO).

[209] Tsung-Yi Lin, *Road to Psychiatry: Across the East and the West* (Taipei: Daw Shiang Publishing, 1994).
[210] World Health Organization, 'Technical Report Series', (Technical Report Series; Geneva, 1950).

New Issues in Mental Health after WWII

Issues thrashed out by the Mental Health Expert Committee of the WHO covered a wide range of topics, which reflected the emergent psychological needs of people overwhelmed by World War II. Not all issues were persistent or far-reaching enough to gain the attention of all member states. The various issues raised not only reflected the early visions of the experts themselves but also passively echoed the work of the WHO or the United Nations to some degree. Most of the agenda items were discussed in study groups; some items did not exist for long and others became important projects. These matters could not be detached from the turmoil of international politics in the postwar world, and in all cases the altruistic philosophy of the WHO was evident.

For example, children became a main focus in mental health. In the devastation of war, children were left uncared for and the social environment became a huge threat to human development. Consequently the mental health problems of childhood and youth immediately gained concern. One of the Expert Committee members, John Bowlby, popularised the view that mental health problems among children were caused by prolonged deprivation. His concern with aetiology was congruent with the project of maternal care developed by WHO, which in turn contrasted somewhat with views expressed by the Social Commission of the United Nations in 1948. The Social Commission had identified the need to study ‘children who are orphaned or separated from their families for other reasons and need care in foster homes, institutions or

other types of group care'.[211] By including refugees from wars and other disasters, Bowlby's approach responded to the Social Commission's report, which was confined to children who were homeless in their native countries.[212]Bowlby's theory also corresponded with Chisholm's emphasis on the value and purpose of the family, and fitted with other projects related to maternal care carried out by WHO. Based on the verdict of the UN Social Council report, the Mental Health Expert Committee was advised to participate in the study of juvenile delinquency, including important medical and psychiatric problems.[213]Experts' opinions on juvenile delinquency varied, and many were voiced to correspond with the UN's programme for the prevention of crime and treatment of offenders.

For adults, the main discussion was about the effect of technological change and 'automation', and the increasing mechanisation of 'work' in postwar society. As noted by a study group member, Charles Walker, 'Automation […] sometimes appears as a saviour, sometimes as a devil or menace to the modern world. And both kinds of phantasy, the phantasy of irrational hope, and the phantasy of irrational fear, have created urgent problems in the mental health field'.[214] This comment opened the debate for psychiatrists to talk about 'stress' among ordinary people rather than frontline soldiers. The conditions of workers in weaving factories and coal mines were brought up in these discussions. Opinions from India, USSR, and China were also heard and considered. To an extent, the discussion fulfilled Hargreaves' appeal

[211] United Nations Economic and Social Council, 'Economics and Social Council. Official Records: Third Year, Seventh Session. Supplement No. 8. Report of the Social Commission', (New York: United Nations Economic and Social Council, 1948), 28, 29.
[212] John Bowlby, *Maternal Care and Mental Health : A Report Prepared on Behalf of the World Health Organization as a Contribution to the United Nations Programme for the Welfare of Homeless Children* (Bulletin of the World Health Organization. [Offprint]; Geneva: World Health Organization, 1951) 179 p.
[213] Lucien Bovet, *Psychiatric Aspects of Juvenile Delinquency* (Geneva: World Health Organization, 1951).
[214] *The effect of technological change and automation.* WHO ARCHIVE WHO/MHA/1 page 2.

(described earlier in this chapter) to study stressful experiences among ordinary individuals.

Also on the Committee's agenda were concerns about the peaceful application of atomic energy, perhaps an unusual concern among mental health professionals. The study group began its activity in the year the International Atomic Energy Agency (IAEA) was launched. 'The safe use of atomic energy' had been proposed by then President of the United States of America, Dwight Eisenhower, to a United Nations General Assembly in 1953. The study group was set up to echo the debate in the United Nations, backing Eisenhower's controversial proposal. At a time when atomic energy was seen as hugely important for scientific development, the committee's discussion of the atomic issue stands out as one of the rare instances when UN agencies directly addressed concerns about the risk of the scientific progress created by human beings themselves. These debates have been preserved in the documents of the relevant discussion groups.

Mental health experts' views on the issue were diverse and vague. Atomic energy was widely considered to pose a threat to the health of various generations, although this view was refuted by a number of scientists among the WHO expert. Members of the discussion panel who held negative attitudes toward the application of atomic energy collected evidence of the harmful influences of atomic energy on people's nervous tissues. Such evidence suggested, among other things, that atomic energy might cause brain malformations and alter the electroencephalographic waves of the brain. The committee further pointed out that unhealthy emotional responses were provoked by atomic energy, which were mostly related to 'fear'. The report on

this series of discussions was the only one that commented on the effect of atomic bomb tests, nuclear waste, and atomic installations of many kinds.[215] After two years of discussion, the study group cited Joseph Addison to conclude that its position on atomic energy was to 'ride[s] in the whirlwind, and direct[s] the storm'.[216] On 28 May 1959, the WHO signed an agreement with IAEA, which had previously prevented WHO from taking a public position on atomic issue. The agreement also marked the closing of the committee's comments.

All these projects, carried out in the first decade of the existence of WHO, reflected the concerns of mental health professionals about the devastation of war and postwar society. Despite the consensus among experts, these projects had not been able to take full advantage of the wisdom of WHO, which sought the cooperation or coordination of national bodies. Thus a *bona fide* international project had not yet emerged. At the end of the first decade of WHO, Ronald Hargreaves wrote that 'systematic research' was 'only accessible to the long-term study of carefully selected research teams'. He added that such teams should be 'facilitated by a critical collection of the available evidence' and that data collection should be carried out by 'one individual who has the benefit of a sufficient amount of technical and clerical help'. In Hargreaves' view, not only psychiatrists but also public health workers, psychologists, anthropologists, and other social scientists had made 'pertinent observations'. However, they had done so while remaining uniformed about each other's work. He acknowledged the strength of a variety of viewpoints which together

[215] Mental Health Uni Sub-Committee on the Peaceful Use of Atomic Energy. WHO ARCHIVE WHO/AH/AE/2.
[216] Mental Health Uni Sub-Committee on the Peaceful Use of Atomic Energy. WHO ARCHIVE WHO/MH/AE/2.

formed a 'critical unification', but maintained that a 'single objective investigator' was an 'absolute necessity'.[217]

In 1958, Hargreaves published an appeal stressing the need to apply insights from the public health field to issues of mental health.[218] In summary, Hargreaves advocated the use of methods from public health administration and epidemiology, coupled with the advantages of the WHO to create a large-scale international, systematic, and practical project. He believed that this project should investigate the fundamental causes of mental health problems in all human races.

The Emergence of the 'Manageable Project' and Four-man Meetings

Hargreaves' 'manageable project', described in his epidemiological proposal, contained four basic requirements: place, people, money, and method. Hargreaves understood, but did not publicise, the need to resume the work of comparative psychiatry initiated by German psychiatrist Emil Kraepelin at the beginning of the 20th Century.[219] However, Hargreaves had a far larger project in mind. He had been trained in Germany, Switzerland, and France, had worked as an expert consultant in the Philippines dealing with the problems of immigrants, and was himself a multi-

[217] Ronald Hargreaves, *Mental Hygiene and the Epidemiology of Psychiatric Disorders*. WHO ARCHIVE M4/445/2. J1, p. 3.
[218] Hargreaves, *Psychiatry and the Public Health*.
[219] Emil Kraepelin is considered the father of comparative psychiatry. His most renowned contribution to psychiatry is the classification of psychiatric symptoms based on phenomenology and his works on comparative psychiatry. Regarding classification, he described dementia praecox and manic-depression. See Emil Kraepelin and George M. Robertson, *Dementia Praecox and Paraphrenia* (Edinburgh: Livingstone, 1919) x, p. 331; G. E Berrios, Rogelio Luque, and Jose M. Villagran, 'Schizophrenia: A Conceptual History', *International Journal of Psychology and Psychological Therapy,* 3 (2003), pp. 111-40. As for comparative psychiatry, Kraepelin's work was preceded by a series of travels, including to Indonesia and North America. Unfortunately, at the time of his death in 1926 his projects remained unfinished.

lingual speaker. Hargreaves was thus convinced that the best approach to research would be a comparative one. Interestingly, many of his colleagues at the WHO shared similar cross-cultural and migrant backgrounds. From a practical perspective, Hargreaves thought that the project should be carried out from a 'centrally situated country, like Switzerland'. Without doubt the headquarters of WHO provided the perfect hub for scholarly exchange and logistics. Yet, by the time Hargreaves drafted his proposal, this setting of place was the only one of the three critical conditions which had been addressed.

The recruitment of personnel was also never easy. To facilitate the project, Hargreaves sought out advocates among individuals with similar aspirations, who were more concerned about data obtained from 'community studies' than hospital settings. In 1956, Hargreaves planned a study group on the epidemiology of psychiatric disorders, and proposed a series of meetings that began in September 1956.[220] The gatherings stimulated scholarly exchange among specialists, and it was hoped that these specialists would become the core personnel of WHO's psychiatric epidemiology project. In the early 1950s, epidemiological surveys were particularly prominent in Scandinavian countries and Germany. Paul Lemkau, then consultant of mental health to the WHO, 'daydreamed' to Hargreaves that the committee might recruit people from 'Norway, Demark, and perhaps in the U.K.' for information exchange. French scholars were considered 'not good enough' for research of this kind.[221]

[220] Hargreaves to Lemkau, 8 Sep 1954, WHO ARCHIVE M4/445/2/J2.
[221] 30 May 1954 Lemkao to Hargreaves, WHO ARCHIVE M4/445/2 J2.

From October 1954 onwards, in his position as Chief of the Mental Health Section at WHO, Hargreaves widely circulated an invitation to psychiatrists around the world and waited for their responses. Thereafter, the correspondence between the WHO headquarters and its potential collaborators snowballed. Hargreaves first wrote to Eduardo Krapf, the German-educated Argentinian psychiatrist (who later succeeded Hargreaves as Chief of MH Section) for advice. Krapf forwarded Hargreaves' idea to the National Institute of Mental Health (NIMH) in the US. Moreover, in response to his proposal, Hargreaves obtained access to several papers written by seemingly visionary individuals, such as Carney Landis, Professor of Psychology at Columbia University. Landis had published a book entitled *Modern Society and Mental Disease in 1938*; this was essentially an epidemiological survey of mental disease in America and in Europe. In a letter from Landis to Hargreaves on 15 April 1953, he pondered 'the possibility of re-doing [the] book' and emphasised 'the changes which have taken place in mental disease statistics since 1935'.[222] During two months of correspondence, Hargreaves became deeply intrigued by Landis's research. Yet he voiced his concern about the shortage of funding and suggested that Landis's data, derived from hospital admissions, were too dependent on factors other than natural variations in the prevalence of psychiatric disorders.[223] Hargreaves' concern reflects a widespread apprehension among specialists, which could have obstructed the project.

[222] Landis to Hargreaves 15th of April, 1953, in WHO ARCHIVE M4/445/2 J1.
[223] Hargreaves to Landis, 17th of June, 1953, in WHO ARCHIVE M4/445/2 J1.

One of the strengths of the WHO was the participation of scholars from North America.[224] Given this support from other strands of academia (e.g. members of Pan-America Health Organization), the WHO acquired a privilege not enjoyed by its previous incarnations as the League of Nations Health Organization (between the two World Wars) and the United Nations Relief and Rehabilitation Administration (UNRRA, during World War II). American psychiatrists showed their interest in Hargreaves' project. For example, FC Redlich at the Yale University School of Medicine communicated his interest to individuals whom he knew were conducting similar projects, such as Ernest Gruenberg, Erich Lindermann, and Paul Lemkau. Many of these individuals later became core personnel in the international field of psychiatry.[225]

Feedback gradually emerged about the pragmatic aspects of the project. For example, Paul Lemkau, who worked at Johns Hopkins, offered his opinion as a pioneer in preventive psychiatry.[226] He mentioned the difficulty of having to travel to collect data from all over the world. He also discussed some dubious or inadequate statistical techniques. Lastly, he was concerned that not enough people would be willing to carry out the task. He mentioned one person in Japan, along with Ernest Gruenberg (New York, Mental Hygiene Commission), and Morton Kramer (United States Public Health Service). Despite Lemkau's doubts, Hargreaves still intended to invite him to act on behalf of the WHO to commit to its project in 1954.[227] In fact,

[224] Having said so, North American individuals who joined the team of the WHO were unusual in the United States, where psychiatrists were more in favour of psychoanalytic approaches rather than phenomenological ones. Leff, Julian; 8 December, 2010. [Personal communication].
[225] Ronald Hargreaves' correspondances. WHO ARCHIVE M4/445/2 J1.
[226] Paul V. Lemkau, Mental Hygiene in Public Health (1955). In the book he offered two types of preparatory work in preventive psychiatry: 1. Being prepared to meet generalised and non-predictable stresses, and 2. Being prepared to meet expected stresses.
[227] 7th of Oct 1953 Hargreaves to Lemkao, WHO ARCHIVE M4/445/2/ J1.

while Lemkau was writing his book, *Mental Hygiene in Public Health*, the work had failed to help him crystallise methods for conducting the epidemiology study.[228]

After personnel, money was the second issue. When Hargreaves was seeking backup and comments for his proposal, he mentioned the Milbank Memorial Fund in a number of letters including those written to Redlich and Lemkau.[229] The Milbank Memorial Fund had been interested in population studies since the 1920s, and played a critical role in scientific research related to human populations, such as family planning, fertility, and eugenics.[230] However, it had not encompassed psychiatric science until Hargreaves' invitation. Seeing an opportunity for financial support, Hargreaves wrote to Gruenberg, then director of the Fund, suggesting a joint project between the Milbank Fund and the WHO and hoping that Gruenberg would direct the project.[231] However, the Milbank Memorial Fund had already committed itself to a local mental health demonstration project evaluating selected services. Although he shared a similar perspective with Hargreaves, Gruenberg did not feel he could take on the role and turned it down as many others had done, including Lemkau and Krapf.[232] Nevertheless, Milbank became the main funding body for the WHO project.

Donald Reid at the London School of Tropical Hygiene and Medicine (LSTHM) was also invited to oversee the project. Together with Bradford Hill, the leading figure in medical statistics at LSTHM, Reid was renowned for his capacity to identify factors causing non-communicable diseases. While Hill's criteria heavily

[228] 12 of May 1954 Lemkau to Hargreaves, WHO ARCHIVE M4/445/2 J2.
[229] Ibid.
[230] Clyde Kiser et al., 'The World of the Milbank Memrorial Fund in Population since 1928', *The Milbank Memorial Fund Quarterly,* 49/4 (1971), pp. 15-66; Clyde Kiser, 'The Role of the Milbank Memorial Fund in the Early History of the Association', *Population Index,* 47/3 (1981), pp. 490-94.
[231] Hargreaves to Gruemberg 22 July 1955, WHO ARCHIVE M4/445/2 J2.
[232] Hargreaves to Krapf 23 of May 1956, WHO ARCHIVE M4/445/2/ J2.

influenced Richard Doll's search for the cause of lung cancer, Reid himself plunged into cardiovascular disease research. Believing that the search for clues about causation had become more systematic, Reid thought that his methods of vital statistics could be applied to mental health research. A number of his studies had found mental status to be one of the variables that influenced the course of cardiovascular or other diseases. For example, mental tension and/or overwork were among the etio-pathogenic factors of atherosclerosis.[233] Reid wrote that 'the evidence accruing from field observation is circumstantial in that it may be enough to suggest a causal relationship but it cannot give final proof of it'.[234] This situation provided the rationale for mental health experts to endorse practical interventions for mental health issues before the aetiology of psychiatric disease had been confirmed.

In addition to Krapf, Gruenberg, and Reid, the Swedish psychiatrist Jan Arvid Böök was asked to join the WHO group because of his expertise in empirical research. These four individuals were 'temporary advisors' and comprised the core personnel of the project's study group.[235] The four-man meeting enabled the consequent escalation of their projects. In a letter from Frank Boudreau (President of the Milbank Memorial Fund) to Jerome Peterson (Director of WHO Public Health Division), Boudreau wrote that '[the psychiatric epidemiology project] promises to be as thrilling and probably just as difficult as the pioneering explorations into cholera, typhoid fever, and malaria. If nothing interferes with your plans, all the "old hands" in

[233] Study Group on atherosclerosis, Geneva, 7-11 November, 1955. London School of Tropical Hygiene and Medicine archives ACC/OS.
[234] WHO/MENT/178.
[235] Temporary advisors of the Mental Health Unit study group. WHO ARCHIVE M4/445/2 J4.

public health will envy you and Dr. Krapf, and the excitement of the chase and WHO itself will grow in the opinion of the profession'.[236]

From September 16 to 20, 1957, the Exploratory Meeting on the Epidemiology of Mental Disorders took place in Geneva. As stated in a note about the meeting, the four participants had agreed that epidemiology might usefully be studied as a route to understanding the aetiology of mental illness.[237] But how exactly should such a study be carried out? The four consultants agreed on the urgent need to establish 'special surveys of baseline incidence rates' for congenital mental abnormalities. In addition, they noted that an 'adequate long term follow-up investigation is needed'. Regarding the scale of the project, they felt it was premature to attempt a diffuse 'global epidemiology' study. However, the WHO could play the role of an 'intellectual catalyst' to stimulate workers in the field to travel and meet together, and to support the training of specialists in the appropriate epidemiological techniques.[238] The meeting also clarified several practical steps, the first being a critical rather than comprehensive literature review of epidemiological works on mental disorders. In addition, 'comparisons between the larger or more competent may be invalidated by differing standards of diagnostic precision'.[239] Based on this proposal, the attempt to develop standardised classifications and diagnostic criteria for psychiatric diseases gradually intensified. However, having formed a well-balanced core group (or 'four-man meeting'), none of the four experts wanted to direct the long-term project. Applying the snowballing method of recruitment once again, it took another few years

[236] Boudreau to Peterson 10th of October, 1957, ARCHIVE M4/445/2 J5.
[237] The philosophy of why epidemiology is assumed to illustrate the reason of cause is beyond the scope of this paper.
[238] Exploratory Meeting on the Epidemiology of Mental Disorders. WHO ARCHIVE M4/445/2 J5.
[239] Exploratory Meeting on the Epidemiology of Mental Disorders. WHO ARCHIVE M4/445/2 J5.

for them to implement the project in any systematic manner. The next chapter contains a description of the project itself.



Figure 6 Donald D. Reid at work at London School of Tropical Hygiene and Medicine. Source: GB 0809 Respiratory Diseases studies/06/08. Various papers relating to DD Reid1960s, Archives of LSTHM, London UK.

Impeding Force: Ethnographic Approaches

While the large-scale international study on mental health was being incubated at the WHO headquarters, comments were sent to Geneva from the various geographical regions. Most of these were ethnological accounts drafted by researchers informed by cultural relativism, questioning the feasibility of the ambitious WHO project.[240] These voices, however, did not actually oppose the early visionaries who

[240] For example, Marvin K. Opler's monograph, *Culture, Psychiatry and Human Values*, which also gave some insights into the emerging project.

had embraced internationalism or initiated the WHO and WFMH. For example, the 1948 International Congress saw the collaboration of psychiatrists, anthropologists, and sociologists. In the early 1950s, the WFMH project *Cultural Patterns and Technical Change,* led by Margaret Mead, was commissioned by UNESCO to study possible methods of relieving tensions caused by industrialisation in various countries. This project was one of the main anthropological inputs into international mental health. Unlike the vertical model of the WHO, it aimed to collect and disseminate existing knowledge of various cultures 'with respect for their cultural values so as to ensure the social progress of the peoples.'[241] Sociologists and anthropologists comprised a relatively high proportion of WFMH participants. Many of these professionals, including Mead, were pioneers of 'cultural relativism', which posited that an individual's beliefs and activities should be understood in terms of that person's own culture. As mentioned in this chapter, although Hargreaves acknowledged the need for interdisciplinary cooperation, he emphasized the importance of 'critical unification' and the 'absolute necessity' of a 'single objective investigator'. While developing the 'manageable project', several ethnographic approaches naturally became opponents of the project.[242] Fortunately they were never allowed to derail the ongoing work of the WHO, but rather became valuable balances to the absolute idealism of the WHO.

As the 'capital' of international medical studies, Geneva was not the only place in the world to be concerned about cross-cultural issues. In 1955, Eric Wittkower and Jack Fried set up a section of Transcultural Psychiatric Studies as a joint venture

[241] World Federation for Mental Health., Margaret Mead, and UNESCO., *Cultural Patterns and Technical Change : A Manual* (Tensions and Technology Series; Paris: UNESCO, 1953) p. 348
[242] Ronald Hargreaves, *Preliminary Statement on a Research Project Dealing with Mental health and Disease from a Comparative Point of View*. WHO ARCHIVE M4/445/2. J1, p. 3.

between the departments of Psychiatry and Anthropology at McGill University in Montreal. Its first achievement was to develop a newsletter and network of psychiatrists who could exchange information about the effects of culture on psychiatric disorders, a topic that was poorly understood at the time.[243] Immediately after publication of the first issue of the newsletter, Wittkower sent a copy to Marcolino Candau, containing a description of the first survey study. Wittkower and Fried managed to circulate a questionnaire among specialists from eighteen countries.[244] Wittkower concluded his concise report on this transcultural project with the somewhat skeptical comment that 'it is obviously impossible to draw any definite conclusions from the heterogeneous material which has arrived from psychiatrists of 18 different countries.'[245] He noted several findings, including that the 'prevalence of mental disorders treated by psychiatrists in various countries varies considerably,' 'transcultural comparison of the prevalence or of marked disorders is almost impossible' and 'there are differences in the relative frequency of illness, of severity of illness, and of symptomatology and of content in relation to cultural background'. However, he did conclude that '[t]he major psychoses are ubiquitous'.[246]

Among the specialists in social psychiatry who shared similar perspectives to those of WHO, Wittkower was probably the most critically minded. Yet he noted

[243] This section also marked World War II as a watershed era in psychiatry. In the newsletter, Wittkower et al. said, 'In the years since World War II psychiatrists and social scientists on every continent have begun to tackle problems whose solutions are recognised to be linked to research going beyond national and cultural boundaries. Whole populations in Asia, Africa and South America are rapidly undergoing fundamental transformations in their mode of life. People are shifting and moving, social and economic structures are rapidly changing, technologically backward populations are being drawn out of relative isolation into the complex fabric of modern industrial economies. The conflict of competing socio-political and ideological systems has given this second half of the 20th Century an air of unrest and crisis'. See (Editorial, Eric. D. Wittkower, Jacob Fried, S. D. Pande, in *Newsletter of Transcultural Research in Mental Health Problem*s, issued by the Department of Psychiatry and the Department of Sociology and Anthropology, McGill University, Montreal, Canada. No. 1 May 1956).
[244] 8th of July 1956, Wittkower to Candau WHO ARCHIVE M4/445/2 J3.
[245] Ibid.
[246] Ibid.

exceptions among the seemingly impossible comparative studies, such as those of some Scandinavian countries and 'Formosa'.[247] Attached to the main text of the newsletter, a report written by Eng-Kung Yeh (葉英堃) was included with other documents contributed by psychiatrists from different countries. Yeh, a student of Tsung-Yi Lin, was at that time training at Duke University Hospital. He answered Wittkower's questions by summarising psychiatrists' activities at National Taiwan University in terms of comparative psychiatric and cultural-anthropological studies. He also referred to Tsung-Yi Lin's paper 'A Study of the Incidence of Mental Disorder in Chinese and Other Cultures', published in 1953.[248] This document was later printed as a pamphlet titled *The Scope of Epidemiology in Psychiatry*, co-edited by Lin's assistant C. C. Standley, and was widely cited by early WHO specialists.[249] In addition, reflecting on his own experiences, Yeh stated that he had observed 'the lightness of depression in patients admitted to mental hospitals', 'the absence of severe anxiety in clinical pictures', 'the comparative rarity of anxiety states in out-patients' and the presence of several culturally bound syndromes. Moreover, he mentioned Pao-Meng Yap's pioneering work in comparative psychiatry; at the time, Yap was researching schizophrenia among the Chinese and trying to identify primary symptoms comparable to those described in the West.

In McGill's second issue of the newsletter published in February 1957, Hsien Rin (林憲), another student of Tsung-Yi Lin, claimed that he found it 'difficult in the study in Taiwan to evaluate the psychosomatic cases, as well as psychoneuroses, at

[247] Ibid.
[248] Tsung-Yi Lin and Rin Hsien, 'A Study of the Incidence of Mental Disorder in Chinese and Other Cultures, Published in Psychiatry', *Psychiatry,* 16/4 (1953).
[249] Tsung-Yi Lin and C.C. Standley, 'The Scope of Epidemiology in Psychiatry', in World Health Organisation (ed.) (Geneva: World Health Organisation, 1962).

the community census examination'. He assumed that 'the psychoneurotics in the cities had obvious neurophysiological symptoms in great numbers'. Also, he noted the appearance of chronic hypochondriasis and a primitive type of hysterical symptom, which showed a marked increase during the population change. By 'population change', Rin meant the migration of people from mainland China to Taiwanese cities. 'These are not aborigines', said Rin, 'Malayo-Polynesians, migrated almost 20 centuries ago and have lived separately without mobilisation, but have had a rapid acculturation course in the past 30 years'. In Rin's view, not only the complexity of populations but also the patterns of population movement hampered the potential of epidemiology.[250] However, the conclusion of Wittkower's report was drawn from specialists' clinical experiences and their own reflections. By emphasising that it was 'impossible' to do comparative studies, Wittkower did not apply the method being developed by WHO, nor did he propose an immediate solution to the predicament. Among the psychiatrists' 'reflections', a report by Eng-Kung Yeh documented the 'Formosan Model', which later drew international attention.

In addition to the Geneva and Montreal circles, another group attempted similar investigations. Dan Blain of the American Psychiatric Association (APA) was curious to know whether the WHO had already conducted surveys, and if so, what methodology had been used. According to Jack Rees, who was then Director of WFMH and who wrote to Eduardo Krapf on behalf of Blain, APA was interested in developing similar studies. Responding to Blain, Krapf dismissed Blain's referential document, characterising it as 'your own Bureau's census survey of 1884, which I

[250] Although sharing similar insight into the need to conduct comparative psychiatry, Rin's approach differed from Lin's. Rin's comments on the standardisation of disease classification and psychiatric diagnoses are discussed in Chapter 6 of this thesis.

don't imagine would stand republication or be of any value now, except as interesting history'. Referring, instead, to reports conducted in Asia, Krapf commented that

> the Taiwan survey of psychiatric morbidity done by Professor Tsung-Yi Lin and his colleagues, which was published in the Alanson-White *Psychiatry* […] was not very long, but it was a good record of a piece of work carefully done, and it was I think responsible for waking quite a number of people up to the needs and the possibilities of surveys.[251]

Prior to the research done by Tsung-Yi Lin and his students, Pao-Meng Yap (a Cambridge-educated anthropologist and psychiatrist from Hong Kong) had put forward his version of comparative studies on mental illnesses. Viewing the causation of mental illnesses as somewhere between biological and psychogenic, Yap stressed the necessity of a quantitative approach. He attempted to treat mental health disorders as real illnesses, working 'towards an illness model for comparative research'. In his foreword, he suggested that the model should be biographical and in principle convertible into other kinds of models. This flexibility would allow for a continuous transition from health to illness and reflect the complexities of multifactorial causation, with a necessarily quantitative dimension. Yap insisted that a unitary framework for all types of psychiatric illness was necessary to '[give] due weight to the biopsychological substrate which alone makes cross-cultural comparisons meaningful'.[252] Yap's approach was pioneering in the field of comparative psychiatry

[251] Eduardo Krapf on 'Formosan Model.' WHO ARCHIVE M4/445/2 J5.
[252] Noted by I.C. Jarvie, who wrote in the Preface for Yap's essay collection, 'The work that Dr. Yap began and can now, alas, no longer pursue'. See Pow-Meng Yap, *Comparative Psychiatry: A Theoretical Framework* (Monograph Series) (Clarke Institute of Psychiatry), 3; Toronto; Buffalo: Published for the Clarke Institute of Psychiatry by University of Toronto Press, 1974) xviii, p. 118.

at that time. As a member of the Expert Committee, he continually contributed innovative inputs to the WHO project. However, he did not join as a core member of the large project because of his previous commitment to work in Toronto. Early work done by Tsung-Yi Lin, Pow-Meng Yap, and other individuals were central to the field later called 'transcultural psychiatry' or 'cultural psychiatry'. For Wittkower, transcultural psychiatry was a newly fashioned scholarly field. However, attempts to explore mental health issues cross-culturally had already been evident during Kraepelin's era, although they were limited in scale and incomplete in their methods.

To understand the causation of mental illnesses internationally, individuals and institutions approached the research question from a variety of angles. The emerging ethnological approaches served as an impeding force while the epistemology of mental health research was undergoing fundamental change. I argue that the work actually conducted by the WHO did not unfold completely in accordance with its original intention. For example, participants involved at the level of Headquarters invested the project with their own interests and with an awareness of their own country's niche.[253] Before the project had been proposed, experts involved in the snowballing network agreed that studying mental health issues among various cultures was necessary and urgent. Their theories and approaches were neither fixed nor inflexible but were adaptable according to different contexts. For example, the standardisation of disease classification and the work of epidemiology had to be conducted simultaneously. Finally, the unique modus operandi of the WHO facilitated

[253] For example, one of the initiators of the WHO's subsequent ten-year project on psychiatric epidemiology was Tsung-Yi Lin, whose reason for joining WHO was his concern for cultural psychiatry.

the smooth progress of the project over the next ten years, albeit with certain hitches. These problems are discussed in the next chapter.

Conclusion

In this chapter, I have outlined the precursors of a new paradigm in psychiatric research during the early postwar period. I argue that World War II affected psychiatric sciences by shifting the concern about war trauma to concern for the general public. At that critical juncture, preventive psychiatry was born of the effort to lessen the human burden caused by war and its aftermath. The focus also shifted from treating mentally ill patients in hospitals to prevention in communities. Regarding the method of prevention, mental health workers no longer selected fit and suitable military personnel and put them on the battlefields. They began to concentrate on everyday stresses associated with industrialization and urbanisation, rather than on extreme experiences.

Second, I have described the verdict of the World Congress on Mental Health held in 1948 as the key event that transformed the pragmatic aspects of mental health care. It was this Congress that resulted in a shift from individual and sporadic research attempts to transnational collaboration. The Mental Health Expert Committee in the WHO and the WFMH were created thanks to the postwar design of the UN special agencies and Brock Chisholm's vision of 'world citizenship'. The UN special agencies were designed to fulfil functionalist economists' notions of the spill-over theory, thereby promoting international cooperation on specific issues and boosting economic growth in developing countries, with the ultimate aim of world peace. Most

concerns raised by the Mental Health Expert Committee were directly associated with psychiatric professionals' views on postwar human conditions, such as the mental health problems of children and young people, and the safe use of atomic energy. The issues overlapped considerably with those being discussed in other UN projects. Mental health professionals apparently formulated these concerns as a collective response to postwar devastation. Nonetheless, the issues can also be viewed as the product of spill-over theories, which the WHO and other postwar international institutions had already endorsed.

Third, I have illustrated the emergence of the Expert Committee's cross-cultural project. The project was based on consensus on the need to study mental health issues cross-culturally. However, it took years for the project to be realised. Apart from the advantageous location of the WHO headquarters in Geneva, problems existed with personnel, finance, and research methods. The first Chief of the Mental Health Section, Ronald Hargreaves, managed to recruit four of his colleagues to the leadership group, namely Eduardo Krapf, Donald Reid, Ernest Gruenberg, and JA Böök; this group was formed in the late 1950s. The Milbank Memorial Fund, one of the main advocates of population studies in 1950s, supported the project. Techniques borrowed from the fields of public health, epidemiology, and statistics contributed to the methodology. Finally, challenges were provided by people who favoured an ethnographic approach and questioned the feasibility of the project. In my thesis, I see this influence as an impeding force, yet one which did not merely obstruct but also stimulated the scope of the WHO project. This long preparation process provided the foundation for the actual ten-year project to begin in 1965, which I elaborate upon in the next chapter.

To summarise, the transformation of psychiatric disciplines in the early postwar period can be seen as a collective response among mental health professionals to war and its aftermath. World War II, like the First, stimulated psychiatric thought. The effects of environmental stress aroused much interest, as did social psychiatry in general, and a new kind of psychiatrist emerged who engaged largely in preventive work away from the institutional sphere. Apart from mutual recognition regarding the need to study mental health issues cross-culturally, the realisation of these professionals' visions was facilitated by the birth of new international health organisations. These organisations tended to be based on the idea of world citizenship and spill-over theories. The emergence of such beliefs reflected Ludwick Fleck's philosophy of *Denkkollective* (thought collective), which was consolidated in the early postwar period in response to the process of social change and emergence of a unique world order. Professionals involved in the process of knowledge-making included an isoteric circle of experts, the exoteric circle of wider society, and marginal individuals who created new issues out of the conflicts.

The newly envisioned public health approach to mental health research and epidemiology was carefully planned by visionary thinkers. The research projects coincided with other projects being developed in UN specialised agencies, and provided fresh ways of looking at mental health issues in different parts of the world. Such an approach, however, had not yet been integrated with Fleck's scientific philosophy. Through complex processes of scientific practice, Chisholm and Hargreaves' individual viewpoints were transformed into thought collectives and objective reality. To illustrate this process, in the next chapter I describe the ten-year

social psychiatry project of WHO. This project functioned against the background of the Cold War and the development of scientific technology, and was a unique example of international collaboration. Indeed, it transformed imperfect attempts to make local comparisons into formal international psychiatric epidemiology. The next chapter also discusses the subsequent challenges that emerged whilst such a paradigm was being established.

Chapter 4

World Mental Health and its Discontent: the Ten-Year Social Psychiatry Programme of the WHO

He: You saw nothing in Hiroshima. Nothing.

She: I saw everything. Everything.

She: The hospital, for instance, I saw it. I'm sure I did. There is a hospital in Hiroshima. How could I help seeing it?

He: You did not see the hospital in Hiroshima. You saw nothing in Hiroshima.

[…]

She: I saw the patience, the innocence, the apparent meekness with which the temporary survivors of Hiroshima adapted themselves to a fate so unjust that the imagination, normally so fertile, cannot conceive it.

He: Nothing. You know nothing.

In the French new wave film *Hiroshima Mon Amour*, the playwright and novelist Marguerite Duras and director Alain Resnais challenged the untranslatability and supposed inscrutability of communications between psychological subjects.[254] In the first scene, the dialogue between a Japanese architect and a French actress illustrates the journey from mistrust to mutual understanding between two individuals from different language and cultural groups. By the end of the film, the cultural clash between them was resolved through love. At the this new wave film was released, mental health experts in the World Health Organization (WHO) had been attempting to demonstrate the commonality, or at least comparability, of the experiences of psychiatric diseases worldwide. Based on the central spirit of 'world citizenship', the

[254] Marguerite Duras, *Hiroshima Mon Amour* (Evergreen Original; New York: Grove Press, 1961).

WHO tried to study people all over the world as a single human race, looking for common causes of psychiatric diseases that could possibly become major threats to human beings after World War II.

As previously noted, the newly established WHO was a visionary and idealistic institution. The discussions within the study groups of the Mental Health Unit during the first 10 years of the existence of the WHO reflected the most important concerns among medical scientists in that period. However, due primarily to lack of funding, the project conceived by the first Chief of the Mental Health Unit, Ronald Hargreaves, took about a decade to implement. In Chapter 3 I described the social and cultural precursors that spurred experts to plan the international large-scale mental health survey of WHO. In this chapter, I discuss in detail how the outline of this survey programme was framed; how social and political factors determined the nature of the programme; what the programme achieved in various aspects of world mental health; and the shortcomings of the transnational effort, whether they were addressed or not. In addition, I examine both the human and non-human factors identified by actor-network-theories concerning this unique process of knowledge construction.

Towards a Universal Paradigm of Modern Psychiatry

The intent to study the causes of mental illness internationally gave rise to two important paradigms of modern psychiatry. The first was the standardised classification of psychiatric disorders, and the second concerned research methodologies for international psychiatric epidemiology. In the traumatic environment post-World War II, medical professionals were driven to help

reconstruct the social order. This effort echoed the postwar movement taking place in the philosophy of science, which I briefly introduced in Chapter 3, in which the universe could be mapped out by a set of formal (e.g. mathematical) rules. Together with other specialists in various fields, medical professionals attempted to build a milieu in which rational attitudes and scientific methods would probe the uncertainty of human destiny.

On a nation-by-nation level, a variety of methods were used by specialists with a range of backgrounds to study mental illnesses in relation to populations. Many of these specialists eventually became the core personnel that carried out the programmes of WHO. These scientists had diverse interests and objectives, and fostered their own research both within the WHO and outside of the organisation. Assorted aspects of their collective endeavour formed components of the drive by the WHO to create an internationally relevant psychiatric epidemiology.

Apart from Geneva, London was one of the key centres where medical experts shared similar visions that collided, collaborated, and finally catalysed a new science. Examples included the unceremonious formation of 'Baker Street Irregulars'[255] and the gatherings of psychiatrists, whether in Maudsley where they tested new ways to treat war-induced trauma among soldiers and civilians, or in Tavistock Clinic where they attempted to reconstruct human relations. London was also the city where German psychiatrists driven out by Nazis during the war had taken refuge.[256] With

[255] Hisao Nakai, Personal Communication (Kobe, 2008). Bader Street Irregulars are any of several different groups named after the original, which appears in various Sherlock Holmes stories. The Irregulars in these stories are a gang of young street children whom Holmes often employs to assist his cases. Nakai adopted this term to portray these psychiatrists as eccentric but convinced of a similar new approach to mental health after World War II.
[256] L. Julian, Personal communication (London, 2010)

diverse psychiatrists assembling in this devastated city, London became the home of new theories and methods.

Institute of Psychiatry, London

Before the end of World War II, mental health professionals had speculated about possible reasons for the increasing incidence of mental illness (especially neuroses) not only among soldiers but also civilians. Aubrey Lewis, the first Chair of Psychiatry at the Institute of Psychiatry (IOP) in London, observed that '[W]ar brings tribulations and horrors which undoubtedly make people miserable and apprehensive, but the bulk of mental illness in any community is not mainly attributable to recent direct stresses.' Lewis was aware of the need to study indirect stressors that were dissimilar to those experienced at the front line of combat. He wrote that 'One cannot speak in the same breath of a community like ours at present and of the people in an occupied and invaded country who have borne over a long period every physical and psychological misery which war can bring.'[257] Apart from the burdens imposed by war, Lewis foresaw the need to measure the 'remediable anxiety and discontents that prevailed during peace.'[258] During the war, nevertheless, treatment of psychiatric diseases among civilians was focused on prevention, and favoured the capacity of civilians to realise their own war-time duties, as allotted to them. Psychiatry also continued to describe the requirements needed to be a soldier in the battlefield; details

[257] Aubrey Lewis Papers IOP/PP3/5/6 15.4.43. Before the beginning of World War II, a committee entitled 'the Study of International Psychology' was organised at IOP in the hope that it would yet be possible to understand and mitigate the psychological forces leading toward war. The committee believed that they were called to mitigate war's evil effects in instances where war did occur. Some psychologists felt that this could best be accomplished by increasing the efficiency of the government's military actions against the Nazis, while others preferred to provide help to the civilian population. This committee, however, was not influential compared with the military psychiatrists. See IOP/PP3/4/2/3 Pryns Hopkins to Edward Mapother 29th September 1938,

[258] Aubrey Lewis Papers IOP/PP3/5/6 15.4.43.

about military screening are provided in the previous chapter of this thesis. Gillespie stated that in the postwar period, 'knowledge of what to do, and where to go to do it, coupled with means of reaching the task required of him as soon as possible, is the best preventive of panic and neurosis.'[259] Such views on 'building a fit man' were common among psychiatrists during the war.

After World War II the preventive aspects of psychiatry continued, but the field as a whole expanded to study the stressors of peacetime as well as those of war. In a BBC radio talk in 1959, Lewis emphasised that

> [m]ental disorder is not limited to particular countries or particular racial groups. It appears in every society and in every class. It can take rather different forms, according to the culture of the people, and it can be affected by social disturbances, natural catastrophes (such as earthquakes) and by political upheavals: but the basic forms of mental illness appear everywhere.[260]

This claim echoed the appeal made by Ronald Hargreaves, the first Head of the Mental Health Unit at WHO, who intended to study how 'everyday stresses' rather than extreme disaster can cause mental illness.[261] In the WHO, mental health experts were 'emphasising the need for social studies of mental disorder, using methods very

[259] IOP/PP3/4/7/2. Gillespie to Mopather (date before 30th March 1939). Gillespie went on, saying, 'Knowledge of the best means of protecting [a civilian] himself, and those who are dependent on him, is also important. But the first consideration is by far the greater. Previous personal preparation of a more general kind, calculated to appeal to the idealism of the individual citizen, is also greatly to be desired. As an adjuvant to this, the motive of any kind of personal gain should be completely removed from war, so that people may not be disturbed in their courage either by the presence of this motive in themselves, or by witnessing its operation in others. Those known to have been psychiatric casualties in the last war, especially pensioners, should be evacuated beforehand from the dangerous areas.'
[260] Aubrey Lewis Papers IOP/PP3/5/26 (1959). P.1
[261] See Chapter 3.

similar to those which threw light on the causes and control of epidemics and infectious disease.'[262]

Such awareness influenced the work of psychiatrists at the IOP. In the early 1950s, the development of neuroleptics (today known as antipsychotics) meant that severe psychosis became treatable. The role of hospitals was also transformed from that of custody to treatment. In postwar Britain, surveys were conducted to investigate the influence of hospital environments on patients' mental functioning; this step reflected the call of the WHO to examine, employ, and improve existing hospital resources. The number of psychiatric inpatients increased sharply during the first ten years of the WHO's existence.[263] A number of social psychiatrists, such as John Wing of the IOP in London, attested to sociologists' observations concerning mental hospitals.[264] Wing's training as an epidemiologist, however, led him to consider the implementation of 'science' to examine mental hospitals in greater depth, rather than relying on simple elaborations of the ideas of sociologists. Wing led a series of studies that attempted to understand the environment in British mental hospitals. Wing was not completely convinced by Erving Goffman's interpretations because Goffman '[did] not use conventional psychiatric terminology, and tend[ed] to explain patients' behaviour solely in terms of their reactions to the social environment.'[265] Thus Wing and his colleagues attempted to use scientific methods to attain their research objectives.[266] They collected and compared case studies from three mental hospitals in England, namely Mapperley Hospital, Severalls Hospital, and Netherne Hospital. A

[262] Aubrey Lewis Papers IOP/PP3/5/26 (1959).
[263] See Chapter 3
[264] In the meantime, the Mental Health Unit of the WHO was also re-considering the custodial functions of mental hospitals.
[265] J. K. Wing and George William Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960-1968* (Cambridge: University Press, 1970) xiii, p. 13.
[266] Ibid.

study was painstakingly designed to examine whether a prolonged stay in any of the three hospitals was associated with adverse effects on schizophrenic patients, and the ways in which such effects could be counteracted and prevented. Clinical conditions, ward behaviours, attitudes regarding discharge, and social conditions were rated with standardised interviews and clinical classifications. Wing concluded the research report by stating that '[a] substantial proportion of the morbidity shown by long-stay schizophrenic patients in mental hospitals is a product of their environment.'[267]

After drawing this conclusion, John Wing and his wife, Lorna Wing, expanded the scope of the study beyond the hospital. From 1964, the Wings established a project using the 'Camberwell Register'. The registry set up a database for statistical studies to plan and evaluate local socio-medical services in Camberwell, a neighbourhood in South London that is part of the Southwark borough. Wing again emphasised the 'scientific' purpose of the study. He hoped to collate the statistical outcomes and translate them into narratives, so that 'the most breathtaking scientific discoveries become commonplace'. In Camberwell, the Wings discovered a kind of 'social laboratory' and saw the prospect of extending the model elsewhere in the UK, followed by 'eventual collaboration with Baltimore [in the US], and then the rest of the world'.[268] Wing's method was time- and energy-intensive. While Wing established his database of patients, the WHO was developing its methods for identifying cases in international psychiatric epidemiology. Eventually, the computing method Wing designed was employed in the later phase of the WHO programme. This will be further discussed later in the chapter.

