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INSANITY ON THE MOVE:
THE “ALIEN INSANE” IN MODERN AMERICA, 1882-1930

by

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ABSTRACT OF THE DISSERTATION

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This dissertation examines the “alien insane” and their place in modern America between 1882 and 1930. It makes original contributions using the “alien insane”—allegedly insane immigrants, who were at once objects of medical surveillance and candidates of deportation, hospital commitment, and citizenship—as an analytical tool to examine how “insanity,” a diagnostic category, became understood as a bureaucratic and racial construction. It also sheds light on the contested interpretations of insanity, the development of American immigration policy and federal powers, and the involvement of state and medical bureaucracies in defining American citizenship. The “alien insane” were deeply implicated in the Progressive discourses of civilization and mobility. Analysis of the discourses explains why and how immigration came to be associated with insanity at this particular moment in American history when the field of psychiatry was professionalized and the public anxiety over new immigration grew. In addition to drawing the line between civilized and settling Europeans and uncivilized and sojourning Asians, these discourses revealed the contemporary racial ideology and gave a new meaning to immigrants’ mobility, which has been taken for granted in immigration studies. Through the “alien insane,” federal, state, and international governments as well as immigration officials, state hospital doctors, social workers, steamship companies, and immigrant communities joined to define “normal” behavior and worthy citizenship. Unlike other deportees, the “alien insane” required costly

institutionalization and humanitarian attention; thus, their reception and care raised questions on the definition of citizenship for immigrants and for American citizens abroad, themselves subject to deportation by foreign states upon leaving their homeland. Moving beyond the immigration stations where historians most commonly encounter immigrant subjects, this study employs neglected and previously unavailable sources, including immigrant patient files of state mental hospitals, to investigate racialization and institutionalization of the “alien insane.” Narratives by American authors and by immigrants also help reexamine immigrants’ perspectives of insanity, assimilation, and American life. This study is about the “alien insane,” but it is also about the work they performed for American culture, for immigration policy, and for both sending and receiving countries to set national boundaries and define good citizens.

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Introduction

In 1906, Veronika, an eighteen-year-old Polish woman arrived in the United States from Austria. Two years later, led by a series of events and alleged insanity, this unfortunate woman was brought to the Ellis Island Immigration Station for deportation. A police officer arrested her on the street for vagrancy and put her into a women's home in New York City. After she attempted to kill herself there, Veronika was committed to Manhattan State Hospital, which informed the Immigration Bureau of Veronika's insanity and public charge status. A warrant of deportation followed for her violation of the immigration act, which required deportation of immigrants who became insane within three years of their arrival. Upon inquiry, her two sisters in New York City claimed that Veronika was always quiet and her family never suffered from insanity. A doctor reported to the elder sister that Veronika had been two months pregnant at the time the warrant was issued, and the sister claimed that Veronika was so ashamed of her pregnancy that she had gone crazy over it. Based on these interviews, the Acting Secretary of the Department of Commerce and Labor claimed that the warrant of arrest should be cancelled since her condition was not from a "prior cause," existing before Veronika arrived in the country. This deportation provision protected Veronika from banishment, or so it seemed. However, five months after her commitment to Manhattan State Hospital, the New York State Board of Alienists physicians declared upon reviewing her case that Veronika was in fact not pregnant but suffering from hebephrenia, a mental disease with an inherited psychopathic tendency.¹ In today's diagnostic terms,

¹ A syndrome characterized by shallow and inappropriate affect, giggling, and silly, regressive behavior and mannerism; a subtype of schizophrenia now renamed disorganized schizophrenia. Definition from online medical dictionary: <http://cancerweb.ncl.ac.uk/cgi-bin/omd?query=hebephrenia>. According to Dr. Gustav Scholer, "Dementia Praecox" is a group of mental disorders, and Hebephrenic type accompanies silly meaningless laughter without apparent cause. Scholer, Gustav (1851-1928) Papers, Rare Books and Manuscripts Division, New York Public Library.

Veronika was schizophrenic. With the new testimony, a second warrant of deportation was issued, and she was finally deported.²

Veronika was different from many other immigrants who successfully settled in the United States. Her case reveals the experience of a small group of unfortunate newcomers in late nineteenth and early twentieth-century America who experienced various mental maladies: some of them, like Veronika, suffered banishment, others remained in mental hospitals, and still others found refuge in their ethnic communities with help of friends and relatives. Their experiences, which carried them through multiple sites and institutional interactions, show how insane immigrants were defined and understood and allow us to comprehend how Americans of the period constructed meanings for civilization, mobility, and insanity itself.

In his examination of the turn-of-the-twentieth-century entry of immigrants, historian Adam McKeown argues: “The ultimate effect of these [border] encounters was not to exterminate movement and replace it by boundaries and by static categories of race and nation. It was to establish hegemony over movement, and define legitimacy and hierarchy to the world stage in terms of race, class, nations, particular kinds of institutions, and particular kinds of procedures.”³ Although he is concerned with much larger processes of immigration and immigrants’ (especially, Chinese) incorporation into the world order, his analysis adds a new perspective to immigration and insanity. Taking a close look at the “alien insane,”⁴ we

² File 51967/180, Box 347, Entry 9, Record Group 85, National Archives and Records Administration (hereafter NARA), Washington, DC. Box 347 has files numbering from 71967/180 to 206.

³ Adam McKeown, *Melancholy Order: Asian Migration and the Globalization of Borders* (New York: Columbia University Press, 2008), 289.

⁴ Here, I use the term the “alien insane” to denote immigrants who were allegedly suffering from insanity. In immigration studies, “alien” refers to an immigrant or a foreigner who is not yet naturalized. When it comes to the history of psychiatry, this term has another meaning; the nineteenth-century word for a psychiatrist was the “alienist,” and according to British psychiatrists Roland Littlewood and Maurice Lipsedge, the alienist defined the relations between “the social world and the world of the mentally ill” and was responsible for the alienation of the insane from the social world. These multiple meanings suggest that the “alien insane,” who were doubly alienated, occupied a unique place in the studies of immigration and

can see this notion of establishing hegemony or hierarchy of the world functioning through immigrant subjects. Indeed, the study of the “alien insane” allow us to examine the way immigration was coded or tracked, interpreted, and understood, as well as how a liberal settler nation, the United States, attempted to control and define qualified members while at the same time satisfying the need for cheap labor and drawing its boundaries.

By the early twentieth century, modern migration control was made to appear reasonable and justifiable through the rhetoric of “civilization,” which according to McKeown encapsulated “a vision of deep institutional differences that could be simultaneously characterized as deep historical cultures and as stages along a common trajectory of progress.”⁵ Under the discourse of civilization, the ideal immigrant, and by extension, the ideal American was defined as a person capable of making free and reasoned choices and conforming to well-monitored institutions.⁶ At the turn of the twentieth century a potential citizen was also viewed as independent, competent, and settled, one whose civic duty and individual responsibility included “the development and regulation of body and mind.”⁷ Ordering the world through its race-neutral language, the civilization discourse nonetheless identified particular peoples unqualified to participate in a modern democracy: hence, as McKeown argues, global immigration restriction policies, which took their cue from the American exclusion of Asians, allowed certain inferior people among them—of course, the Chinese—to travel as free labor but not to settle as free citizens. Perhaps unexpectedly, the civilization discourse also offers valuable evidence in the study of insanity and immigration. Americans of the period understood insanity as a “disease of civilization,” a

insanity. Littlewood and Lipsedge, *Aliens and Alienists: Ethnic Minorities and Psychiatry* (London: Routledge, 1997), 33; see also Appendix A for the further explanation of the term “alien insane.”

⁵ McKeown, *Melancholy Order*, 9.

⁶ Ibid., 117-118.

⁷ Peter Barham and Marian Barnes, “The Citizen Mental Patient,” in *Law without Enforcement: Integrating Mental Health and Justice*, eds. Nigel Eastman and Jill Peay (Oxford: Hart Publishing, 1999), 133-146, 145.

result of the struggle and rapid change accompanying modernity. Population movements were also associated with modernity as they were an outcome of the industrialized states' labor demands and transportation technologies capable of fulfilling these needs; therefore, immigration, itself a product of modern civilization, was often linked to the United States' allegedly growing insane population. Still the civilization discourse explained that insanity was unlikely to occur among those from inferior civilizations. Asians and other people of color, though considered inferior and subject to exclusion (or restricted to temporary residence in the United States), were commonly assumed to be less susceptible, if not immune, to insanity. Upon occasion, as we shall see, these people did and were believed to experience insanity; some were deported, others institutionalized. With the benefit of hindsight, it comes as no surprise that the civilization paradigm contained logical inconsistencies. However, in a study of the immigrant insane, these ironic inconsistencies mandate a search for their function and purpose. The actual numbers of insane immigrants were insignificant. Why, then, did the "alien insane" command the extraordinary attention and alarm of ordinary Americans, public health and immigration officials, and medical professionals at the turn of the twentieth century?

Along with the civilization discourse, immigrants' mobility, whether into the United States, across the continent, into American mainstream society, or in and out of immigration stations and mental hospitals, encouraged and required federal and state bureaucracies, immigration officials, medical experts, hospital attendants, and social scientists to produce structures, institutions, and files to document the movements of immigrants involved in these encounters and interactions. The "free" mobility of people has been understood as an essential and seemingly natural part of modern civilization; however, immigrants' mobility created anxieties and concerns about people moving in and out of national, state, and local boundaries. In particular, the contemporary assumption that linked immigrants' mobility with

growing insanity in America challenged the notion that immigration was a positive influence.⁸ Faced with such anxieties immigration officials, physicians and psychiatrists, public health experts, and social scientists developed their own expert views of immigration and insanity. Some understood the decision to migrate as the choice of mad men and women and attributed allegedly increasing rates of insanity in the United States to these newcomers. Others, adopting a less judgmental attitude toward the foreign born, claimed that the hardships of immigration were to blame for insanity in America. The costly responsibility for care and protection involving insane immigrant public charges sharpened questioning about the “alien insane.”

The apogee of immigration into the United States and the alleged increase in the nation’s insanity rates occurred simultaneously with the development of certain professional disciplines and bureaucracies. As historian Robert H. Wiebe famously demonstrated, the Progressive era saw various fields undergo professionalization and specialization and engineer efficient methods and bureaucratic forms to assure scientific understanding, control, and surveillance of human beings.⁹ These progressive ideals played out differently for immigrants deemed undesirable and allegedly insane. Following the movement of the “alien insane” the historian can examine multiple sites of national borders, immigration stations, state hospitals, and immigrant communities, where knowledge of immigration and insanity was recorded, communicated, and exchanged. The process by which insanity and the insane subject was produced and within which, it should be emphasized, immigrants negotiated with American policies and institutions brought together various actors: immigrants diagnosed

⁸ As Norwegian psychiatrist Leo Eitinger explains, human migration is “not a unitary concept.” It encompasses geographical movement of people, cultural patterns of the migration process, and difficulties attending immigration in sending and receiving countries. Conditions of migration also varied as voluntary (ordinary immigration) and involuntary (coerced or forced—i.e. refugees) forms of mobility coexisted. Eitinger, “Foreigners in Our Time: Historical Survey on Psychiatry’s Approach to Migration and Refugee Status,” in *Strangers in the World*, eds. Leo Eitinger and David Schwarz (Bern: Hans Huber Publishers, 1981), 16-26, 21.

⁹ Robert H. Wiebe, *The Search for Order, 1877-1920* (New York: Hill and Wang, 2000).

with insanity, family and friends who suffered with them, as well as medical experts, social workers, transportation companies, and immigration officials who pronounced them unsuitable to remain in the United States. In spite of all good intentions, immigrants like Veronika were controlled, perhaps even victimized, by these modern institutions and actors. Other allegedly insane immigrants, more practiced in their ability to manipulate circumstances, appear to have negotiated their way through these institutions and controls, sometimes, for example, avoiding deportation despite their alleged insanity, or securing indefinite protection, room and board in the asylum, or even a much desired free passage home.

One of the challenges in examining the “alien insane” is to define what “insanity” meant for different actors and groups of people in the United States and how its meanings shifted in the late nineteenth and early twentieth centuries. Like immigrants, insanity as a medical, political, legal, and lay term was on the move; initially a diagnostic category, it became understood as a bureaucratic and racial construction that drew the line between “us” and “them.” Americans, both lay and professional, had expressed difficulty in reaching consensus on what insanity was.¹⁰ In 1872, an early commentary from Dr. E. T. Wilkins of the California State Commission in Lunacy explained: “insanity assumes so many forms and differs so widely in different persons that no definition can possibly embrace all of its phases.” However, he also declared in the same article with unabashed certainty that insanity was “a disease of the brain affecting the mind.”¹¹ Most psychiatrists of the period also found it challenging to distinguish symptoms and diseases¹²; psychiatric categories developed in the

¹⁰ Allan V. Horowitz and Gerald N. Grob, “The Checkered History of American Psychiatric Epidemiology,” *Milbank Quarterly* 89, no. 4 (2011): 628-657, 651. 632; see also E. Fuller Torrey and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* (New Brunswick: Rutgers University Press, 2001), Appendix A.

¹¹ California, State Commission. *Insanity and Insane Asylums, Report of E. T. Wilkins, M.D.* (1872), 9.

¹² Horowitz and Grob, “Checkered History,” 635.

late nineteenth and early twentieth centuries were based on symptoms and applied loosely, often leading to mistaken diagnosis. The elusive nature of insanity, a disease grounded in behavioral not in somatic symptoms, made its detection difficult and complicated.¹³ As psychiatrists struggled to gain recognition in the medical field, they began to seek and adopt more scientific approaches. Reflecting the moment, in 1913, a renowned psychiatrist, L. Vernon Briggs, expressed his frustration with the term “insane,” which according to him had been used “comprehensively, or loosely.”¹⁴ He advocated “a proper classification,” through which state hospitals and institutions could administer different treatment and supervision to different classes of patients.¹⁵ Such was the diagnostic map confronted by immigrants suspected of insanity. Given the existing exclusion laws, such targeted individuals, whether insane or not, found themselves subject to institutionalization and deportation.

As early as the mid-nineteenth century, immigration authorities and medical practitioners were concerned with the “alien insane”; however, the 1882 federal immigration law marked the first step toward control over the entry of insane immigrants, which coincided with a huge influx of “new immigrants” to the country. The 1882 act excluded any lunatic or idiot from entering the United States. The immigration act of 1891 barred from admission all idiots and insane persons as they were deemed unfit to become American citizens. The 1903 immigration act continued to exclude insane persons and added to the list “persons who have been insane within five years previous [or] who have had two or more attacks of insanity at any time previously.” Deportation became a means to remedy the inadequacies of the immigration acts and their enforcement: a person who had passed medical inspection at the American port but became a public charge within two years (three

¹³ Alan Kraut, *Silent Travelers: Germs, Genes, and the “Immigrant Menace”* (New York: Basic Books, 1994).

¹⁴ L. Vernon Briggs, “Problems with the Insane,” *American Journal of Insanity* 70 (October 1913), 107.

¹⁵ *Ibid.*, 108.

years in 1907 and five in 1917 and after) of arrival “due to conditions existing prior to landing,” including insanity, was deported. The literacy test provision of the 1917 immigration act further tightened mental competence requirements for immigrants. The act also guaranteed that once a deportation decision was made, a warrant of deportation would not be cancelled even after the statute of limitations of the immigrant in question expired. In the 1920s, the national origins acts, which dramatically limited the number of “new immigrants,” yet again transformed the lot of insane immigrants: once deported for insanity, they would not be allowed to reenter the country regardless of whether they had been really insane or not.¹⁶

For the practical purpose of detecting and deporting mentally troubled immigrants, legal and administrative definitions of insanity encompassed a great range of conditions: as long as an immigrant was certified as insane, the type of insanity was “not demanded.”¹⁷ Still, Public Health officers in charge of the medical examination of immigrants struggled to come up with a scientific and efficient way to define and detect insanity. In 1903, the Public Health Services explained in the *Book of Instructions for the Medical Inspection of Immigrants*: “Insanity is a deranged and abnormal condition of the mental faculties, accompanied by delusions or hallucinations or illusions, or manifesting itself in homicidal or suicidal tendencies or persistent mental depression, or inability to distinguish between right and wrong.”¹⁸ In the case of immigrants, however, “particularly the ignorant representatives of emotional races,” temporary demonstrations of delusional or disturbing behavior—refusing

¹⁶ Douglas Baynton, “Defectives in the Land: Disability and American Immigration Policy, 1882-1924.” *Journal of American Ethnic History* 24, no. 3 (Spring 2005): 31-44; Jane Perry Clark Carey, *Deportation of Aliens from the United States to Europe* (New York: Arno Press, 1969).

¹⁷ The 1918 U.S. PHS *Manual* added that officers should offer accurate and scientific diagnosis when the need arose, but otherwise, it was not necessary. U.S. Public Health Service, *Manual of the Mental Examination of Aliens* (Washington, DC: Government Printing Office, 1918), 42.

¹⁸ U.S. Public Health Service, *The Book of Instructions for the Medical Inspection of Immigrants* (Washington, DC: Government Printing Press, 1903), 9. Also see, Kraut, *Silent Travelers*, 70-72.

to talk or eat—were to be tolerated.¹⁹ In the 1910s, the U.S. Public Health Service officers had a broad view of mental deficiency which included “the feeble-minded, paupers, inebriates, criminals, epileptics, the insane, those with congenital asthenia and poor physique” and “the diathetic class and persons possessing stigmata and deformities.”²⁰ In the 1920s and 30s, along with the deepening professionalization and specialization of the field of psychiatry, “insanity” became a legal term, carrying no definite medical concept²¹; still, the term continued to be used outside the medico-legal arena.

The number of immigrants excluded for insanity was miniscule. Less than two percent of all the admitted immigrants were excluded at immigration stations; less than one percent of the excluded were insanity cases.²² However, lay Americans became aware of the link between immigration and insanity through popular novels, courtroom dramas, and personal experiences.²³ Many believed that they did not need science to identify insanity; they could rely upon their perceptions to do the job. As Joseph Collins, M.D., put it in 1924, “[i]t is no concern of the public that insanity is a disorder of the mind: it is the disorder of conduct that gives significance to insanity.”²⁴ Immigrants likewise had their own descriptions

¹⁹ U.S. PHS, *Book of Instructions*, 9-10.

²⁰ John T. E. Richardson, “Howard Andrew Knox and the Origins of Performance Testing on Ellis Island, 1912-1916,” *History of Psychology* 6, no. 2 (2003): 143-179, 159.

²¹ This change reflected psychiatrists’ struggle to establish their profession as a legitimate science. For the definition of “insanity” in the American legal system, see Janet A. Tighe, “‘What’s in a Name? A Brief Foray into the History of Insanity in England and the United States,’” *Journal of the American Academy of Psychiatry and the Law*, 33 (2005): 252-58, 256. For the contemporary discussions of insanity as a legal term, see Walter L. Treadway, *Mental Hygiene with Special Reference to the Migration of People* (Washington, DC: Government Printing Office, 1925), 8-9. He argued that the association between the early care for the mentally ill and that for criminals resulted in the legal term, “insane,” which was applied to “a certain class whose mental disability is complicated by a legal one.” A mental hygiene expert, Treadway suggested a broad consideration of mental disorders beyond the institutional confines.

²² According to Amy Fairchild, between 1891 and 1930, the deportation rate for medical causes never exceeded one percent of the immigrants arriving in any given year. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: The Johns Hopkins University Press, 2003), 4.

²³ Johan Bojer, *The Emigrants* (New York: The Century Company, 1925); O. E. Rølvaag, *Giants in the Earth: A Saga of the Prairie* (New York: Harper, 1927).

²⁴ “The Alienist in Court,” *Harper’s Monthly Magazine* 150 (1924): 280. See also “What Is Insanity?” *The New York Times*, September 15, 1884. This article also questioned the motives behind overusing the label

for the illness (“upside down” as the Chinese called it) but they also picked up American terms, calling the insane “crazy,” “queer,” “mad,” “dopy,” or “peculiar.” Fictional accounts and autobiographic writings by immigrant authors, to be discussed in this dissertation, suggest that immigrants understood in their own terms what insanity was and what it entailed. To them, insanity could be a real disease with serious political and social repercussions, such as exclusion, deportation, or confinement; or, it could be the result of a misunderstanding derived from their language and cultural differences, or different perceptions of reality, proper behavior, or ethics from the Old World, which once in America rendered their behavior deviant.

The causes for insanity were in dispute as well: physical damage, domestic troubles, stresses of urban life, hereditary defects, and mobility that defined the immigrant experience were cited, but none of them could offer a definitive medical explanation for insanity. At the turn of the twentieth century, however, both lay and professional Americans achieved a consensus: insanity, they believed, had been increasing in America and immigration was certainly one, though not the only, explanation for this increase.

Unless detected and excluded at immigration borders, the majority of insane immigrants were deported under either a “likely to become a public charge (LPC)” or a “public charge (PC)” clause of the immigration acts. LPC cases included immigrants with little money, mental or physical defects (including pregnancy), or poor moral characters; PC cases referred to those who became public charges at American institutions, mostly hospitals. The PC clause was not as widely employed as the LPC provision because unlike the LPC cases, in which the burden of proof fell to the Bureau of Immigration, the PC clause allowed immigrants to show whether they became public charges due to their conditions at the time of

of insanity in legal cases and touched upon the class issues as “practical circumstances” allowing the wealthy and influential to get away with their misconduct; most convicted criminals were from the class which did not enjoy such benefits.

entry or due to “causes arising subsequently to landing.” This causality was hard to determine, especially for insane immigrants: the fact that they became insane, which excluded them in the first place from legal entry, was used alongside the notion that the cause of their insanity resided in their assumed hereditary defects or nervous dispositions. Their mental incompetence prevented the immigrants in question from defending themselves. At the same time, those who became public charges for insanity were a matter of great concern to the American authorities, medical professionals, and steamship companies because of the costs of their care, including medical treatment during transportation, and of necessary negotiations and contacts with foreign governments. As we shall see, these economic concerns as well as attempts to establish the federal hegemony, bureaucratic surveillance, and control over immigration often outweighed medical opinion in determining who an insane immigrant was. Historical reconstruction of this process expands our understanding of the meaning of insanity from a medical explanation to a legal and bureaucratic necessity.

My dissertation focuses on “insanity” as a particular condition that shaped the experience of immigrants to America. Many scholars have explored medical examinations and inspections at the American borders and showed the ways in which they controlled and regulated the admission of unsanitary and undesirable immigrants to protect the American public.²⁵ However, because they are almost exclusively limited to the immigration stations, these studies have rarely taken into account encounters between immigration officials and state institutions, implying that the detection and construction of insanity began and stopped

²⁵ See Kraut, *Silent Travelers*; Howard Markel, *When Germs Travel: Six Major Epidemics that Have Invaded America and the Fears They Have Unleashed* (New York: Pantheon Books, 2004); Fairchild, *Science at the Borders*; and Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001). Fairchild's study is broadest in its scope of investigation and poses a few questions on the role of the medical examination at the American borders. However, she focuses on the primary inspection at the border entry and deportation, without examining deportation cases from state institutions. Nayan Shah's study is different from others as it pays particular attention to the West coast and Asian immigration.

there.²⁶ Moreover, the institutional encounters that the “alien insane” experienced from the moment they departed homelands to immigration borders, state mental institutions and back again to national boundaries for deportation revealed “a multiple network of diverse elements.”²⁷ Focusing on immigration stations and immigration officials alone makes it difficult to understand cases like Veronika’s and the situation of other allegedly insane immigrants, in which we find close interactions among seemingly unrelated sites, bureaucracies and agencies in the process of defining, detecting, treating, surveying, and deporting the insane. Furthermore, the attention to this multi-focal analysis of how the insane were treated sheds light on the increasing federal hegemony over established state and local authority. That is, federal surveillance and control of the “alien insane” paralleled other federal challenges to state governments, which resisted the costs of care for the immigrant insane in state funded mental hospitals. So the history of reception of a small minority of immigrant newcomers allows us to examine continuing conflicts between state and federal power throughout American history.

As immigrants passed through borders and interacted with many agencies and actors, a new identity was created for them and systematically recorded in papers and files. This conscious project of the democratic state designed to document the existence of modern subjects served as a means to create, confirm, and track insane immigrant persons. The warrant of deportation for Veronika came only after she had become a public charge at Manhattan State Hospital; she had passed the primary inspection at the Ellis Island

²⁶ There are several exceptions from historians of Canada and Australia. See Robert Menzies, “Governing Mentalities: The Deportation of ‘Insane’ and ‘Feeble-minded’ Immigrants out of British Columbia from Confederation to World War II,” *Canadian Journal of Law and Society* 13, no. 2 (1998): 135-73; Philippa Martyr, “Having a Clean Up? Deporting Lunatic Migrants from Western Australia, 1924-1939,” *History Compass* 9, no. 3 (2011): 171-199. For cases from California, see Natalia Molina, *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2005); Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Berkeley: University of California Press, 2005).

²⁷ Quoted in McKeown, *Melancholy Order*, 15. McKeown’s study was influenced by Michel Foucault’s microphysics of power and institutions.

Immigration Station, but proof that her insanity occurred within three years of her landing (and hence within the designated statute of limitations) required collaboration between immigration officials and state hospital doctors, not to mention assistance from her family members, social workers, and steamship companies. All or most of these events and witnesses were tracked by bureaucratic technologies of record keeping and confirmed under expert eyes. By bringing these agencies and actors together, this study aims to capture particular moments in historical time when the problem of the “alien insane” was being discussed and constructed. Examining these immigrants at many sites and agencies interacting with a variety of historical actors also allows us to explore what went on before, during, and after arrival and deportation of immigrants like Veronika and to follow the trajectory of their movements over the course of their time within the United States and even after their return home. Moreover, the cases of the “alien insane” reveal immigrants’ own perspectives, clearly more difficult to detect and document, of what insanity meant, what their view of America was like, and what they thought of themselves.

My dissertation is primarily concerned with the history of immigration, but I adopt interdisciplinary approaches to explore the insane immigrant population and their movements to, within, and from the United States. Hopefully, my study enriches immigration history and other fields of study interested in immigration. One starting point is to examine the history of psychiatry and immigrant patients’ place in it.²⁸ As already noted, the professionalization and enhancement of psychiatry’s scientific authority occurred simultaneously with the heavy influx of immigrants into the United States. The struggles of state mental hospital doctors to specialize and professionalize the field coexisted with the attempts of immigration officials and public health officers to detect and diagnose insanity at immigration stations. The

²⁸ See, for example, Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1995).

scientific control of immigration was to be ensured by “systematic examination at checkpoints located on or before the border by experts in identification techniques, medicine and psychology.”²⁹ In this era, psychiatric institutions as well as the federal and state governments became active, albeit often unwilling, collaborators in the identification and care of the “alien insane” and ultimately the process of selecting which among these immigrants would remain or face deportation. As we shall see, the agendas and interests of state mental hospital psychiatrists and those of federal officials, including Public Health officers, often diverged, but federal deportation policy required the collaboration of state hospital psychiatrists with federal authorities. Pressured by state governments’ resistance to assuming the costs of care for the immigrant insane and federal deportation policy regarding insane patients, state hospital doctors accepted changing legal and bureaucratic definitions of insanity and suspended their medical judgments and recommendations for treatment.

In addition to shedding light on the close link between the two sites of the mental hospital and the immigration depot, the study of insanity among immigrants makes it possible to explore not only medical practices and institutions but also the experiences of patients and the contingencies of the institutional life (i.e. discharge, transfer, or deportation). Positioning the psychiatric profession and the asylum in relationship to the immigration context promises to broaden existing scholarship on the history of psychiatry. This field began to flourish with the emergence of anti-psychiatric perspectives of the 1960s and 70s, which viewed insanity as a social and economic construction; during the period, refugees from Southeast Asia entered the United States and concerns with their mental condition increased the interest in

²⁹ Andreas Fahrmeir, *Citizenship: The Rise and Fall of a Modern Concept* (New Haven: Yale University Press, 2007), 97. Fahrmeir sees Italian physician and anthropologist Cesare Lombroso’s “criminal type” in 1876 and German physician Robert Koch’s discovery of cholera bacteria in 1883 as important moments that led to the scientific immigration control in Europe and the Americas. Both Lombroso’s criminals and Koch’s cholera bacteria concerned people’s mobility (criminals moving from one country to another, sick people carrying diseases and polluting a national body).

mental health of immigrants and minorities. Until then, the history of psychiatry had been constructed around institutional studies with a focus on the specialization of psychiatry and the solidification of the psychiatric profession.³⁰ In the 1980s, a number of scholars working on the history of psychiatry examined the interaction of the mental institution and multiple agencies involved in the construction of the asylum, including families, friends, and attendants. They began to see mental hospitals not merely as a total institution controlling all aspects of the patients' lives but as a place of relationships and negotiations.³¹ Along with these views came greater attention to patient populations and their place in American society. Class, gender, and religious differences were recognized as important elements of American mental institutions, and patients' own voices were exhumed from patient case files and hospital reports; moreover, scholars now moved beyond the institutional walls to examine the fate of the insane in the community context and shifted their focus from medical experts to family members.³² These scholars did not ignore the presence of immigrant patients at

³⁰ In his influential *Madness and Civilization*, Michel Foucault argued that insanity had become problematic only in the seventeenth century when social and economic changes resulted in the institutionalization of the nonproductive, including the insane, paupers, vagrants, and criminals. David Rothman's *The Discovery of the Asylum* set the framework of explaining social control and mental illness in American history. Refuting Rothman's thesis of American exceptionalism, Andrew Scull argued that psychiatrists' self-interest in professionalizing their field and the new capitalist economy led to their growing institutional authority not only in America but also in England and other European countries. On the other hand, Gerald Grob revealed complexities within mental institutions, which had long been viewed as a monolithic entity. He examined medical practitioners at state hospitals and their good intentions and beliefs in the care and treatment of the insane and traced the rise and fall of the therapeutic institution. Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Vintage, 1988); David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown & Company, 1971); Andrew Scull, ed. *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (Philadelphia: University of Pennsylvania Press, 1981); Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1973). For anti-psychiatric approaches, see Thomas Szasz, *The Myth of Mental Illness: Foundations of A Theory of Personal Conduct* (New York: Harper & Row, 1974); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City: Anchor Books, 1961). For the discussion of Szasz, Goffman, and Foucault, see Torrey and Miller, *Invisible Plague*.

³¹ See Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*. (Cambridge: Cambridge University Press, 1984); Ellen Dwyer, *Home for the Mad: Life inside Two Nineteenth-century Asylums* (New Brunswick: Rutgers University Press, 1987).

³² For example, Roy Porter added the patient's perspectives to the account on the rise of medicine and urged the expansion of the scholarly scope to families and communities. Peter McCandless and David

American mental institutions; they discussed the ways in which the popular social and political discourse of the time led to the interplay between external and internal forces in shaping psychiatric attitudes toward immigration.³³ However, they failed to demonstrate the ways in which full consideration of immigrant patients and the surrounding context could enrich the historical narrative. One of my objectives is to correct this limitation. The insertion of immigrants' perspective in so far as historical records allow it challenges the social and medical norms of the time, and expands the spatial landscape within which the insane and medical experts functioned beyond the already existing institutional studies. The study of immigrant patients not only reaffirms the process by which psychiatrists established their medical expertise but also exposes their developing views of insanity, what caused it, which immigrants should be discharged or deported and why, where they should go, and what policies should be enacted to deal with them.

The study of the "alien insane" also sheds light on the hitherto neglected discussion of race and ethnicity at state mental institutions.³⁴ Except for the institutional studies on the

Wright too highlighted the importance of communities and families outside the medical or institutional purview. Porter, "The Patient's View: Doing Medical History from Below," *Theory and Society* 14, no. 2 (1985): 175-98; McCandless, *Moonlight, Magnolias and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: University of North Carolina Press, 1996); Wright, "Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century," *Society for the Social History of Medicine* 10, no. 1 (April 1997): 137-155. Shelia M. Rothman examines tuberculosis with the patient's perspective by employing what she calls "illness narrative": "written or oral response of the sick person and his or her family to illness and disability." Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 2.

³³ See Grob, *Mental Institutions in America*, in which he includes foreign-born patients as part of his analysis of patient populations. Also see Grob, *The Mad among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994); "Class, Ethnicity and Race in American Mental Hospitals, 1830-75," *Journal of the History of Medicine and Allied Sciences* 28, no. 3 (1973): 207-29; Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 1997); Samuel B. Thielman, "Psychiatry and Social Values: The American Psychiatric Association and Immigration Restriction, 1880-1930," *Psychiatry* 48, no. 4 (November 1985): 299-310. For in-depth analysis of insane populations in California, see Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978).

³⁴ Ellen Dwyer noted the lack of in-depth analysis of race in "Psychiatry and Race during World War II," *Journal of the History of Medicine and Allied Sciences* 61, no. 2 (2006): 117-43. For discussions of race in

American South and recent work on psychiatry among colonized peoples, the history of psychiatry, though attentive to gender, has inexplicably neglected race and ethnicity.³⁵ Joel Braslow's *Mental Ills and Bodily Cures*, a study of California state hospitals, is a case in point: there he writes, "a patient's race had scant institutional import (wards were not racially segregated) and no therapeutic significance."³⁶ According to Braslow, California mental hospitals tabulated the racial classifications of their patients only briefly between the late 1940s and early 1950s. However, this curious inattention to race, particularly in California, where Asians were marginalized, does not mitigate its significance. Most hospital records I examined included a "color" section, and less frequently, a "race" section, but they also recorded and identified patients' nationality, religion, and language. Different meanings and classifications of race and ethnicity at the turn of the twentieth century suggest that despite medical practitioners' focus on objective and scientific medicine—refining medical categories and addressing diagnostic difficulties—they were influenced by the contemporary ideology of race, which was not merely a black-white binary but rather a conflation of various elements—skin color, nationality, language, and religion.³⁷ Statistical data from the

psychiatry, see also Andrew Fearnley, "Primitive Madness: Re-Writing the History of Mental Illness and Race." *Journal of the History of Medicine and Allied Sciences* 63, no. 2 (April 2008): 245-257.

³⁵ See McCandless, *Moonlight, Magnolias*; John S. Hughes, "The Madness of Separate Spheres: Insanity and Masculinity in Victorian Alabama," in *Meanings for Manhood: Constructions of Masculinity in Victorian America*, eds. by Carnes, Mark C. and Clyde Griffen (Chicago: The University of Chicago Press, 1990), 53-66, and "Labeling and Treating Black Mental Illness in Alabama, 1861-1910." *Journal of Southern History* 58 (August 1992): 435-60; Sean Harris, "Found Insane in the Holy Land: Psychiatry and the African American Experience in Illinois, 1870-1910" (Ph.D. diss., University of Illinois, Chicago, 2007). For colonial psychiatry, see Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: The University of Chicago Press, 2007); Ernst Waltraud, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800-58* (London: Anthem Press, 2010); Warwick Anderson, "Immunities of Empire: Race, Disease, and the New Tropical Medicine, 1900-1920." *Bulletin of the History of Medicine* 70, no. 1 (1996): 94-118.