[267] Ibid.
[268] J. K. Wing, 'The Camberwell Register and the Development of Evaluative Research', in J. K. Wing and Anthea M. Hailey (eds.), *Evaluating a Community Psychiatric Service: The Camberwell Register, 1964-71* (London, New York: Oxford University Press of the Nuffield Provincial Hospitals Trust, 1972), pp. 3-9.

Tsung-Yi Lin's Non-Western Approach

Before the research efforts began in Geneva and London, at a distant locale on the Far Eastern island of Taiwan, several psychiatric epidemiology studies were also being attempted. At that stage Taiwan had just been liberated from colonisation and was building its cultural autonomy. Tsung-Yi Lin, the first ethnic Taiwanese psychiatrist, had just returned to his homeland after spending the entire war in Japan, and was eager to try out several population investigations. Realising that differences in psychiatric symptoms existed between Taiwanese and Japanese populations, he decided to systematically sketch a clear picture of psychiatric diseases among the Taiwanese.[269] From 1946 to 1948 he used statistical data obtained by the Japanese colonial government to investigate Chinese populations in three areas of Taiwan: a small village, *Baksa* (木柵); a provincial town, *Simpo* (新埔); and a seaport, *An-Ping* (安平).[270] The survey method consisted of a preliminary information-gathering stage where family elders, local officials, policemen, physicians, and schoolteachers were interviewed. The investigator was able to identify considerable numbers of psychiatrically ill individuals from these key informants. This phase of the inquiry was followed by a house-to-house survey conducted by Lin and his students. Lin reviewed every case during the survey, and interviewed all those in whom the presence of abnormality was equivocal to make a final diagnosis. Over the course of 16 months, a total of 19 931 individuals were interviewed. Of these individuals,

[269] Tsung-Yi Lin, *Road to Psychiatry: Across the East and the West* (Taipei: Daw Shiang Publishing, 1994).
[270] The Chinese arrived on the island in the 17th Century and gradually displaced the indigenous communities, who became confined to the mountains in the interior of the island.

psychiatric illness was found in 214 cases. In 1949, Lin and his students conducted another similar survey among four indigenous tribes. He published the research outcomes while visiting Harvard in the 1950s.[271]

Using the huge database which the study accumulated, Lin and his students were able to conduct a 15-year follow-up study, which was later internationally recognised as the 'Formosan Model' and emulated by other research teams. Ronald Hargreaves was impressed by Lin's research and took the opportunity see him during a visit to WHO's Pacific Regional Office in 1955. According to Lin, the article in *Psychiatry* based on his findings became the key document that enabled him to be 'scouted' by Hargreaves. During his visit Hargreaves took notes on all of his communications with Lin; topics they discussed included the methodology, research outcomes, and future prospects for Lin's work.[272] Later that year, Lin was invited to serve on an expert committee at the Mental Health Unit of WHO, and he then embarked on a worldwide tour.

Lin's studies represent pioneering ventures in psychiatric epidemiology. They not only established a template survey (even if it was not flawless) for the newly emerging scientific paradigm, but also led to the discovery of many culturally specific phenomena, such as *hsieh-ping* （邪病）syndrome in Chinese and Taiwanese populations. These large-scale and prospective surveys did have some drawbacks. Age distributions were not always provided, and standard interviews were not always conducted. Interviews were required to be somewhat flexible to minimise potential

[271] See Tsung-Yi Lin, 'A Study of the Incidence of Mental Disorder in Chinese and Other Cultures', *Psychiatry,* 15 (1953), pp. 313-36. A detailed examination of this study was presented in Julian P. Leff, 'Knocking on Doors in Asia', in Julian P. Leff (ed.), *Psychiatry around the Globe: A Transcultural View* (London: Gaskell psychiatry series, 1988), pp. 92-100.
[272] Lin, *Road to Psychiatry: Across the East and the West*, p. 93.

misunderstandings caused by interviewing indigenous communities that did not completely share the language of the interviewers.[273] Lin's method, however, was one of the rare pioneering studies in Asia, where few pre-existing standards had existed for social psychiatric research.

Despite the imperfection of Lin's research design, his method contributed as a blueprint for WHO's large-scale cross-national programme in psychiatric epidemiology. This programme, initially entitled 'The Ten Year Plan in Psychiatric Epidemiology and Social Psychiatry' (referred to as the Ten-Year Programme), was a collaboration of many different disciplines.[274] It constituted a realisation of WHO's objective—the development of a 'manageable' international study in which the idea of 'world citizenship' was used as a basis to study how mental illness crossed national boundaries and was universally experienced among all peoples. The Ten-Year Programme also provided the foundation for the globalisation of standardised psychiatric diagnoses and research methods in international psychiatric epidemiology.[275] While the WHO was considering tentative proposals for its 1960s programmes, countries presumed to be suitable as the focus of study were listed according to priority: Australia, China, Hong Kong, Japan, and New Zealand. A memorandum written by the Head of the West Pacific Regional Office at the WHO indicated what was sought: a critical review (selective rather than comprehensive) of published articles, either describing new epidemiological methods of investigating mental illness or introducing useful technical modifications of existing procedures with the aim of producing a 'canon of accepted methods'. In other words, the

[273] Leff, 'Knocking on Doors in Asia'.
[274] Tsung-Yi Lin, 'The Epidemiological Study of Mental Disorders by W.H.O', *Social Psychiatry,* 1/1 (1944), pp. 204-06.
[275] See Chapter 3.

intelligent psychiatrist's guide to epidemiology. Tsung-Yi Lin's research stood out as fitting the WHO criteria almost perfectly.[276]

1961: WFMH and World Mental Health Year

By the end of the 1950s, a tacit agreement existed among a number of centres of mental health research that a 'new science' should be pursued in response to newly emerging human needs. This agreement was not confined to Geneva or London. World Mental Health Year was commemorated in 1961, and a conference was held that year. At the conference, one of the pioneers of cross-cultural psychiatry, Belgium psychiatrist Paul Savidon, mentioned that psychiatry should 'adopt the methods of the […] existing sciences' and that it was 'better to understand the mind, which, being intangible, fluid and subtle evaded every scientific approach.'[277] To study the functions of the mind, Sivadon continued, it was necessary to establish a 'common denominator of the motivations, attitudes and behaviour of different human groups'.[278] By establishing the standard method of enquiry, however, Sivadon himself admitted that 'the disparity existing between men and cultures will probably prevent [the] values from becoming universal for a long time to come'.[279]

To develop the new science, a small committee was set up by the Executive Board of the World Federation for Mental Health (WFMH) under the chairmanship of

[276] Memorandum: critical review of published articles. Head of WPRO. WHO ARCHIVES M4/445/2 WPRO.
[277] Paul Sivadon, 'The Development of a Science of Mental Health', in Esther M. Thornton (ed.), *Planning and Action for Mental Health*
World Federation for Mental Health. Meeting (12th : 1959 : Barcelona)
World Federation for Mental Health. Meeting, (London, New York: World Federation for Mental Health, 1961), pp. 155-62.
[278] Ibid. p. 158
[279] Ibid. p. 160

Henry Rümke. The committee formulated theoretical principles by clarifying the concepts on which the science of mental health was being established. Later, however, the WHO rather than WFMH took the lead in the field.[280]

The Slow Incubation of the Ten-Year Programme

It was the WHO's Ten-Year Plan in Psychiatric Epidemiology and Social Psychiatry (Ten-Year Programme) that eventually created the path forward while the theories and methods of social psychiatry were still being developed. Incubation of the programme, however, was slow, primarily because of the *realpolitik* in WHO. In the realm of psychiatric illness, diagnostic foundations and communications about them remained deadlocked for 15 years after World War II.[281] This was true despite the establishment of the WHO and the close interchange of ideas among member countries. One of the reasons for the stagnation of work at the WHO was the *realpolitik* of the United Nations and its trickle-down effect among its specialised agencies. The WHO claimed that no more than two years had passed from the time the Constitution was drafted in 1946 until it was enacted. However, hope for internationalism was soon hampered by the onset of the Cold War, which led to debate about the appropriate role for the United Nations.[282] In addition, the bureaucracy of the WHO hampered its mobility; the organisation behaved just like

[280] According to Norman Sartorius, the WFMH did not ultimately contribute much to research apart from its achievement in the commemoration of 1961 as World Mental Health Year. N. Sartorius, Personal Communication (Geneva, 2010). In the 1970s, however, the financial situation deteriorated until Lin's appointment as WFMH president. See Eugene B. Brody, 'The World Federation for Mental Health: Its Origins and Contemporary Relevnce to WHO and WPA Policies', *World Psychiatry,* 3/1 (2004), pp. 54-55.
[281] Lin, *Road to Psychiatry: Across the East and the West*. p. 116.
[282] Kelley Lee, *The World Health Organization (WHO)* (Global Institutions Series.; Abingdon, Oxon ; New York, N.Y.: Routledge, 2009) xx, p. 14. Also John Farley, 'The Long Wait', in John Farley (ed.), *Brock Chisholm, the World Health Organization, and the Cold War* (Vancouver: UBC Press, 2008), pp. 48-57.

any other in terms of its bureaucratic constraints. Even the growth of the WHO was slowed by political strategising. Those who oversaw projects from developed countries wanted to see only small increases in budgets for WHO, even when more money was needed.[283] In addition, an existing rule involving a fixed percentage of change from action at the prior step in the WHO budget process hampered the realisation of many projects.[284] Money itself became an obstacle to the birth of the Ten-Year Programme.

In spite of these political and financial challenges, many individuals remained deeply committed to the WHO mission. The birth of the Ten-Year Programme, according to Lin, was attributable to its occurrence at the right time and place, and in harmony with the people (*tianshi, dili, renhe* 天時、地利、人和), as elucidated in the Chinese Military Classic *The Sun Zi Art of War* (*Sun Zi Bing Fa* 孫子兵法). Concerning place, Geneva was a cosmopolitan city of international influence where government representatives and professional authorities met. Regarding people's collaboration, the building of acquaintanceships among bureaucrats in the WHO stimulated communication among scholars and the interchange of ideas.[285] However, apart from these optimistic or enabling factors, which Lin described, I argue that other resistant elements delayed the programme's development.

At the time of Lin's appointment as Medical Officer, experts at the WHO were perplexed about the chaotic classification of psychiatric diagnoses employed in the WHO annual statistics. As discussed in my previous chapter, the idea of developing

[283] Ibid. p. 134
[284] Francis W. Hoole, *Politics and Budgeting in the World Health Organization* (Studies in Development No. 11.; Bloomington: Indiana University Press, 1976) x, p. 132.
[285] Lin, *Road to Psychiatry: Across the East and the West*. p. 118.

epidemiology regarding mental health was put forward by the WHO immediately after World War II. Initially, the idea remained at the level of discussing methodological problems.[286] Later, with formation of the four-man technical meeting, the following was stated: '[the memorandum] is not a textbook of epidemiology; the aim in mind is rather to present […] the general principles of this approach in medicine and to point out both its potential and the practical limitation inherent in its application in psychiatry.'[287] Soon after this opportune moment, the classification of mental disorders emerged as a central concern among psychiatric epidemiologists. In 1959, mental health experts agreed that 'if the epidemiological approach is to be used in the study of mental disorders, a common basic terminology and classification will be required.'[288] Stengel's critical examination of classifications employed at different national levels at that time became the first step enabling the WHO to start genuine work towards developing the programme.[289]

In contrast to the bureaucracy in WHO, peripheral participants were bold and reached beyond the *realpolitik* atmosphere with their more progressive attitudes. Policy-makers from lesser developed countries wanted to increase their representation in leadership. The newly appointed medical officer Tsung-Yi Lin was one such progressive. While the WHO was developing an early mental health project 'Education and Mental Health', Lin wrote to the Director-General, saying '[…] our colleagues in Asia have been making continuous [efforts] to convene a meeting of this kind in [Asia]', since 'they played an important role in the selection of the theme'. Lin

[286] World Health Organization., 'W.H.O. Mental Health News', in Mental Health Section (ed.), (Geneva: World Health Organization, 1958). Issue 3. p. 6.
[287] Ibid. Issue 4. p. 11.
[288] Ibid. Issue 5. p. 3
[289] E. Stengel, 'Classification of Mental Disorders', *Bulletin of the World Health Organization,* 21 (1959), pp. 601-63.

also felt that 'WPRO's encouraging willingness to send two representatives [in 1958] is a reflection of this enthusiasm'. He added, 'I realize that the relationship of non-governmental organisations with WHO is with Headquarters, but, for the sake of the future effect of this meeting on the promotion of mental health in [Asia], I wonder whether this matter could be re-considered and WPRO permitted to send at least one representative financed from regional funds?'[290] Under circumstances in which the WHO headquarters lacked sufficient resources, voices from the regional offices were relatively easily heard. Therefore, it is not surprising that Tsung-Yi Lin was put in an important position in the Ten-Year Programme.

The lack of standardisation among local research was a central concern for the WHO headquarters. For example, Eileen Brooke, the statistician hired by the Mental Health Unit, commented in her review of Lin's method that '[The] increasing number of reports in the last few decades have provided much-needed information. It should be mentioned, however, that the reported results of various studies are not comparable, owing to the different methods of investigation: some are drawn from hospital studies, some from filed surveys, others from knownless professions.' Without a more systematic and standardised method of reporting results, it was assumed 'premature' in the early 1960s to conduct studies concerning factors of 'universal significance in the etiology of mental disorders.'[291]

[290] WHO ARCHIVE. M4/86/12 Tsung-Yi Lin to the Director General 11 June 1965.
[291] Queen Mary, University of London Library Archives: Eileen Brooke GB 0370 PP32 Box 3



Figure 7 One of the WHO Mental Health Section Seminars, with Tsung-Yi Lin sitting in the upper-left corner. Source: Eileen Brooke Papers AIMG-0799

The Ten-Year Programme: a Tapestry of Non-State Factors

While the Ten-Year Programme was technically an 'intra-governmental' endeavour, the realisation of a feasible programme required the participation of 'non-state' efforts. The advisory services within the WHO played a central role in facilitating technical cooperation, in contrast to the sluggishness of financial aid and operational activities.[292] A number of the WHO's thematic projects, including the Ten-Year Programme, could not be realised without recruits from the advisory services. These recruits had been recommended by the various regional offices for professional contributions they had achieved in their own countries. Yet they held somewhat different visions from those of their respective nations, and to some degree

[292] Gian Luca Burci and Claude-Henri Vignes, *World Health Organization* (New York: Kluwer Law International, 2004), p. 195.

spoke from personal insight rather than merely articulating their countries' positions. Through working at the WHO, many recruits developed unique identities, both culturally and nationally, which differed substantially from the identity conferred by their countries of origin. For example, while working in the Ten-Year Programme, Lin was actually blacklisted by his government. After being appointed the WHO Medical Officer in 1965, he was not able to return to Taiwan for 23 years.[293] Similarly, American epidemiologists based at the National Institute of Mental Health (NIMH) did not stand for the mainstream psychoanalytic trend, and were peculiar in the environment of American psychiatry at the time.[294] In the following sections I elaborate on the significance of these non-state players.

As mentioned, technical cooperation within the WHO was usually stimulated by the advisory services; the composition of these advisory services was usually outside of Geneva. In 1960, with a view to establishing priorities for mental health programmes, the WHO conducted a survey of resources and facilities available for the preparation for future international projects.[295] At the 15th World Health Assembly in 1962, the technical discussions were devoted to mental health programmes in public health planning.[296] During the first half of the 1960s, a number of seminars were organised regarding the integration of mental health programmes into the public health services in countries such as Mexico (1962), Argentina (1963), United Kingdom (1964), and Jamaica (1965).[297] These seminars were forerunners of the

[293] Details are given in Chapter 5.
[294] Julian P. Leff, Personal Communication (London, 2010). For a detailed explanation of post-war psychiatric culture in the United States, see Marijke Gijswijt-Hofstra, *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam: Amsterdam University Press, 2005) p. 456.
[295] World Health Organization. Technical Report Series, 1961, p. 223.
[296] WHO Chronicle, 1962, 16, pp. 306-311.
[297] World Health Organization, *The Second Ten Years of the World Health Organization, 1958-1967* (Geneva: World Health Organization, 1968) xi.

organisations' main work concerning world mental health and the development of the cross-national collaborative project. For example, the Conference on Techniques of Epidemiological Surveys of Mental Disorders was held in the Western Pacific Regional Office in Manila in 1962. Lin and Standley presented their paper 'The Scope of Epidemiology in Psychiatry' at this meeting. The paper (discussed in Chapter 3) was derived from what was learnt during Lin's two main epidemiological studies in Taiwan in the late 1940s and early 1950s. The Asian experience '[did] not pretend to be comprehensive, but point[ed] out that some of the research done in Asia [had] already proved its scientific quality and practical, operational value.'[298] This meeting laid the foundations for psychiatric epidemiological work in many other countries that the WHO later consulted. To strengthen the personnel at WHO headquarters, the Mental Health Unit looked for experts who had experience with 'cohort studies of mental disorders' and 'cross-cultural research' through seminars and conferences that took place outside of Geneva.[299]

When organising a seminar, the WHO headquarters would select a group comprising twelve international experts plus an additional local group. Most of the local group would be rooted in the host country, and some would be from neighbouring countries.[300] In documents prepared by the Mental Health Unit, all activities taking place in the Field Research Centres (FRCs) were described as 'national' rather than 'country' activities.[301] This terminology was partly intended to defuse the strong nationalist colours of postwar nation states. The Medical Officer of

[298] World Health Organization., 'W.H.O. Mental Health News', in Mental Health Section (ed.), (Geneva: World Health Organization, 1962). Issue 12, p. 3.
[299] WHO ARCHIVES M4/87/7 Peter Baan to E. A. Babayan 4 May 1965.
[300] For example, for the Moscow seminar, five participants were from USSR, others were from Bulgaria, Czechoslovakia, East Germany, Hungary, Poland, Romania and Yugoslavia. WHO ARCHIVES M4/440/23 (4) 1.
[301] WHO ARCHIVES M4/440/23 (65) Michael Shepherd to Tsung-Yi Lin 16th February 1966.

the Programme was authorised to travel extensively to conduct roundtable meetings organised by regional offices, to raise funds,[302] and to look for prospective advisors.[303] In addition, particularly for the Ten-Year Programme, investigators were required to travel to all FRCs to familiarise themselves with the language environment, research settings, and cultural contexts.

The so-called 'harmony with the people' (*renhe*, 人和) mentioned by Tsung-Yi Lin as one of the determinants of the WHO programme should be examined with regard to the extent to which the WHO became truly global in the early 1960s. During the early years of WHO, the organisation encountered some difficulty in integrating with the Pan American Sanitary Organization (PASO); these problems prevented the WHO from obtaining financial or technical support from official sectors in North America. The Arab-Israeli conflict and the controversy of French North Africa also threatened the harmony of WHO's visionary ideals.[304] Active communication between the WHO office in Geneva and PASO did not begin until the 1960s. Regarding the Mental Health Unit, the cross-Atlantic dialogue began with the renowned 'US/UK Diagnostic Project', which was led by eminent psychiatrists at NIMH in the US and the team at Maudsley Hospital in the UK (London). This dialogue and study attempted to measure the gap in understanding of diagnostic and technical terms through the lenses of these two nations. The results ultimately showed that apparent differences were almost entirely due to differing diagnostic practices in the two countries rather than to differences in the actual prevalence of mental

[302] WHO ARCHIVE M4/441/11.
[303] For example, it was during Tsung-Yi Lin's visit to Buenos Aires in 1964 that Argentinian doctor A. Bonhour's epidemiological research programme came to Lin's attention. From WHO ARCHIVE M4/441/11.
[304] See Farley, 'The Long Wait'.

disorders.[305] In the autumn of 1962, when Lin visited NIMH in Bethesda (Maryland, US), psychiatrists there told him about the ongoing study and the news encouraged Lin to conduct a bigger one.[306]

Who or what was the actual mastermind of the Ten-Year Programme? This remains a historically open question.[307] Different building blocks for the programme were being put in place on both sides of the Atlantic. The exchange of ideas between WHO, the London Group, NIMH, and other peripheral groups or individuals was central to the birth of this epoch-making programme. As previously mentioned, during the late 1950s a population-based study of the admission and readmission rates of psychiatric patients at three mental hospitals in London was conducted by JK Wing in concert with other psychiatrists. This survey foreshadowed the work of the same group of British researchers in the Camberwell registries, and the launch of the Social Psychiatry Unit Medical Research Council in 1964. By then, the epidemiological information system and the sampling frame of the London Group were established.[308] Meanwhile, on the other side of the Atlantic Ocean, in 1963 a generous grant of $500,000 from the United States Public Health Services was given to NIMH to plan the establishment of a National Clearinghouse for Mental Health Information.[309] These various research centres naturally became the launch partners of WHO Mental Health Unit.

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[305] J Zubin, 'Cross-National Study of Diagnosis of the Mental Disorders: Methodology and Planning', *American Journal of Psychiatry,* 125/suppl. 10 (1969), pp. 12-20. J. E. Cooper, R. E. Kendell, and B. J. Gurland, 'Cross-National Study of Diagnosis of the Mental Disorders: Some Results from the First Comparative Investigation', *American Journal of Psychiatry,* 125, Suppl (1969), pp. 21-29.

[306] In 1962, the meeting between Tsung-Yi Lin and the NIMH experts was attended by Morton Kramer, J. Zubin, B. Pasamanick, S. Greenhouse, M. Katz, and Robert Felix. See Lin, *Road to Psychiatry: Across the East and the West*. p. 117.

[307] Sartorius, Personal Communication

[308] Camberwell Registries. IOP/CAM9/2

[309] World Health Organization., 'W.H.O. Mental Health News', in Mental Health Section (ed.), (Geneva: World Health Organization, 1963).

In 1964, during the Annual Meeting of the WFMH in Bern, the discussion groups considered a number of topics of interest to WHO's mental health programmes. These topics included epidemiology and its transcultural aspects, and the documentation of information in mental health. Joy Moser, who had been closely collaborating with Morton Kramer of the NIMH in the initial preparatory steps for an international guide for the collection of psychiatric statistics, attended the discussion groups as a WHO representative. The setting up of case registries was one of the main topics for discussion, as it was considered to be crucial for mental health research.[310] Moser visited several regional offices in the early 1960s to survey collaboration possibilities with WHO headquarters for the collection and analysis of information on psychiatric resources. She had also represented the WHO at the WFMH Conference of Information Centre Correspondents in March, and held further discussions with the new Chief of the NIMH Clearinghouse for Mental Health Information regarding further collaboration between the WHO and NIMH to collect information.[311]

In 1964, progress was made with the official establishment of the objectives of the WHO's psychiatric research unit. In April that year, the WHO's Scientific Group on Mental Health Research was convened. The group stated that it

> … was acutely aware of the very wide scope of the subjects which are included under the general topic of Mental Health Research. In selecting some areas and some topics within these areas, as being particularly suitable for research activities on the part of WHO, the

[310] In the same year, this method was employed by the London Group in establishing Camberwell Registers.
[311] M4/86/12 Discussion Groups at WFMH Annual Meeting Bern 3-7 August 1964

> Scientific Group wished to emphasise that it would be necessary to seek the advice of small groups of experts in these several fields in order to work out the precise details of the research undertakings which they have indicated.[312]

The group's attention was directed mainly to two areas, the first being psychiatric epidemiology and social psychiatry, and the second being biological psychiatry. Although the WHO team included specialists in genetic studies, the core staff concentrated on developing social psychiatry and so epidemiology became the core focus of the Unit.

To conduct cross-national mental health studies, finding a common terminology became a burning issue. In 1965, the WHO's Ten-Year Plan in Psychiatric Epidemiology and Social Psychiatry was devoted to comparative research on specific mental disorders. A sum of $25,000 was commissioned to establish three scientific groups, the first of which would deal with nomenclature, classification and statistics; the second of which would deal with epidemiological methodology; and the third of which would address genetic problems. The first group secured the greatest funding, at $13,000.[313] These three projects (particularly the first two) echoed the priorities identified by researchers in London and Bethesda, as well as those of the WFMH, which had just relocated to Geneva.[314]

[312] Scientific Group on Mental Health Research. WHO ARCHIVES M4/87/7
[313] Scientific Group on Mental Health Research. WHO ARCHIVES M4/87/7
[314] In 1963, the WFMH planned to relocate its headquarters from London to Geneva, not only because of the cheaper rent but also because of its international (cosmopolitan) environment. See WHO ARCHIVES WFMH/Ex. 39/16.

Challenges of the 'Comman Language' Programme

The Ten-Year Plan in Psychiatric Epidemiology and Social Psychiatry (as proposed by Tsung-Yi Lin to the Director General) was arguably a 'hit and run' research programme. The objectives entailed considerable difficulties, particularly 'since there was not yet available a well-defined research technique for such a study.'[315] The plan included four sub-programmes—or perhaps, more accurately, four mutually complementary projects. These sub-programmes were planned as an overlapping sequence.[316] They were: A) the standardisation of international classification of psychiatric diagnoses; B) comparative research on specific mental disorders; C) mental disorders in geographically defined populations; and D) training programmes in epidemiological research techniques. The first two programmes were commenced immediately and the latter two were planned for the future, to further the research outcome of programmes A and B.

These programmes were proposed in light of concerns about preparing the 9th edition of the International Classification of Diseases (ICD-9). Programme A began in 1965 and dealt with the production and dissemination of international standards of psychiatric diagnosis, classification, and statistics. These issues had long been a concern for psychiatric epidemiologists, who had not yet taken the lead in psychiatric culture in most areas of the world. Programme A comprised eight seminars at yearly intervals, all of which were attended by a nuclear group of twelve experts from different schools of psychiatry, with each hosting centre adding its own local experts.

[315] The Ten-Year Plan in Psychiatric Epidemiology and Social Psychiatry. WHO ARCHIVES M4/87/7(66) J4.
[316] J. E. Cooper, 'Towards a Common Language', in Giovanni De Girolamo and N. Sartorius (eds.), *Promoting Mental Health Internationally* (London: Gaskell, 1999), pp. 14-46.

The first meeting, entitled 'Problems related to classification of mental disorders, diagnostic variation, and national programmes of psychiatric statistics', was held in London in October 1965. The seminars initially included only a small circle of people, primarily experts from the London Group and mainly Maudsley psychiatrists and their long-term collaborators.[317] The group eventually expanded its reach by disseminating information to individuals in other countries who were willing to collaborate. In the end, the seminars were attended by experts from more than forty countries.

From the start of the classification programme (Programme A), the professionals involved were aware of the need for other developments, such as methods to assess disabilities associated with mental disorders and simple psychiatric classifications for use in primary care.[318] Additionally, they assumed that any classification system developed by the programme would not be seen as the final edition; it was rather to be used for the purpose of treatment and could be changed over time. Experts bearing ideal qualifications were sought to join the programme.[319] In its first proposal, the group identified functional psychoses, especially schizophrenia, as the most important diseases for study. The consensus was that schizophrenia had well-recognised symptoms. All disease categories were covered, with the subjects ordered according to priority.[320]

[317] For example, participants of the first meeting included the British experts Aubrey Lewis, Michael Shepherd and Logan from Maudsley Hospital, and Miss Eileen Brooke from the Ministry of Health.
[318] M. Kramer, N. Sartorius, and A. Jablensky, 'The ICD-9 Classification of Mental Disorders: A Review of Its Development and Contents', *Acta Psychiatrica Scandinavica,* 59 (1979), pp. 241-62.
[319] The qualifications were listed as follows: 1.) Competence in the field of psychiatric diagnosis and classification and/or collection and analysis of psychiatric statistics; 2.) Represent a school of psychiatry and be acquainted with others, or have wide knowledge of biostatistical work in psychiatry; 3.) Influential in own country (if possible also more widely); 4.) Willing to collaborate over a number of years. WHO ARCHIVES M4/87/7.
[320] They were: 1.) Schizophrenia; 2.) The group of diseases included under the category Psychogenic Reaction; 3.) Psychiatric disorders encountered in childhood; 4.) Mental subnormality (also known as

The seminars originally included a balanced list of developed and developing countries, including Chile, France, Israel, Japan, Norway, Poland, the UK, the US, and the USSR.[321] In the longer term, difficulty organising international travel led to the replacement of Chile, Poland, and Israel with other more accessible countries. The seminars were held in the cities shown by year below (Figure 6).[322] Worth noticing is that five of the seven seminars were held in Europe, and none of them was held in the southern hemisphere.



Figure 8 Countries hosting WHO mental health seminars

retardation, defect, deficiency, etc.) 5.) Psychiatric disorders associated with senility and presenility; 6.) Pathological personality. WHO ARCHIVES M4/87/7.

[321] Classification seminars. WHO ARCHIVES M4/87/7.

[322] Cooper, 'Towards a Common Language'. p. 19.

Programme B was initially titled 'Comparative Research on Specific Mental Disorders'. Echoing the concerns of Programme A, Programme B was meant to serve as the testing and practical application phase for certain diagnostic concepts that were developed in the disease classification project. The complementary use of standardised methods of symptom rating would be added during Programme B. After one year of planning, Programme B began in 1966 as the renowned 'International Pilot Study of Schizophrenia'. [323] As with Programme A, practical concerns led to the experts' choice of schizophrenia as the focus of analysis in this long-term international study. Experts commented that 'Confusion and disagreement that still exist over diagnoses, natural history of the illness and the response to the various treatments for schizophrenia make an international study desirable'.[324] Another reason for conducting a long-term international study on schizophrenia was that a substantial amount of work had already been carried out on its epidemiological aspects. Thus it was not simply the 'universality' and 'seriousness of its effects' that led to the choice of schizophrenia as a research topic.[325] Although the classification of mental illnesses had not been fully established, experts had agreed that 'a working definition of schizophrenia can be evolved during the London meeting in 1965 and used in the comparative studies.'[326] The experts also stated that '[a]greement on a definition of

[323] The objectives of the International Pilot Study of Schizophrenia were:
(a) To develop uniform instruments, criteria for diagnosis, and procedures for case finding and measurement of the degree of impairment in schizophrenics in a selected set of countries with contrasting socio-cultural settings.
(b) To assist in the selection and training of the necessary personnel for such collaborative research in the selected countries.
(c) To evolve an adequate organisational framework for continuing collaborative research on mental disorders.

[324] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/445/22 J3.
[325] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87(65) J3,4.
[326] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87/7.

manic-depressive psychosis can be relatively easily reached',[327] indicating the hope of expanding the study to include other psychiatric diseases.

With regard to the location of studies, John Wing (of the Institute of Psychiatry, London) suggested that the chosen areas should be homogenous with regard to inhabitant composition, invariant in population movement, and convenient for research.[328] Overall, experts proposed that the study include six areas, including one in the USSR, and at least one in an Asian country. For the first round of selections, twenty countries (both developed and developing) were chosen as potential sites for the Field Research Centres (FRCs).[329] By the beginning of 1966 the FRCs had been narrowed down to eight: Aarhus in Denmark; Agra in India; Cali in Colombia; Ibadan in Nigeria; London in UK; Moscow in USSR; Taipei in Taiwan (then China); and Washington, DC in USA. A year later, a ninth was added, namely Prague (in Czechoslovakia at that time).[330]

From 27 September to 1 October, 1965, the technical meeting on comparative research was held in Geneva with participants from France, Scandinavia, Colombia, the UK, the USA, and the USSR. The topics discussed by this group of psychiatrists, sociologists, and psychiatric geneticists included: possible methods of case-finding,

[327] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87/7.
[328] In Wing's words, the criteria were: 1.) Existence of a good network of services serving a population of about one million or more (i.e., a large city); 2.) Strong psychiatric leadership, with availability of psychiatric and social science research personnel; 3.) Availability of demographic and sociological information; 4.) Racial homogeneity; 5.) Low rates of in- and out-migration; 6.) Some areas should be from developing countries. WHO ARCHIVES M4/87/7(65) J4.
[329] They include: Argentina, Australia, Ceylon, Colombia, Denmark, France, India, Japan, Lebanon, Nigeria, Norway, Sudan, Switzerland, Taiwan (then China), Thailand, Turkey, the UK, the USA, and the USSR.
[330] World Health Organization, *Report of the International Pilot Study of Schizophrenia* (Geneva, 1973) v. International Pilot Study of Schizophrenia. and World Health Organization, *Schizophrenia: A Multinational Study: A Summary of the Initial Evaluation Phase of the International Pilot Study of Schizophrenia* (Public Health Papers; Geneva: World Health Organization, 1975).

measurement of psychiatric impairments, measurement of factors affecting the evolution and duration of illness, and socio-cultural factors that influence the disease outcome of schizophrenia.[331] The group planned to have annual meetings at which principle investigators would have the opportunity to collaborate with an ever-widening pool of researchers; their work would be reviewed every three to five years.[332]

At the initial meeting, John Wing proposed a method to standardise the diagnosis of schizophrenia. His method was employed in parallel with the US/UK Diagnostic Project, and required a 20-minute film to be recorded of each clinical interview with a patient, to be used to established a standardised symptom-sign inventory and questionnaire. The interview instruments were then developed based on agreement among investigators and translated into different languages. Similarly, experts pursued 'objective and reliable ratings' in measuring the impairment of schizophrenic patients and the socio-cultural factors affecting disease outcomes.[333] It took enormous effort for experts to agree on the method of quantitative rating rather than qualitative descriptions.[334] While the centres and principal collaborators of the International Pilot Study of Schizophrenia (IPSS) were being identified, another epidemiological study, namely the US/UK Project, was also busy with preparations for its first comparative study of hospital admissions in London and New York. In the end, Both the IPSS and the US/UK team carried out a structured interview method, the Present State Examination (PSE).[335]

[331] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87/7(65) J3.4.
[332] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87/7.
[333] International Pilot Study of Schizophrenia. WHO ARCHIVES M4/87/7(65) J3.4.
[334] WHO ARCHIVES M4/87/7 (66) Tsung-Yi Lin to E. Gruenberg 25 May 1966.
[335] Cooper, 'Towards a Common Language'. p. 23.

The IPSS was carried out in three stages: preliminary, initial evaluation, and follow-up. During the preliminary phase, the principal investigators (mostly including those who developed the PSE in London and Geneva) organised their FRC teams, trained their interviewers, and tested all the procedures by selecting and assessing 26 patients. In the initial assessment phase, a total of 1 202 patients from nine FRCs were analysed, with their diagnoses being schizophrenia (811 patients), affective psychosis (164 patients), and other psychoses or non-psychotic conditions (227 patients). Patients were selected by diagnosis rather than by symptoms. Eligible patients had to be aged between 15 and 44 years, and have had psychotic symptoms such as delusions, hallucinations, or other strange and inexplicable behaviour not considered to be associated with mental retardation. Having selected the patients by these symptom criteria, the study psychiatrists then administered the PSE, followed by the Psychiatric History Schedule and the Sociodemographic Schedule.

The IPSS was the first large collaborative study to confront the problem of how to translate the conventionally accepted symptoms of descriptive European psychiatry into non-European languages. For the IPSS, the PSE was translated into seven languages by developing a system of translation and re-iterative back-translation, which depended on finding equivalence of meaning rather than developing a literal word-by-word translation.[336]

The contribution of IPSS could not be examined in the absence of the studies that were to follow. However, it confirmed the feasibility of international collaboration. The general findings of IPSS convinced the researchers that

[336] Ibid.; Leff, Personal Communication

schizophrenia had a similar symptom profile internationally. Nevertheless, the results also suggested that symptomatically similar patients may differ greatly with regard to course and outcome, and that the illness 'appears to be less severe in the developing centres'.[337] This unexpected outcome stimulated the WHO to conduct yet another study while entering the next phase of international collaboration.[338]

In this sequential study, 'The Determinants of Outcome of Severe Mental Disorders' (DOSMED), the methodology was more carefully designed regarding the sampling techniques and statistics, and the number of FRCs was increased. Additionally, Taipei (Taiwan) was removed from the study. The complete list of study areas for both IPSS and DOSMED was as shown in Table 2 below.[339]

Through DOSMED, researchers worldwide were for the first time able to locate the international common ground of psychopathology through informative data, which showed the similar incidence of schizophrenia across areas. The success of the study encouraged epidemiologists to create further international studies in psychiatric

[337] The World Health Organization, *Schizophrenia: An International Follow-up Study* (Chichester: John Wiley & Sons, 1979). To date, various arguments have been put forward about why prognoses of schizophrenic patients are better in developing countries. One the most promising explanations is that in family-oriented societies, patients enjoy better support from family members. Recent studies, however, have pointed out the sample bias in the study. For example, see Alex Cohen, 'Prognosis for Schizophrenia in the Third World: A Reevaluation of Cross-Cultural Research', *Culture, Medicine and Psychiatry,* 16/1 (1992), pp. 53-75.

[338] N. Sartorius, A. Jablensky, and A Korten, 'Early Manifestations and First Contact Incidence of Schizophrenia in Different Cultures: A Preliminary Report on the Evaluative Phase of the WHO Collaborative Study on Determinants of Outcome of Severe Mental Disorders', *Psychological Medicine,* 16 (1986), 909-28; A. Jablensky and G. Gernberg, 'Schizophrenia: Manifestations, Incidence and Course in Different Cultures. A World Health Organization 10-Country Study', *Psychological Medicine,* Supplement 20 (1992).

[339] Cooper, 'Towards a Common Language'. Table 2.2.

epidemiology that focused on non-psychotic diseases (e.g. depression).[340] Other follow-up studies on schizophrenia were continued at certain FRCs.[341]

The Ten-Year Programme proposed by Tsung-Yi Lin was not completed on time. Before Tsung-Yi Lin left WHO, only Programmes A and B had progressed according to schedule. After Lin relocated to Michigan, Norman Sartorius took the helm of the Ten-Year Programme, continuing with Programmes C and D, and with other projects derived from the completed studies. While these programs were simultaneously being conducted, many research instruments (including questionnaires and data analysis technology) began a period of remarkable advancement.

The following section critically examines WHO's international projects by focusing only on programmes A and B. These programmes have great historical significance for the development of psychiatry in the modern world. Programme A created a common language for psychiatrists; Programme B provided scientific evidence for epidemiological assumptions concerning the universality of psychopathology.

Table 2 World regions involved in IPSS and DOSMED research

Country	IPSS	DOSMED
Colombia	Cali	Cali
Czechoslovakia	Prague	Prague
Denmark	Aarhus	Aarhus

[340] For example, WHO (led by Norman Sartorius) embarked on the study of Standardized Assessment of Depressive Disorders (SADD) during the early 1980s. See N. Sartorius et al., *Depressive Disorders in Different Cultures* (Geneva: World Health Organization, 1983).
[341] See Chu-Chang Chen, Hai-Gwo Hwu, and Ching-Jui Chang, 'Deficit Sate of Schizophreniz in 20-Year Follow-up of the International Pilot Study of Schizophrenia', *Validity of Negative Syndrome of Schizophrenia* (Madrid, Spain, 1996), H. G. Hwu et al., 'A Comparative Study on Schizophreniz Diagnosed by Icd-9 and Dsm-Iii: Course, Family History and Stability of Diagnosis', *Acta Psychiatrica Scandinavica,* 77 (1988), 87-97.

India	Agra	Agra
		Chandigarh
Ireland		Dublin
Japan		Nagasaki
Nigeria	Ibadan	Ibadan
Taiwan (China)	Taipei	
UK	London	Nottingham
USA	Rochester	Honolulu
		Washington
USSR	Moscow	Moscow

The Historical Significance of the WHO Ten-Year Programme

The WHO Ten-Year Programme can be examined from a wide variety of perspectives. This section focuses on the historical achievements as well as the strengths and weaknesses of the programme. For this analysis, it is helpful to conceptualise the WHO as a network of social actors who were assembled during a particular space and time. The pros and cons of the WHO project can be fleshed out by examining the dynamics among these actors.

The Effect of Geopolitics on Worldwide Health

Like most UN projects, the Ten-Year Programme was influenced by the geopolitical situation of its time. By the time the Programme was actually launched, the expansive global vision for mental health that had been idealised by forerunners in the WHO had taken on an 'international' rather than 'world' focus. For example, unrest in Israel and Chile prevented using those countries as FRCs even though they had been included in the original proposal. Although the WHO successfully integrated itself with Pan American Health Organization (PAHO) in the shadow of McCarthyism, the Ten-Year Programme could not exempt itself from the threat of

communism. After programme participants were informed about the involvement of USSR delegates, tensions ran high. For example, GC Tooth from the Ministry of Health in London asked that the communications between himself and Geneva should be kept confidential, and requested to play a silent part in the WHO project.[342] Experts from the USSR were invited to arrive in London four days ahead of the first classification meeting in 1965, 'for the purpose of becoming more oriented to "Western" psychiatry before the discussions begin, and to inform [the participants] of present practice in the USSR.'[343] When the group met, Tooth distanced himself from joining any entertainment programmes with the 'crowd' including the four Russian representatives.[344]

Before the fourth classification seminar took place in Moscow in 1968, Marcolino Gomes Candau, Director-General of the WHO (1953 to 1973) expressed his hope that the USSR group 'responsible for arranging [the] seminar would accept without any deletions the list of the participants originally discussed with the Mental Health Unit staff.'[345] In turn, the USSR delegates expressed their wish that the seminar should include delegates from East Germany.[346]It was agreed between the USSR Ministry of Health and the WHO that the WHO would not cover the travel expenditures of Soviet participants.[347] At that time, the WHO did not welcome the participation of USSR's politically allied countries.

[342] WHO ARCHIVES M4/440/23 (65) 3 G. C. Tooth to Peter Baan 26 July, 1965.
[343] Ibid.
[344] WHO ARCHIVE M4/440/23 (65) G. C. Tooth to Peter Baan 1 October, 1965.
[345] WHO ARCHIVES M4/440/23 (4) M. G. Candau to Chief of Mental Health Unit 1968.
[346] WHO ARCHIVES M4/440/23 (4) M. G. Candau to Chief of Mental Health Unit 1968.
[347] WHO ARCHIVES M4/440/23 (4) Peter Baan to J. E. Rochalskij 13 August 1968.

Between 1946, when the WHO Constitution was signed in San Francisco, and 1948, when the WHO was actually established in Geneva, the spirit of internationalism that had prevailed in the postwar world had already become more pessimistic. Because of the controversy caused by several member states relating to issues other than medicine, the United Nations was granted the authority to regulate the WHO membership. Controversy around this point led to the withdrawal of several East European countries in 1949, and consequent problems from 1950 onwards related to North Korea, East Germany, and North Vietnam, we well as disputes about the representation of China.[348] In the Ten-Year Programme conducted by the Mental Health Unit, Taiwan became one of the FRCs not only because of nepotism between the programme director Tsung-Yi Lin and his motherland[349], but also because Taiwan was seen as representing China at that time. China had been identified as a country requiring special attention regarding mental health development. For Lin's successor in the Programme, Norman Sartorius, the idea that Taiwan could represent all of China was unrealistic.[350]

When Lin left the WHO in 1969, the Ten-Year Programme had already completed half of its stage-based tasks. For the common language programme, five seminars had already taken place. The research method for IPSS had also been fully established. Subsequent researchers were able to continue according to the norms established in the programme's preliminary stages. When Taiwan left the WHO in 1971, follow-up studies were continued with financial aid provided by NIMH in the United States. After Lin left the Mental Health Unit, he first arrived in Michigan and then took up permanent residency in Vancouver. While teaching at the University of

[348] Lee, *The World Health Organization (WHO)*.
[349] Chu-Chang Chen, Personal Communication (Taipei, 2011).
[350] Sartorius, Personal Communication

British Columbia, he also took up the presidency of the World Federation for Mental Health. In Vancouver, he was able to replicate his experience in the WHO by recruiting psychiatrists from all over the world and creating new cross-cultural research projects.[351] Thus, the model employed at the WHO began to play a significant role in the development of world mental health research.

In addition to what has already been covered, many details of the Ten-Year Programme defy easy categorisation but collectively influenced the success of the programme considerably. Many of these 'ins and outs' are concerned with the nature of human relationships, the nature of the WHO as a politicised entity, and with the accumulation of detail that ultimately defines the character of any endeavour. In this section I examine some of these finer points to provide a close-up view, in contrast with the overarching descriptions provided thus far. The details of the programme can roughly be divided into 'human factors' and 'non-human factors', within the framework of actor-network theories, through which sociologists re-define social reality.[352] In the 1960s, while the Ten-Year Programme took shape, scientific technologies emerged as a result of the global zeal for numerical rationality, and led to the development of abundant statistical technologies. These non-living apparatus were essential for the WHO to realise its projects. I now examine the human factors at play during that era.

[351] W. T. Soong, Personal Communication (Taipei, 2011).
[352] For actor-network-theories, see Michel Callon and Bruno Latour, *Unscrewing the Big Leviathan : How Actros Macro-Structure Reality and How Sociologists Help Them to Do So* (Boston ;: Routledge and Kegan Paul, 1981) p. 277-303, Bruno Latour, *Science in Action : How to Follow Scientists and Engineers through Society* (Milton Keynes: Open University Press, 1987) [viii], 274 p, Bruno Latour, *Reassembling the Social : An Introduction to Actor-Network-Theory* (Oxford: Oxford University Press, 2005) x, 301 p.

Human Factors

Standardisation: Consensus or Dictatorial Rule?

In any political organisation, including the WHO, the manner in which the most influential people wield power tends to determine how many dissenting voices are heard. Immediately after the end of World War II, idealistic hope prevailed over the administration of the WHO. However, the deeds and actions of the WHO were constrained by bureaucracy. The idealised notion of world citizenship (the 'harmony with people' described earlier in this chapter) was not possible to achieve without nepotism between the WHO decision-makers and potential collaborators. To invite researchers to join the work in the headquarters, programme directors wrote directly to individuals they knew and trusted, asking them to make personal recommendations, rather than publicising information about recruitment in any official medical journals or newsletters. Information was then disseminated through the same pattern among wider interpersonal circles.

Thus the *realpolitik* in the WHO had an enormous effect on relationships of trust in the Mental Health Unit. It took a charismatic leader to act as a troubleshooter. According to his colleagues, Lin was 'managerial' and was not easy to approach.[353] However, as a careful listener and eloquent communicator, he was able to mediate and co-ordinate between numerous comments and opinions. Many of his colleagues remember his ability to summarise, within a limited period of time, complex research conducted by different researchers, integrating the strength of each researcher's

[353] Leff, Personal Communication. Soong, Personal Communication.

expertise and converting the results into his own research impetus.[354] This capacity was crucial in mobilising a vast organisation.

Throughout the Programme, the most important theme was standardisation. Whether the method of standardisation occurred by consensus or by dictatorial rule remains open to interpretation. After selecting its FRCs, the WHO began investigating the background conditions at all psychiatric centres investigated. The variables studied included the institution's facilities, number of beds, and manpower and resources. Uniform methods were used at each of the field stations to screen people admitted to psychiatric facilities so as to profile the number and types of psychiatric patients and provide data for analysis. Each patient had to be 15 years old or older, and 'free of organic or physical diseases.'[355] Letters circulated to all the FRCs were also in the same format.

The politics of the WHO, whether external or internal, reflect many aspects of standardisation in its mental health programme. The limited resources and budget of the programme were equally distributed across all FRCs. Moreover, all FRCs were equipped with standardised facilities. For example, before diagnostic exercises took place, each FRC was equipped with two one-way screens, a calculator, a typewriter, a Xerox machine with tapes and supplies, a tape recorder, two air conditioners, a file cabinet, and a file drawer. To make the interviews uniform in terms of circumstance, the one-way screen was limited to 100 cm x 50 cm. These diagnostic exercises were able to '[c]ontribute greatly to the elucidation of areas of agreement and disagreement

[354] Soong, Ibid. Chu-Chang Chen, Personal Communication (Taipei, 2011).
[355] IPSS. WHO ARCHIVES M4/445/22 J3.

in the diagnostic practices of different psychiatrists and make it possible to come closer to a mutual understanding.'[356]

The Present-State Examination (PSE) Diagnostic Tool

The PSE was developed to unify diagnostic interview methods. While interview schedules were being developed, researchers encountered some difficulty in developing procedures for translating the schedules into different languages and for use in different cultural settings. The WHO favoured active participation by experienced research scientists travelling from the Geneva headquarters to the various field offices to ensure uniformity and reliability during interviews.[357] Initially, Dr A. Richman and Dr G. Ginsburg were sent from Geneva to each FRC to supervise local psychiatrists' use of the PSE. Richman and Ginsburg first went to London to view films taken during interviews with schizophrenic patients; these films were used as a guide to develop the PSE and to test reliability of the observations and of the collaborating investigators' ratings. Thereafter the doctors prepared an instruction manual for use before Phase I of the IPSS (planned for April 1967).[358]

One of Lin's letters to the FRCs stated that 'Scientists participating in the study will try to devise and to apply standard methods of identifying schizophrenics.' They would attempt to 'agree on standard ways to describe the psychological and behavioural characteristics of schizophrenic patients, and for determining the effect

[356] Standardisation on facilities. WHO ARCHIVE M4/440/23 (67).
[357] WHO ARCHIVES M4/87/7(65) J4; WHO ARCHIVES M4/87/7(66) J3 John Wing to Tsung-Yi Lin 21st June, 1966.
[358] Development of Present State Examination. WHO ARCHIVES M4/445/22 J4.

that cultural and social differences have on the course of the disease.'[359] While diagnostic exercises were being carried out at all field centres, the WHO supplied supervisors and sent staff members in person to ensure consistency in all elements of the study. Lin's persistence often also ensured the smooth progress of the research agenda.[360]

Translation, Language, and Misunderstandings: Problems with the PSE

The controversy about standardisation also reflected in the translation of diagnostic instruments. English and French were the official languages of WHO, but it was hotly debated whether papers prepared for project seminars and diagnostic exercises should be in English or French. Those whose mother tongues were Latin-derived languages, such as Portuguese, were in favour of papers prepared in French.[361] A precedent of sorts was established in 1957, during which year the World Psychiatric Association held its second meeting in Zurich. For this conference, the proceedings were published in both English and Interlingua, an international auxiliary language (IAL), which was fashionable during and shortly after World War II.[362] However, this was the first and last conference to employ that particular bilingual policy. The initiators of the Ten-Year Programme naturally employed English as the main language because the project started in London. In addition, Tsung-Yi Lin favoured English as the official language for the project. Before the experts' first meeting on the classification of psychiatric diagnoses in October 1965, some potential

[359] Development of Present State Examination. WHO ARCHIVES M4/445/22 J3.
[360] W. T. Soong, Personal Communication (Taipei, 2011).
[361] Language of diagnostic instruments. WHO ARCHIVE M4/440/23(3) 5, 6.
[362] Interlingua, developed between 1937 and 1951 by the International Auxiliary Language Association (IALA) is an international auxiliary language (IAL). It is nowadays assumed to be the second or third most widely used IAL, after Esperando and Ido, and the most widely used naturalist IAL.

participants had already suggested that all conversations during the meeting should be translated into other languages. Lin, as the project leader, did not think this necessary. He proposed that the English texts be prepared while the videotapes were shown.[363]

The back-translation method previously discussed was undertaken to ensure equivalence in meaning; it was used during Programmes A and B to unify the symptoms described by psychiatrists from all FRCs.[364] Throughout the Programme, the main communication challenges were rooted in cross-cultural misunderstandings and differences in the basic concepts about psychiatric diseases in various societies and cultures. Opposition especially came from the FRC in Bethesda, US. For example, the term 'friend' used in the psychosocial history (PSH) form mentioned social relationships in the context of evaluating social withdrawal, but was criticised as having no clear definition and being difficult to translate.[365] Questions such as 'Can God communicate with you?' were also disapproved of, as they occupied a grey zone between faith and psychopathology.[366] John Strauss of NIMH did not agree to use the PSE screening forms designed at the WHO headquarters. In a communication with the project leader, he wrote that '[W]e have felt that the screening forms coming from Geneva were in certain ways more impractical for use here than the forms that we had developed… I think that the problem stems from the fact that each of the three groups involved in writing the forms, Geneva, London, and Bethesda, has a somewhat different experience and different outlook, as well as different facilities and problems.'[367]

[363] Tsung-Yi Lin's insist in English language. WHO ARCHIVES M4/440/23 (65).
[364] Cooper, 'Towards a Common Language'. Sartorius, Personal Communication.
[365] WHO ARCHIVE M4/445/22 J5 Lyman C. Wynne to Tsung-Yi Lin 19 May 1967.
[366] WHO ARCHIVE M4/445/22 J7 Comments on Research Schedules.
[367] WHO ARCHIVES M4/445/22 J5 Lyman C. Wynne to Tsung-Yi Lin 28 March 28 1967.

While opposition (from Bethesda and elsewhere) was suppressed by Lin, the comments from NIMH became fiercer and lengthier. This transatlantic quarrel became a serious stumbling block, sometimes even delaying WHO's research schedule. For example, Lyman Wynne expressed the following intense objection:

> As you know we have put a lot of time into working on the forms and in thinking about the conceptualizations. Indeed, this part of the work is more meaningful and significant from our standpoint than the data collection itself, which can be done by almost anyone once the concepts, forms, and procedures are worked out. With the difficulties of transatlantic communication, and with the busy schedules that we all have in Geneva, Bethesda, and London, I am sure that there will be continuing problems in keeping each other up to date.[368]

Demands from the NIMH included the condensation of the interviewing instruments and greater accuracy in translations. According to the Bethesda experts, it was unrealistic to expect that the huge document would be used 'right away' in all of the centres in its original form.[369] Lin suppressed many objections not only because he wanted to carry out the work without too much revision, but also because of his own managerial charisma.

Progress Despite Discontent

[368] WHO ARCHIVES M4/445/22/J4 Lyman C. Wynne to Tsung-Yi Lin February 27, 1967.
[369] WHO ARCHIVE M4/445/22 J5 Lyman C. Wynne to Tsung-Yi Lin 19 May 1967

Interestingly, nearly all of the psychiatrists who worked at the WHO headquarters and in the FRCs were bilingual or trilingual. This was an important point, and probably allowed the project to be carried out without facing additional obstacles. Norman Sartorius (from then-socialist Yugoslavia) who took up Tsung-Yi Lin's post on the inter-regional team on the Epidemiology of Mental Disorders, was one of this group of bilingual and trilingual psychiatrists. These professionals had no difficulty in accepting the validity of the cross-cultural and cross-language comparisons that were being made.[370] The experts in the WHO viewed this method of enquiry as valid and trustworthy by default, because they shared similar cultural experiences and objectives. In the FRCs, however, the golden standard was less convincing to local investigators. For example, Erik Strömgren from Aarhus commented on the report of the second Geneva meeting, saying '[…] it could only give meaning to me, if not only the psychiatrists, but also [if] the patient were bilingual, which on the other hand, is not very probable.'[371] Disputes like this were raised in the correspondence between the Headquarters and FRCs. Although Programmes C and D began much later than initially expected, Programmes A and B were completed in time for the revision of the 9th edition of the International Classification of Diseases (ICD-9) in 1975.

According to Tsung-Yi Lin, the 'common interest' among experts and their '*esprit de corps*' made the programme possible.[372] And the so-called *esprit de corps,* as with many other programmes designed by the WHO, provides an implied admonition to the WHO's vertical power structure. For example, according to Chu-Chang Chen, the director of the FRC in Taiwan, Tsung-Yi Lin chose Taiwan as an FRC for the Ten-Year Programme partly for personal reasons. Lin's strength of

[370] Lin, *Road to Psychiatry: Across the East and the West*. Cooper, 'Towards a Common Language'.
[371] WHO ARCHIVE M4/87/(66) J4 Erik Strömgren to Tsung-Yi Lin 30 Sep 1966.
[372] WHO ARCHIVE M4/87/7 (66) J4 Tsung-Yi Lin to Lyman Wynne 30 Aug 1966.

personality in administering the Ten-Year Programme was a somewhat different matter. Not only was it easy for Lin to communicate with colleagues of his home country, by choosing Taipei as an obligatory travel destination, Lin was able to visit his homeland during the years he was blacklisted by his government for political reasons.[373] Interpersonal factors, nevertheless, in the end hampered the smooth progress of the programme. Because of private discord between Lin and the Chief of the Mental Health Unit, Peter Paan, Lin left the WHO headquarters and Geneva in 1969. Two years later, Taiwan ceased to represent China in WHO.[374]

Non-human Factors

Actor-network theory examines the motivations and actions of actors who form elements, linked by associations, of heterogeneous networks of aligned interests. Chapter 3 to the first half of this chapter has examined the efforts of the WHO and its experts in facilitating a specific scientific practice corresponding to the common interest in bettering the mental health of humankind. A key feature of actor-network theory is that actors (or 'actants') are taken to include both human beings and non-human actors such as technological artifacts.[375] In the case of the WHO's Ten-Year Programme in social psychiatry, the networks shared similar characteristics of information technology. They included people, organisations, software, computer and communication hardware, and infrastructure standards. [376] These non-human

[373] Chen, Personal Communication.
[374] Sartorius, Personal Communication.
[375] G. Walsham and S. Sahay, 'Gis for District-Level Administration in India: Problems and Opportunities', *MIS Quarterly,* 23/1 (1999), 39-65.
[376] G. Walsham, 'Actor-Network Theory and Is Research: Current Status and Future Prospects', in A.S. Lee, J. Liebenau, and J.I. Degross (eds.), *IFIP TC8 WG 8.2 international conference on Information systems and qualitative research* (London: Chapman and Hall, 1997), 466-80.

actors/actants were mostly technologies of electronics and communications that were fashionable in the 1960s. Some became the focus of experts' technological pursuit, while others were manufactured for the specific purpose of the Programme.

Video-taping Technology

Technology often affects medicine and medical practice, both for good and for ill; psychiatry is no exception. In psychiatry, psychiatric photographs have been influencing psychiatrists' diagnoses since the invention of photography in the second half of the 19th Century. Photographs have both illustrated trends in diagnosis and served as a tool to stereotype certain human races in the context of colonialism.[377]The development of videotaping technology (the moving picture, an 'extension' of photography) occurred at the same time as the design of WHO's diagnostic exercises. During Tsung-Yi Lin's first visit to the US in 1950, he arrived in Chicago before leaving for Harvard for two years. During his short stay in Chicago, Lin was dazzled by the charm of video recording technology exhibited at the Science Museum.[378] At WHO, other experts also placed their hope and trust in this new 'science'. Before the inauguration of the Ten-Year Programme, the mobile caravan video-tape studio had already been developed by the US/UK team at IOP. They believed that the motion pictures captured by the camera could objectively present patients' symptoms.

[377] For example, see Emma C. Spooner, "the Mind Is Thoroughly Unhinged': Reading the Auckland Asylum Archive, New Zealand, 1900-1910', *Health and History,* 7/2 (2005), 56-79. In addition, a project analysing psychiatric portraits photographed and kept by the late Canadian psychiatrist Edward Margetts (1920-2004) has been undertaken since 2004 by Dr Sloan Mahone in collaboration with Professor David Anderson: Trauma and Personhood in Late Colonial Kenya, retrieved 21 March 2012, <http://www.africanstudies.ox.ac.uk/research/research_programmes_and_projects2/trauma_and_personhood_in_late_colonial_kenya>

[378] Tsung-Yi Lin, 'Professor Tsung-Yi Lin's in Harvard 1950-1952', in Man-Horng Lin (ed.), (Taipei: Harvard Alumni Newsletter, 1996), pp. 24-28.

To pursue the absolute impartiality of research, investigators' subjective visual experiences were strictly regulated. Equipment used in the diagnostic exercises for Programme A were selected on the basis of ensuring the objectivity of observations of patients by local investigators, and consistency across the exercise environments. The apparatus included a movie projector that ran 16-mm film at a speed of 24 frames per second; standardised videotapes were also used and ran for a length of 2400 feet, with a diameter of 14 inches. All filmed interviews were transcribed, proofread, and typed onto a 'ditto master'.[379] To carry out the task of translation while organising seminars on the standardisation of psychiatric classifications, experts discussed establishing an audio-video laboratory. The IOP in London expressed great interest in this idea. In addition, it was proposed that all videotapes be dubbed into a local language for the diagnostic exercises. To this end, a film company was sought.[380]

Data Management Technology

Over the course of the Ten-Year Programme, the technologies of data management were also evolving. In 1965 a conference was organised to discuss the possible complementary roles computers could play in mental health, electronic clinical record systems, and patient management.[381] At the beginning of the IPSS, the speed of data processing was so slow that FRCs were unable to carry out this task themselves. Instead, they had to send gathered symptoms to the WHO headquarters, and then further processed them in London or Bethesda, where their computers were better at data processing. Towards the end of 1965, the maintenance of the Register

[379] WHO ARCHIVE M4/87/7(66) J4 Lyman Wing to Tsung-Yi Lin June 27 1966. 'Ditto master' was the nickname the researchers used for a duplicating machine, also known as 'spirit duplicator'.
[380] WHO ARCHIVE M4/445/23(65).
[381] Conference on the role of computing in mental health. WHO ARCHIVE M4/86/65.

became too cumbersome for the existing punch card methods, leading to its transfer to magnetic tapes in 1966 on the London University Alas Computer. A Piecemeal system for updating the Register tapes was subsequently developed, and analysis of the register data was undertaken as needed. Much later, a series of major analysis programs was written with the aim of producing regular and reliable statistics year by year.[382]

The invention of CATEGO, a computer programming system designed by John Wing, solved the complex problem of analysis. The CATEGO program narrowed down the data collected on symptoms into disease categories. In contrast, at Bethesda another technology was being employed, namely computerised cluster analysis. According to Lin, a computer is a machine, 'different from clinicians' diagnoses… It works for us carefully and objectively. Therefore the exactness, trustworthiness, fixity, and integrity could be ensured. And it is also neutral without partiality.'[383]

Occasionally, experts were bewildered by modern technology. During the closing session of the 4th WHO classification seminar, Dr L. Angyal from Hungary questioned the film demonstration method. In his view, the 'human brain does not work like a calculating machine'. To improve the method, he suggested developing 'fresh elaboration' and 'the enlarging of the symptoms'. Rather than seeking out techniques for investigators to refine their evaluations of symptoms, he held out hope for 'highly developed electronic computer techniques' that would realise a 'five digit subdivision' that could overcome the existing 3-digit ICD system.[384]

[382] Development of Piecemeal system for updating the Register tapes. IOP/CAM6/7.
[383] Lin, *Road to Psychiatry: Across the East and the West*. p. 132.
[384] L. Angyal's address at the 4th classification seminar. WHO ARCHIVE M4/440/23 (4).

Afterlife of the Ten-Year Programme

The preliminary endeavour of the Ten-Year Programme successfully rewrote chapter five of the new International Classification of Diseases in 1975. The 9th edition was believed to be more all-encompassing than its predecessors in describing psychiatric diseases from an international perspective. Furthering the achievements of Programmes A and B, a follow-up study of IPSS called the 'Determinants of Outcome of Severe Mental Disorders' (DOSMED) was carried out under the leadership of Norman Sartorius. This study established the lifetime prevalence of schizophrenia at approximately 1% to 2% of the entire human population. The results of DOSMED provided strong support for the notion that schizophrenic illnesses occur with comparable frequency across all population groups. This concept has been considered a true depiction of disease prevalence by psychiatrists all over the world in recent decades.[385]

The Politics of Large Numbers

Voices inside and outside the WHO questioned the WHO's lofty ambitions from the beginning. In accepting Tsung-Yi Lin's invitation to participate in Programme B, Ernest Gruenberg expressed his concerns about the fundamental problems of disease classification as follows: 'The whole idea of starting with a single disorder on a small scale is good. But differences within one country or area are extremely difficult to measure and of course international comparisons are even

[385] Jablensky and Gernberg, 'Schizophrenia: Manifestations, Incidence and Course in Different Cultures. A World Health Organization 10-Country Study' (Comments please see J. J. Mcgrath, 'A Systematic Review of the Incidence of Schizophrenia: The Distribution of Rates and the Influence of Sex, Urbanicity, Migrant Status and Methodology', *BMC Medicine,* 2/13 (2004).

harder. Many cities have marked internal variations in socio-cultural environments yet differences are hard to objectify.'[386] The project was also criticised for asking too many broad questions that could not be properly answered within a limited period of time.[387]

To satisfy the majority, some trends that had prevailed in psychiatry had to be sacrificed. For example, the diagnostic tradition derived from Freudian psychopathology became voiceless in the WHO programme. Even Tsung-Yi Lin admitted that the symptomatology pursued in the IPSS different considerably from the psychopathology he had learned in Japan.[388] The ICD system was criticised for leaving 'no room for reactive or psychogenic depressions of psychotic degree, which means that such conditions shall have to be classified under manic-depressive psychosis or under neuroses,' and for the fact that '[r]eactive or psychogenic psychoses with predominantly confusional (or hysterical) symptomatology are in the same way hard to place within the system.'[389] Hans Strotzka, the Viennese psychiatrist, wrote a letter to Lin commenting that '[i]n the plans for the future meeting is no mention of "neuroses and psychogenic reactions" which are the most common psychiatric disorders within a population and which need to be clarified most urgently.'[390] As a 'consumer of ICD', Lorna Wing (John Wing's wife) also commented on the validity of ICD. According to her studies at Camberwell, more than 24% of psychiatric patients had obvious 'underlying or precipitating causes' of mental illness. She criticised the ICD for its over-reliance on 'phenomenology' rather

[386] WHO ARCHIVES M4/87/7 Ernest Gruenberg to Tsung-Yi Lin 7 July 1965.
[387] WHO ARCHIVES M4/87/7 G. M. Carstairs to Tsung-Yi Lin 12 July 1965.
[388] Lin, *Road to Psychiatry: Across the East and the West*. p. 128
[389] WHO OFFICAL DOCUMENTS WHO/MENT/183 pp.14, 15.
[390] WHO ARCHIVES M4/440/23 (66) Hans Strotzka to Tsung-Yi Lin 24 Feb 1966. Strotzka's appeal was not realised until posttraumatic stress disorder was made into ICD preceded by the negotiation work between the World Health Organization and American Psychiatric Association in 1980s.

than 'psychopathology'.[391] According to Julian Leff, a participant in the Ten-Year Programme, the practice of psychiatry in postwar Europe and especially London was too heavily influenced by psychiatrists who had fled Nazi Germany during and after World War II. These psychiatrists were mostly advocates of Karl Jaspers' phenomenology rather than Freud's psychoanalysis.[392]

Statisticians hired by the WHO expressed other concerns. They noted the language gap between scientists at the Geneva WHO headquarters and clinicians in the FRCs. For example, Eileen Brooke wrote that the 'classifications in the ICD were far from satisfied with the way the ICD had been working,' She further pointed out that discord existed between the terms frequently used by psychiatrists who supplied data for classification and the terms that described ICD categories. In addition, she raised the concern that statistical data about patient registration were collected only from mental hospitals that admitted inpatients. She stated that 'The material does not include data from psychiatric departments and observation wards of general hospitals; but they cater for [sic] only a very small proportion of the psychiatric patients.'[393]

ICD Did Not Walk Out of Hospital

Echoing Brookes' concern, Lorna Wing suggested that the Camberwell patient register system she was developing should be taken into account by WHO. The database of the Camberwell Register included any patients who had been engaged in

[391] Lorna Wing, 'Observations on the Psychiatric Section of the International Classification of Diseases and the British Glossary of Mental Disorders', *Psychological Medicine,* 1/1 (November, 1970 1970), pp. 79-85.
[392] Leff, Personal Communication.
[393] WHO OFFICAL DOCUMENTS WHO/MENT/183 p. 17

any form of psychiatric services, not just inpatients. Based on the Camberwell Register data, John and Lorna Wing conducted a wide range of epidemiological surveys. One such survey focused on the most common treatment method employed by psychiatrists, namely psychotherapy. The Wings wanted to a) establish how many people in the Register had received psychotherapy; b) estimate the number of patients who had received outpatient treatment and should be referred for psychotherapy; and c) discuss the relevance of the data for planning local psychotherapy services. They found that the number of patients in Camberwell receiving outpatient treatment was two-fold higher than in other areas of South East England; furthermore, the number referred for special psychotherapy was three times higher. The data seemed to suggest that patients suffer from more severe levels of mental illness in areas where psychiatric services are more available. With this surprising outcome, John and Lorna Wing concluded that their research suffered from a limitation common to all 'operational' work, namely that 'one cannot draw clinical conclusions from purely statistical trends or differences… The fact that more patients could have been referred for psychotherapy does not mean that more should have been.'[394] Such research illustrates the symbiotic relationship between diagnostic tools and actual diseases. By implication, if there is no satisfactory diagnostic language in a specific geographical area, does it mean that mental health problems do not exist there? The question has recently been answered by the refinement of epidemiology studies. Researchers now recruit patients not only from institutions but also through other catchment routes in the society under investigation.

[394] J. K. Wing and Lorna Wing, 'Psychotherapy and the National Health Service: An Operational Study', *The British Journal of Psychiatry,* 116 (January 1970), p. 530.

In the 1980s, anthropologists began trying to investigate psychiatric diseases in East Asia. Arthur Kleinman, who worked in Taiwan and China, was one of the most prominent individuals in this field.

Category Fallacy

During the IPSS, scientists observed that schizophrenic patients in the FRCs of Taipei and Cali as a collective showed the most similar profile to the mean values for schizophrenic patients at the headquarters in Geneva.[395] Interestingly, in Taiwan's FRC, diagnoses were made by psychiatrists who had a close relationship with Tsung-Yi Lin, the director of IPSS. Also in the Taiwanese FRC, investigators Chu-Chang Chen and Ming-Tse Tsuang modified the method developed in Geneva. Chen and Tsuang interviewed patients consecutively rather than at the same time; that is, each patient was interviewed twice, once by each separate observer.[396] This method minimised the use of ambiguous terms due to expedient mutual agreement. Similarly, during the IPSS, the WHO headquarters produced a glossary of definitions that represented a consensus opinion on the part of all collaborating investigators. This step was undertaken to disambiguate individual psychiatrists' definitions of the terms used in the study. However, by the time Headquarters produced the glossary, the programme was already at the end of its second year.[397] The glossary, nevertheless, provoked dispute from Bethesda. John Strauss suggested that certain terms should be abandoned as they were used differently by people from different backgrounds, which

[395] International Pilot Study of Schizophrenia. and World Health Organization, *Schizophrenia: A Multinational Study: A Summary of the Initial Evaluation Phase of the International Pilot Study of Schizophrenia*.
[396] WHO ARCHIVES M4/87/7(67) Chu-Chang Chen to Tsung-Yi Lin 27 Sep 1967. During my interview with Dr Chu-Chang Chen in 2011, however, he had forgot their modification of methodology.
[397] M4/87/7(67) Tsung-Yi Lin to Chu-Chang Chen 25 Oct 1967.

could only perpetuate ambiguity.[398] Finally, it was the 'operational definitions' that were pursued by the investigators.[399]

In the 1970s and 1980s, while doing field work in Taiwan and China, anthropologist Arthur Kleinman indicated that the standard format for conducting cross-cultural studies in psychiatry created a 'category fallacy'.[400] He found that in the specific social and political context he was investigating, social suffering among Chinese people was mostly embedded in somatoforms. Moreover, 'depression' was not expressed by Chinese people; the word was replaced with the more acceptable term *Shenjing Shuairuo* (neurasthenia).[401] Kleinman's student, Sing Lee from Hong Kong, further pointed out that neurasthenia in China was a 'postponed diagnosis' that appeared only after Mao Zedong's death, thus bearing a somewhat political connotation as a post-Mao phenomenon.[402] One the contrary, in Taiwan, *Shenjing Shuairuo* became the popular diagnosis that could replace depressive or anxiety disorders, a name that was more accepted among patients who sought help from psychiatric services during the same period. Although Kleinman's viewpoint was disputed by the WHO as his notion did not apply directly to the WHO research, the rediscovery of neurasthenia in China does imply a fundamental problem of the WHO's early years.[403] The use of Taiwan to represent the whole of China meant that

[398] Such as autism, hypochondriasis, insight, ambivalence, negativism, change of personality in schizophrenia, schizophrenic thought disorder, and schizophrenic change of affect. WHO ARCHIVES M4/87/7 (67) John Strauss to Tsung-Yi Lin 6 Nov 1967.
[399] For example, 'mutism' could be defined operationally as 'making no verbal utterances whatsoever', although the word is used in many other ways.
[400] Arthur Kleinman, 'Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness', *British Journal of Psychiatry,* 151 (1987), pp. 447-54.
[401] Arthur Kleinman, *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China* (New Haven; London: Yale University Press, 1986) xii.
[402] Sing Lee, 'Diagnosis Postponed: Shenjing Shuairuo and the Transformation of Psychiatry in Post-Mao China', *Culture, Medicine and Psychiatry,* 23/3 (1999), pp. 349-80.
[403] By focusing on the symptoms of psychiatric disorders (including schizophrenia and depressive disorders) rather than on the language of diagnoses, WHO was able to conduct another large

the WHO study did not use a sufficiently large or representative enough sample for the population known today as the Chinese. This matter was unexplored until the 1980s.

Overall, the IPSS had many promising aspects; in particular, it made clear that large-scale, internationally based enquiry into epidemiology was possible. The WHO further conducted a follow-up survey (DOSMED) in twelve FRCs in ten countries; such follow-up would not have been worthwhile without the great promise held out by IPSS. Using a similar approach, especially the pursuit of operational definitions for symptom profiles, DOSMED consistently demonstrated the 'surprising' finding that the incidence of schizophrenia was fairly similar across different FRCs.[404] Such results, however, have been misinterpreted as providing strong proof that the incidence of schizophrenia does not vary between sites; this incorrect view gave rise to the broader belief that schizophrenia has a 'flat' epidemiological profile across space and time.[405] One of today's authorities in psychiatric epidemiology has argued that these 'dogmatic' beliefs may have contributed to an undervaluing of the relative contribution of environmental, or genetic plus environmental, factors in the aetiology

epidemiological survey in China with the sponsorship a French pharmaceutical company, Synthelabo, in 1980s. By dividing China into twelve areas, such study had characteristically acknowledged the heterogeneity of Chinese populations, colliding with the WHO's imagery of 'world citizenship' in early 1950s. See J. E. Cooper, N. Sartorius, and Yucun Shen, *Mental Disorders in China: Results of the National Epidemiological Survey in 12 Areas* (London: Gaskell, 1996) xi.

Furthermore, if we re-examine Tsung-Yi Lin's early surveillence on mental disorders of the three Taiwanese townships, we can find that his early concerns were the differences, rather than similarities, among populations. As a project leader of the WHO, what he contributed to the project was the methodology serendipitiously favoured by the Mental Health Unit. Evidence of his enquiry into the disparity of psychiatric manifestations among different 'Chinese populations' can be found in a frequently referred paper comparing two types of delinquent youth, 'tai-pau (太保)' and 'liu-mang (流氓)' repeatedly published around late 1950s. See Tsung-Yi Lin, 'Two Types of Delinquent Youth in Chinese Society', in Martin K. Opler (ed.), *Culture and Mental Health* (New York: The Macmllan Company, 1959), 257-71. Opler was one of the main cultural psychiatrists who criticised the feasibility of the WHO's 'manageable project'.

[404] Cooper, 'Towards a Common Language'. p. 29

[405] J. J. Mcgrath, 'A Systematic Review of the Incidence of Schizophrenia: The Distribution of Rates and the Influence of Sex, Urbanicity, Migrant Status and Methodology', *BMC Medicine,* 2/13 (2004).

of schizophrenia.[406] This claim echoes the appeal to study the 'causation' of schizophrenia during the early years of the Ten-Year Programme; such research remains vital and necessary today.

Revival of Chinese Psychology

While world standards for psychiatric diagnoses and disease profiles were being established, criticisms and divergent approaches were also being pursued. During a celebration of the 20th anniversary of the Chinese Society of Neurology and Psychiatry in Taiwan, Hsien Rin disparaged the confusion inherent in both the ICD and DSM systems, saying that it inconvenienced psychiatric education and services. He proposed an in-depth discussion on whether Taiwan should continue to espouse international standards or should rather develop its own classification system.[407] Other professionals also felt that if Taiwanese psychiatrists were not aware of the internationalism or localisation of Taiwanese psychiatry, and simply assumed the suitability of theories and instruments brought in from Western countries, Taiwan could become reduced to a procession zone of global academic assemblage.[408] Beginning in the 1980s, scholars of psychology and psychiatry across the Taiwan Strait began to discuss the sinonisation [*zhong guo hua*] of psychological research. They began to disseminate their appeals to emphasise the characteristics of Chinese culture, abandon the traditional methods of Western psychology, and develop a

[406] J. J. Mcgrath, 'Variations in the Incidence of Schizophrenia: Data Versus Dogma', *Schizophrenia Bulletin,* 32/1 (2006), pp. 195-97.
[407] Hsien Rin, 'Reflections on the Past Twenty Years', *Bulletin Chinese Society of Neurology and Psychiatry,* 7/2 (1981), 49-50.
[408] Keh-Ming Lin, 'Editorial: Psychiatric Research Priorities in Taiwan', *Chinese Psychiatry,* 10/3 (1996), 195-96.

localised approach.[409] For the past three decades, nevertheless, scholars have not yet come to a consensus or conclusion of what Chinese psychology really is.

Conclusion

The WHO can be perceived as a socially acting network consisting of human and non-human actors/actants that interact and follow a specific course. Accordingly, the Ten-Year Programme of WHO's Mental Health Unit was not merely an idealised vision put into practise, but rather a complex network system shaped by historical contingency and controversy. One should see it not only from the perspective of the Cold War, or of institutional bureaucracy, but also from a transnational perspective, examining how non-state agents, including scientists and technological artefacts, associated with one another in the historical context.

At its core, the international psychiatric epidemiology study at the heart of the WHO Ten-Year Programme was derived from the concept of 'world citizenship'. World citizenship here means spirited international collaboration on health issues, the 'magic bullet' that initially was dreamed of after World War II. Researchers had become interested in the psychiatric stresses confronting people during times of peace rather than simply preparing individuals for battle. Thus the field of psychiatry was moving away from suppressing individual interests in the name of preparing people for war. Finally, the interest in world citizenship accorded by the Ten-Year Programme meant developing an understanding of schizophrenia that crossed cultural

[409] For the milestones of such a school of inquiry, see Zhongfang Yang, *How to Study Chinese? [Ruhe Yanjou Zhongguoren]* (Taipei: Laureate, 1996).

boundaries, so that the symptoms of schizophrenia could be recognised in all patients, regardless of language or culture.

I have illustrated most of the factors enabling the accomplishment of the WHO's Ten-Year Programme which began in 1965. The cross-national scientific collaboration among experts from selected regions worldwide represented the world order in the postwar period.[410] In 1975, Chapter Five of the 9th edition of the ICD marked the conclusion of Programme A. Other sub-programmes constituted the later phases, with the revision of research scales and modifications of timeframes. The 'common language' programme served as the foundation for international mental health societies and agents to employ standardised categories for psychiatric diagnoses. Through the IPSS and other studies, the WHO attempted to confirm the universality of psychiatric diseases. The success of the Programme was that other than setting an example of international collaboration in the postwar scientific development, it eventually produced a golden standard for all countries to use, especially undeveloped and developing countries.

Historians have long argued over the political factors that influence WHO projects. Among the criticisms, Javed Siddiqi's attack on the 'vertical model' of WHO, which constrained the Malaria Eradication Programme, is the most powerful one. In a recent monograph commenting on Brock Chisholm and his tenure at the WHO, John Farley discussed the early political disputes within this special agency of the UN. Chisholm, who coined the phrase 'world health' to replace 'international health', left Geneva in July 1953 feeling disappointed. He was frustrated that his

[410] Regarding the way in which science represents politics at the intersection of power, conflict and collective action, see Mark B. Brown and Ebrary Inc., 'Science in Democracy Expertise, Institutions, and Representation', (Cambridge, MA: MIT Press, 2009), xvi, 354 p.

desire for peace had been undermined by the splitting of the world into 'two powerful camps, one [backed] by the evils of Stalinism, the other by the madness of McCarthysim.'[411] As argued by Randall Packard, the hegemony of the WHO in the international arena meant it could incorporate large populations into its exercise of governmental power, turning large populations into productive workers while securing their 'hearts and minds' against communism.[412] In the case of mental health, however, there was widespread belief that although world health had been weakened by political infighting, the shared need to deal with health in an international setting remained essential.[413] The interests of preventive medicine and new social measures created social bonds among a handful of experts at different schools who were partial to the general trends of psychiatry at the time, even if they faced opposition on the home front. Science and professionalism in response to the devastation of World War II also facilitated the progress and tenacity of WHO projects.

Despite its ideals of cross-national collaboration, unfortunately the concerns of WHO in the early postwar period remained Eurocentric. Although efforts were made to include experts from non-Western regions or hold project seminars there, the so-called vertical implementation of WHO policy meant that most developing countries simply tried to meet the standards established by Headquarters, while in-depth discussions remained disputes between Geneva and the United States. In the early years of the Mental Health Unit, Africa was neglected, and this problem was only addressed much later.

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[411] Farley, 'The Long Wait'. p. 186

[412] For example, see Randall M. Packard, 'Postcolonial Medicine', in Roger Cooter and John V. Pickstone (eds.), *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic, 2000), xix, p. 756.

[413] C. Allen, 'World Health and World Politics', *International Organizations,* 4 (1950), pp. 27-43.

Psychiatrists and other scientists relied on technology to a great degree during the Ten-Year Programme, trusting it to fulfil their aims. In this regard, apolitical, non-human actors played as profound a role as their human counterparts. The new technologies (video-taping, storing of information on magnetic tapes, computers) enabled researchers to deal with large amounts of data. The outcome of the research achieved a certain degree of objectivity through this effort. However, technology was accused of leading to a possible 'flattening' of science, with rigid stereotypes set in place that were not flexible enough to encompass a wider range or nuance of disease classification. The 'category fallacy' proposed by the anthropologist Arthur Kleinman was one of the strongest critical objections against the WHO's classifications. Additionally, the large neglected population in China turned out to be one of the thorniest issues in 1980s, leading to another effort to re-establish epidemiological surveys and slow down the integration between the ICD and Chinese classification systems.[414]

From the human aspect, disputes were inevitable as the WHO took on this enormous project. The WHO has a top-down command structure, and conflict and competition came not only from the two major blocs in the world (the US and the Soviet bloc) but also arose between the major Western states. In particular, the distrust often expressed by researchers based at NIMH in Bethesda (US) was notable. On a positive note, due to a lack of funds WHO headquarters often had to rely on its

[414] The first published Chinese psychiatric classification system appeared in 1979. To meet the demand of Chinese populations in terms of culture, the first version of the Chinese Classification of Mental Disorders (CCMD-1) was published in 1984. Its development was spearheaded by Yucun Shen and it was published by a task force organised by the Neuropsychiatric Branch of the Chinese Medical Association. The CCMD-3 published in 2001 is still in use. Neurasthenia has remained one of the culturally specific diagnoses in this classification. See Yucun Shen, 'On the Second Edition of the Chinese Classification of Mental Disorders (Ccmd-Ii)', in Juan E. Mezzich and Yutaka Honda (eds.), *Psychiatric Diagnosis: A World Perspective* (Geneva: World Psychiatric Association, Springer, 1994), pp. 67-74.

advisory services, and obtained many useful resources from regional offices. A charismatic leader was needed to tie it all together, and by many descriptions Tsung-Yi Lin was that person. Recommended by the West Pacific Regional Office as an experienced epidemiologist of strong character, he successfully demanded more funds from the director-general and organised phase-based international research across five continents. Lin left halfway through the Programme due to value conflicts within his unit, leaving Programmes C and D of the Ten Year Plan unfinished.[415]

As an organisation of 'world health' rather than 'international health', the success or failure of the endeavours of the WHO is determined by human and non-human actors, beyond the level of nation-states. The same applies in the field of international public health in general. Transnational linkages are important in structuring the field of public health in WHO efforts. According to Sunil Amrith, international public health was held together by a series of 'administrative pilgrimages', which had been shaped by pre-existing ties such as the British imperial links between India, Burma, and Ceylon.[416] In evaluating the Ten-Year Programme, public health programmes should be considered beyond the skeleton of pilgrimages among nation-states, as non-state factors also played significant roles in structuring this new scientific field. The transnational character of the WHO led many individual governments to become troubled about issues of citizen loyalty; such governments would have preferred that their citizens not be citizens of the world before being citizens of a particular nation-state.

[415] Lin's successor Norman Sartorius came from former socialist Yugoslavia. At the 3rd World Health Assembly, a delegate from Yugoslavia proposed the motion that with regard to China, the communists rather than nationalists should be asked to participate. This motion was defeated in the Assembly by sixteen votes to two. See Farley, 'The Long Wait'. Sartorius, however, denied any political reasons for Lin's departure two years before Taiwan withdrew from WHO. Sartorius, Personal Communication.
[416] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930-65* (Cambridge Imperial and Post-Colonial Studies Series; Basingstoke: Palgrave Macmillan, 2006) xiii, 261 p. 14

John Farley argued in the early years of the WHO that all US citizens employed by the WHO and other UN special agencies should be screened for loyalty and sign a loyalty oath. A number of employees, however, became openly critical of their government's policy and opposed the expressed interest of their countries' governments. [417] Tsung-Yi Lin was blacklisted by Taiwan for political reasons after he became involved as a resistance leader in Taiwan during the early phases of the Ten-Year Programme. Lin travelled internationally with a passport issued by the UN rather than by Taiwan, such was the difficulty he experienced in gaining a visa for travel.[418] In the next chapter, I will carefully analyse the role of Tsung-Yi Lin with regard to his pursuit of a national identity in his own academic odyssey, and will examine his social practice outside of medicine.

Another reason to look beyond the framework of nation states, I argue, is the *esprit de corps* of most WHO projects. Apart from the collective great hope that science and professionalism promised after the trauma of World War II, a mutual imagination borne of respect between individuals from all types of countries (developed or not) facilitated the *esprit de corps* of the projects. As discussed in earlier sections of this thesis, the WHO was designed according to the idea that 'health' could serve as a 'magic bullet' to stimulate the growth of economies world-wide, especially in developing and under-developed countries. This development would help the world to avoid further warfare. The so-called Western and developed countries, however, often underestimated the extent to which public health had been achieved in developing countries, especially before they operated in coordination with

[417] Farley, 'The Long Wait'. pp.186-187
[418] Hui-Ling Hu, 'The Passport', in Hui-Ling Hu (ed.), *Daoyu Ailian (Love Stories on the Island)* (Taipei: Yu-Shan Books, 1995).

WHO policies. For example, it has been shown that in Taiwan and many other islands, the successful eradication of malaria was not the result of WHO's vertical instructions.[419] Instead, medicalisation and the development of infrastructure had allowed these countries to attain WHO objectives.[420] However, member states did adjust their public health policies to meet the WHO timeframes, to demonstrate their determination to work in concert with the WHO.[421] Mental health was no exception.

In 1958, when the 'manageable project' was still taking shape, China was identified as the first of five priority countries for the WHO to seek advisory experts from, due to the idea that China was in desperate need of 'development'. Lin thought that Taiwan could also make a significant contribution to WHO programmes because of its unique experience. Over the course of the programme, a number of newly established nation-states, such as Israel, spontaneously showed their wish to join the programme. These mutual dynamics fulfil the definition of 'transnational linkages' beyond the level of simply 'international'.

The successes and limitations of the Ten-Year Programme in mental health can be seen as a commentary on whether the work of WHO achieved its world health objectives. By 1960, the Mental Health Advisory panel comprised 70 psychiatric experts from 35 countries. During a speech at the International Congress on Mental Health in August 1961, the Medical Officer of the WHO Mental Health Unit, Maria

[419] See Javed Siddiqi, *World Health and World Politics: The World Health Organization and the UN System* (London: Hurst, 1995) xiv; Randall M. Packard, *The Making of a Tropical Disease: A Short History of Malaria* (Johns Hopkins Biographies of Disease, Baltimore, Md.: Johns Hopkins University Press, 2007) xvii.
[420] See Packard, *The Making of a Tropical Disease: A Short History of Malaria*.
[421] For example, despite the fact that the DDT spray policy in Taiwan was meant to end in 1956, it was extended for another two years to synchronise with the launch of WHO's Malaria Eradication Programme. See Centers for Disease Control and Prevention, 'Malaria Eradication in Taiwan', in The Executive Yuan Dept. Of Health (ed.), (Taipei: Centers for Disease Control Prevention, Dept. of Health, The Executive Yuan, Republic of China, 2005), xxii, p. 300.