³⁶ Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997), 23.

³⁷ Studies on racial classifications in U.S. Census illustrate the fluidity of racial or ethnic labels in the late nineteenth and early twentieth centuries. See Martha Hodes, "Fractions and Fictions in the United States Census of 1890," in *Haunted by Empire: Geographies of Intimacy in North American History*, ed. Ann Laura Stoler (Durham: Duke University Press, 2006), 240-70; Jennifer L. Hochschild and Brenna Marea Powell, "Racial Reorganization and the United States Census 1850-1930: Mulattoes, Half-Breeds, Mixed

period shows that the distinctions between foreign-born and native-born, which were much easier to define (although citizenship status often disrupted and compromised this seemingly neat classification), played a greater part in identifying patient populations than those of race and ethnicity. Nevertheless, the popular discourse and ideology at the turn of the century and doctors' own racial stereotypes shaped the process of examination, treatment, and discharge of hospital inmates, especially immigrant patients, whose physical, cultural and linguistic differences from white Americans were readily apparent.

This lack of attention to race and ethnicity at state institutions has been recently addressed by historians of Australia, New Zealand, and Canada. With their focus on the significance of migration or immigration in the study of mental illness, these scholars have noted the presence of the migrant insane in settler communities and the heterogeneity of the inmate populations. Immigration scholar Angela McCarthy explores nineteenth-century immigrant patients at a New Zealand mental hospital and finds surprising diversity among the inmates who demonstrated remarkable success at repeated trans-continental movements. While McCarthy's study emphasizes white European immigrants, Catharine Coleborne broadens the analytical scope to include Maori and Chinese in her study of Australian mental institutions.³⁸ Moreover, these scholars view immigrants not only as colonial subjects but as practitioners of ethnicity; by focusing on ethnic identities, both self-described and externally assigned, the two historians emphasize the ways in which ethnic affiliations continually

Parentage, Hindoos, and the Mexican Race," *Studies in American Political Development* 22 (Spring 2008): 59-96.

³⁸ Angela McCarthy, "Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century Auckland," *Social History of Medicine* 21, no. 1 (2008): 47-65; Catharine Coleborne, "Making 'Mad' Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum," in *Law, History, Colonialism: The Reach of Empire*, eds. Diane Kikby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 106-22. For Maori patients, see Lorelle J. Burke, "'The Voices Caused Him to Become Porangi': Maori Patients in the Auckland Lunatic Asylum, 1860-1900" (M.A. thesis, Waikato: The University of Waikato, 2006); Lorelle Barry and Catharine Coleborne, "Insanity and Ethnicity in New Zealand: Maori Encounters with the Auckland Mental Hospital, 1860-1900," *History of Psychiatry* 22, no. 3 (September 2011): 285-301.

influenced and identified mental hospital patients. Canadian historians interested in the hegemonic ideology of race have also discussed the racial and ethnic dimension of Canadian mental hospital inmates.³⁹ They shed light on how psychiatrists diagnosed and treated their patients as well as what the patients experienced and what consequences the psychiatrists' view of race and ethnicity had, including initial detection of insanity, hospital commitment, discharge, and possible deportation of immigrant patients. These recent studies show that while turn-of-the-twentieth-century institutional records of race and ethnicity were arbitrary and limited, they prove that race and ethnicity contributed to the construction of immigrant patients and their illness.

My dissertation draws from and enlarges this scholarship through the examination of deportation of insane public charges, who were removed from state mental institutions, picked up by immigration officials, sent to the ports they entered, and returned to their home countries. Deportation of immigrants has been a well-explored topic among scholars of immigration history. Since Jane Perry Clark Carey's 1931 study, *Deportation of Aliens from the United States to Europe*, was published, many immigration scholars have emphasized both detention and deportation of European anarchists and political activists during the Red Scare of 1919 and 1920 and removal of prostitutes, pimps, or criminals.⁴⁰ Recently, historians of Chinese exclusion have called attention to hitherto neglected racial and ethnic groups. Erika Lee's *At America's Gates* emphasizes the significance of Chinese exclusion in American immigration history and argues that it helped redefine "American politics, race,

³⁹ Robert Menzies, "Race, Reason, and Regulation: British Columbia's Mass Exile of Chinese 'Lunatics' aboard the *Empress of Russia*, 9 February 1935," in *Regulating Lives: Historical Essays on the State, Society, the Individual, and the Law*, eds. Dorothy E. Chunn, John McLaren, and Robert J. Menzies (Vancouver: UBC Press, 2002), 196-230; David Wright and Tom Themeles, "Migration, Madness And The Celtic Fringe: A Comparison of Irish and Scottish Admissions to Four Canadian Mental Hospitals, C. 1841-91," in *Migration, Ethnicity, and Mental Health: International Perspectives, 1840-2010*, eds. Angela McCarthy and Catharine Coleborne (New York: Routledge, 2011).

⁴⁰ See Carey, *Deportation of Aliens*; Dan Kanstroom, *Deportation Nation: Outsiders in American History* (Cambridge, MA: Harvard University Press, 2007).

class, and gender relations, national identity, and the role of the federal government in controlling immigration.”⁴¹ Mae M. Ngai, further expanding the analysis, claims that border control and deportation policy reflected and shaped the trajectories of racial formation and operated against particular ethno-racial groups by limiting their legal rights.⁴² Others have looked at the process by which the federal government emerged as the full authority of deportation in the early twentieth century.⁴³ My study of insane immigrants continues these promising efforts to connect the study of immigration and immigration policy to broad national concerns, such as the expansion of the federal government both at home and abroad and the meaning of American citizenship.

The cases of insane deportees, like Veronika, revealed the precarious status of immigrants who did not stay in America long enough to enjoy privileges and immunities of American citizenship. At the time, those who entered the United States without a history of insanity, established domicile, and declared intention to naturalize were protected from deportation even when they went insane and could not complete the naturalization process.⁴⁴ However, insanity cases challenged these privileges and immunities as the “alien insane,” in

⁴¹ Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003), 41.

⁴² Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (Princeton: The Princeton University Press, 2005). Racialization was an important part of the American immigration laws and policies. Ideological and economic concerns also have shaped American deportation policy. For example, deportation decisions that specifically targeted the disabled and “immoral” women without male relatives demonstrated the importance of economic concerns in the discussion of American immigration policy.

⁴³ Martha Gardner, *The Qualities of a Citizen: Women, Immigration, and Citizenship, 1870-1965* (Princeton: Princeton University Press, 2005); Deirdre Moloney, *National Insecurities: Immigrants and U.S. Deportation Policy since 1882* (Chapel Hill: University of North Carolina Press, 2012); Torrie Hester, “Deportation: Origins of a National and International Power” (Ph.D. diss., University of Oregon, 2008); Baynton, “Defectives in the Land.”

⁴⁴ Bryan S. Turner, “The Erosion of Citizenship,” *British Journal of Sociology* 52, no. 2 (June 2001): 189-209; Evelyn Nakano Glenn, *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor* (Cambridge: Harvard University Press, 2002); Rogers Brubaker, *Citizenship and Nationhood in France and Germany* (Cambridge, MA: Harvard University Press, 1992); Brubaker, “Migration, Membership, and the Modern Nation-State: Internal and External Dimensions of the Politics of Belonging,” *Journal of Interdisciplinary History* 21, no. 2 (Summer 2010): 61-78; Linda S. Bosniak, *The Citizen and the Alien: Dilemmas of Contemporary Membership* (Princeton: Princeton University Press, 2006).

need of constant care and institutionalization, became a burden upon the public. Thus came discussions on the meaning and definition of citizenship and, in a period of growing federal power, on the responsibility of the federal government to these individuals. These discussions influenced American citizens abroad as well. For example, debates in the 1920s concerning insane American citizens at Canadian mental institutions illustrate the ways in which an individual's mental status and mobility determined his legal and political rights and status. The American authorities realized that the foreign-born insane in America were mirror images of the insane American citizens abroad. Discussions between the two countries concerning their insane citizens abroad served a broader purpose. These nation states, in the process of increasing federal authority, looked into the obligations of the federal government to its citizens and defined citizens' rights both abroad and home. Tensions between state and federal powers were apparent when individual states protested the federal government's insistence that they accept and pay for the care of repatriated citizens. The history of immigration and insanity, then, reveals some unanticipated themes concerning the development of the American state power.

While the discussion of insanity, citizenship, state and bureaucratic power sheds light on the rationale of American statesmen, bureaucrats, and medical professionals, it rarely reveals the agency of immigrants. It is difficult to fathom what immigrants themselves thought of insanity. Their lack of language skills, poor education, and unstable mental condition prevented them from producing sources where we might find their perspectives. Unless they were institutionalized or deported, thus recorded in official documents, insane immigrants, who escaped deportation orders or commitment to mental institutions, left little documentary evidence of their lives.⁴⁵ Moreover, insanity stigmatized family and friends who

⁴⁵ American newspapers often published stories of insane deportees jumping off the ship on their way home or killing others in their insane rage, but they rarely included a full history of these deportees.

commonly remained silent and buried their memories. One example is Steve Luxenberg's *Annie's Ghost*. Luxenberg, a grandson of a Russian Jewish immigrant to America, learned that his mother had a sister named Annie, who unbeknownst to him and his siblings existed and lived most of her life at a mental institution. He restores his forgotten aunt to life through his investigation of the family history, mental hospitals, and the national history of the Great Depression and War.⁴⁶

My dissertation also attempts to restore insane immigrants to life by investigating their experiences in mental hospitals and American society through various narratives. For the stories of immigrants at mental institutions and the ways in which they became part of the American institutional system, I turn to "asylum narratives," which include exposés and memoirs of the late nineteenth and early twentieth centuries. Literary critics and historians of psychiatry have argued that these narratives, the majority of which were written by white, middle-class women, challenged the dominant culture of gender and power relations and demonstrated the lay public understanding of insanity.⁴⁷ They exposed the reality of mental hospitals, criticized the American legal and medical systems, and reaffirmed the narrators' identity as recovered and valuable members of American society. At the same time, these narratives opened a window through which to examine the "alien insane," whose presence was duly noted and written about by the American authors. The "asylum narratives" are complemented by other institutional narratives and fictional or autobiographical writings on insanity by immigrant authors, which introduce immigrants' own perspectives of insanity, assimilation, and Americanization. Literary critic Madelaine Hron argues that works written by immigrant authors have naturalized and minimized pain as a necessary step to become

⁴⁶ Steve Luxenberg, *Annie's Ghost: A Journey into a Family Secret* (New York: Hyperion, 2009).

⁴⁷ Mary de Young, *Madness: An American History of Mental Illness and Its Treatment* (Jefferson: McFarland & Co., 2010), 262; Susan J. Hubert, *Questions of Power: The Politics of Women's Madness Narratives* (Newark: University of Delaware Press, 2002); Benjamin Reiss, *Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture* (Chicago: The University of Chicago Press, 2008).

American.⁴⁸ Thus, early twentieth-century narratives by immigrants seldom discussed their own mental suffering, insane family members, and social or cultural stigma associated with being insane. Most immigrant narratives, including the ones that dealt with insanity, ended with their protagonists settling in the New World, overcoming their inherent weaknesses, if any, as well as their social, economic, and personal troubles; it might be because their stories were not about insanity but indeed about their journey to become American.⁴⁹ Nevertheless, immigrant authors, such as O. E. Rølvaag and Sui Sin Far, suggest that immigrants at the turn of the twentieth century experimented with their own views of insanity and assimilation and carved out complex and humanized understandings of mental troubles even as they internalized the dominant discourse of assimilation and Americanization.⁵⁰

Organization of the Dissertation

Chapter 1 discusses the late nineteenth and early twentieth-century debates among psychiatrists, public health professionals, and social scientists concerned with immigration and insanity. This chapter engages the two discourses of civilization and mobility—discourses often laden with inconsistencies—to examine the ways in which the insane among different immigrant groups and races were defined and understood. At the turn of the twentieth century, insanity was regarded as a disease of civilization, which had been increasing due to struggles of modern life. This discourse had another side to it: it suggested that the “colored” and Asian immigrants, because of their lower positions on the civilization

⁴⁸ Hron also examines the dominant discourses and widespread assumptions of immigrants and immigrant narratives, but she focuses on more recent, relatively unknown works. Madelaine Hron, *Translating Pain: Immigrant Suffering in Literature and Culture* (Toronto: University of Toronto Press, 2009).

⁴⁹ Russell Kazal, “Revisiting Assimilation: The Rise, Fall, and Reappraisal of a Concept in American Ethnic History,” *American Historical Review* 100, no. 2 (April 1995): 437-471.

⁵⁰ See for example, Anne Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus and Giroux, 1998); Albert C. Gaw, ed. *Culture, Ethnicity, and Mental Illness* (Washington, DC: American Psychiatric Press, Inc., 1993); Stanley Sue and James K. Morishima, *The Mental Health of Asian Americans* (San Francisco: Jossey-Bass, 1982).

scale, were protected from the debilitating impact of American civilization. That is, the civilization discourse, though not explicitly racist or even racist, ordered the international world and drew a line separating white European from Asian “new immigrants.” At the same time, the influx of immigration into the United States, which coincided with efforts to legitimize psychiatry as a profession and as a scientific field, led American psychiatrists and public health officials to question the motives for immigration. The mobility discourse problematized this movement of new immigrants into America. That is, unlike the old stock, “new immigrants” from southern and eastern Europe were suspected as unnatural and assisted migrants pushed from their homelands by governments wishing to rid themselves of the expense and trouble of caring for them. American psychiatrists and public health officials, by engaging their medical expertise, debated the link between immigration and insanity. The alleged increase in the rate of insanity in America was most often attributed to immigrants’ undesirable traits, harsh environments in which they settled, or to difficulties in adapting to the new social order; however, this link between immigration and insanity was eventually explained away by new scientific statistical techniques, which declared victory for those investigators who saw environmental and external conditions, not inherent and internal traits, as causes of insanity among immigrants. In the meantime, the more restrictive immigration acts of the 1920s slowed the flow of migration and reduced entry of Asians and other people of color to a trickle. The fierce debates on the undesirability of new immigrants also subsided as they assimilated into American society and became “white.”⁵¹ The factor of “race”—understood as an inherent trait of immigrants and agent of their mobility—in the

⁵¹ For whiteness studies, see Matthew Frye Jacobson, *Whiteness of a Different Color: European Immigrants and the Alchemy of Race* (Cambridge, MA: Harvard University Press, 1998); Ian Haney López, *White by Law: The Legal Construction of Race* (New York: New York University Press, 1996); David Roediger, *The Wages of Whiteness: Race and the Making of the American Working Class* (New York: Verso, 1999); Matt Wray, *Not Quite White: White Trash and the Boundaries of Whiteness* (Durham: Duke University Press, 2006).

development of mental illness among immigrants was replaced by external causes, specifically the process of immigration or migration itself.

The intellectual discussions of immigration and insanity reached American audiences far and wide. Chapter 2 examines how these debates were practiced and implemented in reality and how they influenced admission, exclusion, and deportation of allegedly insane immigrants. It examines deportation files of the “alien insane” at the border areas, mostly at Ellis Island. The deportation process was not confined to the immigration stations alone. The federal government collaborated with states to facilitate the process; individual states were also deeply involved in deportation of the insane even to the point of conducting negotiations with foreign governments and continued their early practice against the growing federal power over immigration. This chapter briefly examines the two states of New York and California and their engagement in deporting the “alien insane.” It also looks into various historical actors involved in the process; despite the centralization of federal authority, the process of deportation still necessitated cooperation of multiple institutions, including state hospitals, social workers, steamship companies, immigrant communities, and foreign governments. In order to give a glimpse into the reality of deportation, this chapter also examines the “deportation party” of the 1910s and 20s, which was organized by the federal government to transport deportees to the immigration stations around the country. The party shows that deportation, designed to control and regulate the mobility of immigrants, actually facilitated their movements as deportees were gathered from state institutions, sent to immigration stations, and shipped back to their ports of embarkation.

The next chapter discusses insanity and immigration as a means to understand various categories of citizens and aliens, the notion of American citizenship, and the federal and state struggle over hegemony at the turn of the twentieth century. It explores humanitarian concerns and financial interests embedded in the process of deporting the “alien

insane” and multiple stages of negotiations among state officials, the federal government, and foreign authorities, which defined the federal government’s responsibility for its citizens and drew the line between citizens and aliens. For example, the story of Nathan Cohen, “a man without a country,” who became stranded after being deported from the United States for insanity revealed how precarious immigrants’ legal and social status was. Insanity further problematized his claim; no country or state was willing to assume constant care and protection for the suffering immigrant unless there was clear evidence of his national citizenship or state residence. Like many mobile individuals, particularly insane persons living within tenuous circumstances, Cohen had neither the papers nor the witnesses that state bureaucracies needed to identify him or confirm his existence as a subject of any state. He was, to be sure, a man without a country. Immigrants who either naturalized or established domicile in the United States were promised “reception and care” even in the case of insanity, but without concrete evidence to prove their status, these immigrants remained vulnerable. American citizens abroad, upon becoming insane in foreign countries, were subjected to the same fate as immigrant public charges in America despite their claim to American citizenship. Their mobility, which made it challenging to locate their residence or domicile, also limited their political and legal claims and left these American citizens without a place to return. Insane American citizens at Canadian mental institutions and negotiations surrounding their deportation and repatriation in the 1920s offer an example of the problems of reception and care for American citizens. In addition to shedding light on the international relations and the principle of reciprocity, their example reveals the continuing struggle over hegemony between the federal and state authorities in the matter of immigration and its costs.

Chapter 4 looks into state hospitals of New York and California, examining the hospital as an agent in detecting, committing, and deporting insane immigrants and investigating the lives of the immigrant insane at state institutions. In the late nineteenth and

early twentieth centuries, both states, concerned with large immigrant populations, developed and centralized the institutional system and were involved in the dynamics of the institutional control of immigrants. This chapter also examines the process of racialization through administrative forms, hospital statistics regarding deportation, diagnostic process, and observed physical and linguistic differences associated with certain immigrant groups. Patient case files from New York and California state hospitals are particularly useful in examining the ways in which immigrant patients' skin color, language, nationality, and other differences allowed doctors and hospital staff to see these immigrant patients as a distinct group and construct the "foreign-born" patient population at state institutions. Moreover, these records not only explain the immigrant patients' medical conditions but also reveal their histories of immigration, family relations, and social views. They show that the state hospitals, considered places of confinement and isolation, also proved to be places of integration: in these controlled environments, it became evident that immigrant patients and their families had learned to deal with various contingencies of American life. The processes of commitment and discharge for immigrant patients demonstrate that they were aware of the functions of the immigration and medical bureaucracies.

Using three sets of narratives—exposés or memoirs on asylum experiences written by American authors, official files and public documents (clemency letters, naturalization tests, and insanity pleas) for immigrants, and fictional or autobiographical accounts of insanity by immigrants—Chapter 5 investigates various perspectives of the link between immigration and insanity. As previously mentioned, immigrants' own writings on mental illness, especially from the late nineteenth and early twentieth centuries, are rare. However, asylum exposés or memoirs ("asylum narratives") from the same period, an established genre of American literature, suggest that immigrant inmates, despite their silence and seeming invisibility, played an important role in institutional life. Immigrants also participated in

creating legal and political files and documents, through which they presented themselves as potential Americans and revealed their values and views. Several novellas and autobiographies by immigrant authors included insane characters; read against the backdrop of American writings on insane immigrants, they show that immigrants had their own understandings of insanity, of assimilation, and of American society. These immigrant voices, though often internalizing the convention of American success stories, enrich the scholarship of immigration by revealing immigrants' alienation and disillusionment as well as their own perspectives of immigration and insanity in modern America.

Chapter One

Civilization and Mobility: Intellectual Debates Concerning Immigration and Insanity

The link between mobility and insanity has had a long history. Examining pathologies of travel in England between the 1700s and the 1900s, historian Jonathan Andrews explains the links between travel and mental disorder:

Travel and change of scene have continued to be embarked upon by mentally troubled and ill individuals, and to be recommended for mental and nervous afflictions well into the twentieth century. Whether as a symptomatic response to mental unrest and trauma of the type now sometimes understood by psychiatrists under the umbrella term ‘fugue’; a sign of disorientation or manic hyperactivity; or a means of working out trauma and of pursuing, or accidentally arriving at self-knowledge, wandering and journeying have long had an association with mental unrest.⁵²

In the American context, this “wandering and journeying,” when associated with the nation’s celebrated mobility myth, carried both positive and negative connotations. According to cultural geographer Tim Cresswell, “[t]he mobility of migrants to the United States and the mobility of people within the nation have often been cast in a positive light as a general fact of American cultural identity,” an affirmation of upward mobility and other chances at refashioning the self.⁵³ At the same time, whether because of their class, race, ethnicity, national origin or mental capacity, Americans excluded some wanderers and journeyers from the mythical, positive, and transformative powers of geographic and economic mobility. As Nayan Shah notes, for example, “White urban and agrarian elites and settlers, in seeking to

⁵² Jonathan Andrews, “Letting Madness Range: Travel and Mental Disorder, c1700-1900,” in *Pathologies of Travel*, eds. Richard Wrigley and George Revill (Amsterdam: Rodopi, 2000), 25-88, 28. In his study of *fugueur*, “mad travelers,” philosopher Ian Hacking explains that America did not have the problem of *fugueur* because of the American tradition of mobility: “There are obvious reasons why America should not be preoccupied by fugue. Go west, young man: the *fugueur* never came back.” Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illness* (Charlottesville: University of Virginia Press, 1998), 61.

⁵³ Tim Cresswell, *On the Move: Mobility in the Modern Western World* (New York: Routledge, 2006), 180. See also James M. Jasper, *Restless Nation: Starting over in America* (Chicago: The University of Chicago Press, 2000); Wilbur Zelinsky, *The Cultural Geography of the United States* (Englewood Cliffs, NJ: Prentice Hall, 1973).

monopolize the advantages of mobility for themselves in the early twentieth century, cast transient male migrants as marginal and replaceable labor, disruptive to the social order and irritants to the political future of democratic nations.”⁵⁴

Geographic mobility itself sometimes carried negative connotations, and Americans had long understood the movements of unfit and undesirable people as a social problem.⁵⁵ In the nineteenth century vagrants and paupers were arrested by police officers for wandering about aimlessly and put to forced labor. Passage of tramp laws throughout the country and the tramp scare at the turn of the twentieth century also demonstrated American ambivalence toward mobility.⁵⁶ Even when tramps and vagrants were legal citizens, according to Tim Cresswell, they were “shadow citizens” whose right to mobility was restrained and whose unsettled habits were believed to embody their inherent undesirability.⁵⁷ At the turn of the century, Americans regarded immigrants especially those not yet naturalized with suspicion. The racial thinking of the period that situated Asian and recent European arrivals at the low end of the hierarchy of peoples confirmed uneasiness about foreign-born newcomers. The mobility of immigrants, in particular those who seemed different from the old stock, served as proof of their innate flaws and predisposition to various social problems. A host of professionals and experts, including mental and public health professionals, many of them proponents of the period’s racial thought, confirmed immigrants’ undesirability, including mental incompetence, alcohol and drug abuse, sexual perversions, and the likelihood of becoming public charges draining the nation’s charitable services, filling its prisons and, of course, insane asylums. The “alien insane,” though their number was small, continued to

⁵⁴ Nayan Shah, *Stranger Intimacy: Contesting Race, Sexuality, and the Law in the North American West* (Berkeley: University of California Press, 2011), 2.

⁵⁵ See John Higham, *Strangers in the Land: Patterns of American Nativism, 1860-1925* (New Brunswick: Rutgers University Press, 1988). For example, Know Nothings and growing nativism of the nineteenth century questioned the value of immigration.

⁵⁶ The first tramp law was passed in 1876 in New Jersey.

⁵⁷ Cresswell, *On the Move*, 160.

garner the interest of American medical professionals and lawmakers for their costly care and for their potential corrupting influence upon American life. Thus arose the need to control them and their mobility through exclusion, deportation, and institutionalization. The flexibility and expansiveness of the term, “insanity,” facilitated this national endeavor by casting a broad net of exclusion. As we shall see, experts and lay persons alike came to understand the mobility of insane immigrants as a predisposing cause or result of their mental maladies. Mobility itself became pathologized and the bodies and minds of immigrants became the site where insanity was located.

Despite imposing exclusionary and restrictive measures and even deportation and confinement to mental hospitals upon them, Americans accepted that Europeans from civilized nations and thus potentially capable of self-rule could become citizens, buy land or homes, settle down, and shed their insanity. They fit well to the three stages of rites of passage that historian Adam McKeown describes for immigrants into the United States: “separation from an old identity embedded in a social structure; a period of liminality and unstructured community; and reintegration into a new identity.”⁵⁸ Asians, on the other hand, were excluded from this model, unable to achieve the third stage of “reintegration.” Legal measures, including the Chinese Exclusion Acts of the late nineteenth century, the Gentleman’s Agreement of 1907, the Asiatic Zone of the 1917 Immigration Act as well as the Alien Land laws of 1913 and 1920, effectively prevented their permanent settlement and rendered their “home-founding” in America impossible.⁵⁹ In addition to the American laws, the civilization discourse explained the hierarchy of the immigrants entering the United States.

⁵⁸ Adam McKeown, *Melancholy Order: Asian Migration and the Globalization of Borders* (New York: Columbia University Press, 2008), 287.

⁵⁹ See Sau-ling Cynthia Wong, *Reading Asian American Literature: From Necessity to Extravagance* (Princeton: Princeton University Press, 1993).

Discussing the migration control of the United States in the late nineteenth century, McKeown engages the discourse of civilization to show how the exclusion of Asian immigrants from America was justified:

[F]ree mobility in the interior of nations and equal access to law were features that distinguished the civilized states from barbaric and despotic ones. The lack of these features in Asia justified intervention. Their presence in the white settler nations, however, could justify exclusion of the uncivilized because liberal institutions of self-rule may collapse under the weight of so many children of despotism who were ignorant of republican virtues.⁶⁰

This view rendered Asian immigrants inferior to or different from the civilized, thus self-ruling, free-moving world of the West and removed the possibility for them to pass through the system to become American. According to McKeown, “civilization” was well suited to the task of global distinctions between peoples because it was a “self-consciously race neutral and ostensibly universal” term; nevertheless, it was limited to a group of “civilized” nations or peoples, and therefore, the term civilization could also be “an explicitly racial concept.”⁶¹ European immigrants, though initially regarded with suspicion and even fear, still were believed to have enjoyed higher and richer levels of civilization than non-European immigrants or the “colored.” However, the civilization discourse was not without contradictions; while it ordered the international world, it also produced various pathologies of modern society. In this context, those who belonged to lower civilization—in particular, Asian immigrants, considered “sojourners” and therefore not settling—were less likely to suffer from these pathologies.⁶²

⁶⁰ McKeown, *Melancholy Order*, 9.

⁶¹ Ibid., 9, 366. Historian Gail Bederman explains: “Human races were assumed to evolve from simple savagery, through violent barbarism, to advanced and valuable civilization. But only white races had, as yet, evolved to the civilized stage. In fact, people sometimes spoke of civilization as if it were itself a racial trait, inherited by all Anglo-Saxons and other “advanced” white races.” Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880-1917* (Chicago: The University of Chicago Press, 1995), 25.

⁶² Matthew Frye Jacobson, *Whiteness of a Different Color: European Immigrants and the Alchemy of Race* (Cambridge, MA: Harvard University Press, 1998).

Between 1890 and 1930, more than 25 million people from all around the world arrived in the United States.⁶³ Ellis Island and the Atlantic seaboard received more than 75 percent of all immigrants during this period. Between 1910 and 1940, Angel Island in San Francisco processed fewer than 100,000, only a fraction of the immigrants arriving in America, but Asian immigrants were a visible component of the immigration flow. The Texas-Mexico border did not attract as much attention as the other borders because it concerned mostly Mexican laborers and immigrants, whose cheap labor was in demand in America.⁶⁴ This unprecedented influx of immigrants coincided with anxiety and fear that insanity would become a widespread phenomenon in America. Northeasterners complained of the large number of the foreign-born insane in their midst and called for new legislation and stricter enforcement of the existing laws to prevent the admission of undesirable immigrants, especially from southern and eastern Europe. In addition to excluding and deporting insane foreigners, some hoped to find a way to protect future immigrants from going insane by distributing them to agricultural areas where they could contribute to the American economy and enjoy the natural environment unhindered by the hardships of urban life. The West too had its share of insane inhabitants. People flocked to the West, especially California, for economic opportunities (gold rush) and health reasons (to treat tuberculosis, for example)⁶⁵; some of them ended up at insane hospitals, adding to the already

⁶³ During the period, about 19 million entered America from Europe; 750,000 from Asia; 3 million from the Americas; 22,000 from Africa; and 40,000 from Oceania. Department of Homeland Security, *Yearbook of Immigration Statistics* 2010. Table 2. Persons obtaining legal permanent resident status by region and selected country of last residence: fiscal years 1820 to 2010.

⁶⁴ Only in 1917 was a full-scale quarantine put in effect at the Texas-Mexico border. For the number of immigrants processed at these ports, see Howard Markel and Alexandra Minna Stern, "Which Face? Whose Nation? Immigration, Public Health, and the Construction of Disease at America's Ports and Borders, 1891-1928," *American Behavioral Scientist* 42, no. 9 (June/July 1999): 1314-1331.

⁶⁵ Ibid. Also see Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (New Brunswick: Rutgers University Press, 2006).

overpopulated wards.⁶⁶ In California, the presence of the Chinese and Japanese insane was duly noted, and the state government devised various ways, including deportation, to deal with them. Midwesterners also witnessed the threat of insanity contained within its immigrant population. Local Scandinavians and those back home became familiar with the stories of insane immigrants through letters home and fictional accounts by former immigrants; medical professionals appeared on the scene actively engaged in managing both state and private asylums in the area.⁶⁷ With the exception of the Texas-Mexico border area, southerners had relatively few problems with the immigrant population; however, they had to deal with an alleged increase in the rates of insanity among African Americans at largely segregated state institutions.⁶⁸ As the fear of immigration subsided with passage of restrictive immigration laws, African Americans' growing mobility in the 1920s and 30s drew the attention of social scientists interested in migration and mental illness.⁶⁹ Native Americans did not escape this national suspicion of and concern with madness. The federal government founded an insane asylum for Native Americans in Canton, South Dakota, in 1901; it admitted insane tribal members from all over the country and facilitated their confinement.

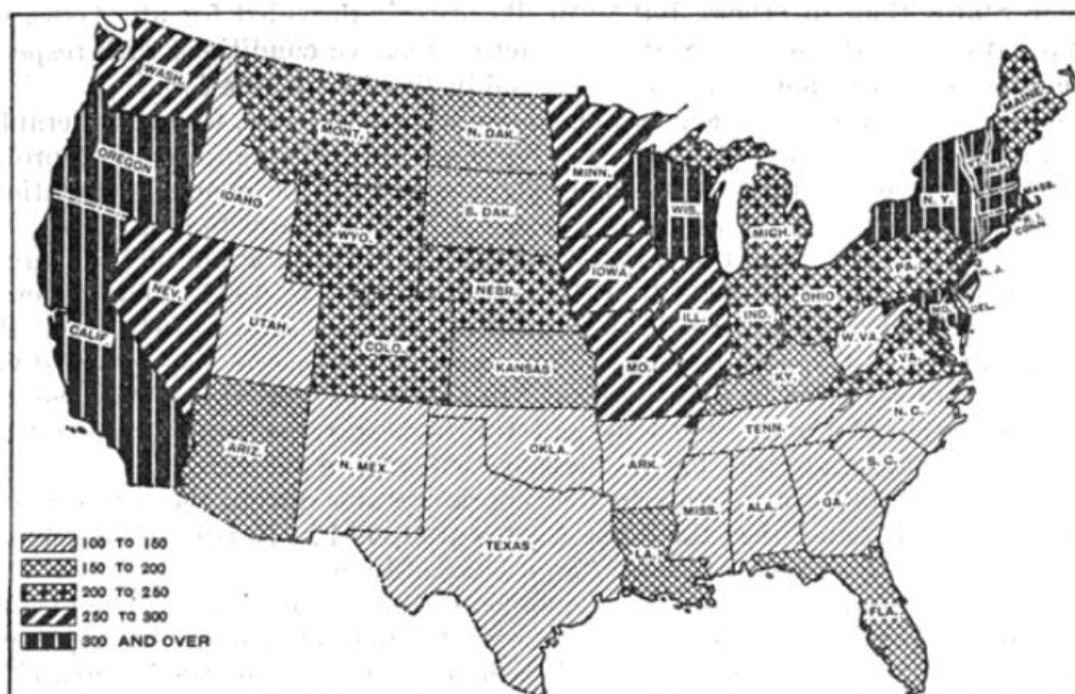
⁶⁶ E. Fuller Torrey and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* (New Brunswick: Rutgers University Press, 2001), 250-52. Torrey and Miller give several explanations regarding the reason why Californians were called "the craziest people in the world." Americans believed that those who were predisposed to insanity were more likely to move to California; miners were responsible for the high rate of insanity; with fewer almshouses, all types of deviant people were committed at state institutions; and foreigners contributed to the high rate of insanity in the region as they did in the Northeast. All these arguments were, however, refuted by other evidence and statistical adjustment. Torrey and Miller emphasize the urban nature of California as a reason for the high insanity rate.

⁶⁷ Ø. Ødegaard, "Emigration and Insanity." *Acta Psychiatrica Scandinavica Supplement* 4 (1932): 1-206; Johan Bojer, *The Emigrants*, trans. A. G. Jayne (New York: The Century Company, 1925); O. E. Rølvaag, *Giants in the Earth: A Saga of the Prairie* (New York: Harper, 1927).

⁶⁸ Gerald N. Grob explains that the pattern of institutionalization for African Americans in the South was variegated, some states segregating patients, others not. *The Mad among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994), 89; Sean Harris, "Found Insane in the Holy Land: Psychiatry and the African American Experience in Illinois, 1870-1910" (Ph.D. diss., University of Illinois, Chicago, 2007).

⁶⁹ Benjamin Malzberg, "Migration and Mental Disease among Negroes in New York State," *American Journal of Physical Anthropology* 21, no. 1 (1936): 107-113; Robert J. Kleiner and Seymour Parker, "Migration and Mental Illness: A New Look," *American Sociological Review* 24, no. 5 (October 1959): 687-690.