Pfister, noted an increase in UN member nations. She stated that this increase was due to countries gaining independence, especially in Africa.[422] However, she reminded the audience that the work of the WHO was complicated by dynamics within the rapidly growing institution.[423]

By the time the WHO Ten-Year project was inaugurated, a new organisation, namely the World Psychiatric Association (WPA), had been formed. The WPA emphasised non-governmental leadership and professional orientation. In the late 1960s, issues related to the abuse of psychiatry in certain countries (such as the USSR) elicited great concern among psychiatrists internationally. These issues were hotly debated in the WPA, whereas the WHO '[had] no position in [this] respect and the Secretariat cannot express any opinion' to respond to the allegations of the WPA concerning the abuse of psychiatry for political ends.[424] In the previous chapter, I mentioned that a study group on nuclear energy drew the conclusion that it was 'riding in the whirlwind and directing the storm', thereby failing to present a powerful opinion or useful suggestions on the safe use of atomic energy. Their expert opinions contrasted with Shunsuke Tsurumi's comment on global postwar, antinuclear attitudes: 'As long as the world is conceived solely in terms of states, and people only as members of states, there can be little basis for criticizing the use of atomic bombs.'[425]

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[422] WHO's mental health evaluation of Africa, however, remained controversial. J. C. Carothers' work, *John Colin Carothers, The African Mind in Health and Disease: A Study in Ethnopsychiatry (World Health Organization. Monograph Series,; Geneva: World Health Organization, 1953)*, attracted much criticism. For example, see Jock Mcculloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995) x; Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge: Polity, 1991) xii; Sloan Mahone and Megan Vaughan, *Psychiatry and Empire* (Cambridge Imperial and Post-Colonial Studies Series; Basingstoke: Palgrave Macmillan, 2007) ix.
[423] WHO ARCHIVES WFMH/IC, 6/7 P.12(111)
[424] M4/86/38 Norman Sartorius to Co..lan A. A. Quenum Regional Director, AFRO 6 September 1976
[425] Shunsuke Tsurumi, *An Intellectual History of Wartime Japan, 1931-1945* (Japanese Studies; London; New York: KPI : Distributed by Routledge & K. Paul, 1986) viii, p. 101.

In the sense of knowledge production, the Ten-Year Programme was exceptional. The uncertainty that permeated the agenda of the Mental Health Unit was similar to the attitude taken by experts toward the use of atomic energy in the first instance; it was the uncertainty of an uncharted vista. Some researchers did not appreciate that schizophrenia was not the only disease that could be studied by methods such as those of the IPSS.[426] Others admitted that during the Ten-Year Programme they did not question the validity of the theories, as it was a precious opportunity for a small country to be involved with such a large-scale international project.[427] This kind of excitement reflects the prestige that accompanied entering the international arena. The first Programme director, Tsung-Yi Lin, did not understand all aspects of the scientific background of the methodology applied in the Programme—for example the cluster analysis of data used at the FRC in Bethesda.[428] However, he was able to gather knowledge and experience from other experts and transform the information into an appealing research programme that attracted an increasing amount of attention from all over the world. After Lin left the WHO, he was able to replicate this method of knowledge in other contexts and so left his footprint all around the world. [429]

In summary, the WHO Ten-Year Programme in Mental Health was a unique example of international scientific collaboration. On the one hand it reflected the appeal of 'world citizenship' popular during the early years of the organisation; on the other hand, it was constrained by *realpolitik* in the sense of international relations and

[426] Leff, Personal Communication.
[427] Chen, Personal Communication.
[428] Lin, *Road to Psychiatry: Across the East and the West*.
[429] Soong, Personal Communication.

the vertical governance of the institution itself. Due to the special conditions that existed after World War II, and the weight of science and professionalism that prevailed over the suspicion or criticism of methodology as well as political obstacles, the Ten-Year Programme succeeded to some degree in establishing a paradigm of worldwide collaboration in medical research. The power of its influence extended across not only the Atlantic Ocean but also across two major political blocs. It also set up a golden standard for many countries where mental health was underdeveloped. However, the limitations of the phase-based Ten-Year Programme became evident as time passed. First, operational definitions flattened the possibility of nurturing culturally specific issues. Second, the effect of world politics (e.g. early exclusion of China from the WHO) and the dominance of phenomenologists also hampered this modern science from probing the deeper layers of the conditions it studied.

In the next chapter I analyse the social practice of Taiwanese psychiatrists, including Tsung-Yi Lin, during the postwar period. This analysis scrutinises the ways in which a non-Western region benefited from globalised psychiatry, especially with regard to disease classification. In addition, I illustrate how these psychiatrists—confronted with the limitations of international golden standards and the boundary of science—dealt with social suffering in Taiwan's distinct historical, social, and cultural contexts.

PART III: THE LOCALISATION OF TRAUMA

Chapter 5

Diagnosing Society:
The Social Practice of Taiwanese Psychiatrists

The previous chapter illustrated how a world-approved psychiatric discourse was assembled by international collaboration, and the discontents it encountered due to the limitations of the WHO's own governing system. This chapter analyses such discontents from the local perspective. I examine the social practice of Taiwanese psychiatrists in response to traumatic events during the post-World War II period, predominantly the 2.28 Incident and its legacy. Through their activities in and outside of psychiatric contexts, Taiwanese psychiatrists reframed the globalised concept of PTSD in their own terms, transforming it into a collective diagnosis of Taiwanese people.

James Scott has stated that the pernicious combination of four elements of state building caused a tragic episode of state-initiated social engineering during the postwar period. According to Scott, these elements included (and still include) the administrative ordering of nature and society; the high-modernist ideology, with its extreme confidence in the powers of the state and hence its overly bureaucratic persuasions; the authoritarian state, which uses coercive power to realise its high-modernist designs; and a prostrate civil society that is unable to resist the state's plans.[430] In postwar Taiwan, the 2.28 Incident was a classic example of the conflation of these elements. Its legacy was also a major source of suffering for the Taiwanese.

[430] James C. Scott and Ebrary Inc., 'Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed', *Yale Agrarian Studies.* (New Haven: Yale University Press, 1998), xiv, p. 445

This particular form of suffering, according to most psychiatrists I interviewed, was not easy to manage using the modern psychiatry practiced in hospitals.

The 2.28 Incident (detailed in Chapter 2) was primarily caused by the poor governance of the newly arrived Chinese Nationalist government. During the Incident and subsequent White Terror period, more than 20 000 Taiwanese people died. Lasting more than half a century, the individual and collective trauma caused by this incident was difficult to heal. In the late 1980s, Taiwanese psychiatrists in collaboration with other social activists initiated the 2.28 Peace and Justice Movement. Their efforts represent a unique example of medical practitioners using their professional force as a collectively resilient, resistant, and reconciling agent to account for the social suffering of Taiwanese people in the postwar decades. On the one hand, their actions benefited from the globalised psychiatric language; on the other hand, their radical approach revealed the limitations of the standardised profile of psychological trauma.

In the previous two chapters, I analysed the WHO rehabilitation project in mental health after the end of World War II. My analysis focused particularly on the cross-cultural collaboration that occurred in the context of the Cold War. In brief, the social psychiatry programmes of the WHO Mental Health Section were designed to further the understanding of why psychiatric diseases develop across all cultures under everyday stress; this approach was relevant in the postwar period, which, although traumatic, did not see civilians being sent to the front line. Through international collaboration, experts attempted to identify the stressors present during the normal human lifespan that are shared across cultures and could potentially cause

psychiatric diseases. Their research outcomes were used to inform an internationally approved psychiatric disease classification. During the development of this classification system, the psychiatric community collaboratively researched schizophrenia in depth in an attempt to define its universal symptom profile. This joint activity heightened the optimism of psychiatric experts, encouraging them to carry out international studies on the epidemiology of other psychiatric diseases.

The supposedly comprehensive psychiatric disease classification and disease profiles did not satisfy everyone. While attempting to reproduce the IPSS methodology in studies of other non-functional psychiatric diseases, such as depression, the WHO found it impossible to unify the expressions of depressive and anxious symptoms across different cultures. In the 1970s and 1980s, anthropologists reiterated that psychiatric diseases are culturally shaped. Each culture has its own unique form of 'social suffering', and social force inflicts harm differentially among diverse individuals and collectives.[431] In the end, the ICD psychiatric classification (which included all forms of mental disease) was globalised by the endorsement of the WHO experts due to its usefulness in most developing countries; the fact that the system allowed for further epidemiological investigations and revisions also acted in its favour. This acceptance took place despite the inadequacy of studies informing the classifications, and heavy criticism of the study's validity.

Based on the conclusions reached at the International Congress of Mental Health held in 1948 at the WHO headquarters in Geneva, mental health experts attempted to develop a common language (terminology) for psychiatrists across the

[431] Arthur Kleinman, Veena Das, and Margaret M. Lock, *Social Suffering* (Berkeley ; London: University of California Press, 1997) xxvii, p. 404;Veena Das, *Remaking a World: Violence, Social Suffering, and Recovery* (Oxford: Oxford University Press, 2001) viii, p. 294.

world. They sought common aetiologies for psychiatric diseases, and gradually established the paradigm of international collaboration invoked by the concept of world citizenship. By contrast, in Taiwan the immediately emerging series of traumatic events negatively affected society. The 2.28 Incident in 1947 and the consequent White Terror period created an unusual social context that differed enormously from the peacetime conditions for which experts were trying to enumerate the characteristics of psychopathology. During half a century of oppression, with its concomitant loss of indigenous language and an extreme form of fear, Taiwanese people were reluctant to express their own suffering. Limited space existed for individuals suffering from trauma-mediated psychiatric disorders to speak about the nature of their experiences. This, coupled with the immaturity of the psychological and psychiatric field in Taiwan, meant that newly established psychiatrists were unable to meet the unique suffering of the Taiwanese with appropriate theories or terminologies.

Argued by American historian of psychotherapy, Philip Cushman, a psychological self is configured by the social practices of local mental health professionals. Through a set of rules in their daily life, accents can be found in their language, and physical bodies thus are to be shaped by the language it they perform.[432] In other words, it is only through social practices of mental health professionals in the local context, a psychological or psychiatric discipline can be constructed with its cultural sensitivity. In the last two chapters, I have delineated the formation and discontent of common language of mental illnesses. The current chapter follows a different line of thought from that presented previously. I examine

[432] Philip Cushman, *Constructing the Self, Constructing America: A Cultural History of Psychotherapy* (Cambridge: Da Capo Press, 1996).

the social practice of Taiwanese psychiatrists with regard to how modern psychiatry was established, transformed, interpreted, and appropriated in the local context. My analysis includes non-WHO and non-hospital perspectives. As elucidated by June Edmunds and Bryan Turner, traumatic events in history tend to be followed by unique generations in society, paradoxically boosting the social influence and depth of thought, speech, and action among those later generations.[433] In postwar Taiwan, many physicians employed their advanced language ability and unique social position to seek ways of identifying traumatised Taiwanese and treat their suffering. This was especially true of new psychiatrists who were emerging along with the institutionalisation of psychiatry. These psychiatrists were exemplified by physicians such as Tsung-Yi Lin, who belonged to the 'lost generation'. Although Lin's own experience was initiated by the 2.28 Incident, he established his mental health career through relocation, which also meant that he became more influential in the worldwide practice of mental health. Ultimately he returned to Taiwan to collaborate with other activists.[434] Another psychiatrist, Yung-Hsing Chen, fits in the category of postwar baby boomers; this was a 'generation that turned to the reality', resumed the anti-colonial work of physicians in the 1920s, and pursued their career aspirations as medical professionals interested in political practice.

I argue that the social practices of these physicians provide an example of how the medical profession was transformed to address the social suffering in postwar Taiwan. The commitment of these doctors to 'the people' was evidenced by the way they distanced themselves from the state's scientific discourse, by their international

[433] See June Edmunds and Bryan S. Turner, *Generational Consciousness, Narrative and Politics* (Lanham, Md.: Rowman & Littlefield Publishers, 2002) vi, p. 197.
[434] For the definition of the 'lost generation' see Wan-Yao Chou, *The Times of Umi Yukaba: Anthology of the History of Taiwan at the End of Japanese Colonisation* (Taipei: Asian Culture, 2003).

activities, and by their joint efforts in the 2.28 Peace and Justice Movement in the late 1980s—specifically their provision of recommendations and prescriptions to alleviate the people's suffering. Rather than solving the problems of individuals, their prescription for Taiwanese suffering targeted the society at large. Their approach was not simply medical but political, and is discussed in the following passages.

Social Role of Taiwanese Doctors in Japanese Colonial Times

The historical origin of the social role of Taiwanese doctors is highly associated with Japanese colonialism from the end of the 19th Century to the end of World War II. In the beginning of Chapter 2, I explained how the Japanese government governed its colony, Taiwan, according to alleged biological principles. To combat highly epidemic infectious diseases on the island and to maintain the health of its own Japanese citizens, while also learning more about the customs of the native people, the Japanese government developed scientific medicine as the most important infrastructure during the colonial era. In most accounts analysing the practice of medicine in Japan-ruled Taiwan, scholars tend to link medical practices and colonialism. [435] However, Taiwanese doctors shaped their own identities along different lines. They constructed their own status and developed their careers within the context of colonial politics. In an analysis such as mine, the social practices among Taiwanese doctors, especially outside of medical practices, must be emphasised in place of extrapolation of the characteristics of colonial medicine.

[435] I introduced the purposes, characteristics, meanings and legacies of Japanese colonial medicine in Taiwan in Chapter 2 of this thesis.

During the Japanese colonial period, the Medical School (台灣總督府醫學校) and the Japanese Language School (台灣總督府國語學校) of the Taiwanese Government-General were the highest educational institutions in Taiwan. They were regarded as Taiwan's Oxford and Cambridge.[436] These schools not only produced professionals but also cultivated intellectual elites and social leaders. During the Japanese colonial period, Tu Cong-Ming (杜聰明, 1893-1986) became the first Doctor of Medical Sciences as well as the first Taiwanese citizen to hold a PhD. He was the preeminent symbolic figure of Taiwanese doctors' social involvement. At the Medical School of Taiwan's Government-General, Tu's research into opium detoxification heralded the start of a new era in native Taiwanese medicine, challenging the convention whereby medical research was monopolised by Japanese researchers. Tu became the first native Taiwanese to serve at an official Japanese medical institution, an unprecedented achievement in Taiwan's history and one which was not repeated until after World War II.[437] However, whether Tu's achievement can be perceived as anti-colonial behaviour remains open for further speculation.

Apart from Tu Cong-Ming, who pursued his career within Japanese institutions, Taiwanese intellectuals resisted Japanese colonisation through a variety of political and cultural activities in the 1920s and 1930s.[438] Physicians comprised a high percentage of these intellectuals. For example, in the Taiwanese Cultural Association (台灣文化協會) established in October 1921, there were twelve doctors among 47

[436] Chengcong Huang, 'An Investigation into Suspension of Taipei Normal School', *Taiwan Minbao,* 11 of December 1924.
[437] Yen-Chiu Fan, 'The Spitiual Heritage of Taiwanese Medicine under the Rule of Japan: Resistance, Anti-Colonisation and the Establishment of Native Medical Tradition', in Du-Jian Tsai and Yu-Mei Yu (eds.), *The Transformation of Medical Morals in Taiwan: Histories and Case Studies* (Taipei: National Health Research Institute, 2003), pp. 69-100.
[438] For example, see Edward I-Te Chen, 'Formosan Political Movements under Japanese Colonial Rule, 1914-1937', *The Journal of Asian Studies,* 31/3 (May 1972), pp. 477-97.

core personnel.[439] Similarly, during the Petition Movement on Setting up a Taiwanese Parliament (台灣議會設置請願運動), a quarter of the important initiates were physicians.[440] During the Security Police Incident (治警事件), six physicians were among the 18 individuals sued by the Japanese government.[441] Most scholarly analyses emphasise, to some degree, the role of medical doctors in these political activities. However, few studies have been dedicated to historical investigation of *why* these doctors devoted themselves to political and cultural activities. In addition, numerous scholarly articles and studies have focused on these doctors' achievements in producing literature that protested against the conditions of the oppressed and marginalised individuals in colonialist society. It has been asserted that literature was a special strategy employed by Taiwanese doctors to defend against Japanese colonisation.[442] By portraying the oppressed and marginalised people in society, the works of individuals such as Wu Xingrong (吳新榮) and Lai He (賴和) are credited as forming the *zeitgeist* of Taiwanese literature under the colonial rule of Japan.[443]

While the socio-economic status of the local medical community rose in the 1920s, doctors also turned out to be important commentators. Many of them transcended the boundaries of the typical definition of their vocation, diagnosing not

[439] Bi-Chuan Yang, *Taiwanese' Resistence under Japanese Colonisation: A History* (Banciao: Daw Shiang Publishing, 1996).
[440] Wan-Yao Chou, *The Petition Movement for the Establishment of Taiwanese Parliment in the Japanese Colonial Times* (Taipei: Tzuli Publication, 1989).
[441] After the application to form the 'Association for Attainment of Taiwan Parliament' was approved by Waseda Police Administration in Tokyo, it aroused the ire of Taiwan Governor's Office. When Chiang Wei-shui and the others returned to Taiwan, the Office mobilised a large force of policemen to arrest all of them for 'violating Security Police Law'. This event is now called the 'Security Police Incident'. For details of the arrested intellectuals, including doctors, see Yang, *Taiwanese Resistence under Japanese Colonisation: A History*.
[442] Jui-Ming Lin, *Taiwanese Literature and Its Zeigeist: Essays on Lai He* (Taipei: Asian Culture, 1993). Chien-Chung Chen, *Studies on Lai He's Literature and Thoughts* (Kaohsiung: Chunhui, 2004). Hui-Cheng Lin, *Studies on Wu Xinrong: The Intellectual History of a Taiwanese Intellectual* (Tainan: Tainan County Government, 2005).
[443] Lin, *Taiwanese Literature and Its Zeigeist: Essays on Lai He*.

only ailing individuals but also a sick society. Doctors spoke up as commentators but also further took actual political action, forming political parties and union groups. In 1921, Chiang Weishui (1890-1931), the founder of the Taiwan Cultural Association, the Taiwan People's Party, the Taiwan Workers League, and other important political organisations, publicly diagnosed the condition of Taiwan in his renowned essay, *Clinical Notes* (臨床講義). He likened Taiwan to a man suffering from symptoms of immorality, an impoverished spiritual life, superstition, poor hygiene, and other problems caused by 'intellectual malnutrition'. He prescribed 'maximum doses' of basic education and libraries to correct the bodily constitution of this diseased island.[444] Chiang Weishui was later credited as the Sun Yat-Sen of Taiwan; his example inspired a greater number of physicians to involve themselves in political activities.

In addition to their local political and cultural activities, during Japanese colonisation Taiwanese doctors endeavoured to connect Taiwan with international society. While the Japanese colonial government tried to demonstrate its authority and ability in the hope of being recognised as one of the great world powers, Taiwanese intellectuals lodged their complaints against the Japanese to the League of Nations. For example, to eliminate the opium use among 169 000 smokers (at the time equivalent to 6 % of the Taiwanese population) the Japanese government did not suddenly prohibit opium, which would have created administrative difficulties. Rather, it strategically enforced a policy of gradual weaning by adopting a licensing system in line with Tu Cong-Ming's detoxification research. The Taiwan People's Party, however, led by Chaing Weishui, believed the licensing system to be a tactic that had

[444] Source: Weishui Chiang, 'Clinical Notes', *Taiwan Literature English Translation Series,* 2007/20 (January 2007), pp. 125-28.

the primary intent of financially fattening the Japanese government, rather than reducing opium dependence. On 2 January 1930, the Taiwan People's Party sent a telegram to the League of Nations accusing the Japanese government of violating the terms of the International Opium Convention revised in Geneva in 1925. This move brought the League of Nations to Taiwan to investigate these issues in February 1930.[445]

Despite the significant contributions of Taiwanese doctors to political and cultural activities in Taiwan during this period, analyses of their contributions are rare. To date, the works of Chun-Kai Chen and Miriam Ming-Cheng Lo are the only Chinese and English monographs that deal with Taiwanese medicine as a profession and review core aspects of the field's professional, cultural, and political development. These aspects include the identity formation, social status, and historical roles of Taiwanese physicians during Japanese colonisation. Chen, for instance, points out that under Japanese colonial rule, two kinds of freelancers existed in Taiwan: doctors and lawyers.[446] While most public sector and industrial institutions were controlled by the Japanese, physicians and lawyers were relatively less constrained and were free from the monitoring of police. According to Chen, in the 1920s Taiwanese doctors devoted themselves to anti-colonial movements, and were second to no other profession in their degree of participation in such movements. Through these movements, physicians could defend their dignity against the Japanese while also developing Chinese nationalism.[447] However, Chen's research does not discuss how the factors

[445] Chen-Yi Chu, 'The Background, Internationalisation and Historicisation of Opium Issues', *Taiwan Medical World,* 49/10 (October 2006).
[446] Chun-Kai Chen, *Studies on the Social Status of Taiwanese Doctors under Japanese Rules* (Graduate Institute of History Series; Taipei City: National Taiwan Normal University, 1992).
[447] Ibid.

which motivated these doctors may also have formed the basis for their collective identity, and mobilised them.

Employing relational theories, the monograph by sociologist Miriam Lo, 'Doctors Within Borders', analyses in detail how the collective identity of Taiwanese doctors was formed under Japanese colonial rule.[448] The title of Lo's monograph was inspired by the non-governmental organisation 'Doctors Without Borders', and signifies the extent to which Taiwanese doctors were swallowed up by the Japanese Imperial structure in the early 1930s, losing their autonomy along the way and literally becoming doctors within the borders of the Japanese imperial regime. Lo argues that Taiwanese doctors' collective identity during Japanese colonisation reveals a blend of 'in-between' characteristics flanked by professionalism and by agents of the Imperialists. As 'national physicians' and 'medical modernists', their collective identity was shaped by the social and cultural context they were situated in. From the early 1920s to the end of World War II, Taiwanese doctors' self-identity experienced three different phases: *anti-colonial*, *demobilised*, and *assimilated*. During the 1920s, a class of 'national physicians' was established through a range of anti-colonial activities. Between 1931 and 1936, the professional autonomy of Taiwanese doctors was demobilised by the colonial government of Japan through the expansion of Japanese Imperial medicine and the integration of medical institutions. Furthermore, the profession withdrew into a cultural sphere that was directly controlled by the imperialists. During World War II, medical modernism became the main source of Taiwanese doctors' identity. Doctors were successfully absorbed into the state machine by its assimilation policy. Lo's monographs effectively illustrate

[448] Ming-Cheng Miriam Lo, *Doctors Within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan* (Colonialisms; Berkeley , Calif. ; London: University of California Press, 2002) xii, p. 236

how idealism turned submissive within the autonomous Taiwanese medical profession during Japanese colonisation. Lo's study, however, is controversial because of her arbitrary staging strategy and the limited representativeness of her case studies.[449]

Another critique of the relationship between Japanese Imperialism and the sacrificed and suppressed autonomy of Taiwanese medical professionals is presented by sociologist Yung-Wen Yeh. Yeh uses the framework of corporatism to depict a situation in which no division exists between the state authority and the oppressed society. Yeh analyses the subtle relationship between the two forces, concluding that the medico-political relationship in prewar Taiwan was not only full of antagonism but also entailed a great deal of compromise between the state in power and medical professionals. This conflict was enforced by the governmental rules laid down in Taiwan.[450] According to Yeh, by training native medical professionals in Taiwan, the Japanese attempted to replace the traditional gentry with these doctors while also developing their own agents of social control. The colonisers' intentions and activities, however, produced an unexpected outcome. Through elite medical education, physicians obtained and further built their collective will to resist colonial oppression. Their training, in combination with an already-honed desire to resist, encouraged physicians to further reflect on the systematic exploitation of the Taiwanese people by

[449] Te-Chih Chen, 'Comments on Ming-Cheng M. Lo's Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan', *Bulletin of Historical Research,* 34 (Dec 2005), pp. 207-22; Jen-Tuo Yao, 'Comments on Ming-Cheng M. Lo, Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan', *Taiwan Sociology,* 4 (Dec 2002), pp. 247-57.
[450] Yun-Wen Yeh, *History of Taiwanese Medical Services: Medico-Political Relationships* (Taipei: Hung Yeh, 2006b).

Japanese colonisation. Furthermore, the situation prompted speculations within society regarding the government's intentions.[451]

The participation of Taiwanese physicians in both medical and socio-political activities continued to some degree in the post-World War II period. In fact, physicians were confronted by an even more 'silent period' in which speech was suppressed under the strict regulations of the Kuomintang (KMT or Chinese Nationalist government). Given the chilling effect of colonial politics, and the suppression of advocacy for benevolent and just causes, how did these physicians continue to speak out about the suffering civilians—who were in the meantime restrained by the political situation?

Nonetheless, from the 1930s to the end of World War II, Taiwanese medical doctors became submissive to the Japanese Emperor. Many of them withdrew from the active roles they had engaged in during the short-lived Taiwanese Cultural Association, in which they had publicly and heartily intervened in state affairs. Instead, they turned their attention exclusively to literary issues. Wu Xinrong (吳新榮), who withdrew from politics to engage in pure medical service, and claimed that 'medicine is my wife; literature, my mistress' is but one example.[452]

In spite of the 'silenced and compartmentalised' identity of Taiwanese doctors, theses about them are currently emerging about their literary concerns. Historians are now paying more attention to many of these physicians' own writings, in which

[451] Yun-Wen Yeh, *History of Taiwanese Medical Services: Medico-Political Relationships* (Taipei: Hung Yeh, 2006b).
[452] Lo, *Doctors Within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan*. p. 107

criticism of political authorities is evident in the depiction of the weak and the poor in society. Taiwanese physicians who worked in this mode, including Lai he (賴和) and Wu Xinrong (吳新榮), often used a rich, realistic mode to communicate their resistance in the form of poetry or fictional accounts.[453] Although doctors were demobilised from maintaining a public presence in politics, the amount of articles they contributed to literary periodicals did not decrease.[454] Their contributions to literature (and to protest through literature) in Taiwan during the Japanese occupation has been regarded as analogous to the contributions made by Lu Xun in China.

In this section, I have outlined the social practices among Taiwanese doctors before and during World War II. These practices included their belief in intervening in society, the distance they put between themselves and the colonial government, and their political and cultural identities. A transition period has also been discussed, during which doctors and lawyers in Taiwanese society began to lose their relative independence from the Japanese Imperial authority. During this period the Japanese attempted to impose imperial medicine on the island, and to co-opt local resistance by training Taiwanese physicians and turning them into agents of the state. However, this strategy did not complete quell the spirit of resistance among Taiwanese doctors. Rather, Taiwanese physicians chose another avenue, namely literature, through which they could articulate the plight of the disadvantaged and oppressed in society. This method enabled them to continue expressing some of the same ideas that they once expressed through public demonstration. The next question is—what happened to the

[453] Chien-Chung Chen, *Studies on Lai He's Literature and Thoughts* (Kaohsiung: Chunhui, 2004). Hui-Cheng Lin, *Studies on Wu Xinrong: The Intellectual History of a Taiwanese Intellectual* (Tainan: Tainan County Government, 2005).
[454] See the appendix of Chao-Wen Wang, 'The Taiwanese Learned Societies in Late Japanese Colonial Times, 1940-1945', (National Tsinghua University, 1991).

practice of Taiwanese medicine after the defeat of the Japanese Imperial power in World War II, and the subsequent reorganisation of Taiwanese society?

Postwar Turmoil and the Beginning of the Silent Period, 1945-1949

After World War II, Taiwanese doctors briefly continued the legacy of their social involvement. The subsequent social turmoil, however, vastly changed their ways of intervening. Historians have pointed out that the 2.28 Incident in 1947 was a watershed in the social and cultural history of Taiwan. From that date, the Taiwanese medical field was pushed into a silent phase that lasted for half a century.[455] Their silence was caused not only by the language policy employed by the new Chinese Nationalist government, but also by the fear that spread across society. Wan-Yao Chou points out that a 'lost generation' emerged after the end of World War II. The generation was silenced by several factors. It had been deprived of literacy education during the war, and was forced to remain silent while people tried to come to terms with the past, both individually and collectively, during the subsequent KMT reign of terror.[456] Under Japanese colonialism, and in particular the *Kominka* (皇民化) period, public education in Taiwan was meant to assimilate Taiwanese people and make them subjects of the Japanese Emperor.[457] Just after the end of World War II, between 1945 and 1947, Taiwan was managed by the *Taiwan Sheng Xingzheng Zhagquan Gongshu*

[455] Yung-Hsing Chen, 'Taiwanese Medical Community and the 228 Massacre', in Yung-Hsing Chen (ed.), *The Historical Development of Taiwanese Medicine* (Taipei: Yuedan, 1997), pp. 97-122.
[456] Chou, *The Times of Umi Yukaba: Anthology of the History of Taiwan at the End of Japanese Colonisation*.
[457] For details of assimilation policy and how it affected the social life of Taiwanese people, please see Leo T. S. Ching, *Becoming "Japanese" : Colonial Taiwan and the Politics of Identity Formation* (Berkeley: University of California Press, 2001) xii, 251 p.In addition,Bosei Lim also emphasised the character of enslave education in the Japanese colonial policy. See Bosei Lim, *Public Education in Formosa under the Japanese Administration : Historical and Analytical Study of the Development and the Cultural Problems* (Tokyo: Takushoku University, 2004).

(台灣省行政長官公署), the administrative Interregnum designed to receive the Chinese Nationalist government. The Interregnum launched a top-down programme to reconstruct Chinese culture in Taiwan through the promotion of a 'national language' (*guoyu,* 國語).[458] After the 2.28 Incident, this policy became much stricter. Regarding the upheaval, the Interregnum decided to transform Taiwanese people into 'pure Chinese' and destroy the 'reactionaries of Japanese thoughts'.[459] The government prohibited books on Japanese history, geography, and culture. In coffee shops and other public spaces, Japanese songs were forbidden. Japanese clogs were not allowed to be worn on the streets or in the household. It was also required that the national flag be hung in every public sector.[460] In brief, after the 2.28 Incident the cultural reconstruction of Taiwan constituted another colonial phase.

The medical community in postwar Taiwan tried to impose its influence on reconstruction. However, this influence was transient and vanished with the arrival of the new Chinese Nationalist government. The tensions between medical professionals and the government continued for a half-century. At the beginning of the postwar period, Taiwanese doctors still actively participated in political activities. In addition to joining the *sanquingtuan* (三青團), which upheld the 'Three people's principles' proposed by Sun-Yat Sen and endorsed by the Chinese Nationalist government, they themselves campaigned for seats in the election of public officials at various levels. According to statistics, in the early postwar period one-fifth of the provincial county legislators were doctors. In certain areas, the proportion of county legislators who

[458] Ying-Zhe Huang, *Uprooting Japan, Implanting China: Cultural Reconstruction in Post-War Taiwan(1945-1947)* (Taipei: Rye Field, 2007).
[459]The 65th Conference Minutes of the Taiwan Provincial Administrative Interregnum, Vol. 6, Chinese Petrolium Co. Archive, in *Compilation of the 2.28 Incident Archives*. pp.186-202.
[460] The 66th Conference Minutes of the Taiwan Provincial Administrative Interregnum, Vol. 6, Chinese Petrolium Co. Archive, in *Compilation of the 2.28 Incident Archives*. pp.204-223

were medical professionals reached 40%. Doctors also comprised 14.29% of the central government (see Table 3 below). These numbers illustrate the important role doctors played in public administration and opinion, especially at the local level.

Table 3 The proportion of doctors at three legislative levels in early postwar Taiwan[461]

Level	Number of legislators	Percentage being doctors
Central	8	14.29%
Provincial	9	19.15%
County (local)	153	20.68%

During the 2.28 Incident, however, many scholars and doctors were killed, arrested, or imprisoned. Because of the high social status of Taiwanese doctors during the Japanese colonial period, the KMT had to suppress them to further its legitimacy in controlling the government.[462] For this reason, doctors became the primary victims during the 2.28 Incident. Tu Cong-Ming, who was then Superintendent of the recently reinstated National Taiwan University Hospital (NTUH), was dismissed from office on 11 March and did not dare stay in his own home overnight for the sake of his safety.[463] Similarly, Dr Hsu Shih-Hsien (許世賢), then legislator of Chia-Yi City, was forced to seek hiding places for herself and her daughters for months.[464] Dr Han Shiquan (韓石泉), the provincial legislator, recalled that three months after the Incident, 'there were no more than twenty legislators present at the provincial assembly. Two third of the whole assembly kept depressed and mute. […] it was like

[461] Source: Xiaofeng Li, *Legislators in the Early Post-War Taiwan* (Taipei: Tzuli Evening News, 1993). p. 111
[462] Chen, 'Taiwanese Medical Community and the 228 Massacre'.
[463] Chao-Chin Huang, *My Memories* (Taipei: Huang Chen Yin Feng, 1982). p. 236
[464] Li, *Legislators in the Early Post-War Taiwan*. p. 224

another world.'[465] Bosei Lim, the first Taiwanese citizen to receive a PhD, disappeared within days of the Incident. He was evidently killed in the Chinese Nationalist Party's crackdown after the island-wide civilian uprising, and was survived by his wife and more than ten young children—in a state of hunger and destitution.[466] Shi Jiangnan (施江南), a doctor who was appointed as a member of the 2.28 Incident Settlement Committee, was arrested and killed for no official reason.[467] Tsung-Yi Lin, the second son of Bosei Lim (then Head of Department of Psychiatry at NTU) recalls how, on the day, 'raffle guns fired at students in bursts. The NTUH emergently called back all doctors to help numerous victims. Witnessing the scene, Taiwanese were horrified. And the silence began to diffuse.'[468] On 11 March, Bosei Lim was carried away in a car by unknown people.[469] In May that year, his name appeared on a list of people who had been executed.

The 2.28 Incident was the flashpoint that pushed Taiwan into a period of coercion. Immediately after the Incident, the 'village clearance' policy (*qingxiang*, 清鄉) aimed to identify those who dissented from the government's policies through census and mass arrests. In 1950, after the Nationalist Government had officially relocated to Taiwan, Chiang Kai-Shek, the chairman, announced martial law in Taiwan. This event is generally considered to be the turning point at which Taiwan entered the period of 'White Terror', during which political dissidents were

[465] Shiquan Han, *Memories of 60: The Autobiography of Han Shiquan* (Taipei: Spring Wind, 2009). p. 86
[466] Tsai-Fan Lim, *Compilations of the 2.28 Incident Historical Archives*, ed. Sheng-Huang Chien, 18 vols. (9; Taipei: Academia Historica, 2002). pp. 338-40
[467] Yung-Hsing Chen, 'Taiwanese Medical Community and the 228 Massacre', in Yung-Hsing Chen (ed.), *The Historical Development of Taiwanese Medicine* (Taipei: Yuedan, 1997), 97-122.
[468] Tsung-Yi Lin, 'Closing Remarks', in Yung-Hsing Chen, Yen-Yu Chen, and Hui-Ling Hu (eds.), *Proceedings of the 2.28 Incident Academic Research Seminars* (Taipei: 2.28 Public Research Group Taiwan-US Cultural Exchange Foundation Modern Acadmic Research Foundation, 1991), pp. 369-74.
[469] Lim, *Compilations of the 2.28 Incident Historical Archives*.

suppressed. Public discussion of the 2.28 Incident was forbidden. Over 140 000 Taiwanese were imprisoned or executed for their real or perceived opposition to the KMT government.[470] An increasing number of doctors faced becoming embroiled in the long-term political turmoil. Instead of getting involved, many withdrew from politics.[471] Despite this chilling effect among medical professionals, young doctors made an effort to organise study groups and promote social reformation of the corrupt Taiwanese government. These efforts, however, spurred more arrests and mass killings of doctors. For first-generation psychiatrists, the situation was similar. Psychiatrists were afraid to express themselves in political terms for fear of being arrested.[472]

In another set of mass arrests on the morning of 6 April 1949, military and police personnel stormed through the student dormitory of the National Taiwan Normal University. The Taiwan Garrison Command deputy chief Chen Cheng (陳誠) ordered the arrest of student leaders, most of whom were ideologically left-leaning due to their disillusionment with the government. Seven of the arrested students were executed immediately, including medical students Xu Qiang (許強), Guo Xiucong (郭秀琮), and Yeh Shengji (葉盛吉), while many others were never seen again. Among them, Yeh Shengji was a new graduate from medical school. His degree thesis, entitled 'A Psychiatric Approach to Nietzsche', was supervised by Tsung-Yi Lin.[473] Before Yeh's death, he was brainwashed and tortured by the KMT's

[470] Chen, 'Taiwanese Medical Community and the 228 Massacre'.
[471] Ibid. Chen, *Studies on the Social Status of Taiwanese Doctors under Japanese Rules*.
[472] Hsien Rin, Personal Communication (Taipei, 2009).
[473] Weili Yang, *Double Nostalgia: Yeh Shengji, a Taiwanese Intellectual's Youth, Wandering, Exploration and Tragedy* (Taipei: Renjian, 1995). p. 243

intelligence service.[474] Psychiatrist Ying-Kun Yeh (葉英堃), who was two years younger than Yeh Shengji, notes that after Shengji's death, the fear and suffering became sublimated into his own national identity as a Taiwanese rather than Japanese or Chinese person.[475] After the 2.28 Incident, the surviving doctors were immensely affected by the consequences of the social unrest and the following period of fear. Some reacted by becoming socially withdrawn; others were stressed by the long-term monitoring of their activities by the government; while yet others relocated overseas but suffered from extreme nostalgia.[476] According to psychiatrist Wen-Shing Tseng (曾文星), who witnessed the bloody carnage at the age of eleven, the government's ruthless actions greatly affected the psyche of the Taiwanese people as a whole, further impacting the political situation.[477]

Despite the heavy-handed government policy and the icy atmosphere among intellectuals, doctors did retain some degree of freedom of speech. While all attempts were made to uproot the Japanese legacy of ideas and culture, the Interregnum did not ban scientific books written in Japanese.[478] In hospitals, doctors were allowed to continue documenting medical records in Japanese. In Chapter 2 I mentioned that, due to a shortage of physicians and demand for medical care in the early postwar period, the practice of medicine developed with a certain *laisséz-faire* persuasion. However, the government limited the autonomy of the medical community by controlling the central administrative unit for health affairs at the level of provincial

[474] Jiashuan Wu, *The Pioneer of Taiwanese Psychiatric Care: Biography of Ying-Kun Yeh* (Taipei: Psygarden, 2005). p. 99-100
[475] Ibid. p. 95
[476] Chen, 'Taiwanese Medical Community and the 228 Massacre'.
[477] Wen-Shing Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America* (Taipei: Psychology, 2010). p. 32
[478] Anon, *Minutes of the 66th Meeting of the Taiwan Provincial Administrative Executive Office*, ed. Sheng-Huang Chien, 18 vols. (Archives Materials on the 228 Incident, 6. Chinese Petrolium Company; Taipei: Academia Historica, 2002).

offices, rather than at the level of the state department. Under these circumstances, some doctors took a stand against the government, others remained silent, and some closed ranks with the government to remain worldly wise and safe.

The Scientific Discourse of Chinese Nationalism

Instead of entering peacetime reconstruction, postwar Taiwan became a military base for the Nationalist Chinese government to fight against the Communists after the social unrest from 1947 onwards. From the viewpoint of the Chinese authority, 'if peace comes suddenly, it is reasonable to expect widespread confusion and disorder. The Chinese [had] no plans for rehabilitation, prevention of epidemics, restoration of utilities, or establishment of repatriation of millions of refugees.'[479] For the new Republic of China on the island of Taiwan, science and technology served as functional instruments of state engineering. They were developed by state authorities and technocrats for the purpose of military competition and economic development. In the early phase of its governance, the Interregnum took a simplistic approach, translating the statistical research conducted by the Japanese colonial government on natural resources and infrastructures into Chinese, and branding them as its own scientific achievements.[480] In reality, due to the lack of reconstruction plans, the postwar period from 1945 to the early 1950s saw a surge in epidemics of cholera, bubonic plaque, smallpox, and typhoid fever.[481]

[479] This quote was a prediction by then U.S. General Albert Wedemeyer made in 1945, cited in Sunil S. Amrith, *Migration and Diaspora in Modern Asia* (New Approaches to Asian History; Cambridge Cambridge University Press, 2011) xviii, p. 112

[480] Taiwan Administrative Interregnum Office of Statistics, *Taiwan Statistics: 1896-1945* (Taipei: Taiwan Administrative Interregnum Office of Statistics 1945).

[481] Shu-Fen Chen, *Epidemics after the War: The Issues and Institutionalisation of Public Health in Taiwan* (Taipei: Daw Shiang Publishing, 2000b).

In the early postwar period, the heavy-handed national policy of the Republic of China influenced several historical conditions. First, it continued to mobilise the national spirit that began during the Sino-Japanese War. Second, it constituted a type of rebound effect from the 2.28 Incident. Third, it was developed to forestall the conquest of China by the communists. As of 10 May 1948, the state was subject to a series of temporary constitutional provisions, known as the 'temporary provisions effective during the period of Communist Rebellion' (*Dongyuan Shiqi Kanluan Linshi Tiaokuan*; 動員時期戡亂臨時條款). These provisions were considered to carry higher legal authority than the constitution. Through these temporary provisions, President Chiang Kai-Shek extended his powers through the height of the Chinese Civil War against the Chinese Communists. During this period, the island of Taiwan was regarded as the primary military base against the Communists. Civilians were ruled as if they were soldiers for the convenience of the government as a guard against civil rebellion.[482] These provisions were not abolished until 30 April 1991, when Lee Teng-hui declared the termination of the Period of Communist Rebellion.

During this time, scientific advances—and control thereof—became the key to wealth and power in China, as in many other countries subject to authoritarian rule. Authoritarian ideologies contradicted the short-lived internationalism that facilitated the birth of international organisations, in which science was employed in pursuit of peace and international collaboration. Instead, the Chinese Nationalist's scientific discourse fit comfortably within the classic state functions. Weibin Zhang argues that the modernisation of Taiwan during the postwar period, in terms of scientific and

[482] Monte R. Bullard, *The Soldier and the Citizen: The Role of the Military in Taiwan's Development* (Armonk, N.Y.; London: M.E. Sharpe, 1997) xiv, p. 223.

technological development, relied on state policies drawn up by the Nationalist Government, which was related to the core spirit of Confucianism. Zhang identifies the main factors that facilitated Taiwan's progress in science and technology; these were the leadership, hierarchical institutionalisation, and so-called R&D activities (research and development) supported by the government in Taiwan from the 1960s onwards. Such progress was designed to improve Taiwan's economic performance.[483] Thus according to Zhang, the scientific and technological achievements of postwar Taiwan were the incidental productions of the government's strategy for economic development, which was heavily influenced by Confucianism.

Zhang's view has been disputed by scholars who see the KMT government as having been a dictatorship rather than a Confucian, benevolent authority. For instance, according to Chung-Hsi Lin, science was used by the KMT government merely as a means or a symbol for the purpose of fulfilling the military objective of forestalling the military expansion of the Chinese Communists. One study revealed that the technological policies of the early postwar period were developed directly by political leadership rather than by scholarly communities; the opinions of local academics were displaced by techniques imported from abroad.[484] In recent research, historian Megan Green observes that from the 1960s onwards, economic development was fostered by the effective coordination of industry and academia or education. Such efforts were central in the origination of a developing state.

[483]Wei-Bin Zhang, *Taiwan's Modernization : Americanization and Modernizing Confucian Manifestations* (Singapore ; New Jersey: World Scientific, 2003) x, p. 224.
[484] Chung-Hsi Lin, 'The History of Technology Policies in Taiwan, 1949-1983', (National Tsinghua University, 1989).

The year 1965 was a turning point for Taiwanese scientific development. The Chungshan Institute of Scientific Research was established to promote scientific research for national defence. State technocrats began to take a more proactive approach in promoting manpower, research, and development directed to science and technology. They also promoted the linkage of this considerable developmental force to the question of industrialisation. Furthermore, from 1965 onwards, Chiang Kai-Shek's government began to promote the use of science against Mao Zedong and the Chinese Communists, who used science to 'oppress the Chinese people and to threaten the rest of the world'.[485] However, realising it was not possible for KMT to defeat (*fangong*, 反攻) Mao due to the withdrawal of financial and military aid from the US, Chiang Kai-Shek also began to suppress any speech against his government.[486]

The Medical Community as an Independent Scientific Group

According to Megan Greene, Chiang Kai-Shek saw himself promoting a 'good kind of science that would protect and defend Chinese culture'. As a result of the marriage between technocratic expertise and political dictatorship, Taiwan became a highly developed state with regard to industry and agriculture.[487] However, Greene also comments that not all institutions designed to guide scientific policy were equal.[488] For example, the state-approved medical care system was developed much later than other functioning arms of the state; workers within public health systems

[485] J. Megan Greene, *The Origins of the Developmental State in Taiwan: Science Policy and the Quest for Modernization* (Cambridge: Harvard University Press, 2008). p. 88
[486] Lin, 'The History of Technology Policies in Taiwan, 1949-1983', p. 72
[487] Greene, *The Origins of the Developmental State in Taiwan: Science Policy and the Quest for Modernization*.
[488] Ibid.

were mostly autonomous rather than mobilised by state administrators. Several reasons may explain this scenario. First, because of the state's ignorance with regard to developing social infrastructure, health issues were never prioritised in state policies during the early postwar period.[489] Second, due to lack of medical personnel and the financial predicament during this early postwar period, the prevalence of infectious diseases suddenly surged. To cope with the increased incidence of infectious diseases, public health programmes had to rely on external resources provided by groups such as the Rockefeller Foundation, the American Bureau for Medical Advancement in China (ABMAC), the United States Agency for International Development (USAID), and the WHO.[490] Third, the government attempted to silence and pacify society at this stage to prevent medical professionals—who were also leading intellectuals—from intervening in public affairs. Accordingly, while doctors enjoyed the freedom of practicing as freelancers, and therefore were to some degree free of the strict state constraints on civil liberties at the time, medicine was suppressed at the highest potential level, namely in the national administrative sector. The highest administrative sector of the health and medical care system, the Department of Health run by the Executive Yuan, was not promoted to the level of *shu* (署, department) from *chu* (處, office) until 1971.

Some professionals within the Taiwanese medical community practised science as a form of resistance against the state functions of taxation, conscription, and preventing rebellion. In addition, science was their vehicle for winning a seat in international society. Taiwanese medical professionals believed that they could

[489] Tung-Liang Chiang, *Health Insurance Policy: The Experience of Taiwan* (Taipei: Gsharp Corporation, 2001).
[490] Shu-Fen Chen, *Post-War Epidemics: Issues and Institutionalisation of Public Health in Taiwan, 1945-1954* (Taipei: Daw Shiang Publishing, 2000a).

become true citizens of the world by speeding up the acquisition of new knowledge in their areas of specialty. Cultural psychiatrist Wen-Shing Tseng notes that the Nationalist government instilled the notion that the Chinese on the mainland were 'enemies'. For this reason, people in Taiwan developed an incipient psychology that revered everything foreign and pandered to overseas powers.[491] This attitude of reverence was reflected in the Taiwanese public health workers' battle against malaria in the 1950s.[492]

Because of the late development of medical systems, Taiwan's medical resources largely depended on foreign aid in the form of training consultants, providing medication, and funding. The abundance of foreign aid and support enabled the medical community to develop a considerable degree of autonomy from the Nationalist Chinese government. Naturally, this autonomy was antagonistic to some of the government's proposals. However, despite this autonomy, the development of mental health as a distinct field in Taiwan was delayed, and was asynchronous with the development of reasonably modern systems in other aspects of medical care. As Taiwan became increasingly industrialised, mental health professionals made no proposals regarding possible medical responses to the stress Taiwanese people had begun to face. In the field of mental health, Taiwan had not yet become a 'world citizen' in its efforts to maintain and care for the psychological well-being of its

[491] Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America*. p. 57

[492] A number of anti-malaria programmes in early postwar Taiwan were facilitated by the financial aids of the Rockefeller Foundation. The Rockefeller Foundation, however, left Taiwan in 1949 for the fear of Chinese Civil War. The unfinished works were continued by public health officials and technical personnel trained specifically to the end of anti-malaria campaigns. It was argued that the success of malaria eradication in Taiwan was caused by a number of factors. It was not only because of Taiwanese government's effort in coping with the World Health Organization regarding its Malaria Eradication Programme (MEP) in 1950s, but also the transformation of medical morals among semi-professional technical personnel regarding their believes in attaining the world standards. SeeTsai and Liang, 'The Significance of Medical Ethics Presented by Malaria Research in Taiwan'.

citizens. In the early phase of postwar Taiwan, the psychological sciences developed two different 'personalities'. One personality, which arose within the newly established academic department, was designed to understand the Taiwanese psyche; the other served as a tool for the KMT government's anti-communist enterprise. Chapter 2 describes how the psychological sciences and psychiatry were developed at NTU after the end of World War II, and what that development meant historically. In this section, I examine some reactions among mental health professionals to state confrontation.

The newly established department of psychology and neurology at NTU was seen as the embodiment of the entire medical community among psychiatrists in postwar Taiwan. The department was developed as a response against Japanese colonial discourse, and did not expand according to the developmental skeleton of the new government. From a range of events, one finds evidence of tension between psychiatrists and the state authority. The web of political warfare organised by the General Political Warfare Bureau involved diverse disciplinary backgrounds. The structure of the web is illustrated in Figure 7 below. The psychological sciences, although young and still developing, were already well-established in the framework of political warfare.

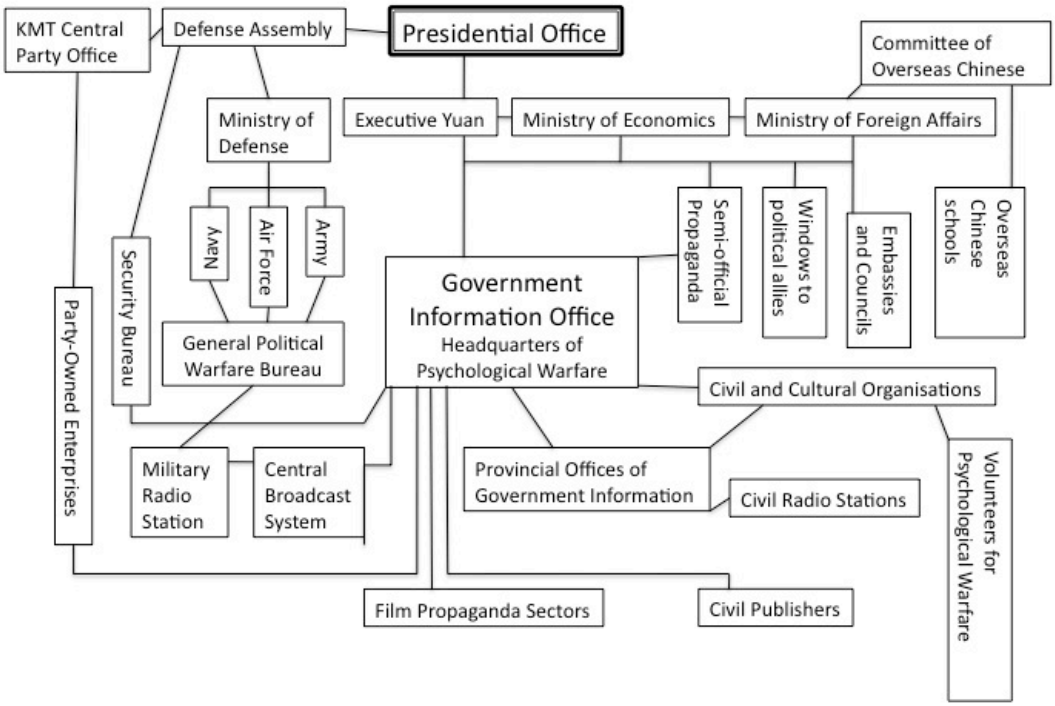

Figure 9 The web of psychological warfare, 1955.[493]

Psychological science was regarded a powerful weapon in the context of the Chinese Nationalist government's anti-communist campaign. In a speech given to the military corps, Chiang Kai-Shek stressed the 'mysterious power' of psychological warfare.[494] The 'Draft of Psychological Warfare for the Entire Populace' (*Quanmin Xinli Zuozhan Caoan*,全民心理作戰草案) was sketched out by the Committee Design and Research for the Restoration of the Mainland (*Guangfu Dalu Sheji Ianjiou Weiyuanhui*, 光復大陸設計研究委員會) in July 1955. The draft accounted for the participation of both soldiers and civilians in psychological warfare. The intended target of warfare education was the entire population of individuals of secondary high

[493] Source: Academia Historica, Index No. 051, Vol. 252, 120000001107A
[494] Chiang, Kai-Shek (1948). *The Importance of Mysticality and Psycological Warfare of the Anti-Communist Wars*. Speech given on the 6th of February, 1948 at the Central Training Centre for Officers' Corps, retrieved 21 March 21, 2012 <http://www.chungcheng.org.tw/thought/class06/0025/0006.htm>

school age or older. The education was to be given through the official syllabi at schools and through public lectures, pamphlets, dramas, movies, slogans, and songs.[495] In 1957, after the Soviet Union launched the first artificial satellite, Sputnik-1, in space, Chiang thought that the success or failure of the two political blocs depended on 'sound mind' among the people rather than the quality of their material life.[496] By 1964, the government had developed an advanced combat system, including a number of 'loyal cadre members' and 'facilities of psychological warfare'. The facilities of psychological warfare comprised radio broadcasting systems, newspapers, television networks, and airborne and maritime communication instruments.[497]

The government's proposal for psychological warfare, however, was not supported by mental health professionals. In March 1950, hoping to establish a centre for psychoanalytic studies, the Psychological Warfare Research Institute of the Republic of China (中華民國心理作戰學會) sent queries to several medical institutions, asking whether the establishment of a psychoanalytic centre might be supported by experts to supervise experiments and research.[498] Emphasising that medical services should be employed in the treatment of actual patients rather than for teaching psychological warfare, Chih-Teh Loo (盧致德) of National Defence Medical College disapproved of the proposal.[499] Tsung-Yi Lin, Head of the Department of Psychiatry at NTU, also declined the initiative with the comment that 'no specialists

[495] Academia Historica, Index No. 051, Vol. 252, 120000001107A
[496] Chiang, Kai-shek, *Speech addressed at the Graduation Ceremony of Women Training Programme*, (特種黨部第三屆委員宣誓分院婦訓班畢業典禮講) the Third Committee of the KMT Party, Yang-Ming Shan, 18th of November, 1957.

[497] Chiang, Kai-shek, Keynote Speech, Conference on the Psychological Warfare, 28th of April, 1964. Online source: http://www.chungcheng.org.tw/thought/class06/0041/0005.htm,
[498] Academia Historica, Office of Health 601.9/44/1
[499] Academia Historica, Office of Health 601.9/44/2

of this kind' could be provided by his department.[500] This stillborn initiative revealed the divide between the ideology of the medical profession and that of the state.

McCarthyism in the Taiwanese Medical Community

As previously mentioned, the Taiwanese medical community enjoyed a *laissèz-faire* period in the early postwar times. With the institutionalisation of various medical specialties in the 1960s, it became easier for the state to regulate increasing numbers of professionals. Inevitably, psychiatry could not exempt itself from the corporatist tactics of the anti-communist government. The Taiwanese Association of Psychiatry was established in 1961. On the one hand, it represented the maturing of this specialised medical science. On the other hand, it signified that the medical profession was becoming absorbed in the power distribution of the state, and that the state saw a need to control the speech and behaviour of professionals. This need became more apparent after the establishment of the National Security Assembly (國家安全會議) in 1967.[501] Meanwhile, as the outcomes of research in Taiwan—including mental health research—became more visible in international society, Taiwanese scientists were increasingly invited to participate in international conferences. Their participation in conferences served two purposes. First, it facilitated the exchange of ideas and experiences between scholars from Taiwan and other countries all over the world. For example, Tsung-Yi Lin was appointed advisory expert of the WHO through his repeated exposure to these international events. Second, for the Taiwanese government, sending delegates to international conferences

[500] Academia Historica, Office of Health 601.9/44/3
[501] Lin, 'The History of Technology Policies in Taiwan, 1949-1983', p. 72

served as a convenient method of monitoring and preventing the expansion of the Communists' international activities.[502]

Individuals who wanted to attend a medical conference abroad were required to apply for permission from the Ministry of Foreign Affairs (MOFA) and from the relevant authority at the Chinese Nationalist Party Central Committee (中國國民黨中央委員會). After returning home, delegates were required to submit a report to the authorities containing a summary of the event, including their own contribution to the conference, experience and knowledge learned from the conference, presence or absence of delegates from 'pseudo China', and the use of the official name of the Republic of China. The use of 'Taiwan' among delegates was forbidden by the MOFA for fear of growing pro-Taiwan power towards independence. This practice continued until the late 1980s. Given these regulations, not all individuals obeyed the rules in the same way. In a number of reports, delegates avoided mentioning official names of countries. Instead, they provided names of cities used by the conference participants. In one exceptional case, namely the World Psychiatric Association conference held in Vienna in July 1983, delegate Cheng-Ching Hsu reported back to the Ministry of Foreign Affairs that during the conference, he managed to 'shatter the conspiracy of the Communists, who attempted to join the Association by rejecting us.' He also wrote that he managed to 'win support from other delegates, that the Association was a pure academic community, which should exempt itself from political intervention.' In addition, at a time when the Taiwanese independence

[502] The first case of Taiwan sending delegates to prevent the Communists' participation in international medical conferences was in December, 1956, after the Ministry of Foreign Affairs was informed that a delegate of 'pseudo China' was liaising with the organisers of a conference on opthmology. Source: National Security to Ministory of Foreign Affairs, 28 December 1956. Academia Historica, Index No. 172-4, Vol. 0044-2, 020000021163A

movement was ongoing, Hsu had to correct other delegates who used 'Taiwan' as the official name of the country, because the 'Republic of China' was its official name and the delegates from China owned the naming rights, so to speak.[503] It is understandable that to survive the Republic of China's harsh political regime, individuals had to find ways to play it safe. During this long-term period of mind control after Tsung-Yi Lin had relocated to Geneva, Taiwanese psychiatry closely adhered to the KMT's principles of national development, according to psychiatrist Wei-Tsun Soong who worked at NTUH.[504] During the White Terror, the government asked some psychiatrists to help interview political criminals under sedation. When Soong was sent by NTUH to Vancouver for further training in child psychiatry, he was told that 'one of your teachers betrayed Taiwan'. This statement was meant to convey that some psychiatrists at NTUH had become hired thugs of the KMT government.[505]

Physicians' Narratives Under Oppression

In the postwar period, physicians' narratives were seen as important accounts to counter the government's oppression. Although having been existing since the Japanese colonial period, the flourishing of such narratives in the postwar period did not re-emerge until the lift of the Martial Law in late 1980s. It was because, as previously mentioned, the Taiwanese medical community entered a silent period after the 2.28 Incident, which lasted half a century. In the closing phase of Japanese

[503] Academia Historica, Index No. 172-4, Vol. 0260, 020000021596A, Ministry of Foreign Affairs, Conferences of Psychiatry
[504] W. T. Soong, Personal Communication (Taipei, 2011).
[505] W. T. Soong, Personal Communication (Taipei, 2011).

colonialism and during World War II, many doctors withdrew from public affairs. Instead, they devoted themselves to literature. Post-war, this practice continued. Given the special position of Taiwanese doctors in the historical context, their unique styles of narrative should be regarded as a literary genre.

According to Wen-Hua Kuo, physicians' narratives' in Taiwan are written for specific purposes. Such narratives can be seen as an 'archive-building' endeavour to restore and preserve the endangered social status and respect which medical professionals once enjoyed. Such narratives, according to Kuo, concretely reflect the social responsibility and professional morality imposed on doctors since Japanese colonial times. They include autobiographies and biographies, memoirs, and historical illustrations of specialised medical departments in hospitals.[506] This archive-building behaviour flourished in 1990, a year in which the Taiwanese medical community was under threat. However, I argue that the attempt to build an experiential archive commenced much earlier, right after the end of World War II. For example, Tu Congming (杜聰明), who preserved his writings and published his own speeches, was a classic example of self-rescue by publication while he was living under persecution.

Amidst the restrictions on freedom of speech, the publications and creative literature produced by the medical community were unique. The *Journal of Formosa Medical Association* (JFMA, 台灣醫學雜誌) had been established during the colonial period and dealt purely with academic research. In 1946 the journal *Taiwan Medical World* (*Taiwan Yijie*, 台灣醫界) was founded by the Taiwan Medical Association, which consisted mostly of private practitioners. *Taiwan Medical World* differed from

[506] Wen-Hua Kuo, 'When Archives Are Dis/Covered: Understanding the Portraiture of Medicine in Taiwan through It's Physicians', *Taiwan: A Radical Quarterly in Social Studies,* 54 (2004), pp. 105-48.

JFMA in that it contained not only clinical discussions and academic reports but also a wide range of other writing, including commentaries on medical administration, reflections on practice, and even creative writing. *Taiwan Medical World* was also one of the few academic journals which the postwar Chinese Nationalist government did not require to replace 'Taiwan' with 'China' or 'Chinese' in its title.

The publisher of *Taiwan Medical World* was the Taiwan Provincial Physicians' Association (TPPA) (*Taiwan Sheng Yishi Gonghui*, 台灣省醫師公會). The TPPA was established mostly by private practitioners to address health care and public health issues among impoverished individuals after the end of World War II. Those who founded TPPA were primarily practitioners who had been held in high repute since Japanese colonial times. Two of these physicians were the director-general, A-Chang Lu (呂阿昌)[507], and the executive director, Li Tengyue (李騰嶽), who had been among the elite group that attained their PhDs during Japanese colonisation.[508] The TPPA was established in November 1946 and underwent reorganisation the following year, after the 2.28 Incident, according to the Civil Organisation Act. This Act was launched by the Interregnum to provide stricter precautions against further political upheaval and to assure social stability. Although the TPPA was organised by freelancers, it was under close government surveillance and was to some degree subordinated by the government. For example, according to the constitution, certain types of people were not allowed to apply for membership of the TPPA. The restrictions excluded individuals who 'betray the Chinese Nationalist government',

[507] Lu A-Chang received his Doctor of Medicine from Kyoto Imperial University in 1935.
[508] Li Tengyue initially was educated at the Medical School of Taiwan Government-General. After graduating from Taipei Medical School in 1926, he entered Taihoku Imperial University (today's National Taiwan University) and read pharmacology with Tu Congming. He received his doctoral degree from Kyoto Imperial University in 1940. Li was not only a medical practitioner but also an active poet.

‘are under circular orders for the arrest of a criminal’, ‘are bankrupted and have not yet restored their rights’, and those who ‘smoke opium’.[509]

Since Japanese colonial times, *JFMA* has arguably been the main platform for the Taiwanese medical community to build its professional image regarding its capacity in academic research.[510] The *JFMA* provided not only a forum for leading medical scholars to showcase their research and clinical experience, but also a display window for Japanese scholars to expound their arguments regarding medical colonialism. During Japanese colonisation, if Taiwanese doctors needed to voice their opinions directly on social or political issues, they had to look for other sites of discourse. Journals and newspapers privately sponsored by Taiwanese intellectuals, such as *Taiwan Youth* (*Taiwan Qingnian*, 台灣青年) and *Taiwan Minbao* (台灣民報), were two examples of these other spaces. As described earlier in this chapter, however, during the assimilation and wartime period medical professionals became less involved in public affairs, and the medical sciences became an instrument for the expansion of Imperial Japan.

In the postwar period, *Taiwan Medical World* began publication in September 1947 as a collective effort among Taiwanese physicians, especially those in private practice. The first general assembly of the Association, however, was delayed by the 2.28 Incident and the subsequent social upheaval.[511] The general assembly created a

[509] *Taiwan Medical World*, No. 1, 1947, pp. 20-21.
[510] Hung-Te Liu, 'Medical Profession and Communities', in Hung-Te Liu (ed.), *Between Medical Administration and Medical Profession: Shi-Jung Chiu and the National Taiwan University Hospital and Taiwanese Medicine of His Era* (Taipei: National Institute for Compilation and Translation, 2005), 181-212.
[511] *Taiwan Medical World*, No. 1, 1947, p. 24

discursive space for and by the medical community without government regulation.[512] The inaugural editorial of *Taiwan Medical World* directly discussed the public health problems immediately after the end of World War II, before the Chinese Nationalist government relocated to Taiwan. Other concerns among the editors and contributors of the journal included the infectious diseases epidemics, illegal medical practice or 'quackery', inflation and price hikes for medicines, and other flaws of the interim government's public health policy.[513]

Articles in *Taiwan Medical World* frequently revealed the tension between the government and the medical community. The first plea made in the journal was that doctors should be exempt from business tax so as to stabilise the business of private practitioners.[514] For more than ten years, this issue had been an ongoing wrangle between the medical community and the government.[515] In addition, the editorial board called for an elevation in status of the administrative authority for public health and health care; they proposed that it should be elevated from Health Bureau (衛生局) to Office of Health (衛生處). The editorial board also favoured legal protection for private practitioners, the regulation of medical education, and the hand-over of medical institutions established by the Japanese, who had laid down the foundations of the health infrastructure in Taiwan. Apart from these proposals, the board directly commented on the design of public health offices, which had been devised by the Chinese Nationalist government during the Sino-Japanese War. It also criticised the proposed health insurance system, saying that it might restrict the freedom of practice

[512] *Taiwan Medical World*, No. 1
[513] Due to the increased price of paper, the journal had to reduce the frequency of its publication from monthly to bimonthly. The editors also needed to sacrifice a considerable number of contributions to reduce the text on the page layout. *Taiwan Medical World*, No. 1, p. 15
[514] *Taiwan Medical World*, No. 1, p. 2-3
[515] *Taiwan Medical World*, No. 7, 1951.

among freelancing practitioners. In addition, in defence of the medical marketplace that had long been sustained by freelancing Taiwanese doctors, *Taiwan Medical World* openly criticised the government's implementation of the Temporary Principles for the Recruitment of Medical Personnel (醫事人員甄訓辦法). This provision was rashly launched in 1946 in an attempt to regulate the chaotic medical conditions in postwar Taiwan, and was believed to be the government's plot to profit poorly trained medical practitioners relocating from Mainland China.[516]

What was unique about *Taiwan Medical World* was that space remained for doctors' contributions in creative writing. The columns *Wenzao* (文藻) and *Yijie Shihua* (醫界詩話), edited by Li Tengyue, represented a continuation of Taiwanese doctors' literary interests, which had first appeared during Japanese colonial times. In these sections, implicit criticism over the politics and social unrest could be found. For example, in a poem published in the second issue of the journal, under the pen name Lu Cun (鷺村), the executive director Le Tengyue (李騰嶽) described the horrors of bombing during wartime, and the social unrest after the Chinese Nationalist government 'regained' Taiwan. He further criticised the corruption of the officials in the Interim Government.[517] Another doctor published a poem, *Wandering Soul* (徬徨的亡靈), in which he wrote 'The sun is laughing at the ignorance among the living; only rationality can appreciate the peace of heaven and earth.' (太陽笑著人世的暗愚，

[516] *Taiwan Medical World* , No. 6, 1950, p. 13
[517] In Chinese:《丁亥中秋一日詣一信堂》（鷺村）：「消魂空炸時，疏開寄容膝，群機挾彈飛，穴居徒顫慄。光復誠同慶，治平豈無術？民生盼康樂，貪污真奚必！」Source: *Taiwan Medical World*, No. 2, 1948, p.18

理性讚美著天下的和平)[518] Bailou Wu（吳百樓) complained about the limited freedom of speech. He wrote, 'Knowing I am a critical man, nevertheless I cannot provide a voice for the nation.' (明知我亦西西者，不便光言為國度)[519] Following the tradition inherited from Japanese times, doctors also attempted to 'diagnose' the collective mindset among the Taiwanese people. An anonymous author speculated that the pursuit of immediate wealth among the Taiwanese was a 'Taiwan Disease'.[520]

On the one hand, the Taiwanese medical community criticised the government's health policies and called for changes; on the other hand, the community also charged itself with catching up with the modern world and becoming a player in international society. The TPPA persistently urged the interim government to import DDT to control the surge of malaria in the early postwar period.[521] The medical community focused on 'consolidating the scientific foundation of medicine' and then 'achieving the world standard'.[522] These doctors considered themselves to be not only scientific Chinese doctors but also members of the 'world citizenship'. Their words illustrate how they situated themselves among the internationalist societies and interests that emerged after World War II. For example, one editorialist wrote, 'From now on we need to construct Chinese medicine from the standpoint of science, cultivating more scientific doctors, promoting their social status. Apart from enhancing the health of the nation, we also need to contribute to the medicine in the world.' [523] A poem

[518] *Taiwan Medical World,* No. 5, 1949
[519] *Taiwan Medical World* , Vol. 2, No. 1, 1959, p. 48
[520] *Taiwan Medical World* , Vol. 2, No. 1, 1959, p. 42
[521] 'The TPPA Writes to the Health Office and Asks for Purchasing Medication from the United States on the 7th of January, 1948'. *Taiwan Medical World,* No. 3, 1948, p. 2
[522] *Taiwan Medical World,* No. 3, 1948.
[523] *Taiwan Medical World,* No. 3, 1948, p. 1

authored by Bu Lao (不老) offered a typical remark about Taiwanese doctors' professional identity. Bu Lao rhymed, in doggerel style, that

The civilisations are competing in the world,

The sciences are being developed frenziedly,

Strive! Quickly strive!

Research should keep improving.

Scientific advances are borderless,

International relations are mystifying.

When will flowers of peace blossom?

Strive! Quickly strive!

No-one doesn't expect the arrival of peaceful world.[524]

The spirit of this doggerel was not the developmental ideology of the Nationalist government. Rather, the verse makes light of—while criticising—the postwar international scientific culture. A belief in rational thought and the pursuit of scientific methods permeated most scientific communities, and science was expected to play a leading role in the achievement of world peace.[525] Moreover, in Taiwan an assiduous collective mentality was shared by medical practitioners, many of whom were disenchanted by the myth of governmental state-building. Yeh Shengji, who put his faith in social medicine and communism, devoted himself to malaria research

[524] *Taiwan Medical World,* No. 2, 1948, p.18 In Chinese, '世界文明世競爭，科學日新無時停，奮鬥！緊奮鬥！研究日精益求精。科學進步浩無涯；國際風雲費疑猜，和平之花何時開？奮鬥！緊奮鬥！無人不盼太平來。'

[525] Please refer to Chapter 4

rather than hospital work before his execution.[526] Anthropologist Tu-Chien Tsai's research suggests that the dedication and focused attitude of many malaria researchers was not mobilised by state policy, but rather stemmed from their dissatisfaction with the regime.[527] Psychiatrist Wen-Shing Tseng describes in his autobiography how his disillusionment with the realpolitik of postwar society led him to embrace the *ganbaru* spirit in his work. *Ganbaru* is a Japanese term (頑張る) meaning 'persistent and unrelenting despite adversity'; this spirit was instilled in Tseng during his Japanese education.[528] Tsung-Yi Lin, who lost his father in the 2.28 Incident, similarly became a workaholic, intensely focused on psychiatric research.[529]

What merits particular mention is the birth of Doctors' Day and the reaction among doctors in postwar Taiwan. In 1948, the Chinese Nationalist government appointed 12 November, birthday of Sun-Yat Sen, as the first Doctors' Day. This move was part of the government's attempt to shape the culture of a newly acquired territory according to the cultural orthodoxy of Republican Chinese. On 12 November 1948, an assembly was held at Sun-Yat Sen Hall in Taipei to celebrate Doctors' Day, with keynote speeches being given by the president of the Taiwanese Medical Association (台灣醫學會), Tu Congming; the director-general of TPPA, A-Chang Lu; and other important government officials. The leader of medical research, Tu, remarked that

[526] Yang, *Double Nostalgia: Yeh Shengji, a Taiwanese Intellectual's Youth, Wandering, Exploration and Tragedy*.
[527] Du-Jian Tsai and Fei-Yi Liang, 'The Significance of Medical Ethics Presented by Malaria Research in Taiwan', in Yu-Mei Yu and Du-Jian Tsai (eds.), *The Transformation of Medical Morals in Taiwan: Case Studies* (Taipei: National Institute of Health Research, 2003), pp. 101-32.
[528] Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America*. p. 21, p. 57
[529] Marnie Copland, *A Lin Odyssey* (Orlean, Mass.: Paraclete, 1987) p. 287.

> After the end of World War II, we [the Republic of China] are listed as one of the five strong nation states in the world. We hope that medical science should be developed and promoted to a certain level, especially in the times of atomic bombs. We need to scientise (*kexue hua*, 科學化) our own medical tradition and refine theories. We cannot cling to experiences and then end up in backwardness.[530]

Mental health issues were addressed during the conference. The head of the Office of Health, Yen Chunhui (顏春暉), commented on the great change in mentality before and after World War II that was caused by 'immigration, starvation, epidemics and other forms of suffering'.[531] As for research into the causes of psychiatric diseases, he did not have any new ideas, but rather repeated the Japanese concepts he had inherited concerning the tropics:

> Apart from what concerns the World Health Organisation to the greatest degree, such as malaria, tuberculosis and sexually transmitted diseases, we need to explore issues related to Taiwan being a tropical area. For example, do sunlight and radiation have any influence on tropical diseases? Is there a relationship between tropical radiation and psychiatric diseases?[532]

The content in the other doctors' speeches reflected their professional identities. Moreover, for the first time a journalist mentioned at this conference that the medical

[530] *Taiwan Medical World,* No. 4, 1948, p.2
[531] *Taiwan Medical World,* No. 4, 1948, p. 8
[532] Ibid, p.4-5

community should deal with mental health problems among Taiwanese populations using 'scientific methods'. On the same day, another comment was made by a journalist who proposed 'scientific methods' to enquire into the 'invisible [psychiatric] disease' and to 'diagnose the ailment of the society' and to 'compete in the world'.[533]

From the Generation of Loss to Long-Distance Nationalism

The freedom of speech briefly enjoyed by the Taiwanese medical community began to wane under the corporatism of the Nationalist Government in the 1960s.[534] During the 1970s, the institutionalisation of specialised medicine and the shift in policy focus from public health to medical care made it easier for the government to regulate the activities of medical professionals.[535] Just as the Taiwanese medical community had been ineluctably woven in with the Japanese Empire during World War II, now it was woven into the desire of the Chinese Nationalist government to provide a unified front against its enemies. China's enemies, during the Cold War, included Communists and dissidents. In *Taiwan Medical World*, Chiang Kai-Shek's manifestos began to appear before the obligatory eulogistic editorials. Some psychiatrists were employed by the government to deal with detained political prisoners by sedating them and using interview techniques.[536] This was one of several compromises several professionals were committed to in order to uphold the

[533] *Taiwan Medical World,* No. 4, 1948, p.5
[534] Yun-Wen Yeh, 'Civilizing Process of Medical Society in Taiwan: A Corporatist Analysis on Medical-Political Relationship', *Formosan Journal of Medical Humanities,* 7/1, 2 (June, 2006 2006a).
[535] For the shift in policy focus from public health to medical care in 1970s, see Meei-Shia Chen, 'The Analysis of the Historical Development of Marketization and Medicalization of the National Public Health System in Taiwan', *Taiwan: A Radical Quarterly in Social Studies,* 81 (March 2011), pp. 3-78.
[536] Soong, Personal Communication.

hospital's financial support from the government, whether or not it was against their wills.[537]

Historian Wan-Yao Chou makes a compelling case for a lost generation of intellectuals in early postwar Taiwan due to the silencing of dissent.[538] As described by the psychiatrist Yung-Hsing Chen, the members of the Taiwanese medical community who voiced dissenting opinions were also rendered silent by the 2.28 Incident and ensuing White Terror.[539] This silence was not broken until Martial Law was lifted in 1987. During this period, the Taiwanese medical community focused on academic research to promote their social status both domestically and internationally. Recent studies have explored the transformation of these doctors' identities through their unpublished diaries and memoirs.

Particularly interesting is the evolution of the writer Wu Xinrong. According to Shih-Jung Tzeng, a number of factors contributed to the development of Wu Xinrong's consciousness of Taiwanese nationalism. These reasons included the frustrated Chinese national imagination, the political turmoil precipitated by the 2.28 Incident, and the isolation of Taiwan internationally in the face of the Cold War. Through these catalysing factors, Wu Xinrong's national identity gradually evolved during the 1950s towards support for a politically independent Taiwan.[540]

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[537] Hsu, 'Personal Communication'.
[538] Chou, *The Times of Umi Yukaba: Anthology of the History of Taiwan at the End of Japanese Colonisation*.
[539] Chen, 'Taiwanese Medical Community and the 228 Massacre'.
[540] Shih-Jung Tzeng, *From Hōnto Jin to Bensheng Ren : The Origin and Development of Taiwanese National Consciousness* (Lanham, Md.: University Press of America, 2009) xxviii, p. 232.

Wu Xinrong's shift with regard to his capacity for identification with Taiwanese nationalism instead of Chinese was also experienced by many other doctors in postwar Taiwan. Chen-Yuan Lee (1915-2011), who initially researched snake venom and in the late 1980s became a proponent of Taiwanese independence and democratic movements, was one of a group of academics who became political activists.[541] Tsung-Yi Lin, who brought Taiwan to the international stage with his achievements in social psychiatry research, was another example. As mentioned previously, doctors who intended to participate in international medical conferences were often under strict regulation and monitoring. Tsung-Yi Lin, as an advisory expert and later Medical Officer of the World Health Organisation, benefited from international travel privileges and to some extent was immune from this sort of monitoring. Many individuals, however, developed political identities dissimilar to those of the Chinese Nationalists. They were prevented from coming back to Taiwan, including Lin himself, who was banished in 1965 until his return in 1988.

Many Taiwanese doctors who studied abroad remained overseas to pursue their careers. From the 1960s onward, there was an 'exodus of an increasing number of college graduates' who were able to study in distinguished educational institutions 'of their own choice while experiencing the privilege and responsibility of being free and equal members of the democratic societies of the U.S., Canada, U.K., France, and other European countries.'[542] According to Tsung-Yi Lin, the contribution of this 'Taiwan diaspora' was central to the eventual liberation and democratisation of the country. The presence of these professionals in the West opened a channel of regular communication that was both global and informal, for the first time in the history

[541] Chen, 'Taiwanese Medical Community and the 228 Massacre'. p. 110
[542] Tsung-Yi Lin, 'Foreword', in Tsung-Yi Lin (ed.), *An Introduction to 2-28 Tragedy in Taiwan : For World Citizens* (Taipei: Taiwan Renaissance Foundation Press, 1998a), pp. 1-27.

Taiwan. The previous occupying powers (Japan followed by the Chinese nationalists) had prevented this type of communication for more than half a century. This breakthrough in international human contact and communication revealed new layers of learning and knowledge to those studying abroad, which eventually filtered back to the homeland. These new features included broader linguistic communications skills and a greater abundance of philosophical and socio-political diversity, as reflected in the various spheres of Western society. Lin observed that this learning process and contact with modernisation had significantly strengthened 'Taiwanese conscience' and identity, eventually undermining the Chinese Nationalist policy of violent repression. Contact with the Western world continued to play an essential role in the period of 'glasnost' until 1987, when Martial Law was lifted. For Lin, the single most important event in this process was the 2.28 Incident and its cultural legacy, a force which tempered the growing sense of Taiwanese national identity and was crucial in the developments leading to the 'Taiwan Independence Movement'.[543]

Medical doctors played a key role in the diversification of viewpoints that led to the burgeoning of movements for an independent Taiwan. The exodus of graduate students abroad in search of greater opportunity included a large number of medical professionals in training; uniquely, this group also included a considerable number of psychiatrists.[544] The Chinese Nationalist government did not foresee the trend which shaped these doctors' identities in opposition to the government—even as it fervently also sent delegates abroad to monitor the activities of Communists. Overseas Taiwanese doctors formed social groups, in much the same way as they did in Taiwan;

[543] Ibid.
[544] See Milton H. Miller, 'Preface: Remembrance of a Friend', Ibid., iv-xiv. Most of the psychiatrists were students and colleagues of Tsung-Yi Lin in 1950s. Lin's 'satellite launch' style of training scheme, characterised by sending his students to different hubs of modern psychiatric schools was examined in Chapter 2.

the background of activism that had surfaced in the Taiwanese medical profession back home served them well in forming these groups. They also developed unique political and cultural identities. In North America, they called themselves *Tai-Mei ren* (台美人, Taiwanese-Americans). During the 1970s and 1980s, societies and associations were established, such as the Formosan Association for Human Rights, the North American Taiwanese Professors' Association (NATPA), the Formosan Association for Public Affairs (FAPA), the North America Taiwanese Medical Association (NATWA), and the North America Taiwanese Women's Association.[545]

The *Tai-Mei ren* actively participated in activities related to Taiwan, trying to influence and intervene in Taiwanese public affairs and politics from abroad. They made full use of their freedom of speech, reviving the prohibited political journal *Formosa* (*Meilidao*, 美麗島) and publishing newspapers such as *Taiwan Tribune* and *Pacific Times*. The awareness of these Taiwanese doctors and their newly fathomed identities successfully formed cohesive bonds among health professionals. From local cohorts to international networks, they re-wrote another chapter of political identity that diverged from the government's version.[546]

Thus Taiwanese doctors who participated in political activities while living overseas were able to continue their social involvement previously existing during the Japanese colonial era, which was suppressed during the Nationalist Chinese priod. They also found themselves in a space with fewer constraints compared with the

[545] Yi-Shen Chen, *An Oral History of People Related to Overseas Taiwan Independent Movement* (Oral History Series, 92; Taipei: Institute of Modern History, 2009).
[546] Yen-Hsien Chang, Chiu-Mei Tseng, and Chao-Hai Chen, *Self-Awareness and Identification: Compilation of Overseas Taiwanese Activities, 1950-1990* (Taiwanese History; Taipei: Taiwan History Society, 2003).

situation back in Taiwan. When Tsung-Yi Lin was appointed Medical Officer at WHO and started his worldwide travels, he was banned by the Chinese Nationalist government from returning to Taiwan. In 1971, when Taiwan was driven out of the United Nations, four authors drafted the *Manifesto of the Taiwanese Self-Determination Movement*, which mapped the early trajectory of Taiwanese intellectuals' pursuit of independence.[547] The four initiators of the *Manifesto* were all Christians, namely Reverend Shoki Coe (黃彰輝), Chuan-Sheng Song (宋泉盛), Wu-Tung Huang (黃武東), and Dr Tsung-Yi Lin. Their *Manifesto* echoed the *Declaration and Suggestion of State Affairs* originally drafted by the Taiwan Presbyterian Church. One of the authors had personally experienced political violence, namely Tsung-Yi Lin, whose family had been victimised in the 2.28 Incident. Reverend Shoki Coe had read of the 'bloodbath' of the incident in the British press, and heard 'a horrific account' of it from classmates while he was studying theology in Cambridge.

Understandably, the Taiwanese identities of these individuals was rooted in the 2.28 Incident. According to Coe, there had been a sentiment, *m kam-guan*, 'the feeling that something is totally unacceptable, a deep wrong' which grew out of 'a strong and painful experience' among Taiwanese after the incident. This sentiment had become part and parcel of being a Taiwanese person. [548] In Coe's memoir he stated, 'my political involvements are [an] outward expression of a twofold inner "wrestling" for the meaning of being a Taiwanese and the meaning of being a

[547] Wu-Tung Huang, *Huang Wu-Tung's Memoir: The History of Taiwan Presbyterian Church* (Taipei: Avanguard, 1988).
[548] See Shoki Coe and Boris Anderson, *Recollections and Reflections* (2nd edn.; [New York]: Formosan Christians for Self-Determination, 1993) xv, p. 275

Christian'. According to Tsung-Yi Lin, the 'Taiwan diaspora' played a pivotal role in the eventual liberation and democratisation of Taiwan.[549]

From Exile to a Return to Reality

Doctors who remained in Taiwan also expended considerable effort in promoting independence movements. According to sociologist A-Chin Hsiao, intellectuals who developed a mentality of despondence, disillusionment, and exile during the 1960s under the authoritarian rule of the Nationalist government now became a 'generation that turned to the reality'.[550] The 'reality' in this context entailed the real political situation, in which Taiwan was gradually isolated by the international society. According to Hsiao, a series of traumatic events such as Taiwan's loss of membership in the United Nations and the severing of diplomatic relations between Taiwan and the US helped to bring forth a clearer vision of Taiwanese identity among intellectuals. This generation espoused the 'actuality' of the Taiwanese situation. Their awareness not only deepened the new version of nationalism among the Taiwanese, but also facilitated new social forces, first *dangwai* (黨外, non-KMT political groups) and then new political parties, that challenged the Chinese Nationalist's governing legitimacy. After the lifting of Martial Law in 1978, political activities organised on the ground snowballed despite the ongoing party-state system. More and more intellectuals were called on to participate in political activism.

[549] Such phenomenon can possibly be explained by 'long distance nationalism', a term coined by Benedict Anderson. See Zlatko Skrbis, *Long-Distance Nationalism: Diasporas, Homelands and Identities* (Research in Migration and Ethnic Relations Series.; Aldershot ; Brookfield: Ashgate, 1999) xv, p. 201.

[550] See A-Chin Hsiao, 'A "Generation in Itself": Authoritarian Rule, Exilic Mentality, and the Postwar Generation of Intellectuals in 1960s Taiwan', *The Sixties: A Journal of History, Politics and Culture,* 3/1 (2010), pp. 1-31. And A-Chin Hsiao, *Return to Reality: Political and Cultural Change in 1970s Taiwan and the Postwar Generation* (Taipei: Institute of Sociology, Academia Sinica, 2008).

A-Chin Hsiao also notes that, during the 1970s, Taiwanese anti-colonial movements that had developed in the 1920s against Japan were now incorporated into narratives about the shaping of non-KMT social forces. This trend was a feature of the emerging 'return to reality' generation.[551] Taiwanese doctors who began to rejoin campaigns for legislators also branded themselves as incarnations of Chiang Weishui, Lai He, and other pioneering doctors who had been socially involved during the Japanese colonial era.[552] Apart from the historical narratives of anti-colonialism, these doctors were motivated to bid for seats in parliament partly as a result of the 2.28 Incident and its legacy. For example, the slogan adopted by Dr Yeong-Feong Lin's campaign for the Legislative Yuan was '2.28, the Restart of Medical Community'.[553] Some doctors joined the 1947 Society (*Siqi She*, 四七社), whose members had all been born in 1947, the year in which the 2.28 Incident took place.[554] Members of the *Siqi She* included scholars, artists, statesmen, lawyers, and doctors. They jointly contributed columns in newspapers.

Among those doctors who participated in public affairs and political activism, psychiatrists played a central role. They contributed both in terms of the sheer number of participants and their capacity for producing theories relevant to their own social practice. Psychiatrist Yung-Hsing Chen provided financial and editorial support for

[551] Hsiao, *Return to Reality: Political and Cultural Change in 1970s Taiwan and the Postwar Generation*. In a recent paper, Hsiao even equals the activities and words produced by the 'retern-to-reality generation' as 'national trauma'. See A-Chin Hsiao, 'Narrating National Trauma: The Return-to-Reality Generation and Political and Cultural Change in 1970s Taiwan', in Academia Sinica Institute of Sociology (ed.), *The First World Congress of Taiwan Studies* (D4; Taipei: Academia Sinica, 2012), 1-30.
[552] Lo, *Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan*.
[553] Yeong-Feong Lin, *2.28 the Restart of Medical Community* (Taipei: Author, 1986).
[554] Ming-Yung Li, 'Expecting the Formation of Taiwan Movement', in Siqishe (ed.), *Awareness and Rebirth* (Taipei: Avangaurd, 1992), pp. 1-8.

Taiwan Literature Magazine (*Taiwan Wenyi*, 台灣文藝), a journal dedicated to pure literature during the White Terror period. During Chen's years as editor, he constantly received contributions from an author with the pen name of Mingzhe (明哲), who was a political prisoner and expressed fierce anti-governmental ideology in his poems. Chen managed to befriend Mingzhe after he was released, but found Mingzhe to be a shy and self-abased individual whose personality had probably been deeply affected by his experience of imprisonment.[555] Mingzhe's story was but one of countless examples that inspired Yung-Hsing Chen to study the 'collective unconsciousness' of the Taiwanese people, and to 'speak for people, eliminating the fear in the depth of their minds.'[556]

Yung-Hsing Chen publicly claimed that 'Taiwan was sick'. He emphasised that Taiwanese illnesses are illnesses of the 'heart', and his prescription for Taiwanese illnesses was the promotion of 'social service' and 'cultural movement'.[557] In 1986, Chen published *Clinical Notes, the Second Volume,* in response to Chiang Weishui's work of 1921. In Yung-Hsing Chen's book, he diagnosed 'political neurosis' among those who had lived through the government's oppression and suffered from 'low mood, agitation, deterioration of memory, anxiety and irritation for more than thirty years.'[558] The consequent 2.28 Peace and Justice Movement realised Chen's ideal of

[555] Yung-Hsing Chen, Personal Communication (Taipei, 2009). Minzhe Shren was the penname of Ke Qihua (柯旗化, 1929-2002). As an educator and poet, Mr. Ke included many poems in two major collections: *Crying from the Homeland* and *Grievous Wishes of the Mother*. *Hometown of the Southern State* is an autobiographical novel, which is full of his philosophy and logics as well as political inclinations. Also see Wen-Cheng Huang, 'The Will and Record of a Literatus- Ke Qihua's Writing Experience in the Jail of Huoshao Island', *Journal of the Chinese for General Education (Tong Shi Yan Jiu Ji Kan),* 15 (June 2009), pp. 77-96.
[556] Chen, Personal Communication.
[557] Yung-Hsing Chen, 'Examining Taiwan Society and Taiwanese from Medical and Cultural Perspectives', *Reflections on Berkeley* (Taipei: Tzuli Evening News, 1986), pp. 137-54.
[558] Yun-Wen Yeh, 'On the Relationship between Medical Care and Politics in the Democratic Development of Taiwan', *Taiwan Democracy Quarterly,* 2/4 (December 2005), pp. 99-126.