Figure 1.1. Number of Patients in Hospitals for Mental Disease, January 1, 1923, per 100,000 of the Population, by States



United States, Bureau of the Census. *Patients in Hospitals for Mental Disease*, 1923 (Washington, DC: Government Printing Office, 1926), 18 (Fig. 1). As of 1923, there were 165 State hospitals, 148 other public hospitals, and 213 private institutions in operation.

Insanity was not limited to white Americans or European immigrants; Asian immigrants and “colored” Americans were perceived to share in a limited way in the national phenomenon.

The “colored” (African Americans, Native Americans, Chinese, and Japanese) insane was not considered to be the significant threat that the white insane posed, and statistical data describing them were underdeveloped and underutilized.⁷⁰ Given their small number, they appeared less likely to suffer from insanity, and paradoxically, their less evolved state was said to protect them from madness. This understanding was well illustrated in the discussion of insanity among African Americans at the turn of the twentieth century. In his study of

⁷⁰ The “colored” was a convoluted and unsettled category. The 1890 U.S. Census classified “colored” to include black, Chinese, Japanese, and Indians (Native Americans). The 1900 Census confirmed what “black” meant, but it still used the “colored” category, which included “persons of negro descent, Chinese, Japanese, and Indians.” See Martha Hodes, “Fractions and Fictions in the United States Census of 1890,” in *Haunted by Empire: Geographies of Intimacy in North American History*, ed. Ann Laura Stoler (Durham: Duke University Press, 2006), 240-70; Jennifer L. Hochschild and Brenna Marea Powell, “Racial Reorganization and the United States Census 1850-1930: Mulattoes, Half-Breeds, Mixed Parentage, Hindoos, and the Mexican Race,” *Studies in American Political Development* 22 (Spring 2008): 59-96, 93.

neurasthenia, Brad Campbell explains that since insanity, like neurasthenia, was regarded as a byproduct of civilization, it was inconceivable for many Americans that African Americans had as many cases and forms of insanity as white Americans. In order to address this dilemma, medical practitioners distinguished the forms and causes of insanity suffered by these two groups and explained that inferiority of African Americans rendered them incompatible with American civilization and claimed that their insanity differed from that of civilized Americans. This “reconfiguration of insanity along racial lines” confirmed the different evolutionary positions that these races occupied and constructed a particular kind of American madness appearing only among privileged white, middle-class men while disqualifying the majority of the population.⁷¹ Similarly, the discourse of civilization rendered Asian immigrants—Chinese and Japanese “sojourners”—unlikely to become mentally ill, and even if they went insane, it was, as historian G. Eric Jarvis explains, “due to their attempts to live in environments beyond their natural capacity.”⁷² This odd assurance explains both the absence of concern for Asian “sojourners” and the prominence of more civilized European immigrants in the nation’s fearful discussions of immigration and insanity.

Civilization and Insanity

Concerns with insanity in America were already present before the influx of immigrants into the country. American psychiatrists, social scientists, and lay people all agreed that the country had long been suffering from insanity and that the number of the

⁷¹ Brad Campbell, “The Making of ‘American’: Race and Nation in Neurasthenic Discourse,” *History of Psychiatry* 18, no. 2 (2007): 157-178, 175. Also see Leland V. Bell, *Treating the Mentally Ill: From Colonial Times to the Present* (New York: Praeger, 1980), Chapter 5 “Blacks and Immigrants.”

⁷² His explanation is for African Americans, but it is also applicable to the Asian insane, especially when viewed through the civilization discourse. G. Eric Jarvis, “Changing Psychiatric Perception of African Americans with Psychosis,” *European Journal of American Culture* 27, no. 3 (2008): 227-52, 235. Mexicans and West Indians were discriminated in similar ways, but the period I examine lacked discussions on these immigrant groups.

insane had been growing. To explain this seeming increase in insanity rates, they employed another version of the civilization discourse; in this narrative, insanity was a disease produced by civilization and its attendant struggles. As early as 1852, American physician Edward Jarvis asserted: “Insanity is...a part of the price which we pay for civilization. The causes of the one increase with the developments and results of the other.”⁷³ In 1869, Henry Maudsley, the prominent British physician, argued that the “great strain of mental work” of an “active civilization” increased the likelihood of mental disease: “There seems, therefore, good reason to believe that, with the progress of mental development through the ages, there is, as is the case with other forms of organic development, a correlative degeneration going on, and that an increase of insanity is a penalty which an increase of our present civilization necessarily pays.”⁷⁴ For him, insanity was a natural outcome of civilization, and the civilized world should bear the burden in silence. Discussing insanity in Canada in 1905, T. J. W. Burgess, a Canadian physician and asylum superintendent, agreed that “[o]ur high-pressure civilization does not come to us without attendant woes.” He explained that in Canada, like any other western countries, modern civilization resulted in the increasing rates of insanity.⁷⁵ Burgess also claimed: “with the advance of civilization life has been more carefully preserved, and consequently we have among us degenerates of all kinds, and insanity is rampant.”⁷⁶ In 1910, F. H. Packard of McLean Hospital in Boston confirmed the role of civilization in increasing insanity in his Harvard Medical School lecture.⁷⁷ He explained that

⁷³ Edward Jarvis, “On the Supposed Increase of Insanity,” *American Journal of Insanity* 8 (April 1852): 333-64, 360. Torrey and Miller, *Invisible Plague*.

⁷⁴ From “The Physiology and Pathology of the Mind,” cited in “The Poor of New York: Report of the Citizens’ Association on the Condition of Our Public Charities, New York, August 2, 1869,” *New York Times*, August 4, 1869. To the Citizens’ Association of New York. Section on “The Insane Hospital.”

⁷⁵ Burgess, however, claimed that heredity was more important than civilization as a cause for the increase in insanity. Given the influence of eugenics in Canada, his emphasis on heredity may be justified. T. J. W. Burgess, “Presidential Address-The Insane in Canada,” *American Journal of Insanity* (July 1905): 1-36.

⁷⁶ “Civilization and Insanity,” *Medical Record: A Weekly Journal of Medicine and Surgery*, December 1, 1906; pg. 870.

⁷⁷ “Causes of Insanity Discussed.” *Boston Evening Transcript*, April 18, 1910.

all the causes of the increase were “incidental to modern civilization, for they are not found among the uncivilized.” Packard explained his idea of “modern civilization”—limited to the western society of Europe and North America—and how exposure to it could lead to insanity attacks among the uncivilized:

It is the unanimous report of qualified observers that mental diseases are quite rare among people of lower civilization. More interesting is the influence wrought upon these people when brought in contact with civilization. For example, the Arab in Europe is subject to general paralysis, although it is a very rare disease in his own country. The North American Negro, when in slavery and cared for like an animal was subject to comparatively little mental trouble, and since the Civil War insanity among the Negroes has trebled and general paralysis, a mental disease formerly almost unknown among the Negroes, is now more prevalent with them than among the whites.

He admitted that people of lower civilization could go insane upon their exposure to advanced civilization. However, civilization itself was not to blame; it was the incapability of these less civilized people, especially the “colored” (Arabs and Negroes) to cope with the civilized western world.

Others had different views of civilization and its impact on insanity. In 1903, John W. Robertson, Superintendent of Livermore Sanitarium in California, asserted that civilization was not the cause of insanity. While admitting that modern civilization greatly changed American life, he argued that it also brought about advances in medicine and care of the mentally diseased, which led to protection of the public and help for individuals. Robertson went so far as to assert that a high insanity rate was “a badge of honor to a nation” because it showed the nation in question was not only civilized but also humanized enough to provide adequate care for its insane. He concluded: “a State which does not show a higher ratio [of insanity] is not, in the best way, caring for her incompetents.”⁷⁸ The publication of the census data in 1906 on the insane in the United States raised alarms, but there was a doubt about

⁷⁸ John W. Robertson, “Prevalence of Insanity in California,” *American Journal of Insanity* 60 (1903): 75-88, 77, 86.

whether insanity was indeed on the rise.⁷⁹ A 1906 *Chicago Daily Tribune* article challenged the expert opinion of the head of a Maryland hospital about the growth of insanity, claiming: “He sees more insane than he does sane people, and for that reason, perhaps fancies the world is going mad.”⁸⁰ Medical professionals themselves denied the increase of insanity in the United States. For example, Dr. Henry R. Stedman of Boston asserted that the prolonged life of insane patients gave a false impression that insanity was increasing in the country. He argued that efforts to eliminate unhealthy and unsanitary conditions in America made the increase in insanity doubtful.⁸¹ Nevertheless, the idea that advances in civilization and its alleged influence on the subsequent rise of insanity rates continued to enjoy prominence. As late as 1931, Charles H. Mayo of the Mayo Clinic, at the address before the American College of Surgeons, asserted that “[t]he price of civilization is an enormous amount of insanity.” Mayo continued: “The world has moved ahead so fast in material civilization that man has almost got behind in his power of adaptation. Every other hospital bed in the United States is for mentally afflicted, insane, idiotic, feeble-minded, or senile persons. There is enormous number who are almost fit for the asylum.”⁸²

Despite the contemporary association between immigration and insanity, the civilization discourse rarely problematized European immigrants. Their susceptibility to insanity as a response to urbanization and industrialization in America placed them along the same line as native-born Americans. The problem was to explain insanity, or lack thereof, in non-white, non-European people. In terms of their lower level on the civilization scale, African Americans, Native Americans and Asians (mostly Chinese and Japanese) were

⁷⁹ See “Is Insanity Increasing? Record of Census Given,” *Chicago Daily Tribune*, August 9, 1906, pg. 8; “The Increase of Insanity,” *San Francisco Chronicle*, December 10, 1906, pg. 6. The article reported that the U.S. was still not as crazy as some of the European countries.

⁸⁰ “The Growth of Insanity,” *Chicago Daily Tribune*, August 11, 1906, pg. 8.

⁸¹ “Insanity Not Increasing,” *Boston Daily Globe*, February 4, 1908.

⁸² “Mayo Finds Insanity Price of Civilization,” *New York Times*, October 15, 1931. Psychiatrist Adolf Meyer and others following his school of psychiatry argued that poor adjustment might lead to psychopathological reactions.

distinguished from white Americans or Europeans; and their mental problems did not garner much attention from American psychiatrists until well into the twentieth century.⁸³ American medical professionals, even those who were involved in the care of African Americans at southern institutions, lacked a clear psychiatric discipline to understand these people due to their biased assumptions or their lack of experience. Northeastern practitioners relied on their southern counterparts to educate themselves on the matter of “colored insanity.”⁸⁴ As Packard argued in 1910, insanity in African Americans was often connected with the negative impact of emancipation and their innate qualities unsuited to freedom and independence. Thus, by the turn of the twentieth century, medical practitioners drew a clear color line between African Americans and white Americans in terms of their maladies.

Inconsistencies within the civilization discourse also hampered the knowledge of Asians. For example, Chinese and their civilization were seen as so alien that nobody knew for sure “what effect years and years and centuries of contact with the civilization and intelligence of the white race would have on them.”⁸⁵ Still, they were often juxtaposed with African Americans in the American imagination. Literary critic Julia H. Lee argues that African Americans and Chinese occupied polar opposite positions in the civilization discourse; while African Americans were believed never to have achieved civilization, Chinese and other Asians (i.e. East Indians) were viewed as having already reached the

⁸³ For black psychosis, see John S. Hughes, “Labeling and Treating Black Mental Illness in Alabama, 1861-1910,” *Journal of Southern History* 58 (August, 1992): 435-60; Harris, “Found Insane”; Matthew Gambino, “‘These Strangers within Our Gates’: Race, Psychiatry and Mental Illness among Black Americans at St Elizabeths Hospital in Washington, DC, 1900-40,” *History of Psychiatry* 19, no. 4 (2008): 387-408. See also Jonathan Metzl, *Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009) and Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Cornell Studies in the History of Psychiatry) (Ithaca: Cornell University Press, 1995).

⁸⁴ Harris, “Found Insane.”

⁸⁵ Mr. Londerbeek, Police Judge, 47th Cong., 1st sess., *Congressional Record* (March 14, 1882): 1903; Congressional debates from the late nineteenth century show that Chinese immigrants were constantly compared with African Americans and Native Americans in terms of their civilization and their “colored” status. For the earlier period, see Moon-Ho Jung, *Coolies and Cane: Race, Labor, and Sugar in the Age of Emancipation* (Baltimore: The Johns Hopkins University Press, 2006).

apogee but been declining, incapable of emulating modern, western forms of civilization.⁸⁶ Japan posed a somewhat different problem. The development of a scientific classification system in the late nineteenth century stratified races and nations of the world and revealed the ways in which not only civilization but also political prowess shaped the global hierarchy. For example, in the 1870 and 1880 censuses, Japanese in America had been enumerated as part of the Chinese population for statistical purposes, but the U.S. Census of 1890 began to treat Japanese as a separate group, reflecting the changing perceptions of Japan in the international world. Japanese occupied a higher social and political stratum than Chinese as “Christian, democratic, cultivated, honest, intelligent, polished, gentlemen, “peaceable, quiet citizens,” the “Frenchmen of the east.””⁸⁷ Moreover, as Japan established its political power on the international scene, it became part of the “family of civilized nations.”⁸⁸ This ordering of the nations also shaped the immigration policies for Japanese, who were subjected to more lenient regulations than Chinese. However, both China and Japan, with their inassimilable people, continued to occupy an in-between status, neither barbaric nor fully civilized. As British psychiatrist G. Fielding Blanford clarified in 1897, “China, India, and Japan are countries whose civilization is of great antiquity, and may be said to hold an intermediate position between the European and that of barbarous tribes.” Their position on the civilization scale influenced the rates of insanity as well: “In the older civilizations, in China, India, and Japan, there is more [insanity than in a primitive people], but still little compared with that which is found in Western Europe.”⁸⁹

The ways in which the civilization discourse explained insanity of the “colored” were well illustrated in the 1916 four-volume study, *The Institutional Care of the Insane in*

⁸⁶ Julia H. Lee, *Interracial Encounters: Reciprocal Representations in African American and Asian American Literatures, 1896-1937* (New York: New York University Press, 2011), 38.

⁸⁷ Hochschild and Powell, “Racial Reorganization,” 73.

⁸⁸ McKeown, *Melancholy Order*, 154.

⁸⁹ G. F. Blanford, cited in *Stockton State Hospital Biennial Report* (1884-1886), 17.

the United States and Canada, edited by Dr. Henry M. Hurd and several medical professionals. In the first volume of the study, Hurd offered a short chapter titled “Insanity among Negroes, Indians, Chinese and Japanese in the United States,” with the survey of the rates and causes of insanity among the four groups. For the section on “Negroes,” Hurd, instead of expressing his own view of insanity among African Americans, reiterated the opinion of a prominent southern physician-expert on African Americans and their insanity, who maintained that emancipation, racial inferiority, and growing knowledge of available institutional care led to an increase in the number of insanity cases among the black population.⁹⁰ Moreover, “negroes” as a race were of “a simple nature, giving little thought to the future, accepting responsibility thoughtlessly, and desiring only the gratification of the present.”⁹¹ This section implied that their type of insanity, despite its rapidly growing rate, was not the same as that of white Americans, and as long as they were restrained and controlled, they would be protected from the disease.

In the next discussion of North American Indians, Hurd admitted that there were diverse opinions as to the rate of insanity among Indians: some argued that they were less prone than whites to insanity while others observed that access to public hospitals equalized its occurrence.⁹² For Hurd, it was their exposure to civilization and enlightenment that produced their insanity. He included an article of H. R. Hummer, Superintendent of the asylum for Indians in Canton, South Dakota, who observed that insane Indians and whites displayed the same mental symptoms but that Indians were more “reticent” and harbored superstitions “fully as prominent as those of the plantation negroes.” They were also “more

⁹⁰ Henry M. Hurd, ed., *The Institutional Care of the Insane in the United States and Canada* (Baltimore: The Johns Hopkins University Press, 1916). Such explanations had been widely accepted during the time period, but there were still doubts. Also see Campbell, “Making of ‘American’”; Gambino, “Strangers within Our Gates.”

⁹¹ Hurd, *Institutional Care*, 377.

⁹² *Ibid.*, 384. The exposure to American life allowed a growing number of Indians with insane relatives to bring the case to court so that they could commit the insane to a public institution.

destructive and decidedly filthier than the white race.”⁹³ Like the section on “Negroes,” this section revealed the contemporary view of Native Americans and their mental health that drew many Americans’ attention at the turn of the twentieth century.⁹⁴ In 1897, the *New York Times* reported that there were only 68 insane Indians in the country, some of whom were “idiots rather than lunatics.”⁹⁵ Two years later, the *Los Angeles Times* reported that there were “no Indian Lunatics” because “a full blooded Indian lunatic never lived.”⁹⁶ Most insane Indians, the *New York Tribune* reported, had “more or less white blood in their veins” as a result of interactions with whites.⁹⁷ Despite their small number, in 1898 and 1899, the American government launched a plan to build an asylum for insane Indians, partly because it believed that they received no proper care from their tribal people who had superstitious fear of insanity.⁹⁸ The mental hospital for the Indian insane became essential, if not to cure them, to propagate humanitarian ideals of civilized Americans among the savage people: “It is well known that feeble minded, demented and insane Indians, as well as the aged and infirm, receive little care and attention from their relatives or tribesmen. A crazy Indian is universally regarded by his brethren as good as a dead Indian.”⁹⁹ In 1901, as the completion of the mental hospital for the Indians came near, the American public began to worry about the possible increase in the rate of insanity among Indians with “the march of civilization”; Americans now realized that “this unfortunate class come from the full-bloods, half-breeds,

⁹³ Ibid., 391.

⁹⁴ See James B. Waldram, *Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples* (Toronto: University of Toronto Press, 2004).

⁹⁵ “Sixty-Eight Insane Indians,” *New York Times*, September 16, 1897

⁹⁶ “No Indian Lunatics,” *Los Angeles Times*, June 25, 1899

⁹⁷ “Insane Asylum for Indians,” Special to *New York Tribune*, May 24, 1899. This view is quite similar to that of Mulattos and their allegedly high insanity rates.

⁹⁸ Ray Stratton, on the other hand, argues that the Cherokee had taken good care of their own sick and ill in the antebellum period. As the Civil War disrupted their community, making it difficult for them to provide care for the ill, the Cherokee Indian Nation passed an act in 1873 to establish a Cherokee Asylum for the Insane, Deaf, Dumb and Blind, thirty years before the building of the mental hospital in Canton. Stratton, “The Cherokee National Insane Asylum,” *Bulletin of the Menninger Clinic* 47, no. 3 (1983): 266-68.

⁹⁹ “An Asylum for Insane Indians,” Special to *New-York Tribune*, January 19, 1902.

and all degrees of blood.”¹⁰⁰ Still, it seemed that Indians showed fewer cases of insanity and their mental condition could be treated by ridding them of civilization. According to the *Chicago Daily Tribune* in 1904, the National Hospital for Insane Indians (Canton Asylum) provided a simple treatment for insane Indians: allowing them “to follow their own likes and dislikes.” Superintendent Gifford stated that he even let the Indians “indulge in native dances” because by going back to their “normal habits” they would regain their health.¹⁰¹ By insulating them from American civilization, Gifford hoped the Indian patients would recover their former selves.¹⁰²

Hurd wrapped up this brief chapter with a cursory examination of the Chinese and Japanese insane. His discussion of the group consisted of three paragraphs covering the two decades between 1890 and 1910. This brevity suggested that the presence of the Chinese and Japanese insane, though duly noted, was a puzzle to medical experts.¹⁰³ Moreover, that they were grouped together with African Americans and Native Americans and not included in the chapter for “immigration” in the same volume also hinted that Hurd did not see Chinese and Japanese as part of the immigration flow into the country that would soon settle in the United States permanently.¹⁰⁴

¹⁰⁰ “Asylum for Insane Indians,” Special Dispatch to *The New York Times*, December 22, 1901

¹⁰¹ “Gain in Indian Insanity,” *Chicago Daily Tribune*, January 3, 1904.

¹⁰² See C. Richard King, “The Good, the Bad, and the Mad: Making up (Abnormal) People in Indian Country, 1900-30,” *European Journal of American Culture* 22, no. 1 (2003): 37-47. King explains the centrality of abnormality to the practices of individuation in Indian country during the first third of the twentieth century. Normalization and regulation from the time period influenced the subsequent policies targeting the group and led to the present-day images and representations of Native Americans as alcoholic and suicidal.

¹⁰³ Examining the notion of “colored insanity” and analyzing medical articles on African-American insanity, Sean Harris claims that “colored insanity” proved “little more than a set of convenient notions that psychiatrists borrowed to explain something they never truly understood.” Harris, “Found Insane,” 183-184. It might have been even more difficult to understand Asian immigrant patients due to language and cultural differences.

¹⁰⁴ The same volume had a chapter titled “Immigration as a factor in the increase of insanity,” which focused on preventing the entry of insane immigrants and facilitating their deportation from America.

The civilization discourse informed the American view of insanity in Asians and shaped the global exchange of medical knowledge. Insanity, it seemed, was curiously absent among the Chinese and Japanese in the United States. As Hurd's section suggests, even when they saw the Asian insane, American physicians and psychiatrists found it hard to understand their symptoms and psychoses. However, American missionaries, government employees, and medical professionals stationed in China and Japan added to the medical knowledge of insanity and offered a knowledge base to American psychiatrists who would examine the Asian insane at insane hospitals or immigration stations.¹⁰⁵ This exchange of knowledge became possible because immigration experience for Chinese and Japanese was rarely taken into account; their inherent and uncivilized traits were believed to remain unchanged regardless of where they were, and therefore what these Americans observed in Asia could be applied to Chinese and Japanese immigrants in the United States.¹⁰⁶ In addition, American psychiatrists were in close communication with those stationed in Asian countries, many of whom took an interest in insanity because they were aware of the alleged increase in mental problems in America and because they were often puzzled by the seeming invisibility of insanity outside the western world. These missionaries and medical experts played an

¹⁰⁵ There are several studies on Chinese and Japanese hospitals and psychiatric systems in the late nineteenth and early twentieth centuries. For Japan, see Akihito Suzuki, "The State, Family, and the Insane in Japan, 1900-1945," in *The Confinement of the Insane: International Perspectives, 1800-1965*, eds. Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), 193-225. For the Chinese, Peter Paul Szto examined connections between missionary organizations and insane asylums and establishment of the Chinese mental hospital system at the turn of the twentieth century. "The Accommodation of Insanity in Canton, China: 1857-1935" (Ph.D. diss., University of Pennsylvania, 2002). For the pre-nineteenth century study of insanity in China, see Vivian Ng, *Madness in Late Imperial China: From Illness to Deviance* (Norman: University of Oklahoma Press, 1990).

¹⁰⁶ Asians and Asian Americans (or immigrants) were distinct groups; however, as literary critics Lisa Lowe and Ann Anlin Cheng explain, the American view of Asia as a perpetually foreign entity often made possible the identification of Asian Americans with Asians. According to Cheng, however, a similar identification of "African Americans" with "Africans" is neither likely nor acceptable. Ann Alin Cheng, *The Melancholy of Race: Psychoanalysis, Assimilation, and Hidden Grief* (Oxford: Oxford University Press, 2001), 69; Lisa Lowe, *Immigrant Acts: On Asian American Cultural Politics* (Durham: Duke University Press, 1996). Since Asians in terms of their mobility and civilization were considered outsiders, I use the American views of Asia as a way to discuss Asian "immigrants" in America.

important role in informing Americans of the mental condition and psychology of Chinese and Japanese immigrants and revealed the enduring influence of the civilization discourse.

As early as 1847, American medical professionals, quoting missionaries stationed in China, argued that insanity was relatively unknown to the country because of its environment and dietary regimen: “The people of China do not live in that fever of excitement we do, are not fed so high with stimulating meats and drinks, and suffer little from mental diseases.”¹⁰⁷ In addition to the diet, they believed that civilization, or lack thereof, played an important role in stabilizing mental conditions of the Chinese. In 1872, Dr. E. T. Wilkins of California quoted residents and travelers from “savage or semi-barbarous nations” of China, Nubia, Egypt, the African shores of the Mediterranean, Syria, and East India to explain that “it [insanity] is found in all countries and among all nations, but is more prevalent among civilized than among savage people.” He cited Mrs. Williams, an American missionary, who had been in China for twelve years and seen only “two who were “upside down,” as the Chinese call it, during the whole time.”¹⁰⁸ Nevertheless, American missionaries and medical professionals began to see insanity through their daily interactions with the “natives.” Many of them claimed that the illness appeared with the introduction of Western styles of life. For example, in 1895, the *Medical Insurance* explained: “Insanity in China is estimated at one in every five thousand; including idiocy, one in every two thousand; while in Japan it is said that any form of mental impairment is seldom met with, except in those portions of country

¹⁰⁷ “Insanity in China,” *American Journal of Insanity* (July 1847): 74-76, 76.

¹⁰⁸ California, State Commission. *Insanity and Insane Asylums. Report of E. T. Wilkins, M.D.* (1872), 37. These countries belonged to ancient, not “primitive,” civilizations. Conditions in China and Japan were different from colonies and were hard to categorize. See Ruth Rogasaki, *Hygienic Modernity: Meanings of Health and Disease in Treat-Port China* (Berkeley: University of California Press, 2004). For colonial psychiatry, see Ernst Waltraud, *Mad Tales from the Raj: Colonial Psychiatry in South Asia, 1800-58* (London: Anthem Press, 2010); Richard C. Keller, *Colonial Madness: Psychiatry in French North Africa* (Chicago: The University of Chicago Press, 2007).

which have been longest and most subject to foreign influence.”¹⁰⁹ Traditional healers and folk remedies treated insanity, and the family, community, or religious organizations assumed the care of these unfortunate people.¹¹⁰ Yet, American missionaries and medical professionals were motivated by the humanitarian ambitions to improve the living conditions in the “heathen lands,” and the “abundance of theories, speculations, traditions and superstitions” in these countries fueled their desire to establish a mental hospital to administer proper care and treatment to the insane.¹¹¹ In 1899, the *Journal of the American Medical Association* reiterated this desire by criticizing Chinese civilization:

It seemed to be assumed that their [Chinese] particular type of non-progressive civilization, and the stereotyped habits and modes of thought, while not favoring the highest intellectual development, were equally unfavorable to tendencies toward pronounced mental disease. The fact, too, of the comparatively low value set on human life in China was thought to be a possible cause for the non-survival for any long period of helpless, demented individuals, who without care must quickly succumb, and the accumulation of insanity, that is one of our most serious social problems, has been thought, therefore, not to be one that troubled to any extent Chinese economists or statesmen.¹¹²

Although not savage or barbarian, Chinese and other ancient civilizations had stopped advancing and progressing. More significantly, the absence of insanity and medical care in China reflected the failure of the ancient civilization and justified the intervention of the

¹⁰⁹ *Medical Insurance*, 10 (1895), 571. Also see Frederick Peterson, M.D. “The Insane in Japan,” *Study in Psychiatry* 1 (New York: The Journal of Nervous and Mental Disease Publishing Company, 1912), 1-8.

¹¹⁰ For the psychiatric care in Japan in the first half of the twentieth century, see Suzuki, “State, Family and the Insane.” According to an American missionary woman, whose husband founded the first hospital in Siam, present-day Thailand, “in Buddhist countries insane people are sent to the temples and cared for by the priests, as hospitals for the insane are unknown in heathen lands.” “The Opening Day,” *San Francisco Call*, January 11, 1894.

¹¹¹ “Absurd Chinese Notions,” *New York Times*, April 2, 1890. This report was based on “Medical Science in China,” prepared by E. P. Thwing of the Canton Hospital and read by Dr. Henry S. Drayton. See E. P. Thwing, “Medical Science in China,” *Medical News*, August 30, 1890, pg. 210, and “The Science of Health: Medical Science in China,” *Phrenological Journal of Science of Health*, August 1890, pg. 82.

¹¹² “Insanity in China,” *Journal of the American Medical Association* 23 (June 1899): 1330.

Western world.¹¹³ As they did for the Native–American insane, these professionals embarked on a civilizing mission in the East.

One of the most notable figures in the foundation of the first Chinese mental hospital in 1898 was Dr. J. G. Kerr. The American missionary devoted his later years to building and managing the mental institution in Canton, China. Dr. Kerr's goal had been thwarted several times because his funders did not consider a mental hospital worthy of their investment.¹¹⁴ In 1890, distressed by the repeated failures in securing funds, Dr. Kerr lamented: "so far China did not have any asylum for the mentally ill when many patients of mental illness, rich or poor, were dying every day from brutal treatment."¹¹⁵ The asylum was necessary to carry out the "care for the insane and rational treatment for the cure of insanity" as well as the "care of members of our mission churches who may become insane." Kerr hoped that by securing money specifically for an asylum, the ordinary mission work would not be interrupted.¹¹⁶ E. P. Thwing, the missionary, medical man and doctor of philosophy, joined forces with Dr. Kerr. After several years' stay in China, Thwing returned in 1890 to the United States to appeal to American benefactors for an insane asylum in Canton. He had another goal in mind: informing American audiences of his experiences in China. Thwing admitted that due to the absence of statistics he could not give a satisfying account of the prevalence of insanity in China; however, he confirmed the popular belief that there was less insanity in the country than in America where "physical, psychic, climatic, and political reasons combine to make American life productive of mental instability." According to him, "Insanity is the price of

¹¹³ Ibid. Citing Dr. Kerr, the article claimed that "the ratio of insane to the general population" would reach "a point not far, if any, below that of European states."

¹¹⁴ This reluctance of the funders might have been related to the popular belief that insanity was rare in China.

¹¹⁵ Peter Szto in "Accommodation of Insanity" sheds light on the role of American missionaries and medical-men in establishing mental health institutions in China; for discussions of Dr. Kerr and mental institutions in China, see Guangqiu Xu, *American Doctors in Canton: Modernization in China, 1835-1935* (New Brunswick, NJ: Transaction Publishers, 2011) for medical development in China more generally.

¹¹⁶ "The Insane of China," *New York Evangelist*, February 26, 1891; 62, 9, Pg. 2.

modern civilization. Personal liberty and the emulous and often speculative features of business life are perilous elements in a medical point of view.” In addition to medical information, Thwing revealed to the American public a sensational and exotic side of China by offering a previously unknown but strangely familiar portrait of the country that reaffirmed its place in civilization:

Hospitals for the insane have never been known in China. Insane people are generally, or often, killed, and many commit suicide. Those that are killed are generally disposed of in this manner by their friends to get them out of their way. Maniacs who are allowed to live are sometimes chained to a wall in a dark room or chained to a post, where they are simply allowed to exist in revolting filth, with no further care than perhaps a bowl of rice once a day.¹¹⁷

He claimed that both Chinese and Japanese had no knowledge of how to care for the insane, and hoped that building an insane hospital would mark “an era in the work of civilizing the natives.”¹¹⁸

Thwing and Kerr’s effort bore fruit in 1898, and since its opening, the Kerr’s Refuge for the Insane had cared for insane Chinese and worked closely with the Chinese police and government in detecting and treating mentally ill residents in the region.¹¹⁹ As the health of Dr. Kerr deteriorated, Charles C. Selden, another medical missionary, succeeded him as the new superintendent of the Kerr’s Refuge. Selden continued communication with the American benefactors and medical experts and informed them of not only his work but also exotic tales of the East: women sold into slavery or prostitution, barbaric marriage practices alien to the West, foot-binding, and the Chinese mind still a puzzle even to those “who know

¹¹⁷ “Caring for the Insane in China: No Asylum in the Empire—Lunatics Are Killed without Mercy,” *Chicago Daily Tribune*, July 29, 1890.

¹¹⁸ “For Insane Chinese: An Asylum to Be Built at Canton,” *San Francisco Chronicle*, September 25, 1892, pg. 17.

¹¹⁹ Charles C. Selden, *Work among the Chinese Insane and Some of Its Results* (Canton, China: The China Baptist Publication Society, 1903). For the first six years, the Kerr’s Refuge operated as a private institution but it soon began to receive public charges, working with the Chinese police force.

them best.”¹²⁰ Calling for more changes and developments, Selden ironically blamed the Chinese environment for producing insanity in general: “Among the conditions that no doubt contribute to the prevalence of insanity, one should speak of the awful poverty; the distress following flood, pestilence and famine at certain times, and in the case of a large number at all times the difficulty of getting enough food to fill the mouths of the family.”¹²¹ Insanity might have been the product of advanced civilization, but in the Chinese context, it was also the lack of civilization that threatened the mental health of the Chinese. This view shared by other missionaries confirmed China’s place in the world as a country incapable of protecting its own people. Thus, establishing a mental hospital was indeed a civilizing and humanizing effort, which American missionaries and medical professionals continued in other countries of the East.¹²²

American missionaries and medical experts considered insanity rare in turn-of-the-century Japan but acknowledged that growing western intervention resulted in the increase in insanity rates. The Japanese were more in tune with the western medical model than their Chinese counterparts were. Already in the nineteenth century, many young Japanese men went abroad for medical training at institutions in Europe, especially Germany, and after return home, they maintained steady communication with western medical experts hoping to

¹²⁰ Charles C. Selden, “Conditions in South China in Relation to Insanity,” *American Journal of Insanity* (October 1913), 415, 422-423. His report showed that many Americans saw foot-binding as a potential cause for insanity, but Selden denied the association.

¹²¹ *Ibid.*, 422-423. Selden did not extend his discussions to the Chinese insane in the United States, although the readership for the *American Journal of Insanity* included superintendents of state institutions, who might have encountered a few Chinese inmates during their tenures.

¹²² Syria is one example. In 1897, Syria founded its first insane asylum in Beirut with the help of Americans aspiring for humanitarian care for the insane: Syrians and foreigners all agreed that Syria needed a hospital for the mentally diseased “as these unfortunates had been treated inhumanely, being chained, scourged and manhandled “to drive the devils out.”” Americans made medical and material contributions to the institution, and the hospital was directed by a professor of psychiatry of American University. Amin A. Khairallah, “A Century of American Medicine in Syria,” *Annals of Medical History* 1, no. 5 (1939): 460-470. The Philip Khuri Hitti Papers, Box 20, Immigration History Research Center, University of Minnesota. For “oriental” mental hospitals in the 1940s, see Eric Berne, “Some Oriental Mental Hospitals,” *American Journal of Psychiatry* (November 1949): 376-383.

modernize their system.¹²³ At the turn of the twentieth century, a growing number of Japanese doctors began to take interest in American medical institutions, and exchanges of medical knowledge grew between Japan and America.¹²⁴ In 1909, Dr. K. Saito, director of the Aojama [sic] Hospital of Tokyo, Japan, familiarized Americans with insanity in Japan. Saito admitted that civilization increased insanity in his country. “Fifty years ago,” he said, “insanity in Japan was very rare. Thirty years ago it began to increase and after the Chino-Japanese War there was a further increase. The increase was even more marked after the war with Russia. I believe that as civilization advances in Japan insanity becomes more common, due to the struggle for existence.”¹²⁵ He was interested in learning advanced medical practices of the West and was on his way to tour the world inspecting hospitals for the insane. The Japanese government also played a significant role in the modernization effort, building its own legal and social infrastructure. In the early twentieth century, two laws concerning the insane and their treatment paved the way for modern psychiatric institutions in Japan.¹²⁶ By the 1910s, the country had established a number of medical schools and affiliated hospitals for the care of the insane.¹²⁷

Japan’s zeal to civilize and modernize its institutions invited the admiration of American psychiatrists. In 1912, Frederick Peterson, Professor of Psychiatry at Columbia

¹²³ Peterson, “The Insane in Japan.” Akihito Suzuki argues that it is crucial to consider the importance of social and cultural forces “from below” in developing and modernizing Japanese psychiatry. He acknowledges the role of western influences but also emphasizes the domestic interactions among various basic social units: the family, community, local and central governments, and psychiatrists. Suzuki, “State, Family, and the Insane,” 224-5.