'psychotherapy' for the Taiwanese people's 'collective unconsciousness'. [559] According to A-Chin Hsiao, Yung-Hsing Chen's approach transformed the 2.28 Incident from historical taboo to a public issue, for the first time.[560]

The Language of Trauma: From Suppression to Opposition to Reconciliation

During a period of more than forty years after the end of World War II, Taiwanese people experienced a chaotic time of decolonisation, intermittent social turmoil, and political oppression. During these four decades, long-term devastation visited the Taiwanese people on many different levels.

As discussed in the preceding sections, during the years of political oppression Taiwanese doctors had attained a special position in society through their social practice, within the limited space they were afforded. These physicians attempted to speak for oppressed people, who did not have the language to express their own suffering. From the perspective of mental health, however, the modern psychiatric system which had developed in Taiwan within a short space of time was reluctant to account for those who had been traumatised by protracted external reality. Activist psychiatrists endorsed a radical method of enquiry, identification, and treatment of the trauma that was shared to some degree by most individuals in Taiwan.

[559] Chen, Personal Communication.
[560] Hsiao, *Return to Reality: Political and Cultural Change in 1970s Taiwan and the Postwar Generation*. p. 59

According to Nan-Chou Su, the initiator of the 2.28 Christian Service for Peace (*Pingan libai*, 平安禮拜), and later Tsung-Yi Lin's correspondent in Taiwan, in the closing years of the 1980s 'there was no single architect of the restoration of the 2.28. The credit should be shared by various individuals and organisations that realised the series of events, including Nan-Jung Cheng (鄭南榕), Yung-Hsing Chen (陳永興), and so on. They were divisions of the same labour.'[561] According to Tsung-Yi Lin, historical events that segregated the forces of social and political reformation in the 1980s included the 2.28 Incident, the White Terror, the Kaohsiung Incident, and the massacre of Lin Yi-Hsiung's family.[562]

In modern psychiatry, diagnoses relating to trauma did not appear until 1980 in the DSM-III, in which the new disease classification of post-traumatic stress disorder (PTSD) appeared. The American Psychiatric Association (APA) helped soldiers returning from the Vietnam War to obtain legal compensation through this diagnosis. PTSD was not assigned a specific code in the International Classification of Diseases (ICD) system until the publication of the 9th edition in 1994, after a series of joint seminars between WHO and APA. In short, PTSD was not globally recognised as a psychiatric disease until 1994. Before this, terminology describing psychiatric

[561] Nan-Chou Su, Personal Communication (Taipei, 2010). Nan-Jung Cheng, also known as Nylon Deng, was a publisher and pro-democracy activist. He founded the magazine *Freedom Era Weekly*. On 7 April 1989, he set himself on fire in support of Taiwanese independence and protest against the government's control of speech.

[562] Lin, 'Closing Remarks'. p. 371 Here, the Kaohsiung Incident is also known as the Formosa Incident, or the Meilidao Incident （美麗島事件）. It occurred as a result of pro-democracy demonstrations that occurred in Kaohsiung, Taiwan on 10 December 1979. The incident occurred when *Formosa* magazine, headed by veteran opposition Legislator Huang Shin-chieh (黃信介) and other opposition politicians, held a demonstration commemorating World Human Rights Day. The police cracked down on the rally. Lin Yi-Hsiung, a member of Taiwan Provincial Assembly and a lawyer, volunteered to defend those involved in the Kaohsiung Incident. He was arrested and charged for sedition. While in prison, his wife sought help from Amnesty International (Osaka office). On 28 February 1980, Lin's mother and twin 7-year old daughters were stabbed to death. The authorities claimed to know nothing about the killings, even though his house had been under 24-hour police surveillance. To this day, no suspects have been mentioned.

diseases related to traumatic events remained a matter of preference, as did the methods of treatment.

The 38-year long Martial Law of Taiwan was lifted in 1987. Tsung-Yi Lin seized the opportunity to return to Taiwan after 22 years of being blacklisted by the government. Through the aid of his student Ying-Kun Yeh, Lin was invited to speak at the 50th Anniversary of the Mental Health Association of China (中國心理衛生協會), at which a number of international scholars were present.[563] Lin also began to interview families of the 2.28 Incident victims. He observed that the psychological reactions among the 'survival victims and their family members', whom he called 'SVFs', resembled the clinical manifestations of PTSD.[564] According to Lin, the emotional manifestations in SVFs looked like the diagnostic criteria of PTSD. However, the patterns of psychological devastation and the time lag until their anguish expressed itself meant that they did not meet the criteria for a PTSD diagnosis. Most importantly, the origin of their suffering, the obstinate and arrogant government, was still present in their lives.[565] In the year Lin started to interview SVFs, PTSD was already an established psychiatric diagnosis in both disease

[563] Mental Health Association China was founded in Nanjing in 1936. In 1955, it was reinstitutionalised in Taiwan. Tsung-Yi Lin was the first chairman of the board. In 1966, Yeh succeeded Lin's office when Lin was appointed Medical Officer at the WHO. Currently, the Association is called the Mental Health Association Taiwan. See Wu, *The Pioneer of Taiwanese Psychiatric Care: Biography of Ying-Kun Yeh*.

[564] Lin, 'Confrontation or Reconciliation? Violent Oppressors Vs. Miserable Survivors'. Such term was borrowed from a study conducted by Lin's colleague during his days in Boston. These SVFs were referred to those who survived the renowned 'Coconut Grove' fire that occurred on 28th of November, 1942. The symptoms described of these SVFs resemble those of post-traumatic stress disorder in today's psychiatry. See Erich Lindermann, 'Symptomatology and Management of Acute Grief. 1944.', *American Journal of Psychiatry,* 151/6 suppl. (1994), 155-60.

[565] The next chapter discusses additional ways of accounting for these victims' distresses, as suggested by various individuals.

classification systems being used internationally, namely DSM-III and ICD-9. Lim himself was one of the main promoters and participants of the ICD system.[566]

Lin was disappointed to learn that most of the surviving families did not dare to speak out about their painful experiences or even to identify themselves as relatives of the victims.[567] Lin realised that the SVFs he interviewed 'had not resolved their difficulties caused by the original shock and the accompanying psycho-social stresses and wounds, in spite of the passage of forty years since the Incident.' He summarised their struggle into five stages.[568] In brief, the psychological problems among SVFs were not caused by the sudden horror at the scene of trauma in a single event. They were instead caused by protracted exposure to stressors over four decades of an atrocious political atmosphere, enforced by Martial Law. Acute symptoms such as feelings of numbness, de-realisation, de-personalisation, and dissociative amnesia turned into chronic fear, withdrawal, stigmatisation, and despair.[569] According to a few psychiatrists trained in the early postwar period, these individuals 'could not at all be alleviated by any treatment in modern psychiatry whatsoever;' furthermore, these psychiatrists themselves 'also all subsisted through the so-called trauma.'[570]

Lin's prescription for the suffering among SVFs was not psychiatry or medicine, but political action. He believed that the problem could be gradually ameliorated through sporadic private and religious memorial activities such as those which started in the early 1960s. Later, SVFs also congregated as a force against the Chinese

[566] Details are provided in Chapters 3 and 4.
[567] See Lin, 'Closing Remarks'. Also Tsung-Yi Lin, 'Confrontation or Reconciliation? Violent Oppressors Vs. Miserable Survivors', in Tsung-Yi Lin (ed.), *An Introduction to 2-28 Tragedy in Taiwan : For World Citizens* (Taipei: Taiwan Renaissance Foundation Press, 1998b), pp. 135-75.
[568] Details are given in Chapter 6.
[569] Lin, 'Confrontation or Reconciliation? Violent Oppressors Vs. Miserable Survivors'.
[570] Soong, Personal Communication.

Nationalist government, which kicked off the democratic movements within civil society both in and outside of Taiwan. These events included the most flagrant assassination attempts of then President Chiang Ching-Kuo in the 1970s, and pleas for Taiwan's independence and self-determination.[571]

On his return from Canada in 1987, Lin became devoted to a wide range of political activities; he also agreed to represent the SVFs. Among the voices jointly appealing for reformation of the government and for democratisation and liberation of Taiwanese society, Lin joined the crusade recruited by the evangelical Christian Nan-Chou Su. Su had been supporting the cause of Taiwan's marginalised populations since the mid-1980s. Tsung-Yi Lin and Nan-Chou Su coined the term 'KIMG Complex' to refer to the power structure composed of the Kuomingtang (KMT, the ruling Chinese Nationalist party), the Intelligence and police forces, the Military forces, and the total Government apparatus.[572] In Chinese, KIMG represents 黨政軍特, *tang-zheng-jun-te*.[573] Su believed that practical strategies for those who suffered were preferable to holding protests against the government every year, as advocated by another psychiatrist, Yung-Hsing Chen. Rather than directly opposing the KIMG Complex, Lin and Su attempted to weaken it through their ad hoc strategy.[574] Tsung-Yi Lin, as a 'realistic idealist' was aware that 'he did not want himself to be seen as a victim'. According to his correspondent Nan-Chou Su, 'his realistic idealism was inherited by the training as a practitioner of positivist science'.[575] Tsung-Yi Lin evidently wanted every step in his plan to be carefully thought out, executed with

[571] Lin, 'Confrontation or Reconciliation? Violent Oppressors Vs. Miserable Survivors'. p.138
[572] Lin, 'Foreword'. p. 4
[573] Su, Personal Communication.
[574] Su, Personal Communication.
[575] Su, Personal Communication.

specific techniques, and realised in terms of functions. Therefore, instead of victimising himself as most activists did, Lin pursued a more idealistic method of reconciliation.

According to Nan-Chou Su, a key period occurred between the lifting of Martial Law in 1987 and 1990, when Lin and Su initiated the 2.28 Peace and Justice Movement. These three years saw the climax of political events and the efforts of pro-democracy politicians facilitating an 'enlightenment period' of the movement.[576] The most promising development was the formation of the Committee for the Promotion of the 2.28 Peace Day (二二八和平日促進會). The Committee elected Dr Yung-Hsing Chen as its president. According to Chen himself, as a psychiatrist, the work proposed by the Committee was a procedure of psychotherapy to deal with the 'collective unconscious' of the Taiwanese people. He stated, 'To speak for those held in people's hearts, and to eliminate the fear in the deepest layer of their minds, isn't it the basic principle of psychotherapy?'[577]

Chen challenged the forty years of silence among the medical community and the reluctance of Christian churches to speak up. In doing so, he became one of the first leaders of a functional organisation solely dedicated to the matter of the 2.28 Incident and its effect on life in postwar Taiwan. The manifesto of the Peace Day Committee included three bullet points: 1. Official publication of the historical facts; 2. Official restoration for the innocence of victims; 3. Appointment of an annual Peace Day on 28 February. The Committee's work, nevertheless, was hampered by

[576] Nan-Chou Su and Shu-Fen Lin, *Towards the Road of Justice and Peace: The Suffering and the Strategies of the Weak* (Taipei: Lim Bo-Sei Cultrual Foundation, 1999). p. 82
[577] Chen, Personal Communication.

the government. Police often besieged its public talks, and violent conflicts frequently occurred during the Committee's street demonstrations. On 4 January 1987, the intelligence force monitored the entire memorial service in which Tsung-Yi Lin's family commemorated their father, Bosei Lim, who had lost his life in the 2.28 Incident. On 20 February, *The Taiwan Church News* was censored for its commentaries on 2.28.[578] According to public statements by the Taiwan Garrison Command, the comments were censored because they 'instigated the hatred in the society, confused the readers, and stirred up trouble between the government and citizens.'[579] In short, the Committee did not achieve its objectives.

Fortunately, Lin and Su's approach was able to transform negative accusations into positive reconciliations. This achievement resulted from Lin's careful study into the reasons behind the lack of dialogue between perpetrators and victims. Lin realised that the impasse was mutually created, and was reinforced by both the government's arrogance and by the excessive tolerance of chronic persecution on the part of victims and their families.[580] Lin thus felt he should act as the victims' representative. In June 1990, Tsung-Yi Lin listed three basic demands in a letter to then-president Teng-Hui Lee. These demands, which centred on the consequences of the 2.28 Incident, indicated that the state should take responsibility for 1. the history and citizens of Taiwan; 2. the innocent victims and their families; and 3. the response of international society. Taking advantage of his role as a leading international medical researcher, Lin was able to elevate his demands to the level of global humanitarianism. Drawing on the experience of Germany, particularly how Germany dealt with the aftermath of two dictatorships, Lin asked the president to publicise the historical truth, build

[578] Su, Personal Communication.
[579] Su and Lin, *Towards the Road of Justice and Peace: The Suffering and the Strategies of the Weak*.
[580] Su, Personal Communication.

monuments, apologise, compensate the victims, and develop humanitarian and educational utilities.

On 8 December 1990, the 2.28 Christian Service for Peace was held at the Grace Baptist Church, which was thought to have close connections with Nationalist officials, including Chiang Kai-shek. Lin and Su strategically invited the family pastors of then-president Teng-Hui Lee and the late Chiang Kai-Shek to give sermons in *Mandarin* and *Hokkien*. This invitation was designed to symbolise cooperation and mutual respect between different ethnic groups.[581] The resulting joint effort by churches of different languages and diverse political ideologies was a historical breakthrough regarding 2.28 activism.

In 1991, Lin and Su organised the Union for the 2.28 Victims and Family Associations (in brief, the 2.28 Union). The immense project of building the 2.28 Union was malleable and contextualised with local traditions. For example, on *Qingming* (清明), the festival during which the Chinese commemorate their departed ones, services were held to remember the late victims. On Mothers' Day, public talks were given to honour the suffering mothers left endured during the 2.28 Incident and White Terror. On *Duanwu* (端午), the Union held a 'river rite'(*heji*, 河祭) at Tamsui River. They distributed symbolic mugwort leaves in memory of martyrs such as Quyuan (屈原) during the Warring States Period of China, who had sacrificed their lives in their concern for their country.[582] All these efforts won more supporters for Lin and Su, increasing the pressure of public opinion. In December 1991 a concert was held at the National Concert Hall in Taipei, with important government officials

[581] Ibid.
[582] Ibid.

invited to attend. Before the opening of the concert, the national anthem of the Republic of China was not played—for the first time ever. Government officials were required to sit among the regular audience and were prevented from speaking on stage. These public events were arranged to pay tribute to the victims' families. The hierarchical roles of the state as the perpetrator and the surviving families as victims were reversed for the first time in Taiwanese history.[583]

By 1995, the pleas made by Lin were almost completed, while the work of transnational justice was still being carried out under debates. On 24 February 1992, then-president Teng-Hui Lee officially apologised on behalf of the government to the victims and their families affected by the 2.28 Incident. The monument to be built in Taipei was designed in 1992; construction was completed in 1995. In the same year, the Act for the Compensation of the 2.28 Incident was launched by the president. Despite these phase-based achievements, debate has continued to the present in Taiwanese society concerning issues of compensation and indemnity. Other ongoing issues include the possibility of opening the entire official archives concerning the Incident and subsequent White Terror period; the refinement of descriptions in official history textbooks; and the implementation of further cultural and educational works.

Conclusion: Transformation of 'Clinical Notes'

This chapter has analysed the social practice of Taiwanese psychiatrists after World War II. Their leadership in the Peace and Justice Movement, and in reclaiming

[583] Ibid.

something other than victimhood status for those who endured the 2.28 Incident, can be regarded as a social prescription for the collective suffering of the Taiwanese people. This suffering had accumulated during World War II and the more than forty years of Martial Law that followed. Such prescription can also be seen as the way in which they appropriated, or loosely coupled, the globalised discourse of trauma in the local context. Echoing what has been argued by Cushman, concerning the significance of social practice in constructing the 'self' aspect of psychological sciences, in this chapter I have explained how Taiwanese physicians' social practice, especially that of psychiatrists, was pivotal for treating the collective trauma of the Taiwanese people during the 1980s. I have also described the history of the literary tradition among Taiwanese doctors. The doctors maximised their use of language, social status, and their role as a fulcrum of international society to restore the dignity of victims who had experienced the most deadly, traumatic event in Taiwan's postwar history. I traced the course of a multi-axis history running parallel between international psychiatric development and the local reception and appropriation of psychiatry in Taiwan. I showed how the globalised paradigm of mental health incorporated the newly-defined disease of PTSD, and provided clinical resources to activist Taiwanese psychiatrists. I also described the interventional model which these young doctors adopted in dealing with Taiwan.

It is important to note that this globalised paradigm has its limitations. For instance, the PTSD diagnosis appeared among the diffuse groupings of internationally agreed upon disease classifications, but it did not fully account for 2.28 Incident SVFs who suffered from protracted psychological difficulties. Sociologist Gili Drori and colleagues comment that 'It is the hegemonic status of science and of the scientific

world view […] that account for the gap between policy initiatives and actual practice.'[584] The criteria for PTSD could not simply be 'picked and pasted' in local contexts.[585] This dilemma led activists such as Tsung-Yi Ling and Yung-Hsing Chen to deal with this trauma through radical political tactics rather than through medical enquiry. Such examples of 'loose coupling' of scientific practice and even appropriating world standards in accordance with local conditions are not uncommon among other countries.[586]

As for what enabled the loose coupling of psychiatric ideas among Taiwanese doctors, one should refer to the social and cultural history of the medical profession. Political activism among Taiwanese doctors is rooted in traditions developed during Japanese colonialism. During the early postwar period, doctors continued in their role as social leaders and members of the intellectual elite. However, 1947 saw their withdrawal from politics as a result of the 2.28 Incident. The state's development of medical care facilities, and the institutionalisation of the medical specialty, led to doctors (including psychiatrists) being co-opted to a certain extent into the state system. They gradually lost their leadership status in society because they became reluctant to criticise the government. During this period, medical professionals struggled to develop a suitable terminology or discourse to address their patients' suffering, which was caused by the state itself.

During the lengthy period of oppression, the Taiwanese medical community sought other methods through which to continue its social practice. On the one hand,

[584] Gili S. Drori, *Science in the Modern World Polity : Institutionalization and Globalization* (Stanford, Calif.: Stanford University Press, 2003) xii, 377 p.. 156
[585] Ibid. p. 161
[586] Ibid. p. 164

it devoted itself to medical research and gained a strong international reputation. The speciality of psychiatry was institutionalised in Taiwan only during the postwar period, and benefited from this late development through bypassing the scientific discourses defined by the Chinese Nationalists. Taiwanese psychiatrists entered the Headquarters of WHO and began to dominate its programmes in social psychiatry. However, due to limitations in methodology, the WHO's optimistic research outcomes did not directly benefit those who suffered diverse psychological problems or were not among hospital inpatient samples. For example, psychiatrists who were practising in Taiwan were reluctant to treat people who suffered in the shadow of the 2.28 Incident, or whose traumatic memories were related to the White Terror or Martial Law periods.

Among the medical professionals who pursued connections with the West and with international society, especially those who were sent abroad to study, many doctors developed an awareness of their own autonomy and national identity as Taiwanese. This development broke with their previous identification as Chinese, as taught by the government. Tsung-Yi Lin, who was banished by the government while he acted as Medical Officer at WHO, was not the only doctor who grew his Taiwanese nationalism in the diaspora. Lin became one of the first proponents of self-determination among overseas Taiwanese intellectuals. These doctors' activities were pivotal regarding the later relaxation of the party-state complex in Taiwan. The medical community both at home and abroad became aware of a budding Taiwanese self-determination movement. At home, opposition was developed through publications. The history of the anti-Japanese movement played a large role in helping

the physicians to frame their narratives as they attempted to incubate an authentic Taiwanese identity among the people.

When Martial Law was lifted in 1987, activists in and outside of Taiwan jointly confronted the party-state complex—in Tsung-Yi Lin's term, the KIMG. A number of restive social events began to challenge the legitimacy of the government's heavy-handed control. Doctors, including a high proportion of psychiatrists, started to run campaigns for the legislature. For them, the 2.28 Incident became a spiritual indicator to connect the suffering of Taiwanese people and their own responsibility to alleviate this chronic ailment. For activist psychiatrists, ideas borrowed from the concept of psychological trauma were used to develop theories concerning the special form of suffering brought about by 2.28 and its aftermath. Tsung-Yi Lin, as the WHO leader in international social psychiatry, analysed the processes of struggle and attempted recovery among direct victims and surviving families. However, he did not attempt to prescribe medication for those who suffered. Instead he pursued a political approach, initiating the Peace and Justice Movement with his collaborators in Taiwan.

By analysing the attempts of Taiwanese psychiatrists to diagnose society, on the one hand I have illustrated the contribution of globalised notions of mental health, especially psychological trauma, to the forging of a theoretical framework of social suffering among the Taiwanese. On the other hand, by examining the radical approach through which activist psychiatrists appropriated the concept of trauma, and the political pursuits of these doctors, I have questioned the validity of the standard symptom profiles of PTSD. Indeed, Taiwanese psychiatrists managed to loosely

couple the world standard of diagnoses while also developing their own practice that was culturally sensitive to the local context and could benefit the local community.

In the next chapter, I examine the terminology and concept of ‘trauma’ as developed in modern psychiatry. I discuss three case studies from Taiwan across different time frames, analysing how the concept of trauma was introduced, applied, and appropriated from a transnational perspective. During these three different time frames, Taiwan had undergone Japanese colonisation, postwar cultural conflicts, and the suppression of Martial Law respectively. Modern psychiatry in Taiwan had also come into contact with German-Japanese and Anglo-American systems, and had been influence by an accelerated period of globalisation. In-depth analysis of my three selected cases reveals the contribution of globalised modern psychiatry in the postwar period, and the limitation of these contributions; it also illustrates the dissemination of such ideas into the global arena.

Chapter 6

Vicissitudes of Trauma: Three Case Studies from Taiwan

What is 'psychological trauma'? Most historians of trauma have repeatedly asked this question. Psychological trauma does not mean solely one thing. The concept requires investigation beyond the typical discussion of how diagnosis moved 'from shell-shock to PTSD', as commonly described within Anglo-American military psychiatry.[587] Trauma is also not a phenomenon rooted in a single culture. The manifestations of trauma are far more complex than suggested by the paradigm shifts proposed by scholars of Western medical history. At the cross-cultural level, trauma studies must include the unique styles of response to specific external realities that arise within particular cultures. In this regard, psychiatric processes must not clash with language competency, social milieus, or historical backgrounds. Thus psychiatrists' responses must function effectively within their cultural contexts.

As noted by Eric Leed, any search for a general definition or theory of traumatic neurosis is futile and misleading. Case histories provide the only adequate description of the phenomenon.[588] In addition, I argue that to comprehend 'trauma' cross-culturally, one must first scrutinise the general understanding of trauma in terms of the history of post-traumatic stress disorder (PTSD) within modern psychiatry. Most historians of psychiatry frame this enquiry as determining the concept of 'trauma' in various cultural settings. In the previous five chapters I have illustrated how

[587] Edgar Jones and Simon Wessely, *Shell Shock to PTSD : Military Psychiatry from 1900 to the Gulf War* (Maudsley Monographs; Hove: Psychology Press, 2005) xvii, p. 300.
[588] See Mark S. Micale and Paul Frederick Lerner, 'Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction', in Mark S. Micale and Paul Frederick Lerner (eds.), *Traumatic Pasts : History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (Cambridge Studies in the History of Medicine; Cambridge: Cambridge University Press, 2001), pp. 1-30.

professionals in the field of psychiatry, both internationally and in Taiwan, have endeavoured to globalise psychiatric issues. Most of this effort has come from psychiatrists rather than other mental health experts. In addition, I have described how the notion of trauma became diffused as it moved from the global to local level, and was received, transformed, and naturalised as a Taiwanese concept through the social practice of Taiwanese psychiatrists. In the current chapter, I focus on the discussion about people who experience psychological trauma, broadly defined, and how clinical or pre-clinical patients of psychiatry regard its manifestations in cross-cultural contexts in 20th Century Taiwan. I summarise the separate trajectories through which trauma was globalised, as examined in previous chapters. Three narratives in particular represent the limited comprehension of trauma as displayed by medical historians.[589]

As I have illustrated in the previous five chapters, the notions and terms of trauma have been transnationally altered throughout the course of history. The generic meanings of trauma and the ways in which it has been defined, applied, and appropriated by various disciplines are diverse. This complex picture of trauma can be appreciated by studying Taiwan, a local context whose key players communicated with other cultures concerning the country's geopolitics and historical cultural containment. This chapter of my thesis examines cases at various points on Taiwan's timeline history. In this opening section I define trauma with regard to its essential

[589] Take PTSD, for example. A range of studies have dealt with the ways in which PTSD was assimilated into local contexts. See K. Friedman-Peleg and Y. Bilu, 'From PTSD to "National Trauma": The Case of the Israel Trauma Center for Victims of Terror and War', *Transcultural Psychiatry,* 48/4 (2011), pp. 414-36. C. Han, 'The Work of Indebtedness: The Traumatic Present of Late Capitalist Chile', *Culture, Medicine and Psychiatry,* 28 (2004), pp. 169-87. D.O. Nordanger, 'Coping with Loss and Bereavement in Post-War Tigray, Ethiopia', *Transcultural Psychiatry,* 44/4 (2007), pp. 545-65. C. Zarowsky, 'Writing Trauma: Emotion, Ethnography, and the Politics of Suffering among Somali Returnees in Ethiopia', *Culture, Medicine and Psychiatry,* 28 (2004), pp. 189-209.

diagnostic constituents and its broadest applicatory meaning. I also define the pathological reaction of individuals or collectives to external events that lie 'outside the range of usual human experience'.[590] Nonetheless it should be noted that this assumed scale of events, denoting a supposedly typical range of human endurance, as well as the development of psychological reactions to adversity, vary widely even within a single condition or context of time and space.

In the previous five chapters, I primarily examined two sites of trauma in what I call 'transnational history'. One site was the perspective of postwar international organisations; the other site was the local perspective of Taiwan, which at one point was assumed to represent all of China at the WHO. From the international perspective—or, more precisely, from Geneva—I have examined the establishment of psychiatric paradigms, including the standardised classification and symptom profiles of psychiatric diseases, in response to postwar trauma. From the local perspective, I have analysed initially how Taiwanese psychiatrists started research into epidemiology, incorporated themselves into WHO programmes, and then successfully institutionalised the discipline in Taiwan. They did so by establishing a psychiatric society, board of speciality training, scholarly journals, and a full range of services. In addition, I illustrated (especially in Chapter 5) how globalised psychiatry was reluctant to account for the Taiwanese people's suffering, and how psychiatrists addressed this issue with their radical political approach.

My thesis so far has illustrated the inability of globalised modern psychiatry to adequately define and treat trauma across multiple cultural contexts. How did the

[590] Micale and Lerner, 'Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction'.

clinical features of 'psychological trauma' change during the course of Taiwanese history? In this chapter, I return to the site of National Taiwan University Hospital (NTUH). My three case studies were obtained from this single geographical setting, but drawn from three different time periods: the interwar period, the early postwar period, and the post-Cold War period. Each era contributed in particular to my proposed historiography of cross-cultural trauma. I regard trauma as either an acute or chronic psychological reaction, ratified by mental health professionals, in response to various conditions of external reality—often natural disasters or human atrocities. The process of ratification usually includes the recognition and description of symptoms and attempts to treat the 'patients'. In these three cases, trauma, broadly defined, found its various ecological niches, as described by philosopher of science Ian Hacking, in different time and space of Taiwan.[591] It was enquired for different purposes, documented in different methods, and was intervened by different disciplines.

The first case study marks the prologue of modern psychiatry in Taiwan against the background of pre-war colonial times. In 1935, a major earthquake struck the central part of Taiwan. Dr Naka Syuzo (中脩三) and his students recruited 364 patients from five different local hospitals and observed their traumatic reactions. Dr Naka further compared these observations with those reported in German studies of soldiers with combat neurosis, and Japanese studies on tropical neurasthenia. He concluded that Taiwanese trauma, for which he adopted the German term *Emotionslähmung*, was characterised by an alteration in the autonomic nervous

[591] To explain the ecological niche, Ian Hacking raised the examples of the Fugue in France and Latah in Malysia, elucidating why certain diseases appeared in particular societies and not elsewhere. See Ian Hacking, *Mad Travelers : Reflections on the Reality of Transient Mental Illnesses* (Charlottesville, Va.: University Press of Virginia, 1998) x, 239 p.

system, influenced by the tropical weather. Such research fits well in the discourse of colonial psychiatry regarding tropical countries.

The second case study is the trauma described in the case registries that were kept by the psychiatric department at NTUH after World War II. In 1946, psychiatric science in Taiwan underwent decolonisation and reinstitutionalisation. The content of psychiatric education evolved from an orientation to the Japanese-German model to the Anglo-American system. Tsung-Yi Lin, who had meanwhile returned to Taiwan from Japan, dominated the establishment of the new psychiatric paradigm. After he arrived at what many considered to be the 'barren land of psychiatry', the department confronted a series of language and cultural conflicts. Patients at NTUH were mainly people who had experienced immigration and ethnic conflicts, including Chinese public servants who had recently relocated from mainland China to Taiwan, Japanese *kaishiain* (會社員, salaried men) who remained on the island, and local Taiwanese individuals who had become increasingly fearful after witnessing the 2.28 Incident in 1947. The case registries revealed the complexity of 'psychological trauma' as it was conceived in the conflicting cultural context of post-colonial Taiwan. The registries also bear testimony to the gradual transformation of the concept of trauma across paradigm shifts, and the controversial and subjective nature of related medical diagnoses.

The third case study focuses on a unique form of trauma, namely the collective trauma of political violence during the 2.28 Incident and its legacy. This type of uniquely Taiwanese trauma was not accounted for in the standard paradigm of modern psychiatry. Following my discussion in Chapter 5, in this chapter I examine

how Taiwanese psychiatrists attempted to act as 'diagnostic critics' to complement the inadequate criteria of PTSD that had prevailed since the late 1980s. To do so they developed the concept of Surviving Victims and Families (SVFs), and spoke out about the enormous suffering that had been long suppressed under the totalitarian politics of Taiwan. In addition, I look at the public acceptance of or resistance to this conceptualisation of trauma, particularly amongst sufferers and including psychiatrists themselves. Both laymen and intellectuals held widely diverse attitudes towards psychiatric experts' attempts to naturalise the everyday suffering of the Taiwanese people. The disagreement highlights the gap between so-called globalised traumatic psychiatry, with its postwar humanitarian concept of world citizenship, and local Taiwanese culture and experience. The concept of world citizenship had inspired the international standardisation of disease classification over four decades; the problems associated with this standardisation emerged only gradually.

Non-psychogenic *Emotionslähmung*: 1935

Japanese psychiatrists left behind the earliest documentation of psychological trauma in Taiwan. The documents revealed vague concepts that were incomplete in terms of reasoning, incompatible with Western narratives, and yet conventional in association with colonial government. British missionaries had introduced modern medicine to Taiwan in 1865, and the Japanese colonial government had established the paradigm of scientific medicine from 1896 onwards. However, modern psychiatry was not introduced to Taiwan until 1910, when Shuzo Kure (吳秀三) and his two assistants conducted a survey on cretinism in the middle regions of Taiwan. One of Shuzo Kure's assistants, Jou Nakamura (中村譲), began to provide psychiatric

services in 1915. In the next year, Nakamura became the first specialist to lecture in psychiatry at Taiwan Sōtokufu Medical School (台灣總督府醫學校). In 1934, Dr Naka Syuzo, the psychiatrist educated at Kyushiu Imperial University, took up the directorship of the psychiatry classroom at the Taiwan Sōtokufu Medical School.

Upon the inauguration of the psychiatry classroom, studies about psychiatric illnesses were inevitably coloured with the characteristics of colonialism, which was a feature of all the great powers before and during World War II. The classroom mainly focused on teaching and research. Before it was incorporated by the Imperial Taihoku University, becoming its affiliated Department of Medicine, patient care had been provided on a limited scale and without regular patient resources. As for psychiatric research, literature about the influence of a tropical climate on individuals was largely translated into the Japanese colonial context since the closing period of the 19th century.[592] Japanese psychiatrists also attempted to theorise about the colonisers' psychiatric manifestations. According to Yu-Chuan Wu, psychiatry served as an instrument to ensure that the colonisers were not failing the Japanese Empire. To this end, the psychiatric disorders of the colonisers, notably neurasthenia and hypochondriasis, were interpreted as psychogenic, spiritually modifiable, and treatable illnesses rather than outcomes of bodily degeneration or climate. Moreover, in an attempt to comprehend the minds of the colonised, the colonisers systematically applied psychiatric and psychological sciences. Because scholars were considered to be both specialists and government officials, their research results were used as references for the colonial government to modify its governing techniques.

[592] See Anon, Tropical Climate in *Journal of Taiwanese Medical Affairs* (台灣醫事雜誌), 18th of April, 1899.

The colonisers' presumptions and hypotheses about the mindsets of the colonised were not necessarily correct. For example, an assistant at the psychology classroom at Imperial Taihoku University, Fujisawa Shigeru (藤澤茂), conducted a social psychology experiment on 'rage' in indigenous people between 1935 and 1938. According to Fujisawa's hypothesis, the minds of indigenous people were 'child-like' and 'emotionally centred', and such people were therefore more prone to acting out their rage. However, the experiment outcomes falsified his hypothesis, as not all the research participants displayed the expected outburst of rage. According to Yu-Chuan Wu, Fujisawa's experiment was flawed because of the colonisers' bogus hypothesis about the mindset of the colonised. Moreover, the suppression of rage might have been partly due to the colonised people repressing or disguising the agony they experienced under the heavy-handed policies of the colonisers.[593]

During the same period, some studies did not venture any initial racial hypotheses. On 21 April 1935, an earthquake in the middle region of Taiwan caused approximately 2 600 deaths and 6 000 injuries. The casualty count was high because the quake was in the centre of an area with soil-brick farmhouses. This event prompted a large-scale study on psychiatric reactions to the earthquake. Dr Naka Syuzo and his colleagues recruited 364 patients, mainly peasants who attended local clinics, and observed their *Emotionslähmung* and other nervous and psychogenic reactions. In contrast to the research of Fujisawa Shigeru, the survery by Naka et al. was not based on prejudiced theories or methods, but on direct and grounded observations. Naka et al. found that instead of showing mania and melancholia, which

[593] Wu, Y.-C. 'Disappearing Anger: The Psychological Experiment on Anger among Formosan Aborigines Conducted by Fujisawa Shigeru in Late Colonial Taiwan.' *New History 18*(2) (2007) pp. 103-155.

are common reactions to catastrophes, the Taiwanese patients tended to display an empty facial expression and the inability to think clearly—the so-called *Emotionslähmung*. Naka et al. performed statistical analyses of the data before concluding that this syndrome dominated the patients' symptoms. The researchers also noted that the earthquake victims rarely displayed purely psychogenic psychic reactions. In addition, 240 of the 364 patients experienced insomnia. Anuria, the inability to urinate, was also present in a high percentage of cases (85 of 351 examined cases, or 24.2%), and 86% of this subgroup had 'reflex anuria'.

To some degree, the survey by Naka et al. was associated with the discourse of colonial and tropical medicine, with its emphasis on racial characteristics and the influence of climate. In the following year, Naka further compared the disorder seen in the earthquake victims (*Emotionslähmung*) with shell shock and other reactive psychoneurological illnesses. He argued that the symptoms of *Emotionslähmung* observed in Taiwan were associated with alterations in the patients' autonomic nervous systems due to the effects of tropical weather.

During the same interwar period, shell shock (and other related disorders) amongst European soldiers and neurasthenia amongst Japanese colonisers were interpreted as psychogenic illnesses. This interpretation exempted the sufferers from any insinuation of physiological inferiority. In the case of the Taiwanese earthquake victims, Naka et al. regarded *Emotionslähmung* as primarily physiological rather than psychogenic. From one perspective, it is difficult not to associate this discourse with the Japanese people's claims of racial superiority. However, from the perspective of methodology, there was a flaw in the research design of Naka et al., namely the study

failed to include patients with *real* psychogenic disorders—namely those who exhibited no physical injuries whatsoever at the time of diagnosis. Of the 364 patients recruited in the survey, nearly all had sustained physical injuries of varying severity.[594] However, in patients with anuria, the disorder was regarded as psychogenic if the physical injuries were not directly related to the bladder or spinal cord.[595]

Thus, extrapolating from European theories to draw conclusions about their own observations, Japanese psychiatrists established their own rationale for explaining phenomena they had rarely experienced in the course of their practices. Without an adequate referencing framework, this rationale reflected not only the inheritance of German psychiatry but also the problem of implementing European theories in a non-Western context. The narratives in the report by Naka et al. illustrate this disjuncture of theories: *Schreckerinnerung*, literally meaning 'shock recollection', was regarded as a neurological ailment, whereas insomnia was seen as psychogenic because it was 'caused less by the pain of the injury but by the fear of losing one's life'.

Most of the narratives produced during the interwar period, such as Fujisawa's 'rage' experiment, included the discourse of climate determinism. However, the climate discourse was notably lacking in the study of earthquake victims by Naka et al., at least initially. In 1942, seven years after the earthquake and initial research, Dr Naka Syuzo compared *Emotionslähmung* with the manifestations of tropical

[594] Numbers of patients vary according to different surveys.
[595] S. Naka, T. Wakesima, and N. Okumura, 'Die Nervöse Reaktion Auf Das Erdbenden in Formosa (1935) [臺灣中部震災（昭和十年）ニ於ケル神經性反應ニ就テ]', *Journal of Formosan Medical Association,* 41/445 (1942), 436-58.

neurasthenia. He reported that the characteristics of 'combat neurosis in the tropics is characterized with the influence of tropical weather, causing the disorder of autonomic nervous system and the obstruction of metabolism'.[596] The racial profiles of patients had also not been analysed as a variable of interest. Psychiatry, in this case, was applied purely for humanitarian intervention after the disaster. Thus although psychiatric diagnoses might have been influenced by the rationale of colonialism, there was some acknowledgement of the universality of the human mindset in response to extreme experiences.

Trauma after World War II: War, Immigration, and Ethnic Conflict

The following section tells another story of trauma. In the early postwar period, psychiatrists in the newly re-established psychiatric department at NTUH directly attributed patients' psychopathology to devastating postwar events. After the end of World War II, psychiatry in Taiwan underwent a wholesale re-institutionalization, with all aspects being revised, including staffing, services provided, objectives, psychiatric education, and theories. Dr Naka Syuzo and most of his colleagues were repatriated immediately after the end of the war. Tsung-Yi Lin, the Tokyo-educated Taiwanese psychiatrist, returned to Taiwan in 1946. The only remaining Japanese psychiatrist, Ryosuke Kurosawa (黒澤良介), who had worked for the Chinese Nationalist government as a consultant, returned to Japan in December 1946. The next year, Tsung-Yi Lin became the director of the new psychiatric department at

[596] S. Naka, 'Issues and Problems About Nervöse in Taiwan [臺灣に於ける神經症に諸問題に就きて]', *Formosan Journal of Medical Humanities,* 41/444 (1942), 352-72.

NTUH. Under Lin's leadership, psychiatry in Taiwan developed in a completely different direction.

Upon his arrival, Lin immediately observed the various manifestations of mental illness among the Taiwanese population. Because of his personal cross-cultural experiences, Lin realised that he had to develop his own syllabus with comparative cultural psychiatry as the central focus. Together with his newly recruited students, he conducted statistical surveys to assess the psychiatric characteristics of various populations in Taiwan.[597] Lin's door-to-door fieldwork not only laid the foundation of his methodology in epidemiology, but also caused WHO to take notice of him. Lin subsequently led the mental health section of WHO in its cross-national studies in social psychiatry.[598]

The epidemiological research of Lin and his students had earned international recognition by the mid-1950s. However, the psychiatric services at NTUH were far less established. With its imperfect theories and limited resources, this newly established medical speciality struggled to provide care and treatment for a drastically increasing population of psychiatric patients. Lin had spent the entire war years in Japan, during which time he received his general medical and psychiatric training, and returned to Taiwan only in 1946. He then spent two years studying psychiatry at the University of Tokyo and one year interning at Matsuzawa Hospital (松澤醫院).[599]

[597] These included surveys of three areas of varying levels of urbanisation from 1946 to 1948, and of three indigenous populations from 1949 to 1952. His research outcomes, published in 1953, formed the basis of a policy paper and earned worldwide attention. Details are presented in Chapters 2 and 4 of this thesis.
[598] See Chapters 3 and 4.
[599] Tsung-Yi Lin, *Road to Psychiatry: Across the East and the West* (Taipei: Daw Shiang Publishing, 1994). p. 3. Founded in 1879, Matsuzawa Hospital is the largest and oldest public psychiatric hospital in Japan. The current name is Tokyo Metropolitan Matsuzawa Hospital.

Because of his limited training experience, Lin more than once refused the invitation to take up the directorship of the psychiatric hospital at NTUH. Ryosuke Kurosawa remained with the NTUH administration until the work left behind by the Japanese staff was handed over. Upon Lin's return to Taiwan, patients were still being admitted to the wards.

The psychiatric department led by Tsung-Yi Lin was not yet large enough to form its own school of thought or practice. With only one other staff member officially trained as a psychiatrist, Lin's department was seen as something of a one-man show. To some extent, the practice of Lin and his students was influenced by the psychiatric schools of thought in fashion at the time. These influences included the international diffusion of Freudian psychoanalysis, the international mental hygiene movement during the interwar period, and remnants of Japanese colonial psychiatry. Traces of these schools can be found in various diagnoses recorded in the patient registries.

Lin's psychiatric insights were also heavily influenced by his supervisor Yushi Uchimura (内村祐之), who specialised in cultural psychiatry. However, Lin's own vision of Taiwanese psychiatry derived from the need to close the gap between Taiwanese and Japanese cultures, which he observed upon his arrival in Taiwan. Because of these differences, Lin's version of cultural psychiatry was relatively incompatible with the colonial approach of Uchimura. Lin cultivated his insight into epidemiology, and emphasized the need to study what caused the differences in prevalence and manifestations of psychiatric disorders among various population groups in Taiwan. The educational syllabi at the psychiatric department of NTUH

included two intact textbooks, which had survived a fire caused by the war. One was edited by Oswald Bumke and the other by Carl and Frederik Lange.[600] Decisions about the development of ward services, treatment, and educational curricula were all made by Lin. As a result of the break in tradition from the original Imperial Taihoku University Hospital and the limited resources to develop the revamped department, some schools regarded psychiatry in the new NTUH as lopsided and occasionally confusing.

In the following paragraphs, the patient registries I analysed had been preserved by one of Lin's students, Hsien Rin (林憲), and were donated to the Academia Sinica in June 2009.[601] These registries covered the records of outpatient visits and admissions. Apart from the small number of patients who remained with the unit after Japan's defeat in World War II, most cases in the registries were patients who had sought help in the context of postwar social and political turmoil. Such patients included those experiencing immigration and ethnic conflicts, Chinese public servants who had recently relocated from Mainland China to Taiwan, Japanese salaried men who had remained on the island, and local Taiwanese people who had become increasingly fearful after witnessing the 2.28 Incident in 1947. Diagnosed mainly by Tsung-Yi Lin and the students he personally trained, these cases illustrate the complexity of 'psychological trauma' as it was conceptualised in the conflicting cultural context of post-colonial Taiwan. The cases in the registries also illustrate the transformation of this general concept during psychiatric paradigm shifts, and the controversial and subjective nature of related medical diagnoses.

[600] Ibid. p.4.
[601] Hsien Rin, Personal Communication (Taipei, 2009).

Statistical Analysis of the NTUH Psychiatric Department Registries

From these recently unearthed patient registries, the current study excluded wartime records held at the psychiatric department of NTUH, to unify the historical context of analysis. From 1945 to 1953 a total of 5 185 records were accumulated, both inpatient admissions and outpatient visits. Unfortunately, no admission records were preserved from 1951 or 1952. Before 1949, the year the Chinese Nationalist government was officially established in Taiwan, the original Japanese version of case registries was still in use. Racial categories included Inlanders (内地人, meaning Japanese), Hokkien, Cantonese, Indigenous People, Koreans, Chinese, and foreigners. In my analysis, the category of Taiwanese includes the Hokkien (福建人), Cantonese (廣東人, recognized today as Hakka, 客家人), and Indigenous populations. After 1949, patient registries were printed in Chinese rather than Japanese, under the heading of the NTUH Department of Neurology and Psychiatry (*Guoli Taiwan Daxue Shenjing-Jingshenke*, 國立台灣大學神經精神科). Racial categories were abandoned; in their place, ancestral homes (*jiguan*, 籍貫) were recorded. For analysis, 'Taiwanese' includes those who were recorded as Taiwanese (*Taiwan Ren*, 台灣人) as well as patients from Taiwan Province (*Taiwan Sheng*, 台灣省) and Native Provincials (*Bensheng Ren*, 本省人). Immigrants from the mainland were categorised according to the provinces they had emigrated from, or simply as mainlanders (*Waisheng Ren*, 外省人). In the following paragraphs, 'outpatient visits' refer to patients who called on the hospital more than once.

The psychiatric paradigm established in Taiwan by Japanese psychiatrists, and the educational background of Tsung-Yi Lin (head of the department) profoundly affected the development of Taiwanese diagnostic theories and treatments for mental illness. The roots of Japanese psychiatry can be traced to German influences during Japan's Meiji period. Patient records at Imperial Taihoku University (renamed National Taiwan University in 1945) were highly influenced by the prevailing racial science before and during World War II, and consisted of the descriptive style of Kraepelin and dynamic (psychoanalytical) psychiatry. Race was categorized in the first page of each patient record, and the suspected diagnosis and etiology of the illness (原因推定) were jointly presented. Modern psychiatry, whether phenomenologically or neurobiologically oriented, has long since discarded this practice whereby the clinician assumed the causation of the patient's mental illness—an approach that was fashionable at the time, and was heavily influenced by psychoanalytic psychopathology.

During the early postwar period, the language of psychiatry in Taiwan gradually transitioned from the Japanese-German to the English-Chinese system. The case registries show that the languages of German, Japanese, English, Chinese, and Romanized Taiwanese were all used intermittently. According to Tsung-Yi Lin, the immediate postwar society was 'total chaos' (*yipian hunluan*, 一片混亂).[602] After the Japanese people returned to their homeland, the Taiwanese people could not quickly adapt to the administrative and technical workings that the former government had left behind. Taiwanese individuals, who had completely different languages and habits from those of the Japanese, suddenly took over all public sectors. According to

[602] Lin, *Road to Psychiatry: Across the East and the West*. p. 5.

Tsung-Yi Lin, the chaos was reflected by the 'odd triangle relationship' involving Taiwanese, Japanese, and Chinese immigrants.[603]

Lin was not the only psychiatrist or intellectual who experienced difficulty with the language barriers and developed an identity crisis.[604] Under these circumstances, Lin began to learn the Mandarin language. He wrote notes in Romanized Taiwanese (台灣羅馬字, Tâi-ôan Lô-má-jī), a transcription system for Taiwanese Hokkien, in the 'present illness' blanks on patient registry forms. He did so in an attempt to faithfully record the patient's current symptoms, particularly when transcribing their verbal communication.[605] Lin continued to use a combination of Japanese, German, and Chinese for noting disease progress and treatment, until the 1950s when English became the dominant language in the registries.

[603] Ibid.
[604] For example, Lin's students Wen-Shing Tseng and Ying-Kun Yeh detailed the social context of language change and their identity shift in the early post-war period. Yeh especially mentioned that during this period, lectures at the medical school were given in mixed official Mandarin (*guoyu*, 國語), Taiwanese, Japanese, English, and German. See Wen-Shing Tseng, *One Life, Three Cultures: The Self-Analysis on Personality Shaped by China, Japan and America* (Taipei: Psychology, 2010). p. 56-58. Jiashuan Wu, *The Pioneer of Taiwanese Psychiatric Care: Biography of Ying-Kun Yeh* (Taipei: Psygarden, 2005), p. 88.
[605] See Figure 1.

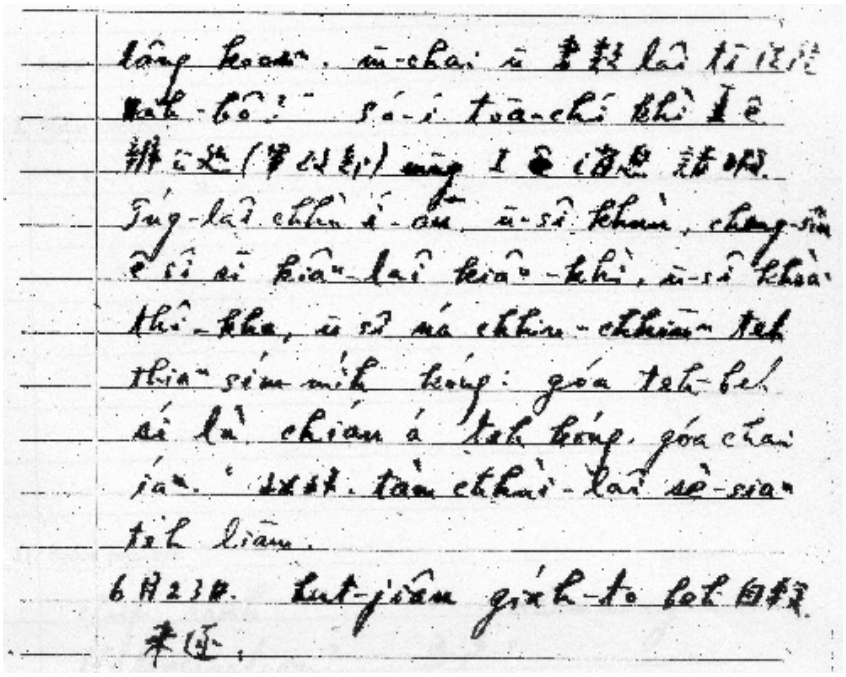

Figure 10 In this note of 'present illness', a case of attempted suicide was written in Romanised Taiwanese to record the presenting narrative about the patient's mother. [606]

The statistics shown in Figure 11 indicate an increase in outpatient visits between 1945 and 1953. In 1947, the number of outpatients was double those in 1946, whereas the number of inpatient admissions decreased. Many patients came to the hospital because of the horrors experienced during the 2.28 Incident and its aftermath. They were mostly diagnosed as having a *Psychogenisch Reaktion*. The number of outpatients surged in 1950, but the number of admissions did not reflect an obvious change because of the limited expansion of admission services. People who called on outpatient services were mostly Chinese immigrants relocated by the Chinese Nationalist government. Most of these patients worked for the military, public sectors, and schools. Many of them were diagnosed as having psychoneurosis (anxiety state) and *Neuröse*.

[606] Image scanned from NTUH Psych Dept Case Reg. 1946, No. 100.

Figures 12 and 13 show a steady increase in the number of Chinese immigrants in both admissions and outpatients. Chinese immigrants accounted for more than 50% of all outpatient visits after 1950. In the registry, the number of cases of functional psychosis (schizophrenia and manic-depressive psychosis) remained stable. This finding echoed the later research outcome of WHO that stated the prevalence of schizophrenia is universal. However, it is less clear to what extent historical events precipitated mental illness in the patients. It is also not clear to what extent the psychiatrists merely assumed that certain events had resulted in particular forms of suffering among their patients.

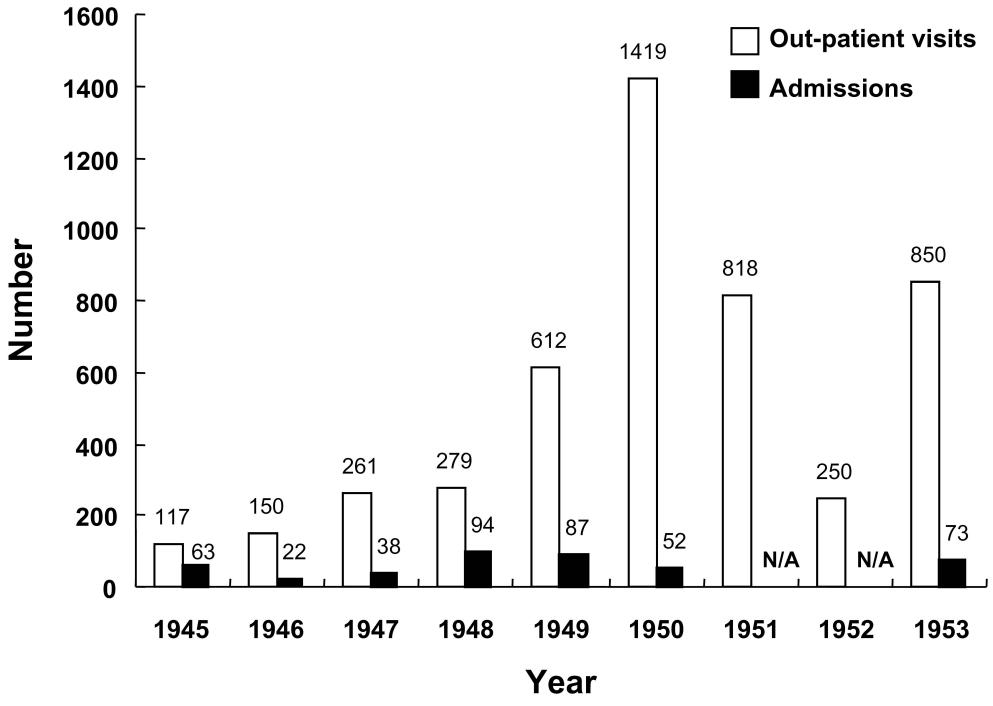

Figure 11 Numbers of outpatient visits and inpatient admissions

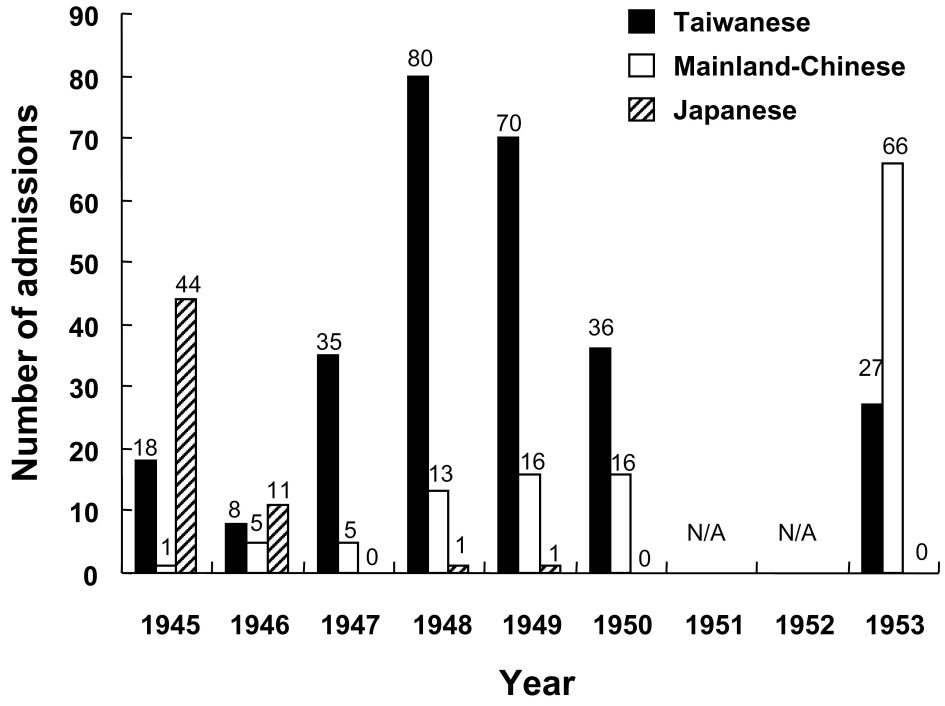

Figure 12 Distribution of racial characteristics among inpatients

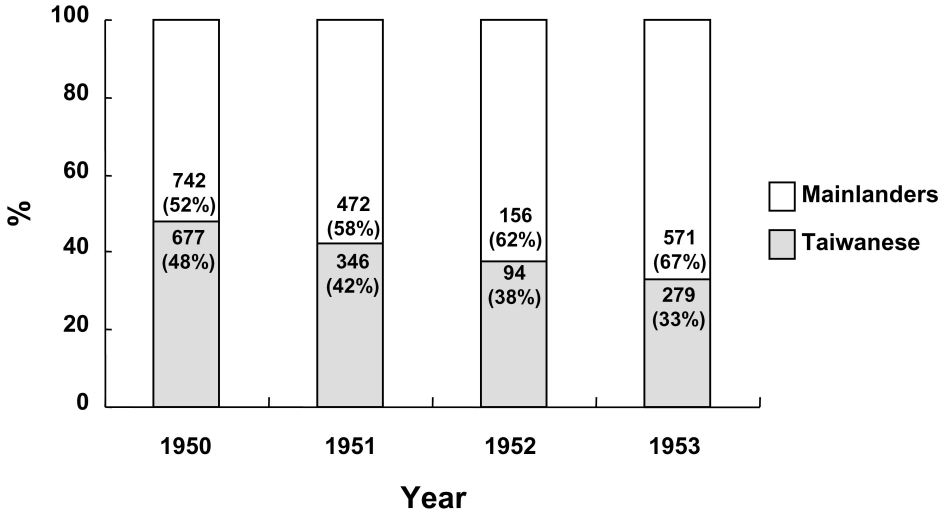

Figure 13 Proportions of Taiwanese and Chinese immigrants (mainlanders) amongst outpatients

During the period in which this set of case registries was preserved, several major events affected Taiwanese society, including the defeat of Japan, the takeover

of the Chinese Interregnum, the 2.28 Incident, the establishment of the Chinese Nationalist government, and the wave of Chinese immigration. These factors influenced the emergence of psychiatric illnesses and the manner in which psychiatrists diagnosed those illnesses in the people who came to them for help. The following section discusses cases of non-psychotic disorders that were recorded as having clearly been caused by specific life events. Functional disorders such as schizophrenia, hebephrenia, delusional disorders, and other psychotic disorders are excluded.

War Termination Depression

The following case study shows how a traumatic event influenced a patient's symptoms, and oriented the doctor's impression of the cause of disease.

After the end of World War II, a special case register depicted a 57-year old Japanese salaried man (會社員). He had been living in Taiwan for three years (since 1942) and visited the psychiatric department because of *Schlafstörung* (sleep disturbance) and *Brustbeklemmung* (chest tightness). According to the patient's hospital records, he began to ruminate about many things and felt uneasy after the end of World War II. He felt tired when making contact with other people. His chest tightness appeared in September 1945. He was admitted to the Governor-General of Taiwan Psychiatric Home (台灣總督府精神病院養神院) for treatment. He was discharged ten days before a second visit to the psychiatric department on 7 November, but his symptoms (including his fatigue and depression) had not improved.

The psychiatrist Ryosuke Kurosawa diagnosed this patient as suffering from depression. The doctor further assumed that 'termination of war' was the main cause of the ailment. The patient suddenly developed a high fever; however, despite his condition no further diagnosis was made. On 22 December, the patient died.[607] In this case, the patient obviously died from a deteriorating physical condition characterized by uncontrollable fever. Nevertheless, the psychiatrist did not pay further attention to the patient's medical condition but concentrated only on his mental infirmity until a few days before his death. This tragic case demonstrates the overwhelming shock of the Japanese defeat in the war and its potential hazards for both the patient and the doctor.

The 2.28 Incident and Psychogenic Reaction

The 2.28 Incident was the first documented event that caused widespread psychological distress among Taiwanese people. Long before the 1980s, when Taiwanese psychiatrists began to remember and retrospectively interpret the legacy of 2.28, the effect of the Incident was immediately evident in the form of mental symptoms among the Taiwanese. Many of the diagnoses these patients received included 'psychogenic reaktion' [sic], that is, 'psychogenic reaction' with partial German spelling. Psychogenic reaction was a general term, informed by the Freudian school of psychoanalytic psychiatry and used to explain somatic complaints deriving from psychological disturbances. In 1948 the term was included in the 6th revision of the International Classification of Diseases (ICD-6) under the category of

[607] NTUH Psych Dept Case Reg. 1945, No. 119.

'psychoneurotic disorders.'[608] Patients diagnosed with psychogenic reactions were usually admitted to the psychiatric department complaining of headache, dizziness, poor sleep quality, and other physical problems. The doctors' notes for 'present illness' invariably started 'after the 2.28 Incident, […].'

For example, a 28-year old married Taiwanese man, who was a land mortgage broker, visited the psychiatric department because of his suicidal ideation (*Suicidversuch*). He also had insomnia (*Schlafstörung*) and angina pectoris (*Brustbeklemmung*). He was a graduate of Waseda University in Tokyo. Tsung-Yi Lin diagnosed this man with psychogenic reaction, a disease directly caused by the 2.28 Incident.[609]

Another more detailed registry case was that of a 27-year old woman who visited the psychiatric department because of chest tightness and feelings of distress. She had an elementary school education. In the outpatient department, she complained to the doctor that she felt 'threatened' when other family members were not home. Ten days before her symptoms had emerged, she had received a telephone call from a certain governmental official, telling her that 'your family has something to do with Lin Rigao' (林日高, a legislator, who was arrested after the 2.28 Incident). Before Lin Rigao was arrested, he often called on this patient's family. Three or four days after the telephone call, she felt horrified every time someone knocked on her door. She developed a depressive mood and negative thoughts. Once she had to run away from home because she thought the police were chasing her. When she returned,

[608] ICD-6 was the first ICD revision published by WHO that included a section on mental disorders. However, it was not widely accepted and used.
[609] NTUH Psych Dept Case Reg. 1946, In-patient No. 280.

she could not recognize her own children. She experienced shallow sleep and terrible thoughts thereafter, such as being chased by people carrying guns. At midnight, when she heard people talking next door, she thought they were bad people; therefore, she kept switching the light on and off. Tsung-Yi Lin diagnosed her as having psychogenic reaction and admitted her to the ward.[610]

However, psychogenic reaction was not the only possible diagnosis in cases related to the 2.28 Incident. A 20-year old male teacher visited the psychiatric department on 21 April 1947 because of *Schaflostigkeit* (sleeplessness) and *Träumreich* (dream-world). He complained that he had slept badly ever since the 2.28 Incident. Apart from insomnia and nightmares, he felt dizzy and experienced a sense of generalized weakness (*Allgemeine Kraftlosigkeit*) during the day. Tsung-Yi Lin diagnosed him as having psychogenic *neurasthenische reaktion*.[611] Neurasthenia was excluded as a psychiatric disease after the launch of the ICD system. However, as previously discussed in my thesis, during Japanese colonial times neurasthenia was described as a condition characterised by fatigue, anxiety, headache, weakness, and other symptoms resulting from nervous exhaustion. In the case of this young teacher, the stress of the 2.28 Incident had caused the patient's psychogenic reaction, and the symptom manifestations resembled those of a case of neurasthenia. Neurasthenia was no longer the 'privilege' of the Japanese people. The colonial undertones of the diagnosis had gradually faded, yielding a neutral term that was accepted by the Taiwanese people.

[610] NTUH Psych Dept Case Reg. 1946, In-patient No. 217.
[611] NTUH Psych Dept Case Reg. 1947, No. 208.

On 21 April 1947, a 41-year old man visited the psychiatric department because of suicidal ideation. He said he had begun to feel ill after the 2.28 Incident. Five days before visiting the hospital, he felt abnormal. During the previous five days he had been unable to eat or sleep normally. At night he was terrified by 'ghosts and gods.' His right arm was numb. He was diagnosed as having 'psychogenic depression.' [612]

On 25 July 1949, a 27-year old elementary school teacher visited the outpatient department. He sought help because the experience of horror had severely disturbed his daily life. Since January 1948 he had been unable to stand still. While eating with chopsticks, his hand tremor prevented him from picking up the food from the bowl. By August 1948 he had begun to suffer from slurred speech and stammering. He rode his bicycle in a serpentine path because of generalized weakness. He said that he had been short-tempered before the 2.28 Incident, but was now incapable of getting angry. He was diagnosed as *Hysterie* with a question mark. This patient only sought help from the doctor one and a half years after the 2.28 Incident, yet the doctor listed '2.28 Incident' in the blank space provided for Aetiology. This note indicates the degree of attention and seriousness with which the clinician regarded the 2.28 Incident.[613]

Adjustment Disorders amongst Chinese Immigrants

In 1949, another epidemic of psychoneurotic disorders began to appear. Newly emerging cases of nostalgia or psychoneurosis among Chinese immigrants reflected the changing power dynamics between people providing the diagnosis and those who were diagnosed, and between the governing and the governed. After the retreat of

[612] NTUH Psych Dept Case Reg. 1947, No. 299.
[613] NTUH Psych Dept Case Reg. 1948, No. 299.

Chiang Kai Shek's Nationalist Government from Nanjing to Taipei, his troops, his followers, and those who were driven out by the Communist Party fled to Taiwan. The 2 million new immigrants merged with six million native Taiwanese, shaping the background constituents of Taiwanese intellectual history. Documents show that as of 1946, diagnoses such as psychogenic reaction and neurasthenic reaction increased drastically among Chinese immigrants.

As shown in Figure 8 above, the number of patients visiting psychiatric outpatient services increased substantially after 1949. Figures 9 and 10 (above) indicate that an increasing proportion of both inpatients and outpatients were Chinese immigrants rather than Taiwanese. Figure 9 illustrates a steady rise in the number of Chinese admissions between 1946 and 1950, reaching a peak in 1953; conversely, the number of Taiwanese admissions dropped steadily each year during the same period. No data were available for 1951 and 1952, but the trend seems clear based on the data for the surrounding years. Similarly, Figure 10 shows that from 1950 to 1953, the proportion of Chinese immigrants among the outpatients rose from half of the entire outpatient population to two-thirds. Most of the Chinese immigrant patients' complaints matched the general definition of neurasthenia formerly experienced by the Japanese people. Their devastation stemmed largely but not solely from migration. Some had personally experienced the Chinese Civil War; some were overwhelmed by the unfamiliar local conditions, both social and natural; and others missed their families who had not moved to Taiwan with them.

Diagnoses given to these patients varied. The term 'psychoneurosis' gradually began to be used after the new disease classification system was introduced in 1948.

Some diagnoses reflected the confusion between psychogenic or nervous disorders. For example, during Japanese colonial times, the term 'neurasthenia' had undergone a transformation from physical or organic to psychogenic pathology. A diagnosis such as 'psychogenic neurasthenic reaction' can be found among these immigrant records, indicating that the disease was not only a psychological reaction or maladjustment, but included relatively more severe corporeal symptoms too.

In 1946 a 24-year old Chinese woman from the mainland visited the outpatient department. In the preceding two months she had experienced disorganized speech, irritability, and panic. She had graduated from junior high school in China with good grades, and in 1940 she had married her current husband. Two months before her visit to the hospital she had been terrified by Communist soldiers, and described an incident when her body was pressed against one of their rifles, which she found particularly frightening. When Tsung-Yi Lin tested her general knowledge, she did not know the date of Taiwan's retrocession (*guangfu*, 光復). Apart from mental disturbances, she had a good appetite and normal sleep patterns. The doctor diagnosed her as having a psychogenic reaktion (*abgerauchen*).[614]

A 35-year old soldier came to the hospital because of a *Kopfschwindel* (headache); he was also having nightmares and his memory was deteriorating. The patient grew tired easily, not only because of his busy administrative work in the military but also because of his poor quality of life. He thus visited the psychiatric

[614] NTUH Psych Dept Case Reg. 1946, No. 262.

department for a diagnostic certificate, on which the diagnosis of neurasthenia was given.[615]

In another case, a 38-year old officer of order from the mainland sought psychiatric help. He was a graduate of Xiamen University. In November 1945 he had relocated to Taiwan with the military troops. Because of his severe homesickness, he experienced *Heftig Schwindel* (severe vertigo), and even fell down abruptly in the bathroom on one occasion. His appetite and sleep were normal. Tsung-Yi Lin diagnosed him as having *neurasthenische reaction*.[616]

In yet another case, a 23-year old politician who worked for the county government sought help from the psychiatric department. He had relocated from Shanghai to Taipei one month before he visited NTUH. His homesickness was so severe that he lost his appetite, and his sleep deteriorated from bad to extremely bad. He urinated relatively frequently but defecated only once a day. He was nervous and his memory had deteriorated to the point where he had to quit his work. Tsung-Yi Lin diagnosed him as having a *neurasthenische reaktion* caused by 'excessive nostalgia.'[617]

In 1947, a 22-year old man who worked at the Office of Transportation visited the outpatient department because of *Kopfschwer Gefühl* (heavy-headed feeling). While still living in China, he was outgoing and had many friends, and had never sought psychiatric help before. He was a college graduate. He had malaria when he was three years old. Before he visited the hospital, he experienced a heavy-headed

[615] NTUH Psych Dept Case Reg. 1949, No. 236.
[616] NTUH Psych Dept Case Reg. 1946, No. 51.
[617] NTUH Psych Dept Case Reg. 1946, No. 115.

feeling, loss of appetite, and irregular sleep patterns for six months. Earlier during the war, while still in China, he had experienced many difficulties that made him nervous. Now, after his relocation to Taiwan, the nervousness was aggravated by poor communication with the local people. In Taiwan, he also developed guilt-ridden thoughts toward his parents. These ideations, however, were not stimulated by the tense political situation. He simply missed his family in Shanghai and thought it would be a consolation if he could see them. Tsung-Yi Lin diagnosed him as having psychogenic neurasthenic reaction.[618]

The topics of diaspora, ill adjustment, and experiences of conflict among Chinese immigrants were later covered by literary, cultural, and social studies; these studies carried the implication of trauma. In a recent study, Aaron William Moore argues that these immigrants, particularly veterans, established a 'language community' to speak about their wartime experiences. They found postwar audiences to be 'either ill-equipped or unwilling to listen' to their private stories. Thus their traumatic stories were not told until much later in unconventional forms of literature, including diaries, testimonials, oral histories, surveys, commercial media, and self-published literature.[619] The case registries, however, directly represent their suffering in the form of psychoneurosis.

Traumatic Neurosis Preceded by Physical Injury

[618] NTUH Psych Dept Case Reg. 1946, No. 204.
[619] Aaron William Moore, 'Problems of Changing Language Communities: Veterans and Memory Writing in China, Taiwan, and Japan', *Modern Asian Studies,* 45/2 (2011), pp. 399-429.

The term 'trauma' was not classified in the ICD system developed by WHO or in the American DSM system until 1980. In the early postwar period, trauma was applicable only to patients who experienced *bona fide* physical injuries. It was not that mental health professionals ignored the importance of mental deficits caused by non-physical injuries. But in the immediate postwar period, cases of actual corporeal trauma, particularly head injuries, combined with psychoneurological illness, took precedence regarding treatment and research. In such cases a military surgeon could often tell whether a wound had healed successfully, whereas a neuropsychologist or psychiatrist could not be sure that the neurological deficits or mental scars of battle were resolved after medical treatment.[620]

To understand the enduring neuropsychological effects of head trauma in the UK, the Head Injury Advice Bureau of the Department of Health and Social Security (DHSS) commissioned the Neuropsychology Unit at the Radcliffe Infirmary to investigate the psychoneurological defects of servicemen who had suffered real head trauma. Most of these patients initially experienced 'post-traumatic fits' and then developed chronic neurological impairments such as hemiplegia, dysphasia, dyslexia, or hemianopia.[621] Longitudinal studies have been conducted on the recovery of these injured servicemen. The DHSS study emphasized the empirical results of tests of the patients' cognition, practical skills, verbal memory and learning ability, visual and spatial perceptions, and other basic neurological functions.[622] Despite the worrying trends revealed in this research, director Freda Newcombe concluded that these servicemen 'had made remarkably good adjustments, both generally and physically.' However, in her report to the DHSS she remarked, 'in the interest of the pensioners, I

[620] See Jones and Wessely, *Shell Shock to PTSD : Military Psychiatry from 1900 to the Gulf War*.
[621] Oxford St Hugh's Head Hospital Archives. Case 10430(486).
[622] Oxford St Hugh's Head Hospital Archives. Case 11428(762).

do draw attention to the persistent residual handicaps (of which the men themselves often make light of or which they do not even mention). I do not usually emphasize them in discussion with the pensioners themselves, since this would be of no practical help.'[623] During follow-up examinations, the servicemen or their wives occasionally complained of these so-called persistent residual handicaps, which were related to depression, changes of mood, and low self-esteem.[624]

In Taiwan, the speciality field of neurology developed simultaneously with psychiatry. Case records show that during wartime, the surgical department referred patients to the psychiatric department. Psychiatrists also referred patients who had physical injuries that had preceded their mental symptoms. In May 1945, a single Taiwanese man who drove a buffalo wagon for a living was referred to the surgical department of the hospital. While he had been looking for a shed to hide in during the air raid on 16 April, a bombshell penetrated the distal end of his left thigh. The patient developed psychiatric symptoms after receiving surgery and care. On the afternoon of 7 May, he suddenly hid underneath his sickbed and began to shout, 'Air raid!' 'Planes are coming!''Flood is coming!' and 'Pigs are coming!'[625] In his agitation, he shattered his cups and bowls. In this case register, hallucination was not recorded and a psychiatric diagnosis was not given. However, similar cases that were associated with actual physical injuries were diagnosed as 'traumatic neurosis.'

If the onset of injury was determined to be too early to act as a direct cause of the patient's neurosis, the doctor would assume that the disease was not associated

[623] Oxford St Hugh's Head Hospital Archives. Freda Newcombe to Dr. Foster, December 21, 1984.
[624] Oxford St Hugh's Head Hospital Archives. Case 10813(561).
[625] 「空襲了！飛機來了！」「大水來了！」「豚が來了」. Some Taiwanese people called Japanese people 'pigs' to express their hatred of colonization. Source: NTUH Psych Dept Case Reg. 1945, No. 118.

with that physical injury and would remove 'trauma' from the diagnosis. However, the teachings of psychiatry offered no concrete definition for how long the mental symptoms were to be distanced in time from the actual trauma. For example, a 26-year old government official sought help from the psychiatric department. His report indicated that he had been admitted a year earlier in Wenjou (溫州) Hospital in China for two weeks after a contusion injury. After discharge, his memory deteriorated and he gradually began to feel numb. While visiting the psychiatric department at NTUH, he complained of dizziness, particularly when busy at work. He was diagnosed as having *Nervosität*.[626] Apparently, the doctor assumed that his symptoms were not caused by the physical injury but by the stress of his recent work.

Like other cases, the expression of trauma would only appear while the symptoms on the neurotic patients were impressed associated to actual physical injuries. The diagnoses, however, were diverse in their phrasing, such as *post-traumatische nervöse*, *traumatische neurose*, and post-traumatic syndromes.[627] [628] This diversity was due to the lack of standardised diagnostic criteria or terminology for neuroses related to physical trauma; neither of the two disease classifications systems in use at the time had established clear guidelines for such disorders.

Medicalisation of Common Suffering

[626] NTUH Psych Dept Case Reg. 1946, No. 236.
[627] NTUH Psych Dept Case Reg. 1949, No. 175; NTUH Psych Dept Case Reg. 1949, No. 490; NTUH Psych Dept Case Reg. 1953, No. 43.
[628] In current days, scientists have been endeavoring to establish the relationship between mild traumatic brain injury (MTBI) and post-traumatic stress disorder. Debates please see Tracy Loughran (2010), 'Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and Its Histories'. *Journal of the History of Medicine and Allied Sciences,* 67 (1), 94-119.

While the postwar developing world was responding to the challenges of increased urbanization and industrialization, Taiwan—as part of the Global South defined by WHO—was confronted by sudden economic hardship before it had any chance of development.[629] The epidemics of infectious diseases, inflation, and a shortage of food resources were all new and abruptly emerging external realities. Numerous patients suffered because of these life stressors and the unexpected, sudden changes in their living standards. When the Chinese civil war reached its peak, hyperinflation affected almost every aspect of the cost of living in Taiwan, including food resources. Tsung-Yi Lin remembered his father's concern: '[The Chinese Nationalist government] shipped packs of sugar to Fuzhou and Shanghai. They flocked together and fled to Taiwan, and sold the public goods in order to feed themselves'.[630] Such worries prevailed amongst then-native Taiwanese people. For them, the 'recovery' of Taiwan, referred to by the new government as *guangfu* (光復), was a disaster.

Patient illnesses epitomized the common suffering among Taiwanese people. On 15 September 1948, a cake maker sought psychiatric help because of extreme anxiety. He reported to the doctor that because of Taiwan's 'retrocession', he had had to close his cake shop because of the inflated price of sugar. He grew weak, and occasionally experienced chest tightness (*Brustbeklemmungs-gefühl*). His son had also lost his job and throughout the following days became withdrawn while staying at home. Once, the patient saw his son attempting to burn the Japanese military boots that he had kept during the Japanese colonial period, because keeping Japanese items

[629] See Chapter 3.
[630] Tsung-Yi Lin, 'My Father Bosei Lim', in Hui-Ling Hu (ed.), *Daoyu Ailian (Love Stories on the Island)* (Taipei: Yu-Shan Books, 1995b). p. 10.

was now illegal. This event made his son feel suicidal. The cake maker could sleep only two to three hours a day. The patient described himself as experiencing 'nerve fire' (神經火) which was migrating up and down. He was diagnosed with 'psychogenic depression' and was hospitalized for three weeks.[631]

Unaccountable Trauma

Aaron William Moore, who studied the memoirs of veterans who had retreated together with the Chinese Nationalist government to Taiwan, observed that veterans crafted a language community to speak of their private memories, leaving their audiences to decide for themselves whether to accept the narratives.[632] In postwar Taiwan, as soon as the Chinese Nationalist government imposed the official language (Mandarin) and banned the Japanese language, 6 million native Taiwanese people suddenly lost their verbal capacity and became a 'loss generation'.[633] At most official public establishments, Taiwanese people—both elite intellectuals and ordinary citizens—were no longer able to express themselves and communicate with others in their own language. Without language, the Taiwanese people had no spaces, codes, or conduct to express their suffering. This may explain the decreased number of Taiwanese people seeking help from the psychiatric services, as shown in Figures 9 and 10 (earlier in this chapter). Under the austere political, social, and cultural conditions of the postwar period, psychiatry could offer limited help for the trauma experienced by most Taiwanese people.

[631] NTUH Psych Dept Case Reg. 1948, No. 291.
[632] These memory writings include diaries, testimonial literature, surveys, oral history documents, commercial media, and self-published narratives. See Moore, 'Problems of Changing Language Communities: Veterans and Memory Writing in China, Taiwan, and Japan'
[633] For an explanation of the 'lost generation', see Chapter 5 of this thesis.

Psychiatrists documented examples of this type of untold trauma. Wei-Tsuen Soong (宋維村), a psychiatrist trained at NTUH, stated that for certain patients presenting at the outpatient department, he could occasionally immediately identify the origin of their distresses as the legacy of the 2.28 Incident or White Terror. However, he 'found no precise terminology to account their suffering, for modern psychiatry is not liable for those patients who suffer from prolonged devastations'.[634] Although standardized psychiatric classifications had by now been introduced to Taiwan, first-line clinicians did not show resistance because 'all Taiwanese were tamed as docile subjects during the White Terror.'[635] The chronic effects of continual stimuli of sorrow, panic, fear, and anxiety were not understood until much later, in the 1980s, when the political climate finally relaxed. By then, the effects on patients of the ongoing political and social stresses had become substantially more complex and were beyond the comprehension of many psychiatrists.

Challenges in Studying Trauma in Early Postwar Taiwan

The uniqueness of these 'trauma' cases is that clinical evidence shows that different communities exhibited complex contents and styles of suffering. As discussed in Chapter 3, the Mental Health Section of WHO was aware of the importance of migration trauma after World War II; however, WHO never systematically explored this subject due to inadequate methodology. In Chapter 4, I indicated that the WHO's cross-cultural research into the stressors that cause mental

[634] W. T. Soong, Personal Communication (Taipei, 2011).
[635] Ibid.

illnesses included only inpatients, not psychiatric outpatients. This limitation arose because patients were recruited to the study through Field Research Centres (FRCs), which reflected only the inpatient populations. Thus the catchments in WHO epidemiological studies did not include communities that were on the move.

In addition, the optimism and excitement brought about by WHO studies on schizophrenia were not diffused to other categories of mental illnesses. However, to accelerate the process of becoming a modern nation state, most developing countries adopted the paradigms already set up by the world standards, without question. The norms established by WHO had both pros and cons. In 1975, Thomas Lambo, a Nigerian psychiatrist and then Deputy Director General at WHO, admitted that the largely institutional-based mental health interventions were often inappropriate or even harmful.[636] In the case of Taiwan, where psychiatric services grew in number and size, the attempt to pursue world standards left the majority of patients unidentified, undiagnosed, and untreated.

In Chapter 3 I mentioned McGill's second issue of its newsletter, published in February 1957. In this newsletter, Hsien Rin (林憲), a student of Tsung-Yi Lin, claimed that he found it 'difficult in the study in Taiwan to evaluate the psychosomatic cases, as well as psychoneuroses, at the community census examination'. Rin assumed that 'the psychoneurotics in the cities had obvious neurophysiological symptoms in great numbers'. Chronic hypochondriasis and a primitive type of hysterical symptom also appeared and showed a marked increase

[636] See the Introduction in Alex Cohen, Arthur Kleinman, and Benedetto Saraceno, *World Mental Health Casebook : Social and Mental Health Programs in Low-Income Countries* (New York; London: KluwerAcademic/Plenum, 2002) x, p. 246.

during the period of population change. By 'the population change', Rin meant the arrival of immigrants from mainland China, who migrated to the cities in Taiwan. 'These are not aborigines', said Rin. 'Malayo-Polynesians migrated almost 20 centuries ago and have lived separately without mobilisation, but have had a rapid acculturation course in the past 30 years'. In Rin's view, not only the complexity of populations but also the pattern of population movement obstructed the potential of epidemiology.[637] After half a century, Rin commented on the validity of PTSD by saying, 'If there is such a thing called PTSD, then all people in my generation have it'.[638] This bold opinion not only disputed the assumed universality of psychiatric diseases but implied that there might be other possibilities for those who had lived through postwar trauma, apart from developing mental illness.

In the 1970s, Arthur Kleinman conducted an ethnological survey in China to study the psychological effect on individuals exposed to prolonged and protracted devastation. His work focused on the psychological casualties of the Cultural Revolution, the most disastrous historical event in 20th Century China. He presented 'special instances of profound psychological wounding' and suggested that those cases represented an extreme on a continuum of personal reactions to traumatic social stress. The patients whose case studies he presented had all experienced similar effects of threat, loss, guilt, and demoralisation. There is a twofold meaning to Kleinman's research. First, he points towards the social origin of suffering that is culturally defined. Second, the research strengthened his later claim of 'category

[637] 8 July 1956, Wittkower to Candau M4/445/2 J3.
[638] Rin, Personal Communication.

fallacy', in which he challenged the validity of the psychiatric norms that were created by the standard format of cross-cultural studies in psychiatry.[639]

The Prolonged Trauma of the 2.28 Incident and its Legacy in Taiwanese People

According to Arthur Kleinman, any response of psychiatry to victims of political violence is inadequate if it diagnoses such patients as having PTSD and treats them for the pathological effects of memory, but fails to address the politics of violence and trauma or the question of how to live a moral life under dangerous conditions.[640] In this third section of the chapter, I consider the special form of trauma which modern psychiatry could not distinguish, relevant not only in Taiwan but elsewhere too. When Taiwanese psychiatrists began to speak about these victims in the late 1980s, they found no precise terms regarding their mental suffering, and could only quote a few similar descriptions for PTSD—the disease that had been recognised in the world-approved classification systems for almost a decade. The only action the psychiatrists could take was to naturalise this special form of suffering experienced by SVFs as a collective trauma of the Taiwanese people, and prescribe their idiosyncratic remedy, which entailed a radical political approach.

In a recent translated work of Didier Fassin, the author assumes that through their categories and via their testimonies, psychiatrists formulate an idiosyncratic reading of the devastations they witnessed. Despites the existing measures of mental

[639] Arthur Kleinman, 'Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness', *British Journal of Psychiatry,* 4/151 (1987), pp. 447-54.
[640] Arthur Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*, (Oxford; New York: Oxford University Press, 2006), p. 260.

illnesses, Fassin argues that psychiatrists thus tell of violence they witnessed in the language of subjectivity instead of impartiality or neutrality of disease categories. 'Trauma', according to Fassin, 'or its clinical qualification as posttraumatic stress disorder, is not only the clinical description of a state of the psyche, it is also the political depiction of a state of the world.'[641] He further comments that those who attempt to intervene trauma 'speak in their instead, by proxy'.[642] In this thesis, the social practice of Taiwanese psychiatrists attests this argument.

The internationally collaborative studies conducted by WHO '[left] out […] patients who fail[ed] to fit the template'.[643] In the case of Taiwan, these patients suffered from (in Kleinman's words) severe social and political constraints, who had been constantly feeling hopeless and helpless, whose demoralisation and despair were responses to real conditions of chronic deprivation and persistent loss, and whose powerlessness was not a cognitive distortion but an accurate mapping of one's place in an oppressive social system. Their sufferings might be medicalised as 'symptoms', and they might be categorised in terms of 'neurotic depression' or later some chronic form of 'PTSD'. However, the anguish felt by these individuals who did not belong to the hospital catchments of the WHO's 'dominant interpretive paradigm in cross-cultural psychiatry' was overlooked by institutionally oriented modern psychiatry.

The first-generation psychiatrists in Taiwan, most of whom were lineal descent students of Tsung-Yi Lin, held diverse opinions about this form of prolonged suffering. For example, Hsien Rin refused to acknowledge it as any form of mental

[641] Didier Fassin and Rachel Gomme, *Humanitarian Reason : A Moral History of the Present Times* (Berkeley: University of California Press, 2012) xvi, 336 p.
[642] Ibid.
[643] Kleinman, 'Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness', (p. 212).

disorder because he saw it as normal distress in an era of devastation.[644] Wei-Tsuen Soong saw the need to account for these individuals' torment but could not find a term for it.[645] Yung-Hsing Chen saw it as the 'collective trauma' of the Taiwanese people.[646] Tsung-Yi Lin himself saw the manifested 'symptoms' of the SVFs resembling those of PTSD and finally prescribed a radical approach towards this unique form of suffering.[647] These diverse comments not only exemplify the complexity of this form of trauma, but also highlight the inadequacy of modern psychiatry in dealing with it.

Clinician's Self-Remedy

Commenting on Tsung-Yi Lin's approach to the 2.28 Incident, Wei-Tsuen Soong said that 'it was his own therapy'.[648] On 28 February 1987, a conference commemorating the 40th anniversary of the 2.28 Incident was held in San Francisco.[649] Whilst presenting his paper 'Bosei Lim and the 2.28 Incident: His Situation and Distress', Tsung-Yi Lin spent most of his 40-minute presentation in tears. For the first time, four decades after the event, he was able to speak about his own sorrow and realised he was one of the SVFs he had defined. He had been just 27 years old when he became the director of the NTUH psychiatric department. As his career was about to take off, his father had gone missing. Lin had had no time to grieve. Instead, he became ever more devoted to patient care and research.[650] Hisao

[644] Rin, Personal Communication.
[645] Soong, Personal Communication.
[646] Yung-Hsing Chen, Personal Communication (Taipei, 2009).
[647] See Chapter 5.
[648] Soong, Personal Communication.
[649] Fang-Ming Chen, 'In Order Not to Let the History Repeat', *Taiwan Tribune,* Oct. 1988.
[650] Marnie Copland, *A Lin Odyssey* (Orlean, Mass.: Paraclete, 1987) p. 287.