¹²⁴ See E. P. Thwing, “Medical Science in China,” *Medical News*, August 30, 1890, pg. 210; “Jap Doctor at Hopkins,” *The Sun*, August 8, 1907. In 1907, Dr. T. Kubo became the first Japanese University graduate to come to America for post-graduate study at the Johns Hopkins University.

¹²⁵ “Japan Also Going Insane: Advancing Civilization and Struggle for Existence Responsible.” Direct Wire to the Times, *Los Angeles Times*, May 15, 1909; *Medical Times*, July 1909, 224.

¹²⁶ Mental Patients’ Custody Act of 1900 and Mental Hospitals Act of 1919 were two major acts that dealt with the insane in Japan after the Meiji Restoration of 1868. Suzuki, “State, Family, and the Insane,” 203-204.

¹²⁷ The *San Francisco Call* however reporting on the German alienist and nerve specialist Dr. Lillienstein’s visit to insane asylums around the world, quoted him that Japan made no provision for its insane, while it had good general hospitals. “Insanity Due to Drugs and Drinks,” *San Francisco Call*, February 7, 1909.

University, reported a lesson he learned from the Japanese psychiatric care for the insane. According to Peterson, the Japanese asylums were well advanced and organized, even to the envy of New York psychiatrists like himself. He acknowledged that the symptoms and diagnoses of insanity in Japan were not different from those in the United States and asserted that the Japanese successfully took up western ideals for the psychiatric care of their people. Peterson was fascinated by some of the features of the ancient Japanese care system under which the insane were sent to a village designated for their use to enjoy a simple life and a return to nature. However, his nostalgic view of the ancient Japanese system suggested that Japan still had a long way to go to achieve a modern psychiatric institution. A 1917 letter to the *American Journal of Psychiatry* (previously, *American Journal of Insanity*) from Naboru Ishida, Nagasaki Medical College, Japan, agreed. Ishida chronicled the history of Japanese medical schools and asylums: headed by Japanese psychiatrists with German training, all of them now provided the “non-restraint system” based on the Western model. However, there still was a large gap between Japanese institutions and their modern ideals: “At the present time, the number and the equipment of the asylums in this country are so few and so lacking in essentials that a greater part of the patients... are obliged to remain outside the asylums, most of them being locked in dark cages, attached to their domiciles, a smaller number being kept in the dungeons undiscovered and the rest mingling with society.”¹²⁸ It might have been necessary for Ishida to discredit his country’s achievements as he hoped to build connections with and learn from American medical men. In fact, his letter helped him launch a new career in America: a year after its publication, Ishida secured a position at a psychiatric clinic in Baltimore with the assistance of the journal editor. The irony of this story, further discussed

¹²⁸ Naboru Ishida, “Correspondence,” *American Journal of Psychiatry* 73 (April 1917): 743-44.

in Chapter 5, was that Ishida, who came to America to learn advanced psychiatry, fell victim to insanity and was eventually sent back to Japan for medical care at home.¹²⁹

Medical experts in America were not much different from medical missionaries stationed in Asia in their knowledge or ignorance of insanity in Asian immigrants but they maintained the belief in Asian resilience to insanity. In 1887, the *Medical Record* reported: “Among the Chinese and aborigines [in the United States] there has been but a small increase of insanity. There is among them less of the refinements of civilization, less competition and struggle for place, power, or wealth, and, as a consequence, less tendency to mental deterioration.”¹³⁰ Not only medical periodicals but also the census data supported this claim. According to the 1890 U.S. Census, “Among the Chinese, Japanese, and Indians the proportion of Insanity and other defects, such as idiocy, deafness, and dumbness, excepting

¹²⁹ In 1919, Ishida again made it to the *American Journal of Psychiatry*, this time, as a victim of possible insanity. Since January 1918, he had worked at a clinic at the Johns Hopkins University and at the Sheppard and Enoch Pratt Hospital in Baltimore, Maryland, to learn the methods of care of the insane and psychiatry in general. Ishida had maintained an amiable relationship with his colleague, Dr. George B. Wolff, until one day he went to the post office in the town to secure Dr. Wolff’s arrest “for slandering him and calling him a spy.” Unable to find the magistrate, he came back with a gun that he had purchased earlier that day. Next day, he shot Wolff for having called him “a Japanese spy and a traitor to my country and this country.” Ishida later added that he committed the murder to defend the honor of a nurse, who according to him had been assaulted by Wolff one night, but it turned out that on the day of the alleged assault, she had been engaged on a duty in another part of the building. The defense team for Ishida pleaded insanity, claiming that Ishida suffered from mental problems at the time of the murder; psychiatrists who examined him acknowledged the possibility of mental illness but they were unwilling to testify. Ishida was convicted of murder in the first degree and was sentenced to life-imprisonment. See “Half-Yearly Summary: Maryland,” *American Journal of Psychiatry* (April 1919): 573-74. Newspapers nation-wide reported his trial, adding a sensational touch by focusing on the alleged love triangle among Ishida, his victim, and the nurse at the Clinic. For details on his trial, see “Japanese Alienist is Held as Slayer,” *Los Angeles Times*, December 22, 1918, pg. IV10; “Kills Brother Physician,” *The New York Times*, December 22, 1918, pg. 10; “Indict Japanese Alienist,” *Washington Post*, March 8, 1919; “Say Jealousy Led Ishida to Murder: State Opens Case Against Japanese Alienist,” *Boston Daily Globe*, March 18, 1919; “Insanity is Plea of Alienist on Trial as Slayer: Japanese Expert on Mental Diseases Took Life of White Physician,” *San Francisco Chronicle*, March 18, 1919, pg. 4; “Psychiatrist, Accused of Murder, Pleads Insanity: Trial of Japanese for Killing Fellow Physician is Begun in Baltimore,” *New-York Tribune*, March 18, 1919, pg. 3; “Insanity Ishida Plea: Sensations Expected at Murder Trial Failed to Materialize,” *The Sun*, March 18, 1919, pg. 5; “Believed Ishida Sane: State Lunacy Board Reports on Condition on February 13. Other Alienists Disagree,” Special to the *Washington Post*, March 20, 1919, pg. 3. During his imprisonment, Ishida became insane and was transferred to a mental hospital. He was sent back to Japan in 1925 for medical care. Chapter 5 further discusses his case, especially the symptoms of his insanity.

¹³⁰ “The Distribution and Care of the Insane in the United States,” *Medical Record* 32 (September 10, 1887), 303.

blindness, was less than among the white population.” The ratio of the insane among the Chinese was “small relatively to the general average,” although they showed greater rates of insanity than “the negroes” and “Indians,” befitting their place on the civilization scale.¹³¹ Moreover, American medical professionals found that the exposure to American civilization, which would supposedly increase the rates of insanity, did not have much impact on the Chinese mental condition. Since they lacked or had a different kind of “nerves,” they became “automatic” workmen, who could withstand monotonous and backbreaking labor without going insane.¹³² Moreover, as inassimilable aliens, the Chinese lived an isolated life, which protected them from developing insanity. According to Dr. Wilkins of Napa State Hospital, California, the Chinese organization in the United States protected its people from the exposure to “the excitements, speculations and other causes that serve to bring on insanity among our [American] people” by helping them live as they lived at home. Wilkins acknowledged that the Chinese “ordinarily are a very frugal, domestic, industrious and ingenious race of people,” but his statement suggested that they lived in isolation—they continued to eat rice and unstimulating food even in America—and that explained why the Chinese were protected from insanity attacks.¹³³ Their long journey to and hardships experienced in the New World rarely received attention from American medical professionals and intellectuals; their less civilized, thus potentially less American, character was believed to shield them from the threat of mental breakdown.

In an effort to defend their right to stay in the country, some emphasized this alleged rarity of insanity among the Chinese in America. In 1909, amidst the fierce anti-Asian immigration agitations, sociologist Mary Roberts Coolidge argued: “the Chinese were less

¹³¹ Theodore H. Kellogg, “The Statistics of Insanity,” *A Textbook on Mental Diseases* (New York: William Wood & Company, 1897), 29. Data based on the 1890 U.S. Census.

¹³² “Chinese Traits: Absence of Nerves in the Mongolian,” *San Francisco Chronicle*, July 5, 1888.

¹³³ E. T. Wilkins, “Proceedings of the Association,” *American Journal of Insanity* (October 1886): 155-56.

liable to insanity and less criminal even, proportionately, than the English, Scotch and Welsh, to say nothing of the Irish, the Germans, the Spanish-Americans and Italians.”¹³⁴ The Chinese insane, or for that matter, the “Oriental” insane, were a novelty for many Americans.

Similarly, a 1907 *Los Angeles Times* article noted that Japanese people were “ever a puzzle.”

The article claimed that the rapid development of Japan might give an impression that “the Japs soon would become pretty good Americans,” but in fact there was “no indication that they were likely to accept our traditions, our moral standards or our sense of true values.”

This difference became more pronounced in the examination of the Japanese mind: “The great difficulty which the examining physicians found in determining whether apparent peculiarities in their Japanese subject were symptoms of insanity or not is simply on a par with every other part of the general Japanese mystery.”¹³⁵ The insanity of the Japanese, in addition to being rare, became evidence of their unfathomable and inscrutable nature and by extension of “Orientals” in general.

Indeed, upon encountering the Asian insane, American medical professionals were at a loss, and they struggled to understand the new patient population, while projecting their own stereotypes and prejudices onto them. Superintendents at state mental hospitals in America, though concerned with Asian inmates in their institutions, had no clear idea what to do with and how to understand these patients. As historian Catharine Coleborne explains of Chinese patients in Australia, they were “difficult to understand and disruptive of asylum and colonial communities” and their representations reflected contemporary anxieties about

¹³⁴ Mary Roberts Coolidge, *Chinese Immigration* (New York: Arno Press, 1969), 449.

¹³⁵ “Ever a Puzzle,” *Los Angeles Times*, Feb. 23, 1907. It is not clear what the background of this article was—considering the time period, political issues must have loomed large—but it seems that there was an examination of insanity for the Japanese shortly before this article was published. No other information available.

“migration, miscegenation and racial difference, and madness.”¹³⁶ For example, in 1886, Dr. E. Cook Webb of Honolulu, Hawaii, expressed frustration at his lack of knowledge of the insane and pleaded eastern experts to send him information on the management and treatment of insane patients. Hawaii itself was a strange place, he claimed, where people suddenly became more violent and an “incipient brain trouble” became worse. What mattered more than climatic issues was the diversity of the patient population. Dr. Webb asserted that the native insane were “the most manageable of any class I have ever seen,” without homicidal or suicidal tendencies. However, he was particularly troubled by the thirty-five Chinese insane under his care, who were, “to draw it mildly, diabolical.” The best way to deal with these homicidal or suicidal Chinese patients was to restrain them. Dr. Webb’s isolation from the mainland medical scene and the lack of interactions with other American medical experts might have added to his frustration; it is also possible, however, that the root of his problem lay in the strangeness of and unfamiliarity with the Chinese population whom he had to manage and treat.¹³⁷ Hawaii’s unique economy and geography, which led to a large number of Asian labor migrants, increased the burden for Webb and his medical administration. Moreover, the heterogeneity of the hospital population made it almost impossible to impose an American medical system, and the hospital administrators did not trouble themselves too much with the proper care for their patients.¹³⁸ American mainland psychiatrists shared Dr. Webb’s distress with the Asian insane, and even renowned medical experts at St. Elizabeths

¹³⁶ Catharine Coleborne, “Making ‘Mad’ Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum” in *Law, History, Colonialism: The Reach of Empire*, eds. Diane Kikby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 106-122, 118.

¹³⁷ “Notes and Comments,” *American Journal of Insanity* (1886), 283. A letter from Dr. E. Cook Webb of Honolulu, Hawaii to Dr. A. E. Macdonald, General Superintendent of the New York City Asylum for the Insane. According to Webb, there were 7,000 Chinese in Hawaii (two-fifths of the entire population) and he was taking care of 35 Chinese; based on his numbers, the ratio of the insane among the Chinese was 1 in 200, lower than that of the general population in mainland America.

¹³⁸ Despite the diverse backgrounds of the hospital population (“Chinese, Japanese, natives, Portuguese, South Sea Islanders and an occasional white person”), no interpreters were available to help patients’ communication. “How Hawaiians Treat Insanity,” *Los Angeles Times*, June 8, 1913, pg. I12.

Hospital in Washington, DC, a federal institution for the mentally ill, acknowledged their ignorance of “oriental psychology.” Discussing the case of a Japanese official brought from the Japanese Consulate in Washington, DC, St. Elizabeths doctors were perplexed by the schizophrenic Japanese, who presented “an unusual problem in oriental psychology with which we had no acquaintance.”¹³⁹ In another case of a Chinese patient, doctors struggled to find ways to measure his normalcy through their own views: “His facial expression was slightly less expressive than the average normal member of his race,” read one doctor’s note.¹⁴⁰ Psychiatrists had trouble communicating with white, European immigrant patients as well, but their frustration might have increased when interacting with Asian inmates. Not fully understood, these patients were likely to be left aside without proper treatment or sent back to their home countries where the doctors hoped they could receive better attention and care.

The civilization discourse explained the seeming lack of insanity among the “uncivilized” and distinguished Asians from European immigrants. Unlike their Asian counterparts, European immigrants of civilized nations were readily associated with insanity. Contemporary intellectuals, medical experts, and social workers were both alarmed and

¹³⁹ Yasue, admitted in December 1925. RG 418, NARA, DC. He was a Secretary of the Japanese Embassy and was referred to the hospital by a Japanese doctor who had examined him previously for his nervousness. He threatened to kill himself, his wife, and children. Yasue had relatively good command of English. The quote is from the second clinical conference report on March 4, 1926. He was discharged as unimproved and sent to San Francisco to be shipped back to Japan for further care. St. Elizabeths had a Chinese-American doctor, Dr. Theodore C. C. Fong, born in Boston; he received his degree from Tufts University Medical College in 1922 and started working there in 1923 or 24. He was mostly involved in treating syphilis (and later, elderly mental patients) and did not appear on patients’ clinical conference reports. It is not clear from the records whether other doctors at St. Elizabeths had ever consulted with Dr. Fong for Chinese or other “Oriental” patients. For discussions of Chinese American doctors, see Judy Tzu-Chun Wu, *Doctor Mom Chung of the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkeley: University of California Press, 2005).

¹⁴⁰ Yu, admitted in February 1930, born in China. RG 418, NARA, DC. Yu was arrested at the White House where he hoped to present a Bible to President Hoover. Doctors provided no plan for future treatment and care because Yu was to be deported to China shortly after his admission (discharged unimproved in April 1930). Filipinos were similarly treated. See Emilio, admitted in June 1930, Sailor, born in Philippine Island, RG 418, NARA, DC. Doctors claimed that his “racial characteristics” influenced his reactions, and that “[it] is not easy to tell about these Philipinos [sic], especially on the emotional side” because of their “racial and language handicaps.”

intrigued by insane newcomers at immigration stations and state mental hospitals and shifted blame for overcrowded mental hospital conditions away from civilization as a cause to the new immigration itself. They feared that foreign governments had been sending out their weaklings to America and were concerned that insanity itself might have led to immigration. If not, why would these people choose immigration over other less extreme options?¹⁴¹

Medical experts and social scientists of the period demonstrated the ways in which debates of immigration and insanity—from which Asians were excluded—centered on the mobility of flawed immigrants into the country. The “immigration problem” became a critique not only of alleged “undesirable” racial or nationality traits of the “new immigrants” but also of their mobility, which was believed to upset the social order of the country contrary to the internal migration of American citizens that fulfilled the American tradition of mobility.

Specialization and professionalization of the field of psychiatry coincided with this influx of immigration into the United States, and the possibility to control insane immigrants grew through new immigration laws. Participation of medical professionals, immigration officials, and social workers in the discussions of immigration and insanity also revealed a convergence of scientific and social concerns, through which ideas of immigration, insanity, and mobility were constructed. The American insistence upon excluding insane persons and debates concerning their presence in America sharpened the understanding of who should be included in the national body. As immigration laws became more restrictive, better statistical techniques were adopted, and new immigrants became integrated into American society, immigrants’ mental condition began to be divorced from racial or nationality traits embodied in their alien status and increasingly associated with social conditions attending migration

¹⁴¹ In 1913, H. M. Swift of Maine, in his comparison of the frequency of insanity among different nationalities and races in Massachusetts (nationalities and races were used interchangeably and Swift classified the patients into seven race groups of Irish, English, Italians, Germans, Canadians, and Russians (Jewish)), saw “immigration,” along with heredity, alcohol and syphilis, as the causes of insanity. Swift, “Insanity and Race,” *American Journal of Insanity* (July 1913): 144-154, 154.

experience. International conversations on insanity and immigration also contributed to this process as immigrant-sending countries were informed of the much debated link between their people and insanity in America.¹⁴²

Emigration and Insanity

In 1932, Norwegian psychiatrist Ø. Ødegaard published an English-language article “Emigration and Insanity,” still cited as a classic in the field, in a Norwegian psychiatry journal. Interested in the relation between migration and mental illness, he compared patient records of Norwegian immigrants in Minnesota with those of Norwegians in Norway from 1889 through 1929 and made a diagnosis of the patients based on his medical knowledge to render American and Norwegian records comparable. Focusing on schizophrenia (called dementia praecox before his time¹⁴³), Ødegaard found this particular illness more common among immigrants and return migrants of Norwegian origin than Norwegians at home and examined his cases with the two hypotheses of stress (immigrant life) and selection (tendencies or personalities predisposed to insanity).¹⁴⁴ Ødegaard was one of the first to offer a reasoned scientific argument supported by statistical data. His work reached many American scholars and medical experts, including Benjamin Malzberg, who in the 1930s and 40s investigated the effect of migration on mental illness.¹⁴⁵

¹⁴² Insane immigrants were not an American problem; Italy, Spain, Argentina, Germany, Canada, Australia and eastern Europe also had to deal with insane immigrants, who shaped immigration policy and contributed to the discourse of psychiatry in many parts of the world. See for example Jonathan D. Ablard, “The Limits of Psychiatric Reform in Argentina, 1890-1946,” in *Confinement of the Insane*, eds. Porter and Wright, 226-247.

¹⁴³ Richard Noll, *American Madness: The Rise and Fall of Dementia Praecox* (Cambridge, MA: Harvard University Press, 2012).

¹⁴⁴ Ødegaard, “Emigration and Insanity.” Despite his effort to maintain objectivity in diagnosis, it might be necessary to note that schizophrenia and its predecessor, dementia praecox, was not clearly defined even well into the twentieth century, and the most educated and best trained psychiatrists had trouble diagnosing the psychosis.

¹⁴⁵ See Malzberg, “Migration and Mental Disease.” Ødegaard’s hypothesis is still being cited by psychiatrists and social scientists investigating migrants/immigrants and their mental health.

His methods and sources aside, Ødegaard's hypotheses of selection and stress were not entirely new. With the growing influx of immigrants to the United States in the second half of the nineteenth century, not only medical experts but also social scientists and social workers believed that immigration, especially of "undesirable" peoples, contributed to the increasing rates of insanity in the country and assisted in formulating the link between immigration and insanity. Though not as scientific or systematic as Ødegaard, others had associated insanity with external causes, such as the environment, or internal ones, including mental makeup. That immigrants moved to the United States because of their restlessness and maladjustment suggested that they had hereditary defects which triggered both the migration process and the eventual illness. American medical professionals also struggled to prove whether these defects were associated with certain races or nationalities, particularly of southern and eastern European countries. Immigrants' mobility, at the same time, entailed changes in environments wherein immigrants were exposed to new languages, new communities, and new social conditions. Even among medical experts a great deal of confusion existed concerning the link between immigration and insanity and the causes of insanity among immigrants; however, they agreed that insanity could be controlled or regulated not only through medical means but also through political and legal endeavors, such as immigration laws and medical examinations at European ports before departure.

While concerns with immigration and insanity began in the mid-nineteenth century, serious discussions on the topic came later with the growing public fear of the "new" immigration. Their allegedly inferior racial traits, inseparable from the negative implications of mobility, fueled the debates on immigration and insanity. In 1883, Dr. Foster Pratt of the state asylum in Kalamazoo, Michigan, explained that insanity in America increased through assisted immigration and intermarriages between Americans and defective immigrants. He claimed that defective people had been deliberately moved from one place to another in

America, and immigrants in particular were assisted by their governments to come to the United States where they became a burden on the public: “They [American states] too have tried the “move-on” policy, and these foreign “poor Joes” have moved on and are now “moving on” by tens of thousands to other states in the interior, to be, wherever they are, a public charge and a living pestilence.”¹⁴⁶ Critical of the mobility of the undesirable, Pratt acknowledged that people made a decision to move based on their “mental or nervous conditions or temperaments”: “Migration among our people has many causes; but, as a rule, the most of it seems to occur among those marked by their different mental or nervous conditions or temperaments,--intelligent energy, irritable restlessness, or fatuous feebleness. The first class seldom go mentally wrong; the second are liable to become insane; the third to become paupers.”¹⁴⁷ For Pratt, immigrants belonged to the second and the third classes, and their migration reflected their unstable and undesirable mental makeup that might have a lasting impact on future generations. Pratt tried to separate the extrinsic cause—“removal” (immigration)—from the intrinsic cause—heredity—of insanity. He was less concerned with environmental factors attending immigration than with the fact of immigration, but he also saw that these two causes were inextricably linked to each other: “The inherited neurosis undoubtedly causes, in very many cases, great restlessness in and dissatisfaction with any environment before, and sometimes long before, insanity is developed.” Because of this inherited condition that led people to immigrate in the first place, Pratt warned, America would be forced to bear the burden of care for not only these immigrants but also their

¹⁴⁶ Foster Pratt, “The Increase of Insanity in the United States: Its Causes and Its Sources,” *Public Health Papers and Reports*, Vol. IX, 1883, 337. In the 1880s, the British government indeed assisted paupers to immigrate to the United States. See Hidetaka Hirota, “The Moment of Transition: State Officials, the Federal Government, and the Formation of American Immigration Policy,” *Journal of American History* 99, no. 4 (March 2013): 1092-1108.

¹⁴⁷ Pratt, “Increase of Insanity,” 344.

degenerate descendents.¹⁴⁸ Moreover, their mobility was different from that of early settlers or American pioneers long celebrated in American history for it was their defective mental condition, not their vigor or strength, that initiated their immigration process.

In his response to Pratt, Fred H. Wines of the U.S. Census Office,¹⁴⁹ based on the 1870 census data, discussed an increased tendency to insanity among non-resident Americans—those who were born and relocated in other states. He argued that this tendency was “dependent upon removal from one state to another,” revealing the role of removal, or migration, in causing insanity, not only in immigrants but also in mobile Americans.¹⁵⁰ Wines was careful not to exaggerate the significance of his findings and turned to the difficulties of immigrant life to explain the allegedly high rate of insanity among immigrants in America. Challenging Pratt’s claims, Wines stated: “It is of course a question whether the removal is the cause of the insanity, or the insanity the cause of the removal; but I think that you will agree with me that the former is a more probable explanation of this coincidence than the latter.”¹⁵¹ However, Pratt did not accept Wines’s explanations and instead questioned the validity of his statement for lack of evidence. There came no definite answer to what caused insanity among immigrants.

At the turn of the twentieth century, psychiatrists and medical experts concerned with the subject of immigration and insanity saw that their duty was to inform the public and protect the country from degeneration. During the period, superintendents at large state mental hospitals, psychiatrists, and social scientists all struggled to prove whether or not immigrants, especially those from southern and eastern Europe, were responsible for

¹⁴⁸ Ibid., 344.

¹⁴⁹ In 1874, Frederick H. Wines compiled a map showing insanity by sex and by age in the United States. His statement might have reflected his interest in the distribution of insanity in the country. For his map, see <<http://www.davidrumsey.com/luna/servlet/detail/RUMSEY~8~1~29207~1130267:Chart-showing-the-distribution-by-a>>.

¹⁵⁰ Pratt, “Increase of Insanity,” 341.

¹⁵¹ Ibid., 341.

overpopulating the American institutions.¹⁵² In addition, they aimed to learn more about these new arrivals by questioning why and how they came to the United States. For example, in 1910, Dr. Sidney D. Wilgus, Chairman of the Board of Alienists, New York, discussed two types of immigration: natural and unnatural. While natural immigration was based on the economic principle of supply and demand, unnatural immigration, largely assisted, included mental defectives, insane, criminals, and paupers.¹⁵³ Thus, Wilgus questioned the mobility of these undesirable people. Using the example of alcoholics, he claimed that their habits “produce thriftlessness and ill-success at home, with restlessness as a result, and finally immigration.”¹⁵⁴ His statement revealed that the unnatural immigrants were pushed to immigrate because of their inherent characteristics prone to produce “restlessness and disaffection with conditions at home,” leading to “emigration.”¹⁵⁵ Wilgus argued that this problematic movement, particularly associated with more recent immigrants, needed to be controlled and regulated. Other experts had different attitudes toward immigration and insanity, diverging from the popular understanding that the alien insane, especially those who recently came to the United States, were most responsible for overcrowding urban mental hospitals. Responding to Sidney Wilgus, Dr. W. D. Granger of Vernon House, Bronxville, New York, argued that many new arrivals were hurried to institutions not because they were products of unnatural immigration but because unlike Americans living in large houses, they suffered cramped living conditions and were unable to take care of the insane on their own. Instead of questioning the qualities of incoming immigrants and pathologizing their mobility, Granger asserted that their strength invigorated American states.

¹⁵² Most employed scientific façade by examining institutional statistics. However, they did not take into account different age distributions. Ødegaard, “Emigration and Insanity,” 29.

¹⁵³ Sidney D. Wilgus, “The Problem of Immigration,” *New York State Hospitals Bulletin* 3, no. 1 (May 1910): 117-151. He was worried about immigrants unable to assimilate or to become a part of the melting pot.

¹⁵⁴ Ibid., 123.

¹⁵⁵ Ibid., 123.

While immigrants' mobility and various environmental conditions relating to immigration were closely linked to insanity, the contemporary thinking that emphasized the hereditary racial or national differences of new immigrants added another dimension to discussions of causes for mental illness. Thomas W. Salmon, one of the most prominent voices on the link between insanity and immigration, showed that divergent ideas coexisted on the American psychiatric scene and they were neither consistently developed nor applied.¹⁵⁶ As the medical superintendent at Ellis Island, Salmon became interested in the matter of mental illness among immigrants to the United States. Examining 100 insane immigrants at Ellis Island and 100 deportation cases from New York state institutions, Salmon found that Germany and Great Britain furnished more insane than "new immigrants"; however, he emphasized the potential danger of the new immigrants to national mental health as they would soon become major contributors to state institutions. He saw that new immigrants were predisposed to mental illness (thus, "the more unstable"), which explained why they immigrated in the first place and succumbed to stresses and hardships of immigrant life.¹⁵⁷ The link between immigration and insanity became more pronounced in Salmon's later article, "Immigration and the Mixture of Races," published in 1913. Here, Salmon focused on the peril of new immigrants to the United States and distinguished them from the old stock: "One of the chief differences between the new immigration and the old is that many of the immigrants coming at the present time are not settlers."¹⁵⁸ Like many opponents of immigration, he believed that new immigrants were restless sojourners with "the general

¹⁵⁶ Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 1997).

¹⁵⁷ Thomas W. Salmon, "The Relation of Immigration to the Prevalence of Insanity in New York States," *American Journal of Insanity* 64 (1907): 53-71, 71. According to Ian Dowbiggin, Salmon's views were not systematic or consistent; what he hoped to gain from his discussions was psychiatrists' hegemony over medical inspection of immigrants at ports of entry. Dowbiggin, *Keeping America Sane*, 219.

¹⁵⁸ Salmon, "Immigration and the Mixture of Races in Relation to the Mental Health of the Nation," in *Medical Treatment of Nervous and Mental Disease*, ed. William A. White and Smith Ely Jelliffe (New York: Lea and Febiger, 1913), 243-276.

intention of returning to Europe at some time, resulting in the period of residence [in the United States] being considered as a more or less temporary experience.”¹⁵⁹ Their continuing movement and liminality would preclude settlement and integration. Salmon did not explicitly state that new immigrants were inherently troubled, but as he did in his earlier article, he hinted at the possibility: “it is certain that some immigrants already insane, many strongly predisposed to mental disease through unfavorable heredity or other causes and a great number of immigrants not fitted to withstand the stress to which they are certain to be exposed in this country, will be admitted.”¹⁶⁰ Moreover, Salmon saw each race as having a different mental makeup: Japanese were suicidal, West Indians had “delusional trends of a persecutory nature,” Hebrews had “hidden sexual complexes,” and Poles were known for remarkable prevalence of mutism.¹⁶¹ As a way to prevent mental diseases in the United States, Salmon advocated regulation of immigration and selection of immigrants.

Despite the criticism against new immigrants for their association with insanity, the majority of medical professionals were not overtly concerned with specific racial or national groups and their susceptibility to insanity. For example, Albert W. Ferris, M.D., President of the New York State Commission in Lunacy, was involved in preventing the admission of mentally unsound immigrants through the ports of New York. Contradicting the popular view, he sided with Italian immigrants, arguing based on Salmon’s data that Italian immigrants were not destined to become burdens on American society. Ferris was suspicious of foreign governments for deliberately sending out “the diseased and inferior” to America, but he was also mindful of the harsh urban environment that Italian immigrants, “almost

¹⁵⁹ Ibid., 269. Other reasons Salmon listed were: “[t]he preponderance of servants and unskilled laborers in the new immigration; the much lower degree of education; the tendency of immigrants to settle among the immigrant population, thus limiting their opportunities for contact with American social and family life” and “the strong ties remaining between the immigrant and the old country through the fact that wives, sweethearts, and relatives still remain there; the intense devotion to the single purpose of accumulating money in the shortest possible time, which narrows life—habits and intellectual interests.”

¹⁶⁰ Ibid., 282.

¹⁶¹ Ibid., 258.

exclusively from the rosy, round, well-nourished vegetarian country people,” had to endure in the new country and claimed that it would certainly wreck havoc on their mental stability.¹⁶²

Though still unsure about the relative impacts of heredity and environment on immigrants’ mental condition, medical professionals were able to tailor both causes to fit their purposes. For public health officers like E. H. Mullan, Passed Assistant Surgeon of the U.S. Public Health Service, who were in close contact with incoming immigrants, heredity was clearly the cause of “idiocy, imbecility, and feeble-mindedness.” However, what he called “mental disease,” which was more difficult to define and detect at crowded immigration stations, was caused by the combination of hereditary and environmental conditions:

In other instances these environmental conditions may become the exciting causes and precipitate an attack of mental disease. This is especially true when the soil is prepared by heredity; that is, when the parents or grandparents have suffered with nervous or mental disease. Again environmental conditions may be so grave that they will not only prepare the way for a mental upset but they will actually precipitate it. This, I think, is the case in many of the newly arrived immigrants, who would never have had a mental breakdown had they remained at home.¹⁶³

Mullan refrained from making a judgment regarding the desirability of the new arrivals; nevertheless, his statement implied that many of those immigrants were indeed predisposed to insanity or mental diseases, which would soon manifest as they experienced the hardships of immigrant life. Mullan also suggested that the mental disease was a result of their mobility which should not have been allowed for those predisposed to mental illness; he recommended the legal exclusion of immigrants afflicted with mental illness and defects. Both public health officers and psychiatrists in charge of state hospitals tended to advocate more thorough implementation of the existing immigration laws rather than restricting

¹⁶² Albert W. Ferris, “Italian Immigration and Insanity,” *American Journal of Insanity* 65 (1909): 717-729, 728.

¹⁶³ E. H. Mullan, “Mental Hygiene,” *Public Health Reports* 29, no. 4 (January 23, 1914): 170-179, 172.

immigration altogether or following eugenicist positions.¹⁶⁴ Various provisions of the 1910s' immigration acts, including literacy tests and medical examinations at European ports, reflected such efforts of medical professionals and immigration restrictionists.

Distribution and Settlement

For many involved in the debates of immigration, insanity in immigrants was a palpable issue in need of serious solutions. It was particularly problematic because it was believed that these new immigrants were deliberately moved to and dumped in the United States and unlike the old stock immigrants would not settle as they always kept in mind the return home.¹⁶⁵ Dr. Sidney Wilgus explained that foreign countries no longer shipped their weaklings to America but that the United States was still burdened with undesirable immigrants arriving through the assistance of entrepreneurial steamship companies and private immigrant aid societies. Representatives of immigrant sending countries, in particular Ireland, insisted that unlike what the American authorities claimed, immigration cost them healthy and stronger workers, leaving them to care for the weak and the ill. According to them, it was the immigration experiences that caused insanity, not their people.¹⁶⁶ Some American psychiatrists too acknowledged factors of human migration and began to question not only international but also internal movements of people and their impact on insanity rates. In 1910, Dr. Granger compared immigration to the United States with migration from the Northeast to the West. He explained that the internal migration, which had continued

¹⁶⁴ Dowbiggin, *Keeping America Sane*.

¹⁶⁵ See Hitora, "Moment of Transition."

¹⁶⁶ In 1906, the Annual Blue-book of the Irish Lunacy Commissioners explained that insanity in Ireland increased because of the emigration of "the strong and the healthy members of the community" and the Irish returning from the U.S., suffering from mental breakdown, increased the number of the insane. It concluded: "There is every reason to fear that a large number of our people crossing the Atlantic in search of fortune in a climate and environment so different to that to which they are accustomed, leave behind them the good humor and peace of mind so happily characteristic of our peasantry." "Insanity in Ireland," *Irish Times*, August 3, 1906; "Insanity among Irish People," *San Francisco Chronicle*, September 23, 1906, pg. 30.

since the American Revolution, “took the young and strong, left the old and feeble,” leading to the higher insanity rate in the Northeast. Unlike Americans left behind, Granger argued, foreigners settling in the Northeast were young, vigorous, married early, and therefore could grow faster than the native populations.¹⁶⁷ By examining both internal and international migration, Granger pointed out hardships and difficulties of immigration as a cause of insanity: “It has always been that the conditions of emigration has [sic] been productive of insanity.”¹⁶⁸ He insisted that native-born Americans, if they had experienced the process of immigration, would have shown the same rate of insanity as that of immigrants.