Nakai, one of Lin's students, remembers that when Lin arrived in Boston in 1951, his father's whereabouts were still unknown. Whilst walking in the streets, Lin often paid attention to people who resembled his father, for he had to presume that his father might have fled to the United States.[651] On the one hand, Lin's odyssey through psychiatry represented the way he had transformed his own traumatic experiences. On the other hand, responding to his professional calling, he had formulated a prescription for changing the lives of other SVFs as well. The foundation of his approach was the reworking of moral experience, to transform traumatised victimhood into an agent of resilience.[652] This to certain extent also exemplifies what Didier Fassin observes concerning the relationship between two genealogies of trauma: medical and moral.[653]

Portrayals of Collective Trauma in Creative Writing

Because modern psychiatry could not address the Taiwanese people's protracted trauma, and because the historical records were buried in the victims' silence, the challenge of giving voice to the trauma was considerable. Non-medical approaches were often better suited to providing a space to express this unique form of suffering. Some of the literary works carried out during this era by Taiwanese doctors were jointly created by the 'return-to-reality' generation (discussed in Chapter 5). These young doctors rebuilt their identity as Taiwanese after yet another series of traumatic events in the 1970s. Li Qiao (李喬) was one of the first intellectuals who

[651] Hisao Nakai, 'A Sketch of Dr Tsung-Yi Lin', in Tsung-Yi Lin (ed.), *Road to Psychiatry: Across the East and the West* (Taipei City: Daw Shiang Publishing, 1994), pp. 241-56.
[652] For the function of moral experiences, see Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*.pp. 196-219.
[653] See Chapter 1. Didier Fassin and Richard Rechtman, *The Empire of Trauma : An Inquiry into the Condition of Victimhood* (Princeton ; Oxford: Princeton University Press, 2009) xii, 305 p.

attempted to tell the story of the 2.28 Incident in fictional style, whereas others began their works by documenting the oral histories of victims. In the historical work *Maiyuan 1947 Maiyuan* (埋冤一九四七埋冤), novelist Li Qiao attempted to construct Taiwanese people's postwar *Geistesgeschichte*.[654] Before writing the novel between 1989 and 1992, Li Qiao had conducted archival studies and had collected more than seventy oral histories over more than ten years. His endeavour also originated from the wish to vindicate his father's grief during the 2.28 Incident.[655] Similar to Tsung-Yi Lin's work, Li's work was a process by which the author could 'remove the psychological obstacle' from himself.[656]

According to Li, whereas historical studies might splinter the time and space of historical facts by presenting a 'flat' story, literature could reconstruct the historical scenes by revitalising characters, including their emotions.[657] Nonetheless, Li often encountered occasions when victims did not want to say anything about their pasts, and the families did not want to re-experience the traumatic moments—which had already been appearing in flashbacks even before being potentially triggered by an interview with Li.[658] Li Qiao's early fieldwork, which began in the 1970s, was more successful than the attempts of later researchers in documenting the oral testimonies of victims or their families, including that of Tsung-Yi Lin. Li also claimed that he collected more data about actual casualties than did any official records.[659]

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[654] Here, *Geistesgeschichte* is a concept in the history of ideas, meaning the history of spirit concerned with the undercurrents of cultural manifestations. Within the history of Taiwan, the people had been shaped by their post-war experiences. See Qiao Li, 'The Meaning of "228" Regarding Taiwanese Geistesgeschichte', in Yen-Hsien Chang, Mei-Jung Chen, and Ya-Hui Yang (eds.), *Anthology of the 228 Incident Studies* (Taipei: Wu San-lian Foundation for Taiwan Historical Materials, 1998), pp. 397-408.
[655] Qiao Li, Personal Communication (Miaoli, 2011).
[656] Ibid.
[657] Ibid.
[658] Ibid.
[659] Ibid.

Hsiao-Yen Peng investigated the appropriation of psychological language in Chinese literature during the 1920s. Peng argues that the boundaries between nations and languages do not block the global circulation of new terms and concepts. According to Peng, it is through 'individual free choice' that the translator manages to cross the boundaries of 'institutional practices' to create.[660] In the case of postwar Taiwan, these individuals were not necessarily medical men but intellectuals who possessed the language that had gradually emerged during the years of oppression. These intellectuals often belonged to the 'scarred populations' and could thus enable stories to break through the routine cultural codes and express counter-discourse that 'assaults and even undermines the taken-for-granted meanings of things as they are'.[661] In postwar Taiwan, the taken-for-granted cultural code for trauma was absolute silence. Li Qiao, as a novelist collaborating with psychiatrists during his fieldwork, occupied an appropriate social space to exercise the transcultural transformation of psychiatric language.

Apart from his fictional attempts, Li Qiao further proposed conducting psychiatric research on 'Psychology of the 2.28 Victims and Families'. His proposed methodology was to obtain a sample of actual victims as well as their spouses and secondary and tertiary relatives, both in and outside Taiwan. The participants would be categorised according to age, educational level, and health conditions, with each category containing fifty individuals. A 'standardised questionnaire' would be

[660] Hsiao-Yen Peng, 'A Traveling Malady: The "Malady of the Heart", Scientific Terminology, and the Neo-Sensation School', *Bulletin of the Institute of Chinese Literature and Philosophy [Zhong Guo Wen Zhe Yan Jiu Ji Kan],* 34 (2009), pp. 205-48.
[661] Veena Das, 'Revisiting Trauma, Testimony and Political Community', in Veena Das (ed.), *Life and Words: Violence and the Descent into the Ordinary* (Berkeley, Los Angeles, London: University of California Press, 2007), pp. 205-21.

administered by a psychiatrist or physician to measure the participant's psychological manifestations, psychiatric disorders, personality, social and economic status, political attitudes, and his or her views of life.[662] However, this study was never pursued despite an effort by several psychiatrists.[663] Psychiatrists did recognise the powerful effect of the 2.28 Incident, and the extension of its legacy over the next four decades due to the government's methods of ruling through fear and political suppression. However, no useful measures could be devised to gauge this unnameable anguish, which the psychiatrists themselves had also endured.

A Case of Torture Trauma that Needed No Treatment

Apart from the endeavours among clinicians and creative writers, victims of political violence also called attention to the issues of psychological rehabilitation among detainees and their families. Tsung-Min Hsieh (謝聰敏，1934-), who initiated 'A Declaration of Formosan Self-salvation' in 1965 with three other activists, was sentenced ten years in prison for treason. Since then, he was imprisoned for two more times different charges fabricated by the Chinese Nationalist government. While in jail, Hsieh experienced a wide raged of tortures and began to study not only physical but also psychological influences caused by detentions.[664] After discharge, while elected a legislator during the pinnacle of *dagwai* (黨外) movements, he began to collect scholarly research into torture worldwide in order to create an act that could

[662] Qiao Li, 'Fragments of the 2.28 Studies: Excepted from the Data Collected for Maiyuan 1947 Maiyuan', in Yung-Hsing Chen, Yen-Yu Chen, and Hui-Ling Hu (eds.), *Proceedings of the 2.28 Incident Academic Research Seminars* (Taipei: 2.28 Public Research Group Taiwan-US Cultural Exchange Foundation Modern Acadmic Research Foundation, 1991), pp. 209-27.
[663] Li, Personal Communication.
[664] Tsung-Min Hsieh, *The Reminiscences of Tsung-Min Hsieh*, ed. Yen-Hsien Chang (Taipei: Academia Historica, 2008).

compensate not only the bodily but also psychological injury rendered by political injustice. Such effort did not win enough supports due to, according to Hsieh, the incapable accountability of modern psychiatric diagnoses and the fear among victims that prevented them from voicing out their own suffering.[665] According to Hsieh, after he was released from prison, for the first two to three months he was not able to answer specific answers to particular questions. Under great pressure, he could only provide approximate answers to questions. Seeking help from Dr Ying-Kuen Yeh, he was reassured by the psychiatrist that because of his insight, his symptoms were not coded as any single one psychiatric diagnosis, for the external reality that caused the ailment were obvious.[666]

Reconciliation: The pursuit of a Minority

Not all SVFs supported psychiatrist Tsung-Yi Lin's prescription for the 2.28 Incident. They had diverse opinions about what victims ought to do, especially regarding the social responsibility so strongly emphasised by Lin. In the early 1990s, Tsung-Yi Lin joined the task force organised by the Executive Yuan of the Taiwan Government on behalf of the SVFs, without consulting them or asking for their opinions. He was criticised for being arbitrary.[667] Lin did not intend to compromise with the government, but attempted to impose his ideas about reconciliation on all SVFs. Later, he published a public memorandum in which he stated that 'the construction work was not only right but also obligation of all Taiwanese citizens…The cohesiveness among victims was based on our common miserable

[665] Tsung-Min Hsieh, 'Personal Communication', (Linkou, 2012).
[666] Ibid.
[667] Reporter, 'Tsung-Yi Lin was Doubted by Victims' Families', *Tzuli Zaobao,* 1 June 1993a.

experience, instead of our diverse original wills'. He further stated that two years after starting his research on the Incident, he had been aware that 'some families already used the 2.28 Incident as a right to hurt other people', suggesting that victims could also become perpetrators.[668] In the memorandum, Lin asserted that the most important task 'for now, is to interview more families, in order to soothe the sorrows, walk out from the shadow of the history, and to exempt the descendants from the fear of the 2.28 trauma'.[669]

Long-term oppression had caused psychological indifference in Taiwanese citizens.[670] The phenomenon is well illustrated in a famous poem, 'From the Day On', written by physician Tsu-Te Chiang (江自得): 'From the day on/ We lost ourselves/ We own nothing/ But indifferent life/ And indifferent death'.[671] According to Li Qiao's recordings during his fieldwork, 70% of Taiwanese people became absolutely indifferent and silent, 20% drew closer to the authoritative dominators, 5% became latent rebels, and another 5% fled Taiwan.[672] In addition, psychiatrist Yi-Fu Lin (林毅夫) observed a certain masochism amongst the Taiwanese people.

Yi-Fu Lin assumed that the structure of PTSD could simply be applied to Taiwanese people's postwar experiences. First, oppression by the Chinese Nationalist government had continued for half a century after the 2.28 Incident. The chronic fear which Taiwanese people experienced was a result of the government's 'post-2.28

[668] Reporter, 'Tsung-Yi Lin Clarifies Himself by Publishing Public Memorandum', *Tzuli Zaobao,* 17 June 1993b.
[669] Ibid.
[670] Amongst political detention cases, 90% occurred before 1970. See Nai-Te Wu, 'Transitional Justice and Historical Justice: The Unfinished Career of Democritisation in Taiwan', *Reflexion [Si Xiang],* 2 (2006), pp. 1-34.
[671] Tsu-Te Chiang, 'From the Day On [Cong Na Tian Qi]', in Tsu-Te Chiang (ed.), *That Day, I Touched Your Wound* (Kaohiung: Li Poetry, 1990).
[672] Qiao Li, *The Ugly Features of Taiwanese* (Taipei: Avanguard, 1989). p. 39.

behaviours'. [673] Also, SVFs and nearly all Taiwanese populations exhibited indifference about politics and withdrawal from social life. Lin further proposed 'Stockholm Syndrome' to describe those who sympathised and identified with, or depended on, the perpetrators.[674]

The above discussion suggests the depth of the problem which most Taiwanese encountered when trying to name the violence perpetrated against them. Veena Das argues that such naming has a large political stake, and not only because language falters in the face of violence. According to Das, the complex knotting together of several kinds of social actors in any event of collective violence makes it difficult to determine whether the event should be deemed sectarian, communal, or state sponsored.[675] In the case of the 2.28 Incident, Tsung-Yi Lin recalled his mother's reminder: '[W]e need to prepare for the long-term fight against the violent government'.[676] This statement had long imprinted itself in Tsung-Yi Lin's mind.[677] In Lin's political prescription, the 'violent government' became the 'KIMG Complex' which he sought to combat and eventually reconcile with.[678] However, many victims of state violence were unable or unwilling to adopt such a strategic approach, and instead attempted to play things safe and remain silent so as to survive. For these SVFs, the government was the perpetual perpetrator. It was the 'local cultural world',

[673] Yi-Fu Lin, *The Psychoanalysis of Taiwanese Masochism* (Taipei: Avanguard, 2004). pp. 44-45.
[674] Ibid. p. 128.
[675] Das, 'Revisiting Trauma, Testimony and Political Community'.
[676] Tsung-Yi Lin, 'Mother', in Hui-Ling Hu (ed.), *Daoyu Ailian (Love Stories on the Island)* (Taipei: Yu-Shan Books, 1995a). p. 50.
[677] Ibid.
[678] For the KIMG Complex, see Chapter 5.

a ‘gray zone in which the moral norms and normality of everyday living, not just pathology’ generated dismay, desolation, and despair.[679]

For Tsung-Yi Lin and other psychiatric activists, their prescription was not only a scientific pursuit and professional practice, but also reflected the ethics of responsibility. By naturalising the SVFs’ suffering as a collective trauma of the Taiwanese people, these doctors intended to find a feasible solution to the originally unaccountable trauma under the framework of their psychiatric discipline. Yet their idealistic prescription remained unpopular. The psychiatrists’ role as diagnostic critics remained elite and separate from the reality of the Taiwanese people, who had largely remained obedient to authority. The interpretation of the 2.28 Incident remained vague and diverse,[680] and the work of transitional justice in Taiwan stagnated.[681]

Conclusion

Psychological trauma is the pathological reaction of individuals or collectives to external traumatic events. Theories about trauma have evolved throughout history according to different social contexts, cultural constructs, functions, and purposes. In this chapter, I have focused not on the evolving psychiatric discourses but on the individual or collective subjects who have experienced trauma, and on bringing these individuals into historiographical discussions. To this end, I define trauma in the broadest sense as the emotional response of humans to extreme life experiences. I

[679] Kleinman construes Holocaust survivor Primo Levi’s ‘grey zones of life where ordinary men and women end up doing terrible things’. Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. pp. 214-15.
[680] Li, Personal Communication.
[681] Nai-Te Wu, 'Is Evil Banal? Problems of Obedience to Authority', *Thought and Words: Journal of the Humanities and Social Science,* 47/3 (2009), pp. 1-25.

eschew the precise definitions of shell shock, war neurosis, PTSD, and other forms of 'scientifically verified' disorders, in the hope of ongoing dialogue that will reveal the historical significance of such terms in complex transnational settings.

The above three case studies illustrate an intricate web of trauma pathology interwoven with a variety of social, historical, and cultural determinants across different time frames, even within the same geographic area. Similar psychopathological manifestations, as diagnosed by different people with different cultural rationales and different purposes, may turn out to be different diseases (e.g. neurasthenia, psychogenic reaction, and psychoneurosis). On the contrary, similar disease designations defined under different circumstances of time and space might denote actual differences in subject matter (e.g. traumatic neurosis, PTSD). The three case studies which I have presented illustrate how the vicissitudes of psychological trauma, from Japanese colonial times to postwar standardised modern psychiatry, varied from the following perspectives.

First, the cases demonstrate the transformation of psychiatric services from inquiry into causation (i.e. psychopathology) to intervention. In the first section of this chapter, apart from diagnosing those who experienced the earthquake, doctors did not mention useful treatment other than trying to explain the patients' unique disease manifestations. In the second section, during the early postwar turmoil, psychiatrists assumed that the dramatically varying population composition, language shifts, ethnic conflicts, migration experiences, and the sudden change of social and economic status were stressors that inflicted pathological and psychological reactions in their patients. In the third section, modern psychiatry (after it had been institutionalised) was

unconcerned about the social origins of the trauma of people who were victims of political violence, and it could not provide those patients with adequate diagnosis, description, or treatment. Their long-term suffering was not even recast as PTSD. Under these circumstances, Taiwanese psychiatrists sought to intervene by means of propagating their own idiosyncratic role as diagnostic critics.

Second, the case studies reveal an exchange in the power discourse between the persons who diagnose and the victims. In the first section, Japanese psychiatrists documented a group of voiceless earthquake victims who did not leave behind any subjective reports other than doctors' objective statistics of their physical symptoms. By interpreting the statistical numbers, the doctors diagnosed certain pathologies according to the definitions provided by colonial psychiatry. In the second section, patients began to speak. In the context of language shift and cultural change, doctors with limited professional training tried to 'translate' the patients' verbal complaints into significant disease categories. In addition, unequal language capacities and socio-economic statuses confounded the accessibility to psychiatric services among those who needed professional help. In the third section, the maturation of modern psychiatry in Taiwan meant that psychiatrists were capable of using psychiatric language in clinical settings, and employed such terminology in their practice. Modern psychiatry's pursuit of precision and exactness, however, meant that no pre-existing diagnosis could account for the suffering of the Taiwanese people, unique and momentous as it was within the local culture.

Third, these cases further demonstrate the search for rationalism among medical professionals in a developing society. The first section showed how by comparing

their patients' symptoms with those described in German military psychiatry, these Japanese doctors tried to reflect on the meaning of physical symptoms they observed. However, the context was quite different from that of the German military, namely a natural disaster in an East-Asian colony. In the second section, against the backdrop of drastic cultural and social transformation, doctors endeavoured to look for a legitimate position for their patients, to alleviate their suffering. In the third case, the reality of treating victims, perpetrators, and rescuers within one single compact structure meant that the sufferers were left unattended, unaccountable, and uncared for.

An adequate description for the mental disorders of victims of long-term political violence was not provided until Judith Lewis Herman coined the term 'complex-PTSD' in 1992.[682] However, that term has not yet become a standard diagnostic classification in modern psychiatry. 'Trauma' is now part of the globalised political rhetoric, yet as a diagnosis it is only valid or convincing among limited populations at local levels. In Taiwan, although PTSD is now an official psychiatric disease, it only became recognised as such towards the end of the 20th Century when an earthquake killed more than 2 000 people and injured more than 10 000.[683] This late development may explain the restricted transnational application of traumatic psychiatry, and may also suggest the need to reconsider the endogenous epistemological issues of psychological trauma. According to Arthur Kleinman, the subversive approach adopted by Taiwanese activist-psychiatrists illustrates the complex relationships between the moral, medical, and political spheres of everyday

[682] Judith Lewis Herman, *Trauma and Recovery* (London: Pandora, 1994) xi, p. 276.
[683] Reviewing the online database of the *Taiwanese Journal of Psychiatry* from its inauguration in 1975 to 2007, only two articles related to trauma could be found, both associated with the Chi-Chi Earthquake in 1999.

life. In examining Taiwan's unique social circumstances, Kleinman argues that these complex relationships can explain the source of pathology, and would either enable or block the possibilities of therapeutic transformation.[684] The social practices of the psychiatrist, in Kleinman's words, attempted to '[make] social change possible as a source of prevention, repair, and remaking of a local world'.[685] Whether or not these efforts succeeded in resolved the social suffering among Taiwanese people remains controversial, and can only be judged as time unfolds.

[684] Kleinman, *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. p. 212.
[685] Ibid. p.212.

CONCLUSION

This thesis has explored the conceptualisation of trauma, as a psychiatric concept, together with other standardised psychiatric diagnoses which emerged and were disseminated in the context of world psychiatry after World War II. I have focused on ways in which the concept of trauma was received, applied, and appropriated in the non-Western context of Taiwan. My thesis demonstrates that trauma, a much-debated concept in the history of medicine, was globally diffused by at least three trends. First, mental health experts who witnessed the price paid by human beings in World War II, and the postwar socio-cultural changes, were prompted to investigate the aetiology of mental illnesses. Based on the aspiration of world citizenship, these professionals envisaged international collaboration in psychiatric research. In this phase, trauma was still a vague concept. Second, the emerging international organisations, such as the World Health Organization analysed in my thesis, provided a platform for international collaboration and mobilised a unique form of knowledge production. The common language programme and the attempt to unify psychiatric disease profiles laid an important foundation for diseases to be recognised, classified, and treated worldwide. Third, although the paradigm of modern psychiatry had been established, the world standards or psychiatric norms were unable to fully account for extreme forms of social suffering in local contexts such as that of Taiwan. These local contexts, which included ongoing civil wars, dictatorships, and large-scale natural disasters, were largely ignored by international organisations. Local experts therefore had to appropriate the standardised norms in their own idiosyncratic ways. My thesis illustrates how Taiwanese psychiatrists

adopted various non-medical approaches to address the suffering among Taiwanese people due to political violence.

This thesis contributes to several scholarly fields, particularly those of trauma study, the history of psychiatry, transnational history, and the history of contemporary China/Taiwan. In terms of methodology, it uses several first hand materials that were not available to earlier research. The most important sources of my data were the historical archives at WHO concerning its mental health projects, and the patient registries of NTUH Psychiatry Department—which had not been accessed at all before 2009. This thesis also examines the oral accounts of local psychiatrists, who provided me with detailed descriptions of the ways in which they appropriated modern psychiatric discourses and transformed them into political tactics to meet local needs. Such practices could never be uncovered by simply looking at medical sources or resources. Combining the sources of international organisations with those provided by the local context, I was able to examine a historical theme beyond the scope of a single state. This vantage point surpassed the limitations of traditional 'world' or 'international' history, which ignore the subtle dynamics between the world context and the local context.

As for the theme of psychological trauma, this thesis has examined the globalisation of the concept of trauma within the postwar world context. Such globalisation has often been observed by scholars of trauma studies, but without their explaining how it actually occurs. This thesis provides a global and civilian genealogy rather than western military discourses that have prevailed the field of trauma studies. It also provides a contextual analysis of the consensus between humanitarian and

medical discourses regarding the concept of trauma. Finally, this thesis contributes to an emerging approach of transnational history by demonstrating how medical knowledge was imagined, realised, and practiced both globally and locally, and in what kinds of social and cultural contexts. This analysis enriches our understanding of the functions and limitations of otherwise presumed world standards.

Nowadays, historians of psychiatry have begun to probe into non-Western areas, mostly to illustrate the clash between East and West. My thesis, instead, provides an account of intellectual history at the transnational level, in which medical knowledge was not only mutually constructed between East and West but was also realised in the development between the global North and South. North and South in this context do not indicate a geographical notion that is meaningful for spatial analysis, but rather a socio-cultural concept that was prominent in the postwar world order and was used to guide the development projects of so-called latecomer countries. Echoing other historical writings about WHO, my thesis provides the first historical analysis of the global project of mental health programmes. The mental health research confirmed the conclusions reached in studies on malaria and other infectious diseases concerning the cultural clashes that obstructed WHO's projects. This study also historicises the global efforts of disease classification; it puts forward the origin of global psychiatric epidemiology to the period of 1940s under the international political and cultural circumstances, much earlier than it was generally assumed by clinicians and epidemiologists. In addition, It also allowed Taiwan, a state which had long been considered peripheral to international society, to be actively incorporated into the WHO's early enterprises. This accommodation was made possible by the limited conceptualisation of Taiwan and China in the context of the Cold War, and the

inadequacy of the WHO's bureaucracy. My analysis shows how a developing country aspired to concatenate itself with the world stage through scientific research and acceptance of international standards, and then loosely coupled those standards to the local historical, social and cultural contexts.

Discussing the differences between Western and Chinese mental health, historian Helaine Selin and Hugh Shapiro argue that Chinese medicine cannot be understood in Western terms.[686] This thesis, nevertheless, demonstrates that the much-criticised 'hegemonic' Western terms were constructed mutually by scholars from both the East and West. This collaboration can be traced back to the immediate postwar period.[687] As for the aftermath of these collaborations, I found no consensus among my interviewees concerning the validity or use of world standards for psychiatric diagnoses in Taiwanese society. Most of the people I interviewed were from the first generation of Taiwanese psychiatrists as well as Tsung-Yi Lin's students. In 1981, while celebrating the twentieth anniversary of the Chinese Society of Neurology and Psychiatry, Rin Hsien (林憲) had pointed out that there was confusion as to whether Taiwan should fully adopt the DSM-III or ICD-9 systems, or develop its own disease classification system that would be more suited to Taiwanese society. When I interviewed Rin in 2009, he complained that the diagnosis of PTSD should not even exist. He said, 'If there is such a thing called PTSD, aren't people of my generation all PTSD patients?'[688] What Rin referred to was the hardship of living and the harsh political context his generation commonly experienced and survived,

[686] Helaine Selin, Hugh Shapiro, and Springerlink (Online Service), 'Medicine across Cultures History and Practice of Medicine in Non-Western Cultures', *Science across cultures.* (Dordrecht ; Boston: Kluwer Academic Publishers, 2003), xxiv, 416 p.
[687] For a criticism of hegemonic Western psychology, see Yang, *How to Study Chinese? [Ruhe Yanjou Zhongguoren]*.
[688] Hsien Rin, 'Personal Communication', (Taipei, 2009).

relatively unharmed. In my personal communication with Hisao Nakai (中井久夫), also one of Tsung-Yi Lin's students in Japan, this ex-director of Hyogo Institute for Traumatic Stress admitted to me that he 'had never been a specialist of "psychological trauma"'.[689] The establishment of an institute specialising in trauma was a logistical response to the Kobe Quake in 1995. This anecdote illustrates the ruptures between world standards and local contexts, which still stand in the face of globalisation today.

The discontent of world mental health that is touched upon in Chapter 4 presents another promising area for further exploration. The conclusion of chapter 4 challenged the idealistic notion of world citizenship that infused the international collaboration in scientific research during the early postwar period. Today, researchers of mental health have abandoned the *a priori* of the global community as a single ethnicity. Instead, they have pursued discussions about subjective experience and the construction of cultural selves. This aspect of global mental health research has been heavily informed by anthropological studies worldwide. As argued by anthropologist Aiwah Ong, globalisation did not lead to the denationalisation of citizenship, but brought about specific articulations between national citizenship and transnational norms. It also promoted the growth of non-state spaces where transnational institutions could protect people on the grounds of their humanity rather than along citizenship lines.[690] Chapter 5 of this thesis demonstrated the strong linkage between globalised norms of trauma and its localised transformation for the purpose of humanitarian claims. Similarly in Taiwan, a country with limited

[689] Hisao Nakai, 'Personal Communication', (Kobe, 2008).
[690] Aihwa Ong, 'Citizenship in the Midst of Transnational Regines of Virtue', *Political Power and Social Theory,* 20 (2009), 301-07. Also see Aihwa Ong, *Flexible Citizenship : The Cultural Logics of Transnationality* (Durham: Duke University Press, 1999) ix, 322 p.

psychiatric services, the concept of trauma was 'renovated' by mental health professionals as a political discourse to resist state violence.

In addition, psychiatric epidemiologists have been developing approaches that combine 'etic' and 'epic' perspectives of enquiry. Since the 1960s, the Cornell School of epidemiologists has been testing this combined approach, although their work remained unpopular until recently.[691] The etic approach, according to the linguistic anthropologist Kenneth Pike, relies on extrinsic concepts and categories that have meaning for the scientific observer. The methodology employed by the mental health experts at the Headquarters of WHO, which sought absolute objectivity and numerical rationality made possible by advanced technology, is a classic example of this philosophy. By contrast, the emic perspective focuses on the intrinsic cultural distinctions that are meaningful to the members of a given society. This approach is currently gaining the attention of psychiatric epidemiologists who are aware of people's subjective perceptions of external stimuli. Regarding studies of trauma, scholarly consensus is growing that trauma is not a unanimous reaction against adversity. Instead, trauma manifests in a variety of ways according to different cultural contexts and differences in individual resilience.

The findings of this thesis echo one of the remarks made by Professor Norman Sartorius, who continued Tsung-Yi Lin's works in WHO. He commented on the common language project and the epidemiology project he was involved in, saying that '[I]n the past 20 years, the rapid appearance of new technologies had caused our delay in accumulating adequate data, in order to help us verify the evidence

[691] James A. Trostle, *Epidemiology and Culture* (Cambridge Studies in Medical Anthropology; Cambridge, U.K. ; New York: Cambridge University Press, 2005) xvii, 208 p.

supporting the concepts and entities of diseases.' He also remarked that 'The growing distance between neuroscientists, clinicians and epistemologists has also created problems.'[692]

Allen Young wrote that trauma, as a psychiatric diagnosis, was 'glued together by the practices, treatments and representations of individuals and professionals to serve their own interests'. According to Young, trauma also describes the subsistence of human suffering. The proliferating categories of diseases, according to Sartorius et al., are 'service languages' that are necessary for people to survive the legalities, insurance systems, and other challenges of modern life.[693] In this thesis, I have not only echoed Allan Young's constructivist view, detailing how diagnoses of trauma have been established and standardised according to various purposes in the postwar context of world health governing, but also how the regimented criteria of trauma found its limitation in wider contexts. Finally, I particularized how trauma in Taiwan was appropriated in various ways to respond to unique forms of suffering according to its ecological niche.

This thesis to some degree provides a historical reference for the ongoing work of psychiatric disease classification. Assen Jablensky, the Australian psychiatric nosologist who participated in the classification work of WHO, states that disease classification is a complex matter. It has included both achievements and conflicts in the development of modern psychiatry. At the time of submitting this thesis, the ICD-11 (WHO) and the DSM-V (APA) were both due to be published soon. While the

[692] Norman Sartorius, A. Jablensky, and D. A. Reigier, *Sources and Traditions of Classification in Psychiatry* (Bern: Hogrefe and Huber Publishers, 1990).
[693] Assen Jablensky, 'Beyond Icd-10 and Dsm-Iv: Issues in Contemporary Psychiatry', in Giovanni De Girolamo and N. Sartorius (eds.), *Promoting Mental Health Internationally* (London: Gaskell, 1999), 47-56.

ICD attempts to reduce the number of disease categories to simplify the treatment principles, the DSM endeavors to locate diseases across a spectrum that covers all aspects of human psychology. Newer classification attempts have been criticised as benefiting pharmaceutical companies and other interest groups.

Trauma-related disorders, which are expected to form an independent category of psychiatric disease in the new editions, are likely to develop a capacity to account for an increased range of suffering. However, this increased complexity is associated with more numerous problems in clinical application. Kenneth Kendler, member of the DSM-V taskforce, points out that the design of new psychiatric classification systems will be dimensional instead of categorical. This principle corresponds with the concept of 'iteration' raised by the philosopher of science, Hasok Chang. Chang describes an iterative system as a mathematical method which does not pursue single but approximate solutions, and can repeatedly enrich and self-correct facts that have been previously verified.[694] This new paradigm, in addition to avoiding the flat and arbitrary nature of scientific measurement, is expected to meet the demands of ever-changing modern society.

However, my thesis has provided evidence that the rapid development of humanitarian psychiatry occurred much earlier than Fassin's observation concerning the international dissemination of new nosographic categories such as PTSD. It emerged right after World World II in the form of international collaboration on

[694] See Kenneth Kendler, 'Alternative Futures for the Dsm Revision Process: Iteration V. Paradigm Shift', *British Journal of Psychiatry,* 197 (2010), 263-65.; Hasok Chang, *Inventing Temperature : Measurement and Scientific Progress* (Oxford Studies in Philosophy of Science.; Oxford ; New York: Oxford University Press, 2004) xviii, 286 p.

mental health research, which created a common language of mental diseases and the of their universally-recognised profiles.

Drawing from his ethnological work experience in global medicine, anthropologist Didier Fassin assumes that 'those who intervened in the international situations in which humanitarian psychiatry had received no training and had no particular expertise in the field of trauma'[695], my thesis has given reasons that are historically attributed to, that experts who attempted to intervene the worldwide postwar trauma have targeted the wrong subjects. Their researched patients in the hospitals while the devastations were mostly outside. They imagined that they were fathoming a useful measure to endure peace while various forms of violence were still ongoing. Fassin states that '[i]t was only after encountering situations and symptoms related to traumatic events that they discovered, often by chance, that the clinical pictures they were observing could fit into the new classification.'[696] In this thesis, the way Tsung-Yi Lin and his collaborators dealt with SVFs of the 228 Incident provides an example arguably fits this supposition.

Finally, the account contained in this thesis of the global approach to disasters provides useful lessons for psychiatric professionals and humanitarian workers. Confronted by modern catastrophes such as the recent disasters in Japan, which included earthquakes, tsunamis, and nuclear fall-out at Fujushima, it is evident that clinicians are aware of the dangers of having too much technological knowledge but too little power to act. The structures of institutionalisation and 'disciplinism' within the psychiatric sciences may prevent professionals from being able to play an active

[695] Fassin and Gomme, *Humanitarian Reason : A Moral History of the Present Times*. p. 205
[696] Ibid.

role in the course of scientific development. If that happens, such professionals may lose sight of the temporal nature of society, and may feel unable to take effective action because of restraints imposed by clinical standards and guidelines. My thesis has merely told a story. More oral and archival sources need to be unpacked by historians so that we can learn more about the transnational histories of trauma, with all of its various causes and origins within different cultural contexts.

Although my research fulfilled its original objectives, it was subject to three main limitations. First, because of the time limit and the research budget, the sites where sources were identified and collected were restricted to the UK, Switzerland, and Taiwan. A depiction of all trajectories of knowledge transformation between the international organisations and local contexts would only be possible by exploring all relevant local archives worldwide. Second, my research data represented only the opinion of experts, rather than those of the victims of trauma. My data sources included scientific projects, correspondence, and oral history accounts, all of which represented the views of experts who possessed certain language skills before they became theory producers. Voices among the users of psychiatric services, or sufferers who had no access to such services, were left unattended. Without their voices, one cannot determine how extensively the ideas of modern psychiatry (especially that of trauma) may have been diffused into the local context, or appropriated transnationally under diverse local circumstances. Third, at the epistemological level, if local traumatic experiences cannot be represented at all by various styles of suffering observed in this thesis, and cannot be at al revealed by verbalisation or textualisation of sufferers' experiences, then it takes efforts for historians of trauma/psychiatry to identify more suitable sources in order to tell a more compelling story of trauma.

Appendices

Clinical Notes[697]

Weishui Chiang (蔣渭水)

Translated from Japanese to Chinese by Peng Fengxian

Translated by Steven L. Riep

Prepared for the patient named Taiwan

Name: Island of Taiwan Gender: Male

Age: Since moving to current place of residence, twenty-seven years

Place of origin: Taiwan District, Fujian Province, Republic of China

Present address: The Government-General of Taiwan, Empire of Greater Japan

Occupation: Prime strategic point guard for world peace

Lineage: Obvious lineal ties to the bloodline of the Yellow Emperor, Duke Zhou, Confucius, and Mencius

Talents: As noted above, the descendant of sages and worthies, strong and healthy with a natural endowment of wisdom

Past medical history: In his childhood, during the time of Zheng Chenggong, the patient was strong in stature, keen of mind, strong-willed, lofty in moral character, and nimble of action. Since the Qing Dynasty, after having been poisoned by political policies, he grew weaker by the day; his will deteriorated, his character grew despicable, and his moral integrity became increasingly debased. After relocating to the Japanese Empire, he received unsound medical care and, although there was some improvement, after about two hundred years of slow poisoning, it has been difficult to successfully treat him with drug therapy.

[697] Weishui Chiang, 'Clinical Notes', *Taiwan Literature English Translation Series,* 2007/20 (January 2007), 125-28. Originally published on 30 November 1921 in *Taiwan Wenhua Xiehui Huibao* [Bulletin of the Taiwan Cultural Association].

Current symptoms: Moral values decayed, sense of humanity spoiled, excessive desire for material goods, lacking spirituality, customs polluted, submerged in superstition, thick-headed and stubborn, completely lacking in basic hygiene, shallow in knowledge, no sense of a long-range plan, concerned only with seeking short-term profit, degenerate and indolent, corrupt, debased, neglected, vain, lacking in modesty and a sense of shame, exhausted and slack in all four limbs, overcome by inertia, dejected in spirit, and no vitality to speak of.

Patient's complaint: Neck pain, dizziness, and hunger pains.
For the most part this is an accurate assessment of the patient. During the examination it was discovered that, commensurate with his size, he had quite a large head, which presumably would indicate a strong capacity for reasoning. Several questions were posed to test his general knowledge, but his answers showed that he failed to grasp the main points of the questions, indicating that the patient is either foolish or mentally retarded. Although he has a large skull, its contents are suspect and he seems to lack sufficient intelligence. When he was asked more challenging questions about philosophy, arithmetic, science, and world affairs, he became dizzy.

Yet his arms and legs are well-developed, due, perhaps, to excessive hard labour. Further examination of his abdomen revealed it to be small and sunken, with the surface covered by row upon row of wrinkles shaped by the intestinal walls, which look exactly like the stretch marks on women who have just given birth. This characteristic is presumably attributed to the Great War that began in Europe in 1916 [sic. 1914]. The patient reports that for a time his abdomen expanded, but last summer's news of peace talks led to a bout of intestinal flu that worsened and became dysentery, which caused the abdomen to contract.

Diagnosis: A mentally retarded child of world culture

Aetiology: Poor intellectual nutrition

Course of Illness: Contracted a long-term chronic illness

Prognosis: Because the patient's basic constitution is good, if given proper medical treatment, he should recover quickly. If, however, the wrong treatment is given or proper treatment is delayed, the disease will attack the vital organs and will likely lead to death.

Treatment: Causal treatment will provide a radical cure.

Prescription: Normal school education: maximum dose; supplementary education: maximum dose; kindergarten: maximum dose; library: maximum dose; newspaper reading club: maximum dose.

If the treatment regimen outlined above is commenced immediately as instructed, a full recovery can be expected in twenty years. Other effective medications are omitted.

Clinical Notes No. 2[698]

Yung-Hsing Chen (陳永興)

Translated by Harry Yi-Jui Wu

Patient: Non-KMT [*Dang-uai*] individuals
Name: Tong-oa-e [Romanised Taiwanese]
Gender: Male or Female
Age: Old or Young
Address: Everywhere on Taiwan Island
Occupation: Democratic movement

Chief Complaint: low mood; agitation; poor memory; feeling anxious for the past thirty years, aggravated for the past half year.

Body Nature: Obviously inherited with qualified body constitutions of Taiwanese prophets, such as Lin Xiantang, Tsai Huiju, Chiang Weishui, Tsai Shigu, Lai He… and other anti-Japanese forerunners.

Past Medical History: These patients were still children when World War II ended and remained youths during the immediate postwar period. Due to their poor economic status, bad environment, and poor nutrition, they grew more slowly than normal people. An unknown disease caused massive casualties. Luckily, surviving individuals have inherited the body constitutions of their ancestors. They were good looking, loud in voice, eloquent in speech, decent in morals, and bold in wills. They were able to learn from the examples of ancestors. They were beloved by local elders and siblings. They grew up to be sympathetic, caring, and ready to stand up for others. Their spirits were full of democracy, freedom, justice, and human rights. They were zealous for the common good. They used to call themselves 'independent from any political parties', and in every election devoted themselves to supporting heroic but tragic characters. While speaking out for the general public, they used to break taboos of speech. They were lucky enough to be elected as a representative and then played

[698] Yung-Hsing Chen, 'Clinical Notes No. 2', in Yung-Hsing Chen (ed.), *Contemplation in Berkley* (Taipei: Tzuli Evening News, 1982), 113-18.

their roles in a challenging situation, battling against heavy odds. They were called ‘cannons’, ‘mortars’ and ‘king-kongs’. In reality, they felt as desperate as dogs barking at passing trains. Once they fell from election or were pressed to stand down as administrators, they felt frustrated. Some of them spent their lives behind bars. Some became depressed to the point of death. Some went abroad and never returned. Such stories were often heard one after another. They were the best examples of miserable lives.

When they grew older, realising that it was never going to be possible to foster democracy simply with brawn rather than brain, some of them published magazines in an effort to waken the public. They advocated ideas about human rights. They gathered to form a political opposition party, but in vain. Frustrations came in droves and led to their ruin. Their courage was recovered only after a long period of resting. Now the international situation has changed (Taiwan was pulled out of the United Nations and lost numerous political allies). Recent times have also seen changes in the internal affairs. Opposition movements gradually regained their vitality. ‘*Dang-uai’* individuals began to reappear in the streets. Numerous kinds of magazines came into being, and the flags and flyers at election time were novel and touching. Books were published to convey the patients’ ideals and ambitions. They became better at organising themselves, and better at propaganda. Democratic movements have entered the phase of ‘a new age created by the young generation’. In the mass movements of people arriving in droves, limitations and obstacles did not deter our patients from achieving even higher goals. Barriers to information and other forms of frustration merely fuelled their passion to bravely carry on. Some of them hoisted the torches of human rights. Some of them sang out songs from their hearts. Some of them lit up the flame of democracy. Some of them cheered while weeping. Some of them began to see light and hope. Meanwhile, however, some of them began to feel unlucky and anxious. Some of them thought of dreadful past experiences, and some smelled messages of danger. Some of them spread their warnings and cautions. Some of them wept or cried softly. Nevertheless, democratic movements were surging. How could they dismiss them?

Unfortunately, bad luck fell on them again. Thunder woke those who were asleep. Some of them either escaped or wept behind doors. Sickened bodies were left uncared

for, their faces haggard. They lost weight and their eyes were sunken. They would probably die young. Who knew when there would be another shock, like a cold-blooded devil that kills? This blow was an unprecedented catastrophe. It carried away their will and courage to survive. Rationality and hope in the human world seemed gone. Their hearts were broken. The ailment has taken everything away, leaving the patient unable to recover in health.

Present Illness: Surviving the catastrophe, the *dang-uai* was short of breath. Wretched and exhausted, they suffered from low mood caused by the exploitation of vitality. They often showed sorrow, agitation and tears. They lost interest in themselves and the people around them. They felt uneasy and bewildered about the future, and lacked a sense of safety. They feared that someone was going to harm them. They experienced anxiety, fear, horror, withdrawal, loneliness, psychomotor retardation, loss of appetite, unstable sleep, nightmares and terrors. After a period of suffering they were blessed by Heaven and cared for by their siblings. They recovered their vigour at approximately 20% to 30% of their previous customary levels. They became more outgoing, and cried less. But in the past few months their memory has deteriorated. They cannot remember how they experienced extreme torment. They have become bad tempered, irritable, impulsive and impatient. They have also become self-righteous, arrogant, and paranoid about rumours and possible betrayal by their friends. They are influenced by emotions in their handling of everyday situations. They feel jealous of their rivals in many affairs. They flaunt their superiority and exhibit power without temperance. These behaviours run contrary to the patient's own pure and humble nature, as if they have become someone else. They are not mindful of their own future or that of their comrades. Those who still care about their own situation are waiting to recover their vitality and confidence. They want to cooperate with others. They are so worried and agonised about the above symptoms that they have come for medical help.

Diagnosis: Political Neurosis

Aetiology: Long-term ill adjustment to the political environment

Course of illness: chronic, accumulated over the past months and years.

Prognosis: Because of their strong constitutions, if the patients are given suitable treatment in time, a good prognosis is expected. On the contrary, if left uncared for, ignored, or punished, their symptoms will be aggravated. Delayed therapy will result in terminally illness and an unthinkable outcome!

Prescription: On the one hand, to treat the fundamental causes of the disease, the unsatisfactory environment should be improved. On the other hand, the patients need long-term support, courage, assistance, and guidance to mature their personality and help them to adapt to their environment. If their symptoms have already affected their daily life and work, sedatives should be given. Medication should be augmented with in-depth and active psychoanalytic psychotherapy, so that they can comprehend and face their own unconscious complexes, release their discontents or impulses, and purge their anxiety and fears. This psychotherapy will not only ameliorate their superficial symptoms but will also help them to explore underlying problems, overcome their own obstacles, grow healthier and more active personalities. Hopefully the treatment will exempt them from the agony of illness, so that they can pursue their ideals and goals worth fighting for!

Psychiatrist
Yung-Hsing Chen
15 July, 1982

Archives Visited

Switzerland

Geneva

The World Health Organization Historical Collections and Archives

Mental Health Section

Director-General Office

United Kingdom

London

Institute of Psychiatry Archives, King's College London Archives

Papers of Aubrey J. Lewis

Camberwell Psychiatric Case Register Records

London School of Hygiene and Tropical Medicine Archives

Various Papers related to Donald D. Reid

Queen Mary, University of London Archives

Eileen Brooke collection (GB 0370 PP32)

Kew

National Archives

FO: International Congress on Mental Health

Oxford

St Hugh's College Head Hospital Archives

Taiwan

Taipei

History of Hygiene Programme, Academia Sinica
Patient Registries at the Psychiatric Department of National Taiwan University Hospital

Academia Historica
Ministry of Foreign Affairs: International Psychiatric Conferences
Papers of Hsu Changhui (許常惠)
Psychological Warfare

Nantou

Taiwan Historica
The Handover of Public Sectors

Oral History Interviews

Prof Hsien Rin: 30th of September, 2009. Taipei, Taiwan
Prof Chu-Chang Chen: 23rd of Mar, 2011. Taipei, Taiwan
Prof Julian Leff: 26th of November, 2010. London, U.K.
Prof Norman Sartorius: 7th of September, 2010. Geneva, Switzerland
Dr Yung-Hsing Chen: 15th of August, 2009. Taipei, Taiwan
Mr Nan-Chou Su: 16th of October, 2010. Taipei, Taiwan
Prof Wei-Tsun Soong: 11th of June, 2010. Huwei, Taiwan
Mr Qiao Li: 8th of September, 2011. Gongguan, Taiwan
Prof Cheng-Ching Hsu: 7th of May, 2012, Xindian, Taiwan
Mr Tsung-Min (Roger) Hsieh: 12th of June, 2012, Linkou, Taiwan

Correspondence

Prof Hisao Nakai 3th of September, 2009. Kobe, Japan

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