In 1915, Dr. A. J. Rosanoff of New York, a Jewish immigrant himself, brought up the problem of internal migration from the East to the West, which according to him, explained an increase in insanity in the West. He claimed: “natives of the state of New York who have emigrated to California have contributed proportionately 2.60 times as many admissions to the state hospitals there as the native Californians, a showing even more unfavorable than that made by the foreign-born population in the state of New York.”¹⁶⁹ Rosanoff showed that it was social and economic factors of migration that resulted in the hospital admissions, not hereditary defects of the migrants. However, these conditions of mobility did not deter medical professionals, such as Thomas W. Salmon, from devising a new scheme to help immigrants.

To deal with the alleged prevalence of insanity in new arrivals, Salmon suggested “distribution of immigrants,” diverting immigrant families away from cities to communities where they would be welcomed and receive much needed help from neighbors. He boldly claimed: “It is certain that success in distributing immigrants to more suitable environments

¹⁶⁷ Wilgus, “Problem of Immigration,” 129.

¹⁶⁸ Ibid., 130.

¹⁶⁹ A. J. Rosanoff, “Some Neglected Phases of Immigration in Relation to Insanity,” *American Journal of Insanity* 72 (1915): 45-58.

will reduce the number of aliens admitted to institutions of the insane.”¹⁷⁰ Salmon hoped that distribution, which had already been adopted by agricultural states, would help relieve immigrants of their suffering and prevent their mental breakdowns. While he was critical of the movement of new people into the country, Salmon was willing to facilitate another form of mobility for them. Unlike immigration, distribution would bring about a positive impact not only because it would provide more favorable environments for immigrants but also because it would be designed and directed by Americans. That is, only the kind of mobility endorsed by Americans was acknowledged and accepted as a way to control and regulate undesirable elements of immigration and protect the mental health of the nation. Salmon was not alone. Albert W. Ferris of New York State Commission chose distribution as his solution to insane immigrants. He wanted to direct Italian immigrants to farming localities and to cooperate with Italian organizations in New York City, immigration officials at American ports of entry, and the Italian government so that America could receive “a valuable class of desirable new citizens.”¹⁷¹ The selection of immigrants in the home country and the distribution scheme within America would further regulate the mobility of immigrants, which these American psychiatrists believed could solve the “immigration problem.”

The distribution schemes were endorsed by psychiatrists, eugenicists, and public health officials interested in immigration. They revealed how the discussion of insanity was linked to the American concern that new immigrants were slow in assimilation because of their not-yet-settled status. Being unable or unwilling to settle and continuing to move about was a threat that called for medical, political, and legal measures. When eugenicist Harry Laughlin published his studies on immigration into the United States in the 1920s, he made several appearances at the Senate and House hearings on the new Immigration Act to explain

¹⁷⁰ Salmon, “Immigration and the Mixture of Races.”

¹⁷¹ Ferris, “Italian Immigration and Insanity,” 729.

his findings from state institutions and advocate stricter immigration laws.¹⁷² One of Laughlin's arguments, which directed greater control over the mobility of immigrants, warrants attention. Like other eugenicists of the period, Laughlin wanted to legally incorporate "general shiftlessness" as a separate category into the immigration act: "[I]n every little Italian, or Scandinavian, or English, or Scotch town, there are village ne'er-dowells who have not made good among their fellows. That is the type of immigrant which we want to exclude, even if he can stand up and get by the immigration officials and is able to pass this country; we do not want him anyway. He is poor immigrant stock."¹⁷³ Although he included the old stock in his statement, his interest in "inferior individual family stocks" failed to hide his doubt about supposedly inferior nationalities or races.¹⁷⁴ Laughlin urged that thorough study of family backgrounds should be carried out before such immigrants left for the United States, promoting the idea of selection over exclusion at American immigration stations. According to historian Desmond S. King, Laughlin wanted to move from a negative eugenic base to "a positive and proactive one that selected desirable immigrants according to agreed-on eugenic criteria."¹⁷⁵ This preference of selection to

¹⁷² Desmond S. King offers an analysis of Harry H. Laughlin and eugenicists' role in forming the 1920s immigration acts with their scientific language and claim to expertise. See King, *Making Americans: Immigration, Race, and the Origins of the Diverse Democracy* (Cambridge, MA: Harvard University Press, 2000), Chapter 6. Here, I focus on the ways in which Laughlin's statistical data concerning insane immigrants were presented and criticized.

¹⁷³ Hearings, HR 66th Cong., 2d sess., April 17, 1920: 20. Other categories that Laughlin referred to include feeble-mindedness, insanity, and criminalistic conduct. Also see Hearings before the Committee on Immigration and Naturalization, House of Representatives, 67th Congress, 3d sess. (1922), 725-831; Cresswell, *Tramp in America*, for the ways in which tramps' mobility was pathologized in relation to nomadism. Charles Davenport's Eugenics Record Office (ERO) collected data on hereditary conditions, including dementia, shiftlessness, and criminalism. See also Matthew Frye Jacobson, *Barbarian Virtues: The United States Encounters Foreign Peoples at Home and Abroad, 1876-1917* (New York: Hill and Wang, 2000).

¹⁷⁴ Nancy Ordover, *American Eugenics: Race, Queer Anatomy, and the Science of Nationalism* (Minneapolis: University of Minnesota Press, 2003), 29.

¹⁷⁵ King, *Making Americans*, 187.

exclusion, combined with the schemes of “distributing” immigrants to agricultural areas, implied further control and regulation of immigrants’ mobility.¹⁷⁶

Surgeon of the U.S. Public Health Services Walter L. Treadway’s 1925 study, *Mental Hygiene with Special Reference to the Migration of People*, was more ambitious in its approach to immigration and insanity. He examined the influence of migration on the development of the government policies on mental hygiene and the prevention of mental illnesses in Europe and in the United States. To better understand the European immigrants, Treadway turned his attention to their homelands. He explained that there was a considerable mix of peoples within the European continent due to mobilities caused by military interventions, and immigrants to the United States came from this mixture of peoples. These mobilities, though dangerous, also stabilized European immigrants through intermingling: “The several races comprising our European immigration may be regarded arbitrarily as groups of people who have had opportunity to stabilize themselves and to crystallize their traditions and customs.”¹⁷⁷ Perhaps because these conditions called into doubt the purity of European races, Treadway found it difficult to prove the superiority or inferiority of one racial group over another. Still, he was concerned with the newer, not-yet-settled immigrants from southern and eastern Europe and explained that the lack of familial support for these new arrivals might have led to a higher rate of mental disorders: “the newer immigration comprises individuals who have not taken root, as it were, within the community.”¹⁷⁸ The foreign-born, alien and non-resident insane, who were not going to settle, deserved no more than what “the wayfarer in distress” would receive from American public institutions, and

¹⁷⁶ For distribution and assimilation of immigrants, see National Industrial Conference Board, “The Immigration Problem in the United States,” Research Report Number 58, 1923.

¹⁷⁷ Walter Treadway, *Mental Hygiene with Special Reference to the Migration of People* (Washington, DC: Government Printing Office, 1925), 75. He used classification adopted by the Immigration Service.

¹⁷⁸ *Ibid.*, 122.

“certain general differences in the kind of immigrants arriving” made it doubtful whether they could become part of the country.¹⁷⁹

Statistics and New Categorization

By the time when Walter Treadway’s book was published, attention to the link between immigration and insanity had been diminishing. According to psychiatrist Samuel B. Thielman, an “obvious reason for the decreasing concern of psychiatrists about immigration was the course of legislation.”¹⁸⁰ The 1924 and 1929 immigration acts adopted national origins quotas which greatly reduced immigration from southern and eastern Europe and virtually terminated Asian immigration. Advanced statistical techniques as well as the accumulated immigration and institutional data questioned and helped dispel the stereotypes concerning immigrants and their mental health.¹⁸¹ In the early twentieth century, statistical data compiled by state institutions and the American government had given a boost to anti-immigration leagues: according to historian Mae M. Ngai, “the census was the favored form of scientific evidence cited by restrictionists and nativists during this period.”¹⁸² However, these data were challenged by various sectors and often presented unexpected outcomes. Even without thorough adjustments of age, gender, and spatial distributions, national-level studies and their statistical data had already found that insanity was more prevalent among the old stock immigrants than the more recent ones. To bridge the gap between the actual finding and the popular belief, however, these studies began to shift their focus away from racial categories to conditions of migration.

¹⁷⁹ Ibid., 150, 125.

¹⁸⁰ Samuel B. Thielman, “Psychiatry and Social Values: The American Psychiatric Association and Immigration Restriction, 1880-1930,” *Psychiatry* 48, no. 4 (Nov., 1985): 299-310, 308.

¹⁸¹ Allan V. Horowitz and Gerald N. Grob, “The Checkered History of American Psychiatric Epidemiology,” *Milbank Quarterly* 89, no. 4 (2011): 628-657, 646.

¹⁸² Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (Princeton: The Princeton University Press, 2005), 30.

Using relatively sophisticated statistical data for its time—mainly the 1904 special report of the U.S. Census—the Dillingham Report of 1911 acknowledged that insanity was more prevalent among “the foreign-born” and “certain immigrant races or nationalities”; however, the report, expected to highlight the undesirability of new immigrants, showed that they were not in fact the real problem.¹⁸³ According to the 1904 data, the order of the foreign-born nationalities contributing most to the hospital population as of 1903 was: Irish, Scandinavians, Germans, French, Scotch, Hungarians and Bohemians, English and Welsh, Italians, Russians and Poles, and Canadians.¹⁸⁴ The report offered a convoluted explanation drawing upon heredity and environment to explain what appeared to be lower rates of insanity among new immigrants and high incidence upon those from northern and western Europe. Heredity, represented as “racial and nationality traits” in the report, was explained as follows: “It is generally held that the nationalities showing the least liability to insanity are also among the most primitive in point of education and standard of living.” Moreover, “[t]he comparatively primitive condition of some of these peoples may perhaps for the present render them less liable to insanity than others. At least this appears to be true of the immigrants from eastern and southern Europe.” The report suggested that once they settled and became integrated, they would start showing higher rates of insanity. It confirmed that insanity was “apparently more prevalent” among the sturdy old stock immigrants, but at the same time asserted that it was the “conditions of American life,” not their heredity, that were “conducive to an increase in insanity.”¹⁸⁵ The distinctions within European immigrants were, however, soon replaced by interests in individuals and their reason for immigration.

¹⁸³ Reports of the U.S. Immigration Commission, *Abstracts of Reports of the Immigration Commission*, Vol. 2 (Washington, DC: Government Printing Office, 1911), 251; *Congressional Record*, April 17, 1924: 6534.

¹⁸⁴ *Abstracts*, 244. Also see King, *Making Americans*; Dowbiggin, *Keeping America Sane*.

¹⁸⁵ *Abstracts*, 251. See special report of the United States Census Bureau, *Insane and feeble-minded in hospitals and institutions, 1904*.

In 1925, Walter Treadway, Surgeon of the Public Health Service, also found in his analysis of the official institutional statistics that northern and western European immigrants, not their southern and eastern counterparts, had contributed the larger number of the insane to American institutions for the first two decades of the twentieth century. In order to reconcile this finding with the contemporary understanding of immigration, he qualified it by adding that “the “old immigration” will furnish more cases until the “new immigration” itself became old.”¹⁸⁶ Treadway saw that mental traits, aptitudes, and proclivities could be “derived from an entirely different source than directly from parents” through social contacts, traditions, the unity of written language, and unwritten laws.¹⁸⁷ He acknowledged that racial or national traits could explain disease rates in different groups; however, he was also aware that external factors, including language difficulties, economic situations in Europe and America, and selection by profit-seeking steamship companies, explained higher rates of mental diseases among immigrants. Thus, Treadway advocated individual selection: “The problem of fairly selecting our immigration from Europe and restricting the asocial groups may rest better upon individual selection than upon racial or national group selection.”¹⁸⁸ Like many of his contemporaries, he resorted to the convenient classification of foreign and native born, which allowed him to distinguish immigrants from native-born Americans (they were not yet on the same level as the native-born) and emphasize the still remaining link between immigration and insanity. Although he did not see the “new immigrants” a threat to the nation’s mental health, he was ambivalent about their virtue. Treadway concluded: “the

¹⁸⁶ Treadway, *Mental Hygiene*, 154.

¹⁸⁷ *Ibid.*, 114.

¹⁸⁸ *Ibid.*, 125. According to historian Ian Dowbiggin, at the turn of the twentieth century, the focus on individuals was not uncommon among American psychiatrists whose “alarm over immigration had long since emphasized the exclusion of insane individuals, not races or nationalities.” Thomas Salmon, for example, also paid attention to individuals although his racialization of the “new immigrants” defeated his intention. Dowbiggin, *Keeping America Sane*, 230.

high incidence of mental disease among the foreign born, as shown by admission to public institutions, remain open to further speculation and still awaits solution.”¹⁸⁹

These broad, national-level studies in the early twentieth century were primarily concerned with proving who were responsible for overpopulating American mental institutions. However, some contemporaries had been analyzing institutional statistics to measure not just racial or nationality traits but also environmental factors of immigration. For example, at the turn of the twentieth century, the National Liberal Immigration League investigated several hospitals and prisons in New York and found that negative assessments of immigrants were derived from “the deliberate purpose of creating a false impression.” The League claimed that the “undesirable class” of immigrants “cannot be accused by any reasonable man of being the sole cause of the deficit” in New York hospitals. Statistics for foreign-born prisoners or juvenile delinquents were also misleading, the League argued, as they did not consider conditions of urban life and difficulties in initial settlement.¹⁹⁰ In 1913, social worker Morris D. Waldman of the United Hebrew Charities, examining the New York State Hospital Commission data of the immigrant insane, pointed out that institutional statistics rarely took into account availability of private institutions for native-born Americans as well as profound environmental changes and the specific age distributions among immigrants. He also suspected that these statistical data, especially information regarding patients’ nativity and length of residence in America, came from unreliable and mentally unstable patients themselves and were shaped by conjectures of statisticians in the absence of accurate information. Therefore, Waldman warned that “facts” and “figures” required careful assessment and cautioned against an ungrounded “anti-foreign feeling”

¹⁸⁹ Treadway, *Mental Hygiene*, 163.

¹⁹⁰ “Figures on Immigration,” first page, YMCA Folder 36 (articles), Immigration History Research Center, University of Minnesota. Date unknown, but it seems to be written sometime after 1904.

based on the exaggerated and inaccurate statistical data.¹⁹¹ Other social workers shared Waldman's concern and called for more attention to social conditions of immigrants. In 1913, H. G. Friedman of New York asserted: "we are giving an undue amount of attention to the matter of immigration and forgetting the bigger issue." He urged instead public health professionals' "attention to the causes of urban life, to the causes of congestion, to the conditions under which our native and immigrant population alike live," and to "study the causes of insanity both among the native and foreign-born."¹⁹²

Social scientists and psychiatrists, examining hospital and census statistics, too noticed statistical errors in the studies of immigration and insanity and began to emphasize environmental factors over racial differences as a cause for insanity among immigrants.¹⁹³ Federal and state statistics, they understood, did not take into account differences in means and resources as well as age, social, and spatial distributions among the immigrant population. Adjusting these differences, they realized that various conditions attending migration might be more significant in understanding the link between immigration and insanity. As early as 1903, John Robertson, the superintendent of a California sanitarium, argued that the prevalence of insanity among the foreign-born might be attributed to a different age distribution of the native and foreign-born groups.¹⁹⁴ In 1913, H. L. Reed, political economist at Cornell University, urged consideration of the abnormal age distribution among immigrants—they tended to be younger than the general population—

¹⁹¹ Morris D. Waldman, "The Alien as a Public Charge, with Particular Reference to the Insane," *Proceedings of the New York State Conference of Charities and Correction*, 13th conference (1913), 82-117.

¹⁹² Friedman, *Ibid.*, 116. Despite Friedman's call to examine insanity among both the native and foreign-born, immigrants' susceptibility to environmental conditions further entrenched the "binary discourse of superiority/inferiority" and continued to problematize immigrants. See Yoosun Park, "Constructing Immigrants: A Historical Discourse Analysis of the Representations of Immigrants in US Social Work, 1882-1952," *Journal of Social Work* 6, no. 2 (2006): 169-203, 186.

¹⁹³ Alejandro Portes and Ruben G. Rumbaut offer a brief section on statistics of insane immigrants. *Immigrant America: A Portrait* (Berkeley: University of California Press, 1996).

¹⁹⁴ Robertson, "Prevalence of Insanity."

before blaming immigrants for various American problems that included insanity.¹⁹⁵ In 1915, Dr. A. J. Rosanoff of New York asserted that interpreting statistics required corrections and qualifications. Carefully examining the 1910 U.S. census data on the insane population and adjusting for age and spatial distributions, Rosanoff unraveled the contemporary view of immigration and insanity. He argued that the concern with the immigrant insane was unfounded and that there was only a slight difference in the occurrence of mental illness between the native-born and foreign-born. He added: “It is thought that this remaining slight difference may be accounted for by the heavy stress entailed in the migration and in the subsequent process of adjustment to new conditions and more exacting standards of living, and possibly, by other, less obvious, disturbing factors.”¹⁹⁶ He called for acknowledging and remedying the unfavorable conditions of immigrant life, rather than regulating the immigrant stock. Moreover, Rosanoff saw that insanity was not transmitted from one generation to another: according to him, the fear that immigration would increase the rates of insanity in the future generations was “not real but imaginary.”¹⁹⁷

In the 1920s, the studies of eugenicist Harry H. Laughlin rekindled interest in the institutional statistics. Despite the supposed thoroughness and objectivity of Laughlin’s study and its general acceptance by American lawmakers and the public,¹⁹⁸ his statistical use of the data was open to criticisms. In the social work journal *Survey*, zoologist Herbert Spencer Jennings, himself a eugenicist, criticized the statistics Laughlin presented at the 1922 House hearing and his conclusion that “the recent immigrants, as a whole, present a higher

¹⁹⁵ H. L. Reed, “Immigration and Insanity,” *Journal of Political Economy*, Dec. 1913, 954-6. He was writing against Prescott F. Hall, “Immigration and Immigration Restriction,” *Journal of Political Economy*, October 1913.

¹⁹⁶ Rosanoff, “Some Neglected Phases,” 56.

¹⁹⁷ *Ibid.*, 52-53.

¹⁹⁸ Congressman Albert Johnson (R-WA), for example, praised Laughlin’s study as “biologically and statistically thorough and apparently sound.” Quoted in Cybelle Fox, *Three Worlds of Relief: Race, Immigration, and the American Welfare State from the Progressive Era to the New Deal* (Princeton: Princeton University Press, 2012), 99.

percentage of inborn socially inadequate qualities than do the older stocks.”¹⁹⁹ Jennings offered other explanations for the high percentage of the insane among immigrants, including language barriers and environmental pressures, and showed that contrary to what Laughlin asserted, there was no clear distinction between northern/western and southern/eastern European immigrants in the rates of insanity. Sociologist Joseph M. Gillman also gave a scathing criticism of Laughlin’s 1922 hearing report:

In the case of insanity, for instance, even Dr. Laughlin is constrained to admit that, “after the shock of immigration is over, and adjustment more or less established, the children of immigrants...show a lower incidence of insanity than that found among the immigrants themselves...” The “bad blood” which we have in our ignorance admitted apparently does lose its virulence under the all-healing benevolences of the American environment.²⁰⁰

Gillman’s statement did not explain what caused insanity among immigrants, but he found problematic heredity an unacceptable explanation. In a later article, he refuted the “race hypothesis” in Laughlin’s study, which upheld the “Nordic myth” by valuing northern and western European immigrants over their southern and eastern counterparts without any justifiable statistical data.²⁰¹

In 1932, the Norwegian psychiatrist Ø. Ø. degaard too offered a brief discussion of the study of Harry Laughlin, who according to him “appeared in the guise of an expert whose advice was supposed to furnish a basis for the further legislation concerning immigration.”²⁰² In his article “Emigration and Insanity,” Ødegaard pointed out that although Laughlin acknowledged age and geographical distributions might lead to errors, he concluded, without correcting his data, that the new immigrants had a higher percentage of insanity than the old

¹⁹⁹ Quoted in Jennings, 309. Herbert Spencer Jennings, “Undesirable Aliens: A Biologist’s Examination of the Evidence before Congress,” *Survey* 51, no. 6 (Dec. 1923): 309-312, 364.

²⁰⁰ Joseph M. Gillman, “Statistics and the Immigration Problem,” *American Journal of Sociology* 30, no. 1 (July 1924): 29-48.

²⁰¹ Gillman, “Statistics and the Race Hypothesis,” *Social Forces* 4, no. 4 (1926): 783-88. Gillman briefly discusses “Negroes” in American urban areas who showed higher mental age than native-born whites from southern states to argue that education, not inherent racial traits, influenced the Army intelligence tests. However, the “race” in this article was largely limited to European peoples.

²⁰² Ødegaard, “Emigration and Insanity,” 38.

stock or the native-born. Hoping to achieve a balance between “objective scientific research” and “the practical solution of social problems,” Ødegaard chose his methods and subjects carefully so that he could consider the two causes of insanity—selection and stress—separately and reduce the possibility of statistical errors.²⁰³ Moreover, comparing Norwegians in America and Norway, not Norwegians and native-born Americans, he aimed to eliminate “all the factors connected with racial differences” and focus on the “problem of immigration.”²⁰⁴ This shift away from racial differences to immigration marked him different from other psychiatrists and social scientists.

Ødegaard explained that the higher rate of insanity among Norwegian immigrants in Minnesota than Norwegians in Norway “might have some connection with the restlessness, dissatisfaction etc. which is frequently observed in such personalities [schizoid type].”²⁰⁵ That is, immigrants were more likely to develop insanity because their mental predisposition—“an innate restlessness”—led them to immigrate.²⁰⁶ He admitted that “mental and physical hardships of emigration and of immigrant life may cause mental derangement in persons who would otherwise have remained sound.” Yet, he also claimed that difficulties and hardships of immigrant experiences, though associated with senile and arteriosclerotic psychoses, did not explain schizophrenia, the most visible psychosis among Norwegian immigrants; he concluded that the selection “due to a prevalence of certain psychopathic tendencies,” rather than stress, was the dominant cause of schizophrenia.²⁰⁷ Unlike Laughlin, however, Ødegaard did not see these psychopathic tendencies or personalities as a defect; he argued that many individuals with these traits were better suited to an immigrant life because their adventurous nature facilitated their adjustment to changes. Moreover, he emphasized

²⁰³ Ibid., 10, 50-51.

²⁰⁴ Ibid., 51.

²⁰⁵ Ibid., 82.

²⁰⁶ Ibid., 113.

²⁰⁷ Ibid., 176.

that the U.S. should care for its fair share of insane immigrants as the benefits it reaped from immigration were greater than the cost of care the country had complained about. Instead of calling for more restrictive immigration regulations, Ødegaard advised deportation, primarily for humanitarian reasons, of immigrant mental patients, most of whom would never get along inside or outside American mental hospitals. He also urged prospective immigrants to consult psychiatrists to determine their mental makeup prior and suggested that the American government screen the future immigrants at consulates abroad so that the undesirable and mentally unfit would not leave for the United States in the first place.

While Ødegaard's interest lay in a particular national (or racial) group and the effects of migration within it, Benjamin Malzberg, then assistant director at the Statistical Bureau of the New York State Department of Mental Hygiene examined more diverse groups of people in America. Like many psychiatrists and social scientists who studied immigration and insanity, Malzberg offered his criticism of Laughlin's 1922 hearing report, "The Melting Pot," for his failure to consider age and gender distributions of the immigrant inmate population and for neglecting environmental factors while favoring heredity.²⁰⁸ As an example to counter Laughlin's findings, Malzberg referenced African Americans and Irish immigrants and their association with general paresis and alcoholic psychosis respectively, arguing that their diseases were derived not from their hereditary problems but from their environmental and cultural backgrounds. In his 1935 article, he again challenged Laughlin's finding that Japanese, Chinese, and "African negroes" had lower rates of insanity than native whites of native white parentage. According to him, African Americans were now known for greater rates of mental diseases, and Chinese and Japanese in New York and Massachusetts

²⁰⁸ Malzberg claimed when age, sex, and environment were taken into account, the differences between the native and foreign groups would further diminish and they would have "practically the same" first admission rates. Benjamin Malzberg, "Mental Disease and 'The Melting Pot,'" *Journal of Nervous and Mental Disease* 72, no. 4 (October 1930): 369-378, 378.

showed higher instances of mental illness than native whites.²⁰⁹ Curiously, the age, sex, economic, and spatial distributions Malzberg carefully considered in his study of the European immigrant population were not taken into account for these non-white groups.

Benjamin Malzberg's studies show that interests in racial differences among European immigrants now diminished; at least in terms of their mental makeup, European immigrants did not display any differences from native-born whites. In 1936, examining foreign-born whites in New York, Malzberg concluded: "it is the thesis of this study that though some inter-racial differences [between "negroes" and whites, or Japanese and whites] with respect to mental disease appear highly probable, there is no evidence to indicate the existence of intra-racial differences within the white race, as represented by native and foreign groups in New York State."²¹⁰ Malzberg became more interested in the effect of migration on mental illnesses and found that the first admission rate of migrants was higher than that of residents, regardless of their parentage (foreign-born or mixed). His findings revealed more than a new interest in migration: the alleged "racial" differences of European immigrants were replaced by the hitherto neglected "inter-racial" differences and various

²⁰⁹ Malzberg, "Mental Disease among Foreign-born Whites, with Special Reference to Natives of Russia and Poland," *The American Journal of Psychiatry* (November 1935), 629. When it came to Chinese and Japanese mental patients, Malzberg did not take into account age differences perhaps because their number was too small to reflect accurate rates of mental disease among the populations. However, Horace M. Pollock, based on the same census data explained: "The high rates among the Chinese are partly due to their age distribution, there being few children among them." Pollock, "Frequency of Dementia Praecox in Relation to Sex, Age, Environment, Nativity, and Race," *Mental Hygiene* 10 (1926): 596-611, 609. By the 1930s, the hospital commitment rate of the Chinese became more or less equal to that of the general population. According to sociologists Berk and Hirata, demographic changes could not explain the sudden increase of the commitment rate. Thus, they come to a tentative conclusion that this might be the result of their "gradual involvement with formal agencies of social control" as they became better integrated and more visible in American society. See Bernard Berk and Lucie Cheng Hirata, "Mental Illness among the Chinese: Myth or Reality?" *Journal of Social Issues* 29 (1979): 149-166, 165. Also see Charles C. Jew, and Stuart A. Brody, "Mental Illness among the Chinese: I. Hospitalization Rates over the Past Century," *Comprehensive Psychiatry* 8, no. 2 (1967): 129-134.

²¹⁰ Quoted in American Association for the Advancement of Science, and Forest Ray Moulton, *Mental Health* (Washington, DC: The Science Press, 1939), 129. By that time, Malzberg claimed that African Americans had higher rates of mental disease than whites, but he did not explain the differences. Malzberg, "Mental Disease among Foreign-born Whites in New York State," *American Journal of Psychiatry*, 1936.

environmental factors associated with the process of migration.²¹¹ Examining migrants and their insanity rates allowed Malzberg to look newly into African-American migrants and to argue that “the fact of migration” could explain their high insanity, which had been previously attributed to their race.²¹² His studies reflected concerns with the Great Migration of African Americans of the period,²¹³ but they also revealed that by this time, the new immigrants from Europe and their mobility, whether because of the 1920s’ restrictive immigration acts, newer and better statistical techniques, or a shift in the medical thinking on immigration and insanity, no longer posed a threat.

Conclusion

The mobility of “new immigrants” was often contested and criticized in relation to the growing “immigration problems,” such as an increase in insanity rates in America. Their mobility, unlike that of American frontiersmen or pioneers, was rarely celebrated: it was more likely to be associated with their inherent undesirable qualities than with their strength and resourcefulness, and therefore closely linked to insanity. However, psychiatrists and social scientists recognized that instead of being mere carriers of insanity, these new arrivals were potential Americans, who would settle and dwell in America, raising children and earning a living. Despite the raging anti-immigration agitations, the medical professionals, while acknowledging the needs for stricter enforcement of the immigration acts and careful selection of immigrants, realized that “new immigrants” or “foreign-born” patients,

²¹¹ See Malzberg, “Migration and Mental Disease.”

²¹² Ibid., 113. However, he maintained his doubt about migrant patients’ predisposition to insanity. In 1968, Malzberg claimed: “It is possible, though not proven, that migrants were selected with respect to some biological characteristics which might increase the risk of a mental disorder,” *Migration in Relation to Mental Disease* (Albany: Research Foundation for Mental Hygiene, Inc., 1968), 206.

²¹³ Grob, *Mad among Us*; Sean Harris explains that in the 1920s, a few articles challenged certain aspects of “colored insanity” but it continued to have its influence until the late 1930s. Malzberg’s studies were one of the first to move away from this monolithic view of insanity among African Americans. See Harris, “Found Insane,” 183.

especially in terms of their mental makeup, were in fact not much different from old stock immigrants and native-born Americans. Growing interest in racial stratification and classification notwithstanding, medical experts and social scientists understood that these “new immigrants” were indeed “white” and would eventually enter mainstream American society. In this logic, insanity during the period was for whites, produced by and through western civilization. Excluded from the possibility of mobility and having no chance of becoming part of American civilization, non-whites, such as Chinese and Japanese, were considered protected from its stresses and illnesses. However, the relative lack of mental troubles for Chinese and Japanese was not considered an asset; the insanity debates confirmed the non-white, non-American status of Asian immigrants. Their distance from western civilization explained why they allegedly suffered less from insanity and why they were protected from the typically unsettling effects of mobility. African Americans and Native Americans were viewed through the similar discourse of civilization and mobility, but despite segregation and discrimination, they were not, of course, subject to deportation.

Trapped in the competing narratives of civilization and mobility, both Asian and European insane immigrants had to deal with legal and social obstacles imposed by their precarious immigrant status. The debates on immigration and insanity shaped the social and political reality that the “alien insane” experienced. They could be physically removed from their adopted country, forcibly returned home, or left to drift from one continent to another. In addition to regulating and restricting immigrants’ entry to the United States, the federal and state governments initiated deportation proceedings for insane immigrants who had not yet settled in America and sometimes even for those who had stayed in the U.S. for decades. Many different sites, including immigration stations, state hospitals, social work agencies, and steamship companies, also came together in the process of deporting the “alien insane.” And immigrants themselves, both insane and sane, became major players in the deportation

scene through their movements in and out of the complicated legal, political, and social landscape.

Chapter Two

Insanity at the Borders: Deportation of the “Alien Insane,” 1882-1930

In 1928, German-born Lillian Bar came to America and married an American soldier, Fred Rosenbusch.²¹⁴ A year later she gave birth to a child, and when she became “irrational” soon after, her husband took her to a hospital where she was diagnosed with “Post-puerperal fever.” She was later committed to Manhattan State Hospital for the insane and diagnosed with “Psychosis with other somatic diseases, post tardum [sic] delirium.” Her husband took her home six months later, but when he felt she needed more treatment, they went to Kings County Hospital, New York, where she was diagnosed with “dementia praecox.” Since she had been in the United States less than five years and become a public charge for her insanity, she was ordered deported. At the Ellis Island hearing, before the actual deportation order, she was diagnosed as having “constitutional psychopathic inferiority and mental instability both before and when she entered the United States.” The extant condition of insanity before her arrival in the U.S. rendered her subject to deportation. In 1931, Lillian was deported to Germany and immediately got better. German doctors confirmed that she showed “no manifestation of psychosis” and was “normal mentally and physically.” Still, she was not allowed to join her family in the United States because once deported as insane, she could not reenter the country. A social worker of the National Council of Jewish Women brought her case to attention to the Sub-Committee on Sanitation, Medical Care & Treatment, which reported that “[t]he case of Mrs. Fred Bar Rosenbusch illustrates so well the many complications in life brought about by illness.”²¹⁵ The Rosenbusch case demonstrated

²¹⁴ Passage of the 1922 Cable Act ended derivative citizenship.

²¹⁵ News Bulletin for the Members of the Committee on Ellis Island, edited by Helen Arthur, Secretary, September 1933, Folder , Box 18, Foreign Language Information Services (hereafter FLIS), Immigration History Research Center, University of Minnesota (hereafter IHRC).

difficulties of diagnosing insanity and attendant woes. Medical professionals failed to agree with one another and public health officers had a different view of her illness; doctors from the other side also intervened, complicating the process of medical diagnosis, deportation, and reentry. Her marriage to an American soldier, as it would have before passage of the 1922 Cable Act, could not prevent her deportation because without declaring her intention, she was still an alien. Some unanswered questions about Mrs. Rosenbusch suggest further complexities. Who notified the American authorities of her illness and hospital treatment? How was her deportation processed? What was her journey to Germany like? What happened to her husband and children from whom she was separated after her deportation?

This chapter examines deportation of insane immigrants in the late nineteenth and early twentieth centuries with a special emphasis upon the multiple levels of interaction and collaboration among various agencies involved in the deportation process. It investigates the ways in which becoming both an immigrant (implying an unstable legal standing and mobility) and insane (involving confinement and medical care) influenced the implementation of the deportation process, and challenged and defined the premises of American deportation policy. Many studies of American immigration policy have focused on deportation for political reasons, for moral turpitude, or banishment of Asian immigrants who gained illegal entry to the United States. Deportation or exclusion of immigrants with disability or public charge status has also been gaining attention.²¹⁶ However, the unique

²¹⁶ Deirdre M. Moloney, "Women, Sexual Morality, and Economic Dependency in Early U.S. Deportation Policy," *Journal of Women's History* 18, no. 2 (Summer 2006): 95-122; Erika Lee, *At America's Gate: Chinese Immigration During the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003); Douglas Baynton, "Disability and the Justification of Inequality in American History," in *The New Disability History: American Perspectives*, eds. Paul K. Longmore and Lauri Umansky (New York: New York University Press, 2001), 33-57; Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: The Johns Hopkins University Press, 2003); Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (New Brunswick: Rutgers University Press, 2007); Natalia Molina, *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California

situation of the “alien insane” enriches our understanding of the history of U.S. deportation policy. Though small in number, the “alien insane” were important actors on the deportation scene; they garnered unusual public attention, and numerous organizations, including federal, state, and foreign governments, were involved with their detection and deportation. For criminals and other public charges, deportation could be a form of punishment; however, deportation of the “alien insane” was understood as a humanitarian endeavor to provide them with better care and protection. The insane immigrants, unless deported, would end up at American public institutions and the responsibility for their care fell on the federal and state governments; if deported, foreign governments were required to assume their care in their homelands. As Chapter 1 shows, medical professionals and social scientists were concerned with the impact of mobility upon immigrants’ mental condition. Yet, the process of deportation brought about unexpected outcomes for immigrants and American authorities alike as it required moving the deportees from hospitals to immigration stations to foreign ports to their final destinations, often covering greater lengths than they had originally travelled to come to the United States. This process also gave immigrants room to exploit the American system to their advantage by offering them free passage home or opportunities to escape while being deported.

Many scholars have discussed deportation as a significant aspect of American immigration policy. Lawyer Daniel Kanstroom’s model of deportation laws as either border control or post-entry social control is particularly useful.²¹⁷ Deportation of the immigrant insane involved border control: the immigration laws excluded those who were insane or had been committed to insane asylums prior to immigration. However, in the case of insane

Press, 2005); Torrie Hester, “Deportation: Origins of a National and International Power” (Ph.D. diss., University of Oregon, 2008).

²¹⁷ Daniel Kanstroom, *Deportation Nation: Outsiders in American History* (Cambridge, MA: Harvard University Press, 2007).

immigrants, post-entry social control also came into play. Subject to a three or five-year statute of limitations that began upon their entry, these immigrants, even if they had passed primary inspection, could be deported when they had become public charges at state mental institutions. Unlike the exclusion at the immigration entry ports, post-entry deportation necessitated greater levels of cooperation among various organizations as it required detection, transportation, and eventual removal of the deportable immigrants in short succession. According to historian Torrie Hester, between 1882 and 1904 the federal government assumed control of “what would become one of its most formidable powers”: deportation.²¹⁸ State governments lost control of immigration in 1876 when the Supreme Court declared all state laws relating to immigration unconstitutional, but with their longer prior experiences in deporting or returning the immigrant insane, they frequently interfered with the federal policy.²¹⁹ For state governments, deportation was also a “remedy” for inefficient and incompetent execution of the immigration laws by the federal government. To deal with insane immigrants and their deportation, for example, state commissions in lunacy brought state institutions and their medical professionals into the discussion and worked alongside the federal and international governments as well as immigrant communities. The involvement of foreign authorities further complicated the tasks of the federal and state governments. As historian Deirdre Moloney argues: “While rooted in the nation-state,

²¹⁸ Torrie Hester, ““Protection, Not Punishment”: Legislative and Judicial Formation of U.S. Deportation Policy, 1882-1904,” *Journal of American Ethnic History* 30, no. 1 (Fall 2010): 11-36.

²¹⁹ Prior to 1876, the control of immigration was left to the jurisdiction of the separate state. Hidetaka Hirota argues that state deportation policies in New York and Massachusetts paved the way for federal immigration policy of the 1880s and asserts that not only race but also economic consideration shaped American immigration policy. Hirota, “The Moment of Transition: State Officials, the Federal Government, and the Formation of American Immigration Policy,” *Journal of American History* 99, no. 4 (March 2013): 1092-1108. The federal departments and bureaus in charge of immigration changed several times. Until 1902, Department of Treasury oversaw the Bureau of Immigration; between 1903 and 1906, Department of Commerce and Labor, Bureau of Immigration; between 1906 and 1913, Department of Commerce and Labor, Bureau of Immigration and Naturalization; between 1913 and 1940, Department of Labor, Bureau of Immigration (from 1933, Immigration and Naturalization Service); the INS was under Department of Justice in 1940 until 2003.

deportation was a transnational process. In enforcing immigration, both policy officials and politicians acknowledged the malleability of the state, its definition, its borders, and the often bilateral or multilateral constituents concerned with immigration issues.”²²⁰ Social workers too participated in the deportation process, assisting immigrants to locate their relatives or friends at home and informing them of necessary steps to take; at the same time, they projected their own ideals of worthy subjects onto these immigrants, offering judgments on who should remain and who should leave the country. In addition, steamship companies became important players in the deportation process. They were required by law to take back the insane immigrants they had shipped to the United States; however, concerned with the danger of transporting the insane and the expenses of carrying out the task, the companies challenged the federal authorities by questioning the efficiency of the immigration laws and boasting their superior knowledge of international affairs.

This chapter first examines the ways in which the “alien insane” were examined and detected at American immigration stations. Then, using deportation cases of insane immigrants who had gained entry but were later found at state institutions as public charges, it traces state governments’ interactions with the growing federal authorities in the matters of deportation: New York and California, especially their lunacy commissions, offer useful points of comparison as they devised own measures to implement deportation or repatriation of the “alien insane” in their midst.²²¹ Other agencies—foreign governments, social work agencies, and steamship companies—are examined in relation to their involvement in

²²⁰ Deirdre Moloney, *National Insecurities: Immigrants and U.S. Deportation Policy Since 1882* (Chapel Hill: The University of North Carolina Press, 2012), 231.

²²¹ Strictly speaking, “deportation” was a federal policy. However, state governments had liberally used the term to refer to repatriation, return, or removal of immigrants from their states and appointed their own “deportation” bureaus and agents. This use might have been a remnant from the past when states were in charge of immigration. As the example of New York demonstrates later in this chapter, states soon realized that the term carried negative implications and tried to portray their work as a voluntary and humanitarian endeavor, different from the federal policy of removal. In this chapter, I adopt the contemporary use of the term “deportation” to indicate both federal and state policy for immigrants.

deporting the “alien insane.” This chapter also sheds light on the reality of deportation by examining immigrants’ responses to deportation or removal and briefly discusses deportation parties of the 1910s and 1920s to demonstrate how transporting insane aliens complicated the deportation process and taxed the American authorities.

Medical Examinations at Entry Points

A large body of scholarship on medical examinations at American immigration stations and borders shows that despite the fear of exclusion among arriving immigrants, primary inspection was cursory and the actual number of exclusion cases was miniscule, with less than two percent of the number of the admitted.²²² The number of exclusion cases for mental defects was even smaller,²²³ but mental examinations at the American borders drew the attention of the American public as well as medical professionals interested in the science of detecting mentally undesirable immigrants.²²⁴ Detecting mental defects required skills and

²²² John T. E. Richardson, “Howard Andrew Knox and the Origins of Performance Testing on Ellis Island, 1912-1916,” *History of Psychology* 6, no. 2 (2003): 143-170.

²²³ For the descriptions of mental examination of immigrants at Ellis Island, see Alan M. Kraut, *Silent Travelers: Germs, Genes, and the “Immigrant Menace”* (Baltimore: The Johns Hopkins University Press, 1994); Fairchild, *Science at the Borders*; Vincent J. Cannato, *American Passage: The History of Ellis Island* (New York: Harper, 2009); Howard Markel, *Quarantine!: East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore: The Johns Hopkins University Press, 1999); Markel, *When Germs Travel: Six Major Epidemics that Have Invaded America and the Fears They Have Unleashed* (New York: Pantheon Books, 2004). Percentage was calculated from the U.S. Department of Labor, *Annual Reports of the Commissioner-General of Immigration to the Secretary of Labor, 1908-1923*. Craig Robertson offers a section on the inspection procedures at Ellis Island in *The Passport in America: The History of a Document* (New York: Oxford University Press, 2010), 164-171. During the time period, 1,780 immigrants were debarred from entering as “insane persons,” while the total number of immigrants debarred from entering the United States was 271,821. Between 1907 and 1908, out of 527,511 immigrants, only 2,095 were held for extended mental examination, but still, the annual report focused on the gravity of the problem of the “alien insane.”

²²⁴ In 1903, the *Book of Instructions for the Medical Inspection of Immigrants* divided “diseased, abnormal, crippled, and deformed aliens” into two classes of A and B. Class A included people suffering from dangerous contagious diseases, loathsome diseases, insane persons, and idiots. Class B referred to “all diseases and deformities which are likely to render a person unable to earn a living”: hernia, heart disease, pregnancy, poor physique, chronic rheumatism, senility and debility, and poor eyesight belonged to this class. The revised inspection manual of 1910 divided aliens with mental or physical defects into three classes of A, B, and C. *Book of Instructions for the Medical Inspection of Immigrants*, prepared by directions of the Surgeon-General (Washington, DC: G.P.O., 1903), 10-13; *Book of Instructions for the*

elaborate testing schemes. It was not an easy task when only six seconds (average two minutes for the final questioning process) were allowed for medical inspectors to examine immigrants. Most immigrants managed to pass the examination and enter the country; however, if medical inspectors observed definite signs of mental illness, they placed an “X” chalk mark on the individual’s garments and sent him to a special examination.²²⁵ In 1905, Ellis Island medical superintendant Thomas W. Salmon showed how mental deficiency and insanity were detected:

If the manner seems unduly animated, apathetic, supercilious or apprehensive, or if the expression is vacant or abstracted the immigrant is held and carefully examined. A tremor of the lips when the face is contorted during the eversion of the eyelids, a hint of negativism or retardation, an oddity of dress, unequal pupils, or an unusual decoration worn on the clothing—any is sufficient to arouse suspicion. The existence of well-marked stigmata of degeneration always serves to detain the immigrant for further inspection...Old persons are invariably questioned to determine the degree of mental deterioration present, and as a result cases of senile dementia are sometimes found.²²⁶

Inspectors also examined the facial expressions of immigrants to see whether they showed any signs of mental disorders. Since language differences compromised the process of detecting or diagnosing insanity, immigration officials used non-verbal, performance-based tests, developed by medical officers like Howard Knox; even illiterate immigrants could understand puzzle, mimicry or visual comparison tests without any help from an interpreter.²²⁷ However, medical officers soon realized that these intelligence tests, while useful in mental deficiency cases, lacked value when it came to immigrants suspected of

Medical Inspection of Immigrants (Revised January 18, 1910), prepared by direction of the Surgeon-General (Washington, DC: G.P.O., 1910)..

²²⁵ Kraut, *Silent Travelers*; Elizabeth Yew, “Medical Inspection of Immigrants at Ellis Island, 1891-1924,” *Bulletin of New York Academy of Medicine* 56 (1980): 488-510.

²²⁶ Thomas W. Salmon, “The Diagnosis of Insanity in Immigrants,” *Annual Report of the Surgeon General of the Public Health and Marine-Hospital Service* (1905), 271. Cited in Kraut, *Silent Travelers*, 71.

²²⁷ In 1913, Knox developed a performance test to examine immigrants’ mental capacity, which did not require knowledge of American society. See Richardson, “Howard Andrew Knox.” By 1918, the effectiveness of performance tests was put to doubt as officials realized that these tests could not always detect mentally defective people. See United States Public Health Service, *Manual of the Mental Examination of Aliens* (Washington, DC: Government Printing Office, 1918), 30; also see Ellis Island Immigration Museum exhibit.

insanity, which required lengthy interviews and examinations (See Appendix B for the mental test for immigrants published in the *San Francisco Chronicle* in 1912).²²⁸ Therefore, the United States Public Health Service mental examination manual of 1918 urged the examiners to equip themselves with knowledge of the languages and customs of the immigrants. It also cautioned that “[e]ven with a careful, well-trained interpreter, much is lost in any examination of an insane person” and that “many things which would be of greatest significance to a psychiatrist mean nothing to an interpreter, and therefore remain untranslated.”²²⁹ The manual cautioned as well that “a bright, intelligent alien may, because of faulty interpretation, appear stupid or demented.”²³⁰ However, competent interpreters, essential to detecting and diagnosing insanity, were not readily available at immigration stations. Despite the numerous problems caused by the lack of proper communication with immigrants, immigration officials made it a high priority “to have honest interpreters than to have interpreters with finished education.”²³¹

The problems associated with detecting and diagnosing immigrants upon entry had long been recognized. As early as 1906, reformer James Reynolds, who investigated the treatment of the insane and mentally defective at Ellis Island, contrasted the immigration station with New York state mental institutions and condemned its work: “the intelligence and the efficiency exhibited in the state institutions were in striking contrast to the

²²⁸ U.S. PHS, *Manual*, 15-16.

²²⁹ Ibid., 16. Also see “Medical Inspection of Aliens,” U.S. Public Health Service, January 29, 1923, Box 48, FLIS, IHRC.

²³⁰ U.S. PHS, *Manual*, 17.

²³¹ Letter dated October 24, 1907 to the Secretary of Commerce and Labor from F. F. Sargent, Commissioner-General. File 15053/1C, Entry 9, RG 85, NARA, DC. Immigrants with a Chinese background were often suspected of potential fraud and dishonest conduct. Although the Bureau of Immigration did not have enough Chinese interpreters to deal with Chinese immigrants coming to the United States, it wanted to hire someone it could trust and sent out its officers to California and nearby states to secure Chinese interpreters. Bureau letters in 1907 in the same file. For interpreters at Angel Island, see Robert Eric Barde, *Immigration at the Golden Gate: Passenger Ships, Exclusion, and Angel Island* (Westport: Praeger, 2008); for Chinese interpreters, Lee, *At America's Gate*, 60-63.

inefficiency of the Government service.”²³² Not surprisingly, however, the Bureau of Immigration charged with federal enforcement powers continued to rely upon government medical officers at immigration stations. In 1907, the Secretary of the Department of Commerce and Labor ordered

that every certificate sent to Ellis Island submitted by any physician other than those of the Public Health and Marine Hospital Service, on which a warrant for the arrest of the alien [in violation of the immigration law] may be predicated, shall be investigated thoroughly by one or more medical officers detailed by Dr. Stoner [Surgeon General of the PHS and MHS] for that purpose, and the certificate made by the physicians of the Public Health and Marine Hospital Service so detailed by Dr. Stoner, shall accompany the certificate originally submitted when the papers are sent on here asking for the warrant of arrest.²³³

It was an interesting request considering the claims of medical professionals at state institutions, in particular in the State of New York, that medical officers at Ellis Island were not qualified to detect subtle and often invisible signs of mental defects due to their lack of medical expertise. To fend off further criticisms against the incompetence of the federal medical officers and to assert federal authority, the Comprehensive Immigration Act of 1917 required: “Medical officers of the United States Public Health Service who have had especial training in the diagnosis of insanity and mental defects shall be detailed for duty or employed at all ports of entry designated by the Secretary of Labor, and such medical officers shall be provided with suitable facilities for the detention and examination of all arriving aliens in who insanity or mental defect is suspected, and the services of interpreters shall be provided for such examination.” Nonetheless, detecting mental defects at the ports of entry turned out

²³² Memorandum dated November 28, 1906 to the President, Washington, DC, “Regarding the Treatment of the Insane and Mentally Defective at Ellis Island.” File 51467, Part 3, Reel 1, Records of the Immigration and Naturalization Service (hereafter INS).

²³³ Letter dated March 22, 1907 from Secretary [recipient not stated]. File 51602/139, Entry 9, RG 85, NARA, DC. Also see, memorandum dated January 10, 1907 from Commissioner-General of Immigration Robert Watchorn to Secretary of Commerce and Labor, concerning Doctor Darlington’s report on medical examinations at Ellis Island. File 51467/1, Part 3, Reel 1, INS.

to be “far from perfect,” and medical officers continued to be criticized by state hospital doctors and psychiatrists.²³⁴

Mental Examination and Deportation after Entry

The majority of immigrants passed primary inspection at immigration stations; however, they were subject to a three or five-year statute of limitations; if declared insane during that period they could face deportation, and those declared a public charge at a state institution were especially vulnerable. In order to detect deportable immigrants after their initial entry and process their deportation, the federal immigration acts established an elaborate reporting system, necessitating close cooperation and collaboration with state and charitable organizations as well as hospital staff. A 1922 Bureau of Immigration statement described the collaboration:

It is a requirement of the existing immigration law that periodically our public, charitable, reformatory, and penal institutions be overhauled by immigration officials for the purpose of clearing them (upon the expiration of sentences, etc.) of alien inmates thereof, who constitute a charge upon the tax payers or the United States, the several states and territories. The lack of sufficient funds has rendered it an impossibility for the Immigration Service to keep these institutions entirely free from alien public charges who are subject under the immigration laws, to deportation from the country. . . If the various institutional and state authorities would see to it that the nearest immigration station is promptly advised of the receipt in such institutions of deportable alien charges, the work in this direction would be very greatly facilitated.²³⁵

The federal and state governments were the two major actors in the deportation proceedings. The care of insane immigrants, in particular, meant the long-term financial burden for state institutions, and both the state and federal governments debated who should take responsibility for the “alien insane.” On the one hand, state authorities criticized the federal government for not relieving them of the financial burden. On the other hand, the federal

²³⁴ Edith Abbott, *Immigration: Selective Documents and Case Records* (New York: Arno Press, 1969), 223.

²³⁵ M. J. Peters, Law Officer, Bureau of Immigration to Ivan Mladineo, Manager, Yugoslav Bureau, F.L.I.S., August 4, 1922, Box 48, FLIS, IHRC.

government argued: “There is no particular reason why the entire burden in this connection should fall upon the Federal Government, which is no more responsible than the several States for the present unfortunate conditions.”²³⁶ In spite of the states’ criticism of the work of the federal authorities, inspectors and officials of the Immigration Bureau worked closely with state and municipal workers to detect and deport the alien insane from the United States, and often expressed satisfaction with the state agencies’ contributions to the process. However, they also observed that local government officials were ill equipped for their tasks. The level of cooperation between state, city, municipal governments, including penal institutions, insane asylums, and almshouses, and immigration officials varied from place to place. States with large immigrant populations, such as New York and California, were cooperative and quick to inform immigration officials of deportable aliens under their care, but some states lacked an efficient reporting system, knowledge of the immigration laws, and financial as well as human resources. For example, in 1923, the immigration inspector in Ohio complained that he had not received any reports of deportable aliens from Ohio state institutions for fourteen years. He was frustrated that these institutions did not bother to hire interpreters to get more information from their immigrant public charges.²³⁷

Once federal officials received a state hospital report regarding a deportable immigrant, they located relevant documents for the alien and visited the hospital for further investigation. When satisfied with the investigation evidence, the Secretary of the Department of Labor issued a warrant of deportation. Whether he was in New York, Montana, or Washington, once a deportation decision was rendered, the immigrant was sent back to his

²³⁶ Letter dated December 16, 1914 to Dr. Michael Osnato, Medical Examiner in Charge, Bureau of Deportation, State Hospital Commission, NY, from Acting Secretary. File 53775/202B, Entry 9, RG 85, NARA, DC.

²³⁷ Money matters always intervened with the efficient management of deportation cases; most letters from the file were from 1923, composed as a response to the immigration bureau inquiry regarding the level of cooperation with state and public mental and penal institutions to deport immigrant public charges. File 54951/Gen, Entry 9, RG 85, NARA, DC.

port of entry; more often than not, he would experience long and arduous trips from a local institution to the immigration station. At the port of his entry, the steamship company, which had brought him to the U.S., would take him back to his home country, or the port where he had initially boarded the steamship. Insane immigrants in particular were brought to immigration stations for deportation from state hospitals and asylums all around the country, where they were interviewed and detained until warrants of deportation were issued.

This section now turns to the two states of New York and California to further investigate the ways in which the federal and state governments interacted with each other as they deported the “alien insane” after entry. Even when the federal government began to assert its responsibility for deportation, both states managed to carve out their own plans to address the problems of the “alien insane.” As sociologist Jane Perry Clark Carey explained, New York and California were not representatives of the whole country in their management of state institutions and insane immigrants. Unlike many other states, they were equipped with adequate hospital facilities due to the great number of immigrants passing through their immigration stations, and they were aware of the public interest in eliminating the “undesirable” immigrants. Both states also centralized the management of mental institutions and deportation of the immigrant insane through State Commissions; New York State Hospital Commission, which later became the Department of Mental Health, established a State Deportation Bureau, and California Commission in Lunacy appointed a State Deportation Agent to deal with deportation of the immigrant insane.²³⁸ However, they were different from each other in terms of their immigrant populations: while New York had a mostly European immigrant population, California had more diverse immigrant groups,

²³⁸ Letter dated October 8, 1923 to U.S. Department of Labor regarding cooperation from state, city, municipal officials in connection with the enforcement of the immigration laws (reporting deportable immigrant inmates, cooperating with immigration officials). File 54951/Gen, Entry 9, RG 85, NARA, DC.

including several Asian immigrant communities. This difference led to divergent responses to deportation.

Federal Immigration Bureau vs. State Commissions

New York

One of the most popular destinations for immigrants, the State of New York was destined to meet the alleged problems associated with the growing number of new arrivals to the country. As Chapter 1 shows, state asylums and hospitals were concerned with immigrant inmates overcrowding their institutions. New York was active in deporting undesirable immigrants to their home countries even before the federal exclusionary measures against the “new immigrants” were adopted at the turn of the twentieth century. Since the mid-nineteenth century, state hospitals had been working with the Emigration Bureau (later, the Bureau of Immigration) to send back immigrant patients to their home countries. In 1873, a State Commission in Lunacy was established to represent the state’s mental hospitals. To relieve hospitals of unwanted financial burdens and to promote humanitarianism for immigrant inmates, the Commission also oversaw deportation of immigrant patients and became actively involved in federal immigration policy, in particular, the provisions on deportation.

In 1904, the New York State Assembly introduced a bill entitled “An Act to amend New York’s insanity law providing for the examination of immigrants at the port of New York to ascertain their mental condition.” As a state-level initiative, it urged the formation of the Board of Alienists to find and deport “insane, idiotic, imbecile or epileptic” immigrants. The bill suggested that the Immigration Bureau failed to carry out its work at the immigration station and let undesirable immigrants pass through; thus, the proposed bill would intervene with the federal government in implementing its policy. The bill, however, was not well

received. The state's Special Assistant to the Attorney-General claimed that what the bill demanded "will be simply a burden and restraint upon commerce without furnishing any protection to the public" because the "immigration of aliens is a part of our commerce with foreign nations and is one of the subjects confided to Congress by the commerce clause of the Constitution." He recommended that the Commission further discuss the matter with the federal government and argued that the appointment of the Board of Alienists would be "entirely ineffective" because it provided "no new method or means of exclusion and no new agency not accorded to them [people of the State] by the Federal statute."²³⁹ In the same year, the Governor of New York informed President Roosevelt of the conflict between the New York State Board of Alienists and the federal immigration authorities at Ellis Island. The alienists—medical experts in the field of psychiatry—fought for final authority in detecting and deporting immigrants allegedly suffering from insanity. The Immigration Bureau resented their intervention. William Williams, Commissioner of Immigration at Ellis Island, appealed to the Commissioner-General of Immigration, making it clear that the Bureau of Immigration had not been negligent in carrying out its duties, contrary to the accusations of the State of New York:

Most of the insanity of aliens in the State of New York will be found to have arisen subsequent to the time of their arrival. Whenever it can be shown that it is due to causes existing prior to landing the Commissioner-General of Immigration, upon presentation of a proper medical certificate, orders deportation within two years. At great expense the Federal authorities sought last year to impress upon all charitable institutions throughout the whole country, including New York State, the desirability of reporting all such cases. The true remedy lies probably with Congress, and the

²³⁹ Letter dated April 14, 1904 to the Secretary of Commerce and Labor from Special assistant to the Attorney-General, Acting as Solicitor. This was not allowed for 1) constituting "an unwarranted interference with foreign commerce on the part of a State"; 2) The New York statute that required the presence of a board of alienists for examination "cannot be constructed as an exercise of the police power" as "it is entirely ineffective, it provides for the exclusion of no class not excluded by the Federal law, it provides no new method or means of exclusion and no new agency. It affords people of the State no protection not accorded to them by the Federal statute." File 52320/11, Entry 9, RG 85, NARA, DC.

immigration authorities have not been backward in recommending stringent action by that body.²⁴⁰

In addition to refuting the claim of federal inefficiency, Williams denied any “friction” between the New York State and the immigration authorities at Ellis Island. In the end, the Department of Commerce and Labor, which oversaw the Bureau of Immigration, stepped in and confirmed the authority of the federal government in the matter of controlling and regulating immigration into and from the United States. This did not, however, deter the state from renewing its efforts to exclude and deport the “alien insane.” Two years later, New York came up with another suggestion to lessen their burden of care for insane immigrants: appointment of three alienists connected with the State Board of Lunacy as Acting Assistant Surgeons at Ellis Island. This time, the Immigration Bureau acquiesced. In March 1906, it was decided that “these three alienists be invited as individuals to be present as often as they choose to witness the examination of immigrants at Ellis Island and that courtesies be extended them so that if they have reason to think that any immigrant who has been passed by the examiners may be insane they may invite your attention to the fact that you will give the matter further consideration.”²⁴¹ However, lacking the diplomatic powers of the federal government, New York continued to experience difficulty working with various agencies involved in deportation cases. Foreign governments refused to have American officials examine their people at the ports of embarkation in Europe, and steamship companies were unwilling to accept deported insane immigrants on board; therefore, “this co-operation has not been as useful as might be expected.”²⁴²

²⁴⁰ Letter dated December 23, 1904 to Commissioner-General of Immigration, Washington, DC. File 52320/11, Part 3, Reel 3, INS.

²⁴¹ Letter dated March 1, 1906 to Surgeon George W. Stoner of Public Health and Marine-Hospital Service from Surgeon-General. Ibid.

²⁴² New York, State Commission, “Report of the Board of Alienists,” 23rd *Annual Report* (1912), 81-82.

The zeal for deportation resurfaced in 1912 with the appointment of a special commissioner on the alien insane.²⁴³ The New York State Commission hoped that a thorough investigation of the subject would help the state shift financial responsibility for the immigrant insane to the federal government. The Commission also had a humanitarian goal in mind: “This state has an especial interest in securing the most humane methods of deportation... These patients [insane aliens deported from American public institutions] for no fault of their own, were removed from the security and comfort of our hospitals, to be transferred across the ocean and delivered into the hands of those who in many cases, had no interest in them and no warning that they were to be sent.”²⁴⁴ The Commission reasoned that the insane immigrants, once deported, would receive better care in their home countries surrounded by familiar faces and healthier environments. However, despite its alleged interest in humanitarian treatment, the Commission was aware that many insane deportees ended up stranded in Europe without attendants to guide or deliver them to their final destinations. Still, persisting in deporting as many insane immigrants as possible, it criticized federal immigration officials for the failure of deportation policy and called for more effective federal initiatives. The state government also urged the federal authorities to deal with the problems of “aliens and non-residents” at state institutions for the insane. The State Commission argued that these patients “should be cared for by the general government, either in hospitals of its own, or by the government making arrangements with other states, or with this State [New York] for their care—the expense to be borne by the general government.”²⁴⁵

²⁴³ In the same year, the American Medico-Psychological Association adopted resolutions concerning the insane aliens at American and Canadian institutions and declared that this should be dealt with “solely from a medical standpoint.” In letter dated January 31, 1912, State Commission in Lunacy’s proposed changes in the federal immigration law. File 52730/8B, Entry 9, RG 85, NARA, DC.

²⁴⁴ State commission in Lunacy letter dated January 31, 1912 to the Secretary of the Commerce and Labor. File 52730/8B, Entry 9, RG 85, NARA, DC.

²⁴⁵ Letter dated March 7, 1912 to Hon. Charles Nagle, Secretary of Commerce and Labor, Washington, DC from the office of the state commission in lunacy, forwarded through the office of the Governor of New York. File 52424/1, Entry 9, RG 85, NARA, DC.

In turn, immigration officials complained that the lack of resources prevented them from carrying out their tasks properly: “A dollar will only go so far, and we can not get two dollars worth of work for one dollar.”²⁴⁶ In its annual reports, the State Hospital Commission continued to discuss the issues of the “alien insane,” pointing out defects of the immigration laws and calling for better measures to prevent the entry of insane immigrants to the country and to the state. The Commission also took matters into its own hands; it “repatriated” insane immigrant patients from state hospitals under its supervision and cooperated with patients’ relatives and friends.²⁴⁷ Even those who had been in the United States for many years, exceeding the statute of limitations, were not safe from repatriation. The Commission praised the virtue of its scheme and emphasized that repatriation was different from the federal deportation: “It should be stated that in no cases are aliens returned by the State against their will, or without the consent of their friends or next of kin. Although the term ‘deportation’ is conveniently used to describe the return of such cases, they are not deported in the same sense that aliens subject to deportation under the Federal Immigration Law are returned.”²⁴⁸

In 1921, the state changed the title of “Bureau of Deportation” of the Commission to Medical Examiner’s Office. It admitted that only the federal government had the authority over the matter of deportation and that the state, having “neither the right nor the power” to deport, was merely to report the cases of deportable aliens to the immigration authorities; in addition, the state officials were eager to present their own work of deportation or repatriation in a positive light by eliminating the word, *deportation*, which was “very offensive to friends and relatives of the insane.”²⁴⁹ Still, the State of New York resented its limited power over

²⁴⁶ Letter dated July 8, 1912. File 52730/8B, Entry 9, RG 85, NARA, DC.

²⁴⁷ New York, State Commission, 25th *Annual Report* (1914), 316-317.

²⁴⁸ New York, State Commission, 23rd *Annual Report* (1912), 82.

²⁴⁹ New York, State Commission, 31st *Annual Report* (1920), 150-151.

deportation and demanded that the federal government develop a better and more efficient solution to deal with the “alien insane.”

In the 1923 hearings, Spencer Dawes, MD, of the New York Hospital Commission criticized the joint resolution of October 19, 1918, which came out as a result of World War I, as “an example of ill-considered legislation.” Revealing the gap between the federal policy and the state responsibility in the matter of immigration, he continued:

This resolution is intended to be humane and generous and really is, but at whose expense, may I ask? It provides for the reentry of certain classes of aliens otherwise excludable as likely to become public charges, but makes no provision for their care and maintenance after they arrive. It says that any idiotic, imbecile, feeble-minded, epileptic, or insane person, or one afflicted with constitutional psychopathic inferiority or mental defect acquired while serving in the Great War may be admitted. If idiocy, imbecility, feeble-mindedness, or constitutional psychopathic inferiority could have been thus acquired, all present-day medical opinion is wrong.

Dawes’s position highlighted the tension between the two authorities. He argued: “It is plain to be seen that most of these cases will enter the port of New York, and that that already overburdened State will “hold the bag,” will pay the bill incurred by reason of the generosity of the Federal Government.”²⁵⁰ While the New York State Commission in Lunacy made full use of its own resources in deporting insane immigrants, it continued to blame immigration officials at Ellis Island and called for better policies from the federal government.

California

At the San Francisco Immigration Station (Angel Island after 1910), the Special Board of Inquiry examined and deported those who had been detained for dangerous and contagious diseases, such as trachoma, favus, and hookworm, and who had become public charges at state institutions. The minutes of Boards of Special Inquiry between 1899 and

²⁵⁰ 1923 Hearings, Statement of Spencer Dawes, 614.

1909 included a few cases of insane immigrants deported from San Francisco.²⁵¹ Most were European immigrants, who had entered the country through Ellis Island, come to California, and become public charges at state mental hospitals. They were transported across the continent back to Ellis Island to be deported onboard the steamship which had shipped them to the United States in the first place. Exclusion and deportation of Asian immigrants for insanity was rare in the Special Board of Inquiry minutes, but other sources tell us that Chinese and Japanese immigrants suffering from insanity were also likely targets of deportation from the state.²⁵²

Struggling to deal with the growing number of the insane at its institutions, California blamed other states for letting their residents come to California and become public charges, and criticized the federal government for its lax deportation policy.²⁵³ California established a State Commission in Lunacy in 1897, which carried out similar functions to those of the New York Commission. Compared with New York State, which had had acrimonious relationships with the immigration officials at Ellis Island, California seemed to have lacked close interactions with the federal government. Rather, it worked intimately and often directly with foreign governments to implement its deportation plans, even though as a state it had no political authority to handle deportation. Unlike New York, which complained about the influx of new immigrants from southern and eastern European countries, California emphasized its work with “Oriental” countries, in particular, China and Japan.²⁵⁴ The biennial

²⁵¹ *Minutes of Boards of Special Inquiry at the San Francisco Immigration Offices, 1899-1909*, M1387, RG 85, NARA, DC.

²⁵² For example, the *Biennial Reports* of the California State Commission in Lunacy had a separate table for Chinese and Japanese deportees from state institutions and explained how the State worked together with foreign consuls to facilitate their deportation.

²⁵³ As for the insanity rate in California at the turn of the twentieth century and various explanations for it, see Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978).

²⁵⁴ For the Canadian case, see Robert Menzies, “Governing Mentalities: The Deportation of ‘Insane’ and ‘Feeble-minded’ Immigrants out of British Columbia from Confederation to World War II,” *Canadian Journal of Law and Society* 13, no. 2 (1998): 135-73. Canadian provincial governments took a similar

reports of the State Commission in Lunacy of California and newspaper reports from the late nineteenth and early twentieth centuries show that California had attempted upon several occasions to return Chinese and Japanese insane inmates to their respective home countries. As early as 1898, the California State Commission in Lunacy called on the Chinese and Japanese Consuls for assistance and both were willing to help the state authorities send Chinese and Japanese mental patients back home. Since there was no insane asylum in China, only the milder Chinese patient cases would be considered for deportation (in humanitarian spirit), and Japanese patients would be sent home so that they could be cared for at asylums in Japan.²⁵⁵ In 1899, several newspapers based in California reported the removal of eighty-five Chinese and Japanese insane inmates of California state hospitals, referring to the “provisions of the last treaty with the Oriental countries” which would allow the removal.²⁵⁶ To the Commission’s embarrassment, it turned out that there was no such treaty with these countries²⁵⁷; however, the Secretary of the State Lunacy Commission, John F. Carrere, pushed the plan forward. He asserted that “from the start the matter [of deporting the Asian insane] has had humanity as its basis, the Commission in Lunacy understanding that a demented Jap could be much better cared for by his own countrymen than by strangers.”²⁵⁸ The State paid all costs of deportation and made arrangements with a steamship line. The same arrangements were applied to the Chinese insane, although it is not clear from the newspaper reports whether they too were sent back to their home country. In July 1899, the Japanese insane from state hospitals in California were returned home on the Japanese

approach to deporting the Chinese insane in the early twentieth century by using direct communications with Chinese or Japanese consuls (deporting insane Japanese immigrants did not succeed) rather than relying on the immigration acts to do the job.

²⁵⁵ “Investigation for Agnews: Action of the State Commission in Lunacy,” *Sacramento Daily Union*, July 24, 1898.

²⁵⁶ “No Room for the Orientals: Must Leave the Insane Asylums,” *San Francisco Chronicle*, May 25, 1899.

²⁵⁷ “Matter of Insane Orientals: There Is No Treaty Providing for Their Deportation,” *San Francisco Chronicle*, May 29, 1899; pg. 3.

²⁵⁸ “Insane Japanese: The True Facts Concerning Their Proposed Deportation,” *Sacramento Daily Union*, May 19, 1899.

steamer *Nippon Maru*.²⁵⁹ According to Carrere, it was supposed to be a humanitarian endeavor not a financial concern, but in fact, it was neither. If Californians had hoped to cut down the expenses and lift the burden of taxpayers, they would have saved greater sums of money by sending back deportable Irish, English, or German patients home as they occupied a larger number of hospital beds; Chinese and Japanese inmates were singled out again and again for deportation despite their small number at the state hospitals. Between 1909 and 1910, the State Commission in Lunacy worked together with the Japanese consul, Hon. Matsuzo Nagai, in San Francisco. Nagai assisted the Commission in distributing to Japan the information collected by the state hospitals of their Japanese inmates so that they would be returned to relatives and friends back home. On January 16, 1910, the *San Francisco Chronicle* reported, however, that this decision did not originate in “Tokio [sic]” and was implemented by the consul himself without the endorsement of the Japanese government. The reason behind this deportation effort was not clear, but the consul, according to the article, claimed: “we believe the unfortunates of our own nationality should be cared for, when they become a public charge, by our own people.”²⁶⁰ It is also likely that under the political circumstances and anti-Asian immigration agitation, both the Chinese and the Japanese governments were more willing than other countries to negotiate with the Commission to take back their unfortunate citizens. The interest in deporting the “Oriental” insane belied the state’s racially motivated deportation plan, and the discriminatory immigration acts—the Chinese Exclusion Acts and the Gentlemen’s Agreement—made them an easy target for removal.

²⁵⁹ These insane Japanese were placed on board *Nippon Maru*, which had been fumigated for the suspicion of bubonic plague and in consequence lost clients on its return trip. On *Nippon Maru* and the bubonic plague scandal in 1899, see Barde, *Immigration at the Golden Gate*.

²⁶⁰ “Nagai to Send Insane to Japan: The Consul-General Says His Government Will Care for Them,” *San Francisco Chronicle*, Jan. 16, 1910; pg. 31.

The California State Commission in Lunacy continued to take part in deporting immigrant and non-resident patients throughout the 1910s, devising its own plans without the involvement of the federal authorities. In the ninth *Biennial Report* (1913-1914) of the Commission, Charles Waymire, the Commission's auditor in charge of deporting non-resident and foreign-born inmates from California, boasted that the Commission deported 125 Chinese inmates to their native villages: "The average hospital residence of the 125 Chinese was eight years, and it is safe to say that their average hospital life would continue for a like period, as the Chinese, under the care and treatment received in our hospitals, are a long lived and healthy portion of the hospital population."²⁶¹ Previously, the State Commission in Lunacy acknowledged that China lacked asylums or mental institutions to provide proper care for the Chinese insane, but it posed no problem as their return promised considerable financial relief to the State. Moreover, their deportation was carried out by the Commission without official warrants of deportation from the federal authorities. After World War I, the State Commission embarked on a more vigorous deportation plan. In the eleventh *Biennial Report* (1917-1918), Charles Waymire, the former auditor, became the deportation agent; this change reflected the establishment of the Deportation Bureau within the Commission in 1915 and indicated the growing importance of removing the foreign-born and non-resident patients from California state hospitals. Moreover, Waymire's appointment illustrated the close link between deportation efforts and financial interests of the State. This time again, Chinese and Japanese inmates were overrepresented among the deportees and their removal was singled out as the major achievement of the newly named deportation agent. Waymire expressed his sincere gratitude to the Japanese and Chinese governments for taking back their insane citizens. It is not clear how much role the federal government played in bringing the international governments into play, but it seems that the State Commission

²⁶¹ California, State Commission, 9th *Biennial Report* (1913-1914), 31.

had taken a principal part in the whole process. Waymire continued to function as a deportation agent, well into the 1920s.²⁶² The interests in Chinese and Japanese still remained; however, the influx of immigrants from Central and Latin America, after the construction of the Panama Canal, and from the Philippines in the 1920s, further complicated the landscape. The Commission acknowledged the role of the federal immigration authorities in deporting the “alien insane” from California and increasingly relied on the federal policy to facilitate deportation and lift the financial burden from its institutions.²⁶³ At the same time, especially when Chinese and Japanese inmates were concerned, it made full use of its own resources, contacting international government agencies, urging friends and relatives to accompany their fellow insane to home countries, and appropriating the commission funds to send them back. By taking the matters into its own hands, California was able to return even those who had been in the United States for more than a decade and therefore could not be deported under federal warrants. New York and California elected different politics to deal with immigration and insanity and demonstrated the ways in which the two large agencies of the federal and state governments were involved in the process of deportation.

Reality of Deporting the “Alien Insane”

The number of immigrants deported for becoming insane within three or five years after landing rarely exceeded thirty a year. For example, during the fiscal year ending June 30, 1908, only seventeen aliens were deported by the Department as having been members of the excluded class—for insanity—at the time of their admission. This number alone does not

²⁶² File 54951/005, Entry 9, RG 85, NARA, DC.

²⁶³ The *Biennial Report* (1923-1924) of the California State Department of Institutions explained: “It is greatly to our advantage to foster federal deportations as it costs us nothing and other state and country are relieved of the burden of their care for all time.” While working closely with the federal authorities, the State of California and the Department still hoped to negotiate with foreign governments—now, Mexican and Filipino officials—to send back immigrant patients so that they could be “among people of their own temperament and languages.” California, Department of Institutions, 2nd *Biennial Report*, 15; 4th *Biennial Report* (1927-1928), 18.

explain why immigration officials were concerned with removing insane immigrant from the country. However, shifting the focus to state hospitals changes the whole picture. During the same fiscal year, the Department reported that 754 aliens were deported for becoming public charges because of insanity. Upon passing primary inspection at immigration stations, their insanity was hard to detect or discover afterward; yet, the public charge clause of the immigration acts revealed that there were a considerable number of insane immigrants at state mental institutions discovered and deported, and that the majority of insane immigrants became entangled with the immigration authorities only after they became public charges at state institutions. Between 1908 and 1923, 6,706 immigrants were deported because they had become public charges for insanity; during the same period, the total number of public charge deportees was 8,802 (see Table 2.1). That is, the insane constituted about 69 percent of the public charge deportees and about 13 percent of the total number of deportees after entry, the majority of whom included “likely to become a public charge” cases, along with prostitutes, anarchists, and criminals. If the cases in which deportation was not processed in time and canceled warrants were included, the actual number of insane immigrants eligible for deportation could have been much larger. As Chapter 3 will show, the burden of care and reception associated with being public charges raised the concern with the “alien insane.”

Table 2. 1. Nationwide Debarment and Deportation of Insane Immigrants

	DEBARRED from entering	DEBARRED from entering	DEPORTED after entering	DEPORTED under public charge clause ²	DEPORTED for <u>insanity</u> ¹
	TOTAL	for <u>insanity</u> ¹	TOTAL	after entering TOTAL	under public charge clause ² after entering
1908-1923	271,821	1,780	46,638	8,802	6,706

¹ Does not include imbecile, feeble-mindedness, epileptics and constitutional psychopathic inferiority

² Public charge clause includes insanity, other mental conditions, loathsome or dangerous contagious diseases, pregnancy, physical conditions and other causes.

Sources: compiled by author, *Annual Reports of the Commissioner-General of Immigration*, 1908-1923

The Bureau of Immigration had been aware of the difficulties in determining deportability of insane immigrants. In 1909, the Bureau explained that there were three kinds

of “aliens suffering from mental afflictions”: those who were certified at the time of admission; those who were discovered later to have been so afflicted at the time of admission; and those who became public charges, after admission for having already suffered from insanity. According to a U.S. solicitor, the third kind contained “two different and independent grounds for the deportation of an alien”: one was being an insane at the time of arrival and the other was becoming a public charge from “causes existing prior to landing.”²⁶⁴ Another problem involved was to define a “public charge” (PC) status.²⁶⁵ Becoming a PC subjected an immigrant to deportation, but he could remain in the United States when his friends or relatives provided bond or financial aid for him. PC cases involving insanity, however, was a little more complicated: “In the case of an insane alien, for example, the question is as to whether the alien was insane when he landed. That question can in no respect be modified by a subsequent consideration. It does not even involve the alien’s financial condition at that time. Had he been a millionaire he could not lawfully have entered the country.”²⁶⁶ Being insane at the time of arrival meant that the alien in question was in the country in violation of the law, thus rendering his entry illegal. This alone should qualify the immigrant’s deportation, regardless of his public charge status. *United States ex rel. Donatello v. Commissioner of Immigration at Port of New York* (1925) clarified that the grounds of deportation based on becoming a public charge and on one’s mental condition

²⁶⁴ Letter dated June 21, 1907 from the Solicitor, Office of the Solicitor, Department of Commerce and Labor to the Secretary of Commerce and Labor in response to his letter dated May 25, 1907. File 51384/40, Entry 9, RG 85, NARA, DC.

²⁶⁵ For definitions of PC, see Jane Perry Clark Carey, *Deportation of Aliens from the United States to Europe* (New York: Arno Press, 1969); Deportations of LPCs or PCs, see Moloney, *National Insecurities*. For public charge deportation of homosexual immigrants, see Margot Canaday, *The Straight State: Sexuality and Citizenship in Twentieth-Century America* (Princeton: Princeton University Press, 2009).

²⁶⁶ Letter dated June 21, 1907 from the Solicitor, Office of the Solicitor, Department of Commerce and Labor to the Secretary of Commerce and Labor in response to his letter dated May 25, 1907. File 51384/40, Entry 9, RG 85, NARA, DC.

were “independent of each of the other.”²⁶⁷ That is, even when an insane alien’s family or friends were willing and able to repay his hospital expenses, thus making him no longer a PC, it could not prevent his deportation because his insanity upon entry should already be enough for his deportation. However, being insane and becoming a PC for the reason of insanity were used interchangeably in many deportation cases. The warrants of arrest or deportation for immigrants often read: the alien “is insane and is a public charge from causes existing prior to landing, said causes being insanity.”

Deportation of insane aliens also revealed the concern with immigrants’ competence embedded in the discussion of public charge (PC) and likely to be a public charge (LPC) cases. In 1891, the new immigration act replaced the phrase “*unable* to take care of himself or herself without becoming a public charge,” with “*likely* to become a public charge.”²⁶⁸ Immigration inspectors and officials at Ellis Island as well as the American public and immigrants themselves acknowledged the arbitrary definition of the LPC provision. In 1909, in a hearing at the Commissioner’s Office, Ellis Island, Jewish lawyer C. Dushkind, enraged at the exclusion of many immigrants under the LPC clause, highlighted how unstable the term was: “The Courts have ruled that the term “likely to become a public charge” does not refer to any future time. In other words, if we apply that law to a future time, we are all likely to become public charges. The Courts have said that the term means likely to become a public charge today, and not next year.”²⁶⁹ Thus, the term could not properly judge an immigrant’s potential to become a good citizen; moreover, ambiguous standards, such as

²⁶⁷ *United States ex rel. Donatello v. Commissioner of Immigration at Port of New York et al.*, May 12, 1925.

²⁶⁸ Baynton, “Disability and the Justification,” 45. Emphases are Baynton’s own.

²⁶⁹ File 52600/13, Entry 9, RG 85, NARA, DC. The hearing took place on September 27, 1909. In the pre-World War I years, the inspector general at Ellis Island defined those who had less than 10 dollars—later increased to 25 dollars—as persons likely to become public charges.

poor physique, moral turpitude, and sexual perversion, were used for a LPC status.²⁷⁰ Insanity, along with other mental illnesses, also became a cause for LPC deportation. It could limit a person's ability to earn a living for the rest of his life, making him dependent on others' good will; therefore, even if one did not become a public charge, he could still fail to become an independent citizen and be deportable. Dr. Spencer Dawes of the New York State Hospital Commission brought up this issue in the 1923 House hearing before the Committee on Immigration and Naturalization. He explained: "I feel that the provision that the alien must be a public charge should be struck out of the law in so far as it relates to mental cases—there is no reason, eugenically, why a rich alien who is insane, an idiot, an epileptic, or constitutionally inferior should be allowed to remain and a poor person deported. All we should have to prove is that he is an alien and is insane."²⁷¹ Nevertheless, as historian Douglas Baynton shows, the definition of the LPC provision was left to the discretion of immigration inspectors, and immigrants' class status often made a significant difference in bending the rule.²⁷²

Immigrants were quick to learn that by traveling in passenger cabins, not steerage, they had a better chance of gaining entry to the United States since inspection for the first and second cabin passengers were not as strict as those in the steerage; they would rather borrow money to buy passenger tickets than risk exclusion with more thorough inspection for steerage. Class mattered even during deportation trips, and American officials took immigrants' social standing into consideration. In 1919, the Assistant Commissioner of Immigration, Ellis Island, expressed his opinion concerning the cases of deportation at the

²⁷⁰ Baynton, "Disability and the Justification"; Canaday, *Straight State*; Moloney, *National Insecurities*.

²⁷¹ Statement of Spencer L. Dawes, M. D., of the New York State Hospital Commission, U.S. Congress, House, Committee on Immigration and Naturalization, *Alien Seamen – Insane Aliens- Statement on Various Immigration Problems*, Hearings, 67th Congress, 4th Session, on H.R. 14273 (January 30 and February 6, 1923), 614.

²⁷² Baynton, "Disability and the Justification," 45. Martha Gardner and Deirdre Moloney also show that gender played a role in LPC cases. Gardner, *The Qualities of a Citizen: Women, Immigration, and Citizenship, 1870-1965* (Princeton: Princeton University Press, 2005); Moloney, *National Insecurities*.

government expense: “Ordinarily, it is believed, the practice should be to return such aliens in the class in which they arrive, but, at least, an alien who arrives first class should not be deported in the steerage unless there is some very good reason for doing so, but should be placed in either the first or second cabin.”²⁷³ Steamship companies often refused to take back mentally troubled passengers unless they were under special authorization by the federal law; however, for “saloon passengers,” capable of financing their own care, the companies did not object to having onboard “even those who are excessively disturbed.”²⁷⁴ Thus, class differences, as Dr. Dawes rightly pointed out, did influence not only entry but also deportation, and the majority of immigrants with no money or connections had fewer options when they faced deportation.

*International Dynamics of World War I and Conflicting Interests*²⁷⁵

Deportation of the “alien insane” was an international event involving both the departing and home countries, and the conditions back home were as important as those in America. World War I posed great challenges to deportation efforts as the volatile situations in Europe destabilized transportation. The federal government cancelled warrants of deportation as it was impracticable to send back the immigrants to Europe. For several years during and after the war, the annual reports of the Commissioner-General of Immigration included a table titled “Aliens ordered deported to countries whence they came, in which orders of deportation were suspended because of war conditions.”²⁷⁶ Many parties involved

²⁷³ In his response to the July, 24, 1919 letter from Assistant Commissioner of Ellis Island. File 54549/670A, Entry 9, RG 85, NARA, DC.

²⁷⁴ Letter dated January 21, 1912 from State commission in Lunacy, New York to the Secretary of Commerce and Labor. File 52370/8B, Entry 9, RG 85, NARA, DC.

²⁷⁵ For World War I and Ellis Island, see Cannato, *American Passage*.

²⁷⁶ In 1918, 1,045 deportation orders were suspended due to war conditions, while a total of 1,551 were deported after entry during the same fiscal year. Prior to war, between 2,000 and 4,600 aliens were deported after entry annually. U.S. Department of Labor, *Annual Reports of the Commissioner-General of Immigration to the Secretary of Labor*, 1918.

expressed their frustration and concern with these suspensions. As steamship service was discontinued and warrants of deportation were cancelled, deportees, especially those in need of hospital care were either confined at private sanitariums or sent back to the state institutions where they had previously been committed. Steamship companies responsible for returning deportees home asked state governments to take the deportees back for temporary care during the war and promised to pay for their keep. However, the State Commissions did not take this proposition kindly and adamantly refused to accept it. The Commissions feared that it might become impossible to deport these immigrants if their statute of limitations expired before the war ended. State hospitals and steamship companies turned to the federal government for action. However, the federal government, contrary to what the state governments expected, refused to provide financial support for the maintenance of the insane deportees and merely suggested that they be released on “personal recognizance” and required to report their whereabouts every thirty days or notify officers of any change in residence.²⁷⁷ Michael Osnato, M.D. of the New York State Hospital Commission, argued that instead of returning the “alien insane” via the steamship line on which they had come to the United States, the federal government should “buy transportation for these aliens wherever possible on Lines other than those responsible for their deportation, thus deporting them on the Lines still running to the countries to which they properly belong.”²⁷⁸ However, the Acting Secretary of the Department of Commerce and Labor openly expressed his frustration at state governments’ demands for speedy execution of the deportation orders. He asserted that the federal government was “not responsible for the unfortunate conditions which now exist and render deportation impossible either because of the requirements of law (statute of

²⁷⁷ Memorandum for the Secretary dated September 24, 1914. File 53775/202A, Entry 9, RG 85, NARA, DC.

²⁷⁸ Letter dated December 8, 1914 from Michael Osnato, M.D. of the State Hospital Commission to W. B. Wilson, Secretary, Department of Labor. File 53775/202B, Entry 9, RG 85, NARA, DC.

limitations) or through the ordinary dictates of humanity (due to the war in Europe)”²⁷⁹ He emphasized the “physical impossibility to deport aliens to certain European countries” and argued that “it is equally impracticable to deport subjects of those countries to certain other countries.”²⁸⁰

Still, even within the Bureau of Immigration did exist efforts to take advantage of the war in Europe. In August 1914, Special Immigrant Inspector A. Warner Parker suggested that while there was a war in Europe, the Bureau should divert its attention to removing “Asiatic aliens—Chinese, Japanese, etc.” by detecting Chinese prostitutes, exclusion law violators, and other undesirables.²⁸¹ It should not give an impression that the Bureau was “raiding” these people, but the task could be done wisely and successfully, argued Parker. In fact, California had already been deporting Chinese inmates from state mental hospitals in June and July of 1914, many of whom had been in the United States for several decades.²⁸² Despite the wartime obstacles, the state governments did not curb their enthusiasm to deport undesirable immigrants. They urged friends and families of the insane aliens to bear the expenses of return trip home or called for the steamship companies to reship the deportees whenever steamship services became available. The State Commissions paid for the expenses of deportation themselves when other means failed and used non-federal channels, as the

²⁷⁹ Letter dated December 16, 1914 to Dr. Michael Osnato, Medical Examiner in Charge, Bureau of Deportation, State Hospital Commission, from Acting Secretary. Ibid.

²⁸⁰ Ibid.

²⁸¹ Letter dated August 7, 1914 from A. Warner Parker, Special Immigrant Inspector to the Commissioner-General of Immigration. NARA, DC. File 53775/202A, Entry 9, RG 85, NARA, DC. In 1903, the administration of Chinese exclusion was put under the Immigration Bureau. In order to avoid judicial hearings necessary in exclusion cases, immigration officials began to apply general immigration laws, which required only administrative hearings. In 1909, following the Amendments to the Chinese Regulations, the Department of Labor and Commerce decided to deport Chinese who entered in violation of the immigration act under both the Chinese exclusion laws and the immigration act, facilitating their deportation. The Chinese Exclusion Act became incorporated into the general immigration act in 1921. See Lucy E. Salyer, *Laws Harsh as Tigers: Chinese Immigrants and the Shaping of Modern Immigration Law* (Chapel Hill: The University of North Carolina Press, 1995); McKeown, *Melancholy Order*, 255.

²⁸² These deportation cases were not processed by government orders. California received assistance from the Chinese government or from friends and family of the Chinese patients; the state also used its own hospital appropriations to remove the Chinese patients from the hospitals to China. See Chapter 3 of this dissertation.

examples of New York and California illustrate, in deportation to successfully send back even those who had been in the United States for more than a decade. The hints of humanitarianism employed by both the federal and the state governments were nothing but rhetoric.

Even after the armistice, the Bureau of Immigration found it hard to implement deportation to several countries in Europe, including Russia, the Balkans, Germany, Austria, Turkey, and Greece, and the efforts of its officers to make use of every possible opportunity for deportation were not as fruitful as the public had hoped.²⁸³ The creation of new countries after World War I further complicated the problem because it now became difficult to figure out to which country the deportees should be sent.

Social Workers

The federal government assumed the responsibility for deportation, but it required assistance from welfare/social work organizations. As the case of Mrs. Rosenbusch illustrates, social work agencies assisted detection and deportation of undesirable immigrants, established a well-knit network with their agents stationed throughout Europe, and ensured safe delivery of deportees. For instance, the Council of Jewish Women had been working since the early 1900s with Jewish societies at European ports to meet insane immigrants and send them home safely.²⁸⁴ In 1921, the Council's monthly bulletin *The Immigrant* further detailed: "we furnish clothing and other accessories, cabling our correspondents in Europe to meet them [immigrants deported for "reasons of immorality, insanity, feeble-mindedness and

²⁸³ For the debates on deportation after war, see U.S. Congress, House, Committee on Immigration and Naturalization, *Conditions at Ellis Island*, Hearings, 66th Cong., 1st sess., (November 24, 25, 28, 1919), 30.

²⁸⁴ Letter dated October 3, 1912 to Cable, Assistant Secretary of Commerce and Labor, from Sadie American, Executive Secretary of the Council of Jewish Women. File 51564/3C, Entry 9, RG 85, NARA, DC.

other causes”] upon arrival and assist them in reaching their former homes in safety.”²⁸⁵

Despite their willing and systematic assistance, they did not hesitate to question or challenge the authorities. Social work agencies complained that in deportation cases, not only immigrants but also their workers did not receive enough information from the government. The whole procedure was rushed; relatives and friends often received no notice of deportees’ departure, and social workers could do nothing to help them. Yet, social workers knew how to manipulate the system: they often advised immigrants and their family members to get in touch with their consuls to learn the whereabouts of newly arriving immigrants who were either detained at immigration stations or about to be deported from the U.S. Naturally, the federal government complained about the involvement of social workers for adding to their already large workload and interfering with their task. In 1921, the Commissioner of Immigration at Ellis Island, banned immigrant aid workers from asking immigrant inspectors to make investigations of and prepare affidavits for the detained aliens.²⁸⁶ In another letter from the same year, C. M. Depuy, Immigrant Inspector, presented a critical view of social work at Ellis Island:

Allowing for a few noteworthy exceptions, each Social Service worker authorized to practice at this Station [Ellis Island] constitutes an agency for bringing about ways and means of defeating the intent and purpose of the Immigration law. The organizations which they represent are un-American in character, and their sympathies are with the foreigners, regardless of the best interest of the United States...Rarely, if ever, does a Social Service worker assist Government officials in determining facts which would bring about the deportation of an inadmissible alien.²⁸⁷

²⁸⁵ Section on the Bureau of Case Work, *The Immigrant*, Council of Jewish Women, Department of Immigrant Aid, May-June 1921, 3.

²⁸⁶ Letter dated November 15, 1921 to Immigrant aid works, Ellis Island, by Robert E. Tod, Commissioner. Box 48, Foreign Language Information Services, IHRC.

²⁸⁷ Letter dated October 18, 1921, Memorandum for the Commissioner from C. M. Depuy, Immigrant Inspector, Page 2, Box 48, FLIS, IHRC. For later correspondences limiting the work of social workers at Ellis Island, see Rockefeller Archive Center (1924) material from Curran to social workers at Ellis Island.

The Immigration Bureau's attempt to remove social work groups from Ellis Island faced vehement protests from the agencies. In fact, the services of social workers were necessary to lessen the burden of the federal government in dealing with immigrants since they took care of many private tasks, some of which the federal government had no capacity or knowledge to deal with; they also kept close and sometimes personal ties with immigrants and their relatives, offering them consolation and support. In 1924, Commissioner-General of Immigration Henry H. Curran sent out a memorandum to prevent conflicts between government officers and welfare workers. Reminding that all welfare workers were stationed at Ellis Island under proper authorization, Curran called for respect for and cooperation with them. However, his memo made it clear that social workers would not "interfere with any officer in the discharge of his or her official duties."²⁸⁸

Social work agencies were interested in the ramifications of deportation and familiarized themselves with the complicated deportation procedures. In 1930, the social worker Edith Terry Bremer asserted: "It is indeed time a group of people whose work brings them into accurate knowledge of foreign people and their life among us should undertake to study the human consequences of this deportation business."²⁸⁹ She urged workers to learn immigration laws of local institutions so that they could better understand the procedures and assist immigrants. Social workers also challenged the deportation provision of the immigration acts by pointing out the lack of power for the American authorities to implement it; they were aware that when foreign countries refused to take back deported immigrants, the U.S. government had to acquiesce and assume responsibility for these people, and often

²⁸⁸ Letter dated April 19, 1924 to all officers from Henry H. Curran, Commissioner. Box 48, FLIS, IHRC.

²⁸⁹ "A Forward Look for International Institutes." Box 1: IISF-board of Directors Minutes, 1930, Folder 9, International Institute of San Francisco, IHRC.

social workers had to step in.²⁹⁰ Despite their assistance in the federal procedures, in some cases, as C. M. Depuy complained in 1921, social workers used their knowledge to prevent the deportation of immigrants, believing that they could give these immigrants a chance to better themselves by keeping them in the United States. For example, when a woman in Iowa, who faced deportation for being likely to become a public charge, wrote to the Foreign Language Information Services for help, it contacted a fraternal organization, instead of the immigration office so that the organization could bond itself to the federal government to pay sanitarium expenses for her tubercular husband and dealt with other financial matters. This saved the woman and her husband from deportation.²⁹¹ However, the involvement with the immigration matters did not mean that these social workers saw immigrants as their equals. Many scholars have shown that American missionaries, social workers, and organizational agents assumed superior positions and patronizing attitudes toward immigrants.²⁹² Social workers also decided who should remain and who should leave. The famous Donaldina Cameron of San Francisco rescued many Chinese and Japanese prostitutes in the West Coast region, and her Home took part in committing insane Chinese and Japanese women to state institutions. Her work also included assisting the federal authorities in detecting and deporting undesirable immigrants, but using her influence, Cameron and her Mission Home associates were able to manipulate the deportation process. Perhaps a bit exaggerated, they boasted that they kept a deportable immigrant in the Mission Home against government

²⁹⁰ Ernest Freund, "Deportation Legislation in the Sixty-Ninth Congress," *Social Service Review* 1:1/4 (Mar/Dec 1927): 46-57.

²⁹¹ "Buried Treasure and the F.L.I.S." Box 8, Folder 1, Immigration and Refugee Service of America, FLIS, IHRC.

²⁹² See Peggy Pascoe, *Relations of Rescue: The Search for Female Moral Authorities in the American West, 1874-1939* (New York: Oxford University Press, 1990). Yoosun Park, "Constructing Immigrants: A Historical Discourse Analysis of the Representations of Immigrants in U.S. Social Work, 1882-1952," *Journal of Social Work* 6, no. 2 (2006): 169-203. Park's essay gives a good overview of social work discussions on immigrants through three contemporary social work journals.

orders and made an arrangement with other organizations for the care of deportees.²⁹³ In many cases, Cameron was the one who decided whether or not these women should be sent back to their home countries. What these immigrant women wanted did not matter because it was the social workers who should determine what was good for them.²⁹⁴ Still, social workers proved to be invaluable sources for many immigrants and deportees, especially those who were allegedly insane. They continued to work with immigrants both in and outside the United States. Even when the federal government and the steamship companies failed to trace the deportees, social workers kept in touch with the immigrants they had taken interest in and assisted them throughout their journey home.

Steamship Companies

Another real problem of deportation was transportation. The federal government urged steamship companies to take responsibility for the “undesirable” immigrants they had shipped to the United States. In addition to being fined for bringing in undesirable immigrants and paying for return trips of deportees, steamship companies reimbursed one half of the expenses of inland transportation required for deportation.²⁹⁵ Steamship companies were more than a mere transportation provider. Like social workers, they needed to work together with a number of agencies, including foreign governments. Since the insane

²⁹³ The case of Kum Choie. She was sent to the Victoria Orphanage and Home in Hong Kong after staying for a year at the Mission Home. In 1902, Cameron and her associates at the Mission Home followed the advice of a lawyer to deport a Chinese prostitute they rescued because she was in the United States illegally, but they arranged her to be taken to a rescue home in Hong Kong instead of sending her to her hometown. Folder 4, 1891-1900, 1899, Annual Report: 78; Folder 5, 1901-1910, 1902 *Annual Report*: 47. Mildred Martin Papers, Special Collections and University Archives, Stanford University.

²⁹⁴ Box 18, Folder 4, 1900 Occidental Board Reports: 73, Mildred Martin Papers. For actual help provided, see the 1917 report, 35. When immigration officials barred Chinese wanting to land in the United States, Cameron intervened and convinced the Immigration officials of the genuineness of their claims. Donaldina Cameron also asserted that she was able to “prevail upon the Department” to prevent or delay deportation of immigrants. Also see Pascoe, *Relations of Rescue*.

²⁹⁵ As of 1907. By the law of 1917, steamship companies were fined 200 dollars for bringing excluded classes of immigrants.

deportee should be handed over to proper authorities on the other side, steamship companies were knowledgeable in the immigration laws and provisions related to their operations.²⁹⁶

They also participated in forming and shaping legal as well as medical norms in their struggle with the immigration authorities. On November 29, 1901, A. S. Anderson, the passenger manager of the American Lines, Philadelphia, protested against the requirement for the steamship company to pay for the hospital bills and the return passage of Anna, a Finnish-born insane. She became a public charge at Manhattan State Hospital, New York City, shortly after she landed in Philadelphia; she was to be deported and her expenses were to be borne by the steamship company which had shipped her to Philadelphia.²⁹⁷ Replying to the commissioner's request for Anna's hospital bill payment, Anderson attempted to challenge the legal and medical expertise that burdened his line with the deportation expenses. He argued that the federal government tried to "saddle" the financial burden on someone else by digging up evidence of diseases, which could or might have existed before the immigrant's arrival but were hard to prove. Explaining the case of Anna, Anderson added:

Mr. Larned [Commissioner of Immigration, Ellis Island] states that the certificate of Dr. Dent [of Manhattan State Hospital] "that the woman is insane, and that in his opinion, causes leading to her insanity existed prior to her landing in this country" may be only a loose expression of the doctor's; but if it is exact, as a medical man's usually is, it does not necessarily come under the law which requires the steamship companies to pay the expenses of deportation. For instance, the causes leading to the insanity might be worry and trouble, which may have existed for a number of years; but those causes may not have produced the effect of insanity until some time after her arrival here. Unless she was actually insane upon her arrival here, or there was some disease existing before her arrival, which produced the insanity, I do not think it is a case for us to deport without pay.

²⁹⁶ For transpacific steamship lines, see Barde, *Immigration at the Golden Gate*. Despite the details it provided on the structure of steamships, steamship lines, and transportation from Asian countries to Angel Island, Barde's study does not deal with the role steamship companies played in transporting deportees.

²⁹⁷ "Letters and Telegrams." Box 7, RG 85, NARA, Philadelphia. Anna Hynynen, who arrived in 1901 through Philadelphia and became an inmate at Manhattan State Hospital in October of the same year, turned out to have been committed to an asylum in England. Her history was constructed through the letters from three agents—commissioner of immigration, steamship company passenger manager, and superintendent of the state hospital—with the help of her family members both in the United States and in Finland.

Anderson argued that there should have been a definite sign of insanity in the first place to diagnose her with insanity; in this case, the woman's illness should have been detected upon her arrival, not after she became a public charge, and it revealed the incompetency of the federal government and its medical inspection. He knew that his lay opinion would not make much difference to the Immigration Bureau and the federal policy; nevertheless, his lack of medical expertise did not deter Anderson from participating in the discourse. Eventually, Anderson's steamship line shipped Anna back to her home country, and its representatives in Liverpool oversaw her safe delivery to her relatives and friends in Finland; however, conflicts between the federal government and steamship companies continued throughout the early twentieth century.

Even after they agreed to take back and transport insane deportees, steamship companies needed to deal with various issues involving their charges. As Anderson's example suggests, one of the largest obstacles they encountered was the federal government. The Trans-Atlantic Passenger Conference Report of 1907 challenged the federal authorities in sending government-appointed attendants with insane deportees. Insane immigrants required attendants to provide constant care throughout their journey home so that they could harm neither themselves nor other passengers on board; however, the steamship lines saw that this federal practice clashed with foreign jurisdiction. Trans-Atlantic steamship company agents were familiar with the requirements of each foreign government to which they delivered deportees from the United States. In Germany and Holland, the governments took charge of the deportees upon their arrival²⁹⁸ and sent them to their destinations under the government authorities. Great Britain placed its own people at a hospital until it located

²⁹⁸ Foreign immigrant patients who were dropped off at German or Dutch ports might have been treated at a local mental hospital near the ports and returned home when they got cured or improved. See Stefan Wulf and Heinz-Peter Schmiedebach, „Die sprachliche Verständigung ist selbstverständlich recht schwierig.“ Die „geisteskranken Rückwanderer“ aus Amerika in der Hamburger Irrenanstalt Friedrichsberg 1909,” *Medizinhistorisches Journal* 43 (2008): 231-263.

where in the country they belonged. Scandinavian immigrants were sent to Stockholm with steamship attendants and handed over to proper authorities. The Italian government was well known among the steamship companies for its good care of insane Italian deportees,²⁹⁹ but Russian and Hungarian authorities often refused to take back their insane people from America.³⁰⁰ The international relations became all the more important because the U.S. Bureau of Immigration and the steamship companies had to deal with two phases of deportation: “the transportation to the other side, and from the other side to the destination.”³⁰¹ The transportation “from the other side to the destination” posed a greater problem as attendants employed by the federal government would either lose their power to proceed with the deportees to their destinations or hand over their charges to the steamship companies upon arrival at ports with nothing more to do. The steamship companies emphasized that they had maintained close relationships with foreign governments, and their agents, unlike federal employees, were allowed to accompany insane deportees to their final destinations. Moreover, managers of the steamship lines insisted that having a government-appointed attendant did not diminish their workload but rather complicated the already complex situation. Mr. Cortes of the British Lines argued: “If that passenger was to escape from that [government-appointed] attendant, our Company would be held responsible for it. We are under bonds to that effect. We have a case in point at present where a man who was sent over with an attendant made his escape and can’t be found, and our company is liable to

²⁹⁹ Conference held on October 22, 1907 in the office of the Secretary of Commerce and Labor. File 51758/3, Part 4, Reel 4, INS. The New York State Bureau of Deportation had complained throughout the 1910s that the consul-general of Italy “objects to granting passports to any insane Italian subjects and prevents whenever possible their repatriation.” According to the Italian vice consul’s letter to Spencer Dawes, MD, of the NY State Hospital Commission, the reason for refusal was because “the commander of the steamship might refuse to receive him [insane Italian] on the steamer.” See New York, State Commission, 31st *Annual Report* (1920), 148-149.

³⁰⁰ File 51564/3E, Entry 9, RG 85, NARA, DC.

³⁰¹ File 51758/3: 8, Part 4, Reel 4, INS.

be called upon at any time.”³⁰² Despite the federal assumption of American deportation policy, the federal authorities were not yet fully established in the matter of deportation and transportation, whereas the steamship companies had long maintained amicable relationships with foreign governments.

In an attempt to resolve the situation, Mr. Winter, the representative of the Trans-Atlantic Steamship Lines, suggested: the immigration authorities “should give the Lines a fair chance to show that the spirit and intention of these statutes [appointment of an attendant who shall accompany a deported alien] can be carried out without doing the vain thing of appointing an attendant who is going to be superseded every time when he reaches the other side.”³⁰³ Mr. Biers also defended the position of the steamship companies, pointing out the ineffectiveness of appointing attendants: “No attendant could absolutely prevent him [insane alien] in every one of the 24 hours; he would have to rest and various other things, so that as a practical situation he has absolutely to depend on the custody of the ship’s officers for a part of the time unless the government is prepared to send three or four attendants and have them watch him by relays, which is not contemplated.”³⁰⁴ In the matter of deportees in need of medical attention and attendants, Mr. Winter asserted that his company was better suited to the task, while the federal government would not be able to afford to send more than one attendant for a case.³⁰⁵ In addition, financial interests intervened although both the representatives of the steamship companies and the federal authorities tried to hide their apparent concern with money matters. One of the complaints from the steamship companies was that most government-appointed attendants refused to stay in the steerage with insane deportees, demanding to travel in the second class cabin, while the steamship companies

³⁰² Ibid., 12.

³⁰³ Ibid., 24.

³⁰⁴ Ibid., 26.

³⁰⁵ Ibid., 51.

became responsible for their return passage home and expenses they incurred in Europe. In the end, on condition that they would be given a trial to proceed without a federally-appointed attendant, the steamship companies agreed to take in “the cases of diseased, disabled, and insane aliens rejected at the ports of this country as well as the cases of those ordered deported under Departmental warrant.”³⁰⁶

Throughout the 1910s, however, steamship companies had to fight against the pressure from the Bureau of Immigration, and to some degree state governments, concerning the financial responsibility for detained and deported immigrants. For example, in November 1911, a rule entitled “Deportation of insane and diseased aliens requiring special care and attention” demanded steamship companies to provide the Bureau with a detailed daily report on deported aliens, in addition to signing and returning Form 597 upon receiving them.³⁰⁷ The 1913 Urgent Deficiency Appropriation Act made the responsible steamship company bear the expenses of detention of deportable immigrants, but as before the federal government had trouble imposing the law. The Bureau of Immigration had been collecting head taxes for incoming immigrants, and steamship companies and even the U.S. circuit court of appeals claimed that these taxes should be used to maintain and keep detained immigrants.³⁰⁸ The contention over the expenses continued to stall the relationships between the federal government and steamship lines until 1924, when the new immigration act specified that attendants hired by the Secretary of Labor to tend to and accompany mentally ill deportees would be paid by the same agency responsible for the expense of the

³⁰⁶ Letter dated December 12, 1907 to the Secretary of Commerce and Labor from the Committee members. File 53775/95, Part 3, Reel 3, INS. Also see 51564/3B

³⁰⁷ File 51564/3C, Entry 9, RG 85, NARA, DC. Later in December 1912, a report by each ship’s medical officer was also required. However, lacking the systematic implementation, the rule caused troubles for both steamship companies and the immigration authorities. Form 597 was mandated in 1907.

³⁰⁸ Ibid. Steamship companies became responsible for “all expenses incident to the care and detention of aliens brought to American ports as candidates for admission.”

accompanied deportees.³⁰⁹ Proper blank forms were now used to record and locate the whereabouts of the deported insane aliens as well as to insure their delivery to relatives or friends. Nevertheless, transporting deportees, especially those who were insane, required not only financial backing but also careful planning by the parties involved.

Discussing the Canadian deportation cases in early twentieth-century British Columbia, historian Robert Menzies describes the pitfalls of the “human assembly line” in deporting insane and feeble-minded immigrants: itineraries were poorly coordinated, information did not reach railroad or steamship companies in a timely manner, patients were often dumped at foreign ports not reaching their final destination, or immigrants ended up harming themselves without proper supervision on the way home.³¹⁰ In the United States as well, the deportation system entailed unexpected outcomes at every step of the way: deportees managed to run away, or worse, kill themselves by jumping off steamships, or occasionally in violent rage harm not only themselves but others. The 1907 Trans-Atlantic Passenger Conference was in part initiated from the complaints from steamship lines (one passenger manager complained: “You give us notice on the day before sailing!”³¹¹), immigrant communities, and social work agencies that insane deportees did not receive proper care and failed to arrive at their destinations. Steamship companies in particular were forced to deal with unforeseen and dangerous situations because they were not always fully informed of the conditions of their passengers. For example, in 1907, the *San Francisco Call* reported an instance of two Japanese insane—one with a mild form of dementia and the other showing violent behavior—who drew attention of the steamer passengers for their erratic and violent behavior, with a headline, “Insane Japanese On Board Steamship *Asia* Creates Lively Times.” The steamship company was unaware that these steerage passengers were insane and

³⁰⁹ Carey, *Deportation*, 462-463.

³¹⁰ Menzies, “Governing Mentalities,” 160.

³¹¹ File 51758/3: 31, Part 4, Reel 4, INS.

had no knowledge of who was responsible for putting them on board; in the meanwhile, other passengers struggled to get hold of one of the men, who was eventually put in a straitjacket and kept under guard until he was handed over to the Japanese authorities in Yokohama.³¹² In December 1911, Anton Gross, who had been an insane patient at the Central Islip State Hospital in New York City, was deported to Germany. It seems that the steamship company which brought him to Germany might not have known his real mental condition and let go of him without providing further treatment. At a hotel in Berlin, Gross became violent and ended up killing three people, wounding several others, and getting shot by the police.³¹³ Moreover, the humanitarian goal of deportation advocated by the steamship companies and the American government was often compromised during the return voyage; some of the deportees were exposed to brutal treatment. In September 1913, Albert O. Nielsen, the shipping master of Baltimore, conveyed three insane deportees from New York to the West Indies, and he reported to the *Sun* “a humorous account of his experience on the steamer *Parima* at St. Thomas, Danish West Indies.” He was in charge of “three crazy negroes”: August King to Barbados, Sara Lee to Kitts, and Lena James to Antigua. He wrote: “You can believe me that I have my hands full. Never no more for me; not for the United States.” Nielsen paid particular attention to August King and boasted: “The man went for me twice, he being a dangerous brute, but people about Gaff Topsail Corner that know me can guess what I did to him. He may arrive at Barbados with his mind clear and wonder where he is.”³¹⁴

³¹² “Insane Japanese On Board Steamship Asia Creates Lively Times,” *San Francisco Call*, August 20, 1907. This article reflected the anti-Asian immigrant sentiment advocated by the newspaper, by drawing a rather comical picture of the whole situation and referring to the Japanese insane as “the beggar,” “the little maniac,” or “the little brown man.”

³¹³ File 52730/8B, Entry 9, RG 85, NARA, DC. The *New York Times*, reporting this case in 1911, stated that Anton Gross claimed himself to be an American citizen, and the article was titled “Insane American’s Fight.” However, Thomas W. Salmon’s letter in the NARA file shows that Gross was an “alien” whose documents for deportation indicated that he was dangerous and needed attention and care.

³¹⁴ “News of the Shipping,” *The Sun*, September 24, 1913. This article offers a rare example of insane West Indian deportees, whose number grew in the 1910s and 20s as immigration from the West Indies increased during the time period.

Without any mention of attendants to care for them, it is not hard to imagine what might have happened to these insane deportees and what measures were taken when they became disruptive or violent on board.

Deportation of the “alien insane” also had an impact on mental institutions in European ports. German scholars Stefan Wulf and Heinz-Peter Schmiedebach examined “insane returnees” at the Friedrichsberg Asylum in Hamburg in the year of 1909 and showed that many of these return migrants—southern or eastern Europeans—had been deported from the United States and placed there by steamship companies, mainly the Hamburg-American Line, before they recovered and left for home countries. German doctors were frustrated by the lack of patient information from the American side and had difficulty in understanding the actual medical condition of the “insane returnees” due to their language barriers and racially-charged, though meager, information about the patients from American doctors and officials. These instances of insane deportees alerted the authorities of the need to devise more efficient and safer delivery systems and called for better cooperation among agencies and authorities. Still, the reality of deportation rarely reflected the perspectives of the immigrants, the very ones to experience the pitfalls of deportation.

Immigrants’ Responses to Deportation

Deportation concerned not just deportees but also their families and friends both in the United States and back home; immigrant communities were particularly concerned with the “alien insane” who required care and protection throughout the deportation process and also back in home countries. However, immigrant communities often had trouble locating these insane immigrants once they were deported from the United States. State Commissions, which played an important role in deporting the “alien insane,” shared their concerns and criticized the federal authorities for their ineffective policy. For example, the New York State

Hospital Commission, blaming the federal government and steamship companies, discussed several cases of missing patients and listed complaints from their relatives and friends. In the 1905 report, Dr. E. C. Dent, Superintendent of Manhattan State Hospital, stated:

I have received several communications from the relatives of patients deported, who claim, up to four or six weeks after such deportation, they have been unable to find that they have arrived at their homes, and could obtain no trace of them. Any conditions which do not afford protection to the insane alien until she reaches her home, are indeed unfortunate, and it appears to me, that some steps should be taken by the proper authorities, toward remedying these matters. The steamship companies do not appear to hold themselves responsible beyond the port where the patient was originally received aboard their steamship.³¹⁵

According to the same report, the New York State Charities and Association, having “made some inquiry into the methods pursued in the deportation of insane aliens,” was convinced that “the methods of deportation are not such as to afford the patients proper care and protection in all cases, nor to do justice to their friends and relatives.”³¹⁶

Nevertheless, immigrants were not helpless in negotiating their fate: even insane immigrants, supposedly too troubled to function, met deportation decisions with a reasonable amount of resistance. Some ran away when they learned that warrants of deportation or arrest were issued: when deportees could not be located, the warrants got cancelled. Some simply refused to talk to government officials and medical professionals, making it impossible to prove who they were and where they had come from.³¹⁷ Though expensive, they learned to appeal to legal measures by hiring a lawyer and fighting for their rights to stay in the country,

³¹⁵ New York, State Commission, 16th *Annual Report* (1905), “Deportation of Insane Alien” in State Charities Aid Association—Annual Report,” 983. State Commission was trying to send back foreign-born patients to their home countries without being limited by the years they stayed in the United States (five-year statute of limitations).

³¹⁶ Ibid. From the Manhattan State Hospital, West. B1432-95, Box 2, New York State Archives. This issue got more complicated when the port of embarkation was not their home and they had to be again transported from the port to their hometown within the European continent.

³¹⁷ In his study of Chinese insane immigrants repatriated from Canada, Menzies also writes that their language barriers and mental impediments inadvertently protected them from repatriation by obscuring their histories and anomalies. Menzies, “Race, Reason, and Regulation: British Columbia’s Mass Exile of Chinese ‘Lunatics’ aboard the *Empress of Russia*, 9 February 1935,” in *Regulating Lives: Historical Essays on the State, Society, the Individual, and the Law*, eds. Dorothy E. Chunn, John McLaren, and Robert J. Menzies (Vancouver: UBC Press, 2002), 196-230, 216.

often with the help from fellow immigrants who had a little more leverage and knowledge in American ways.³¹⁸ Mexican citizens in the United States, for example, clearly knew what to do in the case of deportation and complained that the immigration officials “do not give persons subject to deportation sufficient notice after final action by the Secretary of Labor to allow them an opportunity to apply for a writ of habeas corpus.”³¹⁹ They also appealed to congressmen in their constituency, although many new immigrants without voting rights could not have used that option. In addition, immigrants reached out to social workers for advice and help. The National Council of Jewish Women reported various instances of immigrants asking for help in bringing over their spouses who had failed a mental test and been unable to enter the United States.³²⁰ Even when all failed, immigrants still voiced over and over again their intention to stay in the United States, leaving their marks on hearings and inspection documents. However, their alleged insanity made it difficult to have their voices heard, and no one was willing to take their accounts at face value.

Inadvertently, federal deportation policy helped those who wanted to return home but lacked resources; many immigrants were aware of the cost of becoming illegal, but they were ready to manipulate the system which required steamship companies to pay for the return expenses of the deportees and apportioned funds for other deportable cases. In California, for example, elderly Chinese men wishing to return home turned themselves in to the

³¹⁸ Dorothee Schneider, *Crossing Borders: Migration and Citizenship in the Twentieth-Century United States* (Cambridge, MA: Harvard University Press, 2011).

³¹⁹ File 54933/351E, Entry 9, RG 85, NARA, DC.

³²⁰ News Bulletin for the Members of the Committee on Ellis Island, edited by Helen Arthur, Secretary, September 1933, FLIS, IHRC. When a wife of a native-born American citizen in Poland was denied a visa after failing the mental test at the Consul, her husband, who had returned to the United States for work, visited the office of the National Council of Jewish Women. He carried two letters written by the wife in Yiddish to show that she was not feeble-minded. He explained that she did not receive formal schooling but learned from a private teacher and knew a little Polish and how to read and write in Yiddish. He reasoned: “he has lived with her for a year and a half, and he certainly would have noticed if she were feeble-minded.” He also claimed: “being a village girl without any experience or schooling, his wife need not necessarily be feeble-minded, even though she might not be able to pass the tests given at the Consulate’s office.”

immigration authorities as illegal immigrants and earned free passage home as deportees.³²¹ Some requested to be sent to a different place for deportation: this “trans-shipment” allowed those who had entered the United States from a third country—not their native state—to return to their real home. In 1906, for example, the New York State Commission in Lunacy reported a case of a mentally-ill Spanish woman, who had come to the United States from South America: she was returned to Spain upon her appeal that she had no friends to take care of her in South America and would rather go to Spain where she had family.³²² This might have become possible because her deportation was arranged by her friend, not by the government warrant; still, it shows some of the options available to and adopted by deportees.

Immigrants also used the deportation process to manage their own communities. They were aware of the statute of limitations of the immigration acts and manipulated it so that they could both provide care for their suffering friends at public expense and prevent them from being deported. In 1914, John F. Mann, an employee at the Ellis Island Immigration Station, wrote: “Many cases are found, however, of insane aliens who are placed in public institutions but their relatives defray the expenses until after the three year limit has expired, when they cannot be deported, and then refuse any further payment for the rest of their lives and this after only three years residence in the United States.”³²³ Contradicting the belief that immigrants lacked knowledge of the American immigration system, Robert DeC. Ward also stated in 1924 that they knew immigration laws better than most Americans did.³²⁴ Not only did they know the laws but also they made full use of the system. They reported to

³²¹ Barde, *Immigration at the Golden Gate*, 133-134. He cited, “Chinese Profit by a Rate War,” *San Francisco Call*, December 3, 1903. Barde sees the *Call* report as a reflection of the anti-Chinese agitation of the time period. In 1903, the Commissioner-General of Immigration, Terrence Powderly, also complained that some Chinese immigrants manipulated the loopholes in deportation proceedings and appeals to district court to secure free passage home. Hester, “Deportation,” 76-77.

³²² New York, State Commission, 18th *Annual Report* (1907), 54.

³²³ Article enclosed in the letter to the Commissioner-General of Immigration by Acting Commissioner of Immigration, Ellis Island. Letter dated December 5, 1914. File 55224/371A, Entry 9, RG 85, NARA, DC.

³²⁴ Robert DeC. Ward, “Higher Mental and Physical Standards for Immigrants,” *Scientific Monthly* 19, no. 5 (1924), 537.

the authorities fellow immigrants who threatened the peace of their communities or tracked down wives and husbands who had deserted them so that these unworthy subjects would be deported or denied entry.³²⁵ Immigrant communities were weary of inviting unwanted prejudices against them, and this might have contributed to the reporting of undesirable immigrants by community members. For example, in February 1914, the *San Francisco Chronicle* reported that Japanese immigrants in California planned to send back a Japanese man, who was sentenced sixty days in the County Jail for inappropriate conduct. President of the Japanese Association T. Terado claimed that the Japanese man was “a disgrace to the law abiding Japanese” and should be deported.³²⁶ Immigrants had similar attitudes toward fellow insane inmates at state hospitals (examined in detail in Chapter 4), and they often solicited the assistance of their home governments, not to mention their own communities in America.

For insane immigrants, the possibility of deportation was a real threat, and the ignominy of insanity further stigmatized them. Some tried to be deported not as insane but as a seaman or a passenger to prevent job-related complications back home or the stigma of being branded as insane. For example, in 1908, Antoine Makhat, an Armenian from Turkey, was ordered deported for insanity of chronic form after he had become a public charge at Central Islip State Hospital, New York. His uncle requested the Commissioner of Immigration to release him on parole and promised to send him to Turkey after the expiration of the thirty-day parole. The uncle reasoned: if Antoine was “deported by direction of the United States Government the nephew will be unable to get work in Turkey.” The New York Commissioner and State Board of Alienists agreed to parole him as long as the uncle furnished bond and paid Antoine’s hospital expenses. However, the uncle, while willing to pay the bond of five hundred dollars, did not have enough means to pay for the hospital bills.

³²⁵ For more cases on husbands and wives using immigration laws, especially the clause of likely to become a public charge, for deporting their unwanted spouses, see Moloney, *National Insecurities*.

³²⁶ “Japanese Would Deport a Fellow Countryman,” *San Francisco Chronicle*, Feb. 6, 1914; pg. 3.

On June 18, 1908, Antoine was officially deported on the French Line, which had brought him to the United States.³²⁷ There is no record to show what happened to Antoine after his deportation; however, it is not difficult to imagine that his life as an insane deportee would have been markedly different from that of a successful emigrant.

As the previous section on steamship companies shows, the deportation process was fraught with unexpected events and constant worries. It became even more complicated as immigrants had to take several lengthy trips to reach the American port through which they had entered the United States, the port of embarkation on the other side, and finally their home. Deportation was designed to control and regulate the movement of undesirable immigrants, but in fact, mobility was embedded in the deportation process. Then, how did they travel from hospitals to immigration stations to their home countries? What was it like to be an insane deportee traveling with criminals, prostitutes, and anarchists, in addition to attendants and guards, and meeting new immigrants at every depot, who were picked up on the way by an immigrant inspector?

*Logistics of Transporting and Deporting the Insane Alien*³²⁸

Oct 12th 1909

Left official station at
4:28 for – Elldridge Cal
Fare – 25 via S.P.R.R. to
bring down insane alien

March 12th 1924

Left State Asylum Napa
at 6:35 am for
San Francisco in state Hospital Auto, no charge
to government.
Left Automobile at Sausalito

³²⁷ Aged 31, race: Armenian, country: Turkey, landed on September 9, 1907, New York. Deported June 18, 1908. File 51967/188, Entry 9, RG 85, NARA, DC.

³²⁸ Carey, *Deportation*. For transpacific transportation to and from Angel Island, see Barde, *Immigration at the Golden Gate*.

and boarded San Quentin
 Pacific Steamer for
 San Francisco
 had in custody Matron Lopez
 insane alien
 Ferry fare for self and alien
 for Sausalito to San Francisco³²⁹

John A. Robinson, an immigrant inspector stationed in San Francisco, had been in charge of transporting deportable immigrants for the first three decades of the twentieth century. He picked up deportees—prisoners, insane immigrants, and prostitutes—from penal or charitable institutions in California and brought them to deportation sites. His twenty-two volume journals recorded names and case numbers of the deportees he accompanied and the expenses for supper, room, and transportation. The journals also included various kinds of transportation—hospital auto, automobile, taxi cab, steamer, ferry—and the places where he picked up or discharged deportees.³³⁰ Despite the lack of information on individual deportees, Robinson’s journals give a glimpse of what occurred once deportation orders were issued for deportees: they became a series of trips to take and expenses to be remunerated. While his journals are a microscopic study of deportation, records of a transcontinental deportation party shed light on the larger structure and logistics of deportation and reveal various contingencies of transporting the “alien insane.”

Prior to 1914, a deportation party was not a familiar fixture in American immigration policy. In the absence of a coast-to-coast national deportation system, immigration officials and inspectors of each district, like John A. Robinson, handled the deportation of insane

³²⁹ John A. Robinson papers pertaining to the U.S. Immigration Service, San Francisco, California, 1906-1936, California Historical Society.

³³⁰ Ibid. In the 1920s, he was engaged in an effort to eliminate “white slavery” and worked closely with social workers like Donaldina Cameron.

immigrants as well as other deportees under the supervision of the Immigration Bureau.³³¹ In addition, U.S. Marshals participated in deportation efforts, accompanying deportees to various ports of the United States and in some cases to their final destinations. However, these trips, even short ones, were fraught with difficulties and accidents, and those in charge of transporting the insane, believed to be dangerous and violent, had to be particularly careful.³³² Transcontinental travel to deport insane immigrants involved not only immigration officials, matrons, and attendants to take care of them but also a special railroad car with “padded walls and barred windows” to prevent them from harming themselves or escaping.³³³ Transoceanic travels were harder to control. In 1907, U.S. Marshal A. W. Merrifield of District of Montana left for China with seven Chinese immigrants, three of whom were insane. When the ship they sailed on was wrecked near an island in Japan, one deportee managed to escape. As the trip went awry, the Great Northern Steamship Company, which was to pay for the deportation expenses, did not carry out its promise, and Merrifield had to buy his own ticket to return to the United States. It incurred extra expenses for the marshal, but he had to wait for several months to get them reimbursed from the federal government; in the meanwhile, he went through endless paperwork and futile communications with several officials just to get his money back.³³⁴ As efficient plans were not yet expected of the federal government, foreign consuls, state governments, social workers, and immigrants themselves

³³¹ Letter dated Feb. 1, 1916 in regarding arrangement for deportation parties. File 53775/202B, Entry 9, RG 85, NARA, DC.

³³² “Insane Japanese Gives De La Torre A Scare,” *San Francisco Call*, March 23, 1900. Deputy Immigration Commissioner A. de la Torre of San Francisco carried a revolver when he “bravely” delivered an insane Japanese to the Japanese consul. The insane Japanese acted strangely during the trip, and de la Torre, thinking the Japanese was about to assault him, pulled out his revolver and commanded him to be seated. It turned out that the Japanese was merely interested in the automobile: “Me like see wagon, no hose.” However, de la Torre’s reaction and the tone of the newspaper article, which praised him for his bravery, reflected the danger embedded in transporting the insane.

³³³ “State Will Deport Insane Foreigners,” *Los Angeles Herald*, February 16, 1909. Insane immigrants discussed here had been committed at Ukiah, Stockton, and Napa State Hospitals, California.

³³⁴ File 52138/2, Part 1, Reel 8, INS.

often took part in the deportation efforts, organizing small groups of deportees at their expense and sending their own agents to accompany the deportees back home.

Against this backdrop, the formation of a deportation party in 1914 became a significant event reflecting both the rise of the federal power and the multilayered interactions between the federal government and local agencies. Nevertheless, the new system, like the federal deportation policy, was criticized by state governments and local agencies for incompetence of the Immigration Bureau in handling the deportation process. In 1914, Henry Weiss, Inspector of Immigration at Seattle, Washington, became the first officer of the deportation party. As a former employee of a tourist agency, he had travel experiences and much needed language skills to do the job. Weiss led the transcontinental deportation party which left Seattle for San Francisco bound for New York, picking up deportees on the way. On his return trip, he took care of westbound deportees, mostly Asians, who were assembled at New York City or New Orleans, Louisiana (travel by water from New York City to New Orleans), for deportation at the West Coast ports.³³⁵ The deportation party consisted of various “classes” of immigrants: “Many of these people are insane, others are diseased, still others are of the immoral classes, while a considerable number consist of persons who have been unfortunate in some way but are not objectionable traveling companies.”³³⁶ The actual number of insane deportees was quite small, but they were constantly referenced in government, social work, and steamship company communications because of the potential danger they posed on the deportation party; they needed attendants and medical professionals throughout the journey to ensure their and other deportees’ safety. Moreover, taking good care of the insane was required by American humanitarianism, and

³³⁵ Memorandum dated February 1, 1916 for the Acting Secretary—details the history of the deportation party and routes used. File 53775/202A, Entry 9, RG 85, NARA, DC.

³³⁶ Letter dated December 6, 1919 from Commissioner-General to Hon. Oscar A. Price, Assistant Director-General of Railroads, Washington, DC. File 54645/325, Entry 9, RG 85, NARA, DC.

therefore, there were constant surveillance and scrutiny over the work of the deportation party.

As the first officer to take charge of the task, Henry Weiss underwent difficult adjustment periods and met criticisms from immigrants, social workers, and medical professionals involved in the party as well as his own colleagues of the Immigration Bureau. Many of the criticisms centered on insane deportees. In 1914, Immigrant Inspector Ainsworth of the San Francisco office, who had observed one of Weiss's deportation party trips, sent a letter to the Commissioner-General of Immigration, Washington, DC, to describe its conditions. He was most concerned with the insane aliens and approached the issue with deep sympathy:

I am not particularly interested in the criminals or in the immoral aliens, but I do wish to make a plea for the helpless, friendless, insane, who are transported in a manner utterly at variance with the care given by either private enterprise, State or Federal government. I blush to think of the criticism that would be leveled against the Immigration Service if the manner in which these aliens were crowded into this car on this occasion on one of the hottest days we have had become known to the public.

He claimed indignantly: "There were in this party altogether thirty-nine aliens, eight attendants, one officer in charge, and three negro servants, making a total of fifty people in a possible berthing space."³³⁷ However, Inspector Weiss denied the accusation. He detailed the conditions of the deportation party and asserted that there were in fact thirty-four, not fifty, people in the party and that, unlike the San Francisco inspector, the accompanying surgeon was satisfied with the trip.³³⁸ Such accusations were not uncommon. About two months before, Weiss had defended his deportation party against similar accusations, and referred to the letter from E. C. Reid, a doctor who had accompanied the deportation party and much praised its travel conditions. According to Reid, "We had excellent meals, and the car was

³³⁷ Letter dated June 27, 1914. File 53775/202A, Entry 9, RG 85, NARA, DC. One of the 14 sections of the tourist sleeping car was assigned to "the colored cook, waiter, and porter."

³³⁸ Letter dated July 23, 1914 to Commissioner-General of Immigration, Washington, DC. Ibid.

kept in a thoroughly sanitary condition throughout, despite the fact that we had several untidy and troublesome patients in the party.”³³⁹ A medical professional with several years’ experience in the Government Insane Asylum (later, St. Elizabeths), E. C. Reid’s testimony would have assured the Immigration Bureau of the satisfactory conditions of the deportation party.

The party had, however, a number of real issues. It had difficulty finding and hiring attendants both qualified and willing to take a trip at a short notice. Female deportees needed female attendants for assistance and care, but it was not required by law, and more often than not no records of attendants’ sex existed. Immigration officials had their fair share of hardships. They were often forced to rush the deportation process due to the lack of communications among various parties involved. Officials at Ellis Island, the most popular destination for deportation parties, did not always know when to expect deportees from various parts of the country. Local immigration offices fared worse: since notice from the party did not arrive in time, they often ended up waiting with deportees long after the party had already left their area. The “undue haste” of the transcontinental deportation party also pressured them. It took time to bring over deportable immigrants from state institutions where they were detained to immigration stations; moreover, immigration officials at large ports could not pay sufficient attention to the deportation party because they were expected to deal with not only expedited deportation orders but also steamships-full of new arrivals.³⁴⁰ Since individual immigration officials had no authority to use their own initiatives to facilitate the deportation process, they were often forced to let go of deportable immigrants when the time limit for deportation expired while they waited for department orders.

³³⁹ Letter dated May 19, 1914 to Henry Weiss; E. C. Reid was at present Assistant Superintendent of Ukiah, Cal., Insane Asylum. File 53775/202, Entry 9, RG 85, NARA, DC.

³⁴⁰ Letter dated May 27, 1914 from Samuel W. Backus, Angel Island Commissioner of Immigration to Commissioner-General of Immigration, Washington, DC. Ibid.

Expediency and economy in transporting and deporting the aliens compromised the needs of immigrant communities as well. As the deportation party quickly moved from one place to another, sometimes without even a week's notice, immigrants found it difficult to keep track of their friends and relatives scheduled for deportation. Even when they promised bond money to postpone the departure of their family members, they often found these deportees gone without notice.³⁴¹ Once the deportation party left, family members rarely had means to get help or to hope for reunion with their ailing parents or children.³⁴²

Following Henry Weiss, Inspector Leo B. Russell took over the troubled position of the deportation officer in 1916.³⁴³ Russell took security as his top priority and focused on improving the conditions of the Deportation Car. He complained that the Pullman Cars used for deportation did not have windows secured or doors guarded, thereby allowing some of the deportees to escape. Moreover, workers and porters employed by the railroad companies feared the deportees and failed to carry out their responsibilities. The lack of communication and coordination continued to take its toll: frequent delays on the part of railroad companies distressed the deportees and made the job of the officer more difficult.³⁴⁴ Steamers failed to leave on a given date, incurring the Immigration Bureau at various ports unnecessary expenses for the extended care of their deportees and further lengthening the period of detention for the immigrants. Burdens of the deportation party increased after the war was over in 1919 with more deportees to transport as "steamship sailings become stabilized."³⁴⁵

³⁴¹ Ibid.

³⁴² Ibid.

³⁴³ File 54645/325, Entry 9, RG 85, NARA, DC; *Annual Report of the Commissioner-General of Immigration*, 1920, 307-10.

³⁴⁴ Letter dated April 2, 1919 from Leo B. Russell to Commissioner-General of Immigration. File 54549/670, Entry 9, RG 85, NARA, DC.

³⁴⁵ Letter dated December 6, 1919 from Commissioner-General to Hon. Oscar A. Price, Assistant Director-General of Railroads, Washington, DC. File 54645/325, Entry 9, RG 85, NARA, DC. For deportation of the insane aliens, see *Report of the Department of Labor*, Vol. 8 (1921), 578.

Despite these problems, the deportation party became a strong feature of the federal deportation policy by the 1920s. In 1920, Inspector Leo B. Russell took charge of the newly established Deportation and Transportation section of the Immigration Service, and E. M. Kline, the Immigration Inspector from Chicago, became Deporting Officer. Russell and Kline took turns on different routes, each in charge of one deportation party. One of Kline's deportation trips in 1920 left San Francisco to New York, arriving at Hoboken, New Jersey, four days later, with ninety-eight deportees in total, among whom were insane, criminals, public charges, and anarchists. Three cars were used to transport them and each car had four attendants to care and guard the immigrants. A large combination kitchen car, capable of feeding three hundred people, provided the deportation party.³⁴⁶ Into the 1920s, reflecting the social and political environment of the period, the Russell and Kline deportation parties began to transport a large number of anarchists and immigrants with fraudulent and surreptitious entry. Still, the party officers and the federal government continued to pay attention to insane immigrants. The combination of saving expenses and humanitarian interests in easing the suffering of the deportees was an important part of the party organization. Russell's memorandum to Commissioner-General Husband in October 1921 reflected these concerns. Russell suggested a prompt formation of another deportation party: "This is in the interest of economy in saving jail bills and also in the interest of humanity in taking these people out of jails as soon as possible after their prison sentences have expired."³⁴⁷ The immigration officials took a similar approach to insane immigrants at state hospitals who could be deported but had to wait for the deportation party to transport them. However, these humanitarian intentions never fully materialized. In 1931, remarking on the functions of the deportation party, Jane Perry Clark Carey noted that in some cases insane

³⁴⁶ Memorandum for Mr. Caminetti from Leo B. Russell. File 54814/8, Entry 9, RG 85, NARA, DC.

³⁴⁷ Letter dated October 17, 1921. File 55135/1A, Entry 9, RG 85, NARA, DC.

aliens were segregated and guarded but in others they were left to mingle with “convicts, children, and illegal entries,” which defeated the humanitarian intention of deportation emphasized by the federal government.³⁴⁸ Carey explained that it became difficult to pay special attention to the insane deportees as the deportation party continued to grow and that some deportees indeed became stranded without ever reaching home.

Conclusion

A deportee’s journey did not end at the immigration stations; he had to travel to his port of embarkation and then to his hometown. However, the problem is that the deportees who arrived at large European ports en route were sometimes left there to wander about without reaching their final destinations; they had tickets for their hometown, but no attendant or officials forced them to complete the journey, and they often ended up roaming about the foreign lands. These deportees, once a problem for the American authorities, now became a serious concern for European countries. For example, in 1926, Germany required a police patrol for deportees passing through its territory to their final destinations and demanded that the departing state, in many cases the United States, pay for patrol expenses so that the deportees would not be stranded or left behind in Germany.³⁴⁹ Under these circumstances, the federal authorities devised a scheme to ensure deportees’ safe arrival home. It was not always easy for the American authorities to keep track of criminals or political deportees; they needed no institutional care and protection from their home countries and were more often than not let go upon arriving in Europe. However, insane immigrants, left unattended, could end up becoming public charges in a foreign country, or worse, being stranded unable to reach home; therefore, the federal authorities made sure that these insane

³⁴⁸ Carey, *Deportation*, 472.

³⁴⁹ Letter dated June 4, 1926 to Commissioner-General Harry E. Hull. File 54933/351F, Entry 9, RG 85, NARA, DC.

deportees were delivered to their final destinations by having relatives, police officers, or heads of institutions where they would be sent confirm their arrival by signing official documents, which would be returned to the Bureau of Immigration. This scheme reduced the risk of losing track of the insane deportees and guaranteed their safe delivery.³⁵⁰

Nevertheless, the reality differed from the theoretical delivery and sign-off proposed and advocated by the federal authorities, steamship companies, and foreign governments. Often in need of costly institutional care, the insane deportees became a burden upon their home countries, and if not deported, upon the American federal and state governments. Thus, what mattered more than their safe delivery was to find out who these insane deportees were and where they should be sent; this in turn required refining the meaning of citizenship. The growth of federal power and the establishment of the international order at the turn of the twentieth century also influenced the ways in which American citizenship was defined, boundaries between citizens and aliens were drawn, and social, economic, political and legal rights for citizens and aliens were specified. The next chapter looks into the example of a “man without a country,” the benefits of derivative citizenship, domicile, and residence, and the 1920s’ debates concerning deportation and repatriation of insane American citizens committed to Canadian state institutions to discuss how immigration and insanity shaped and redefined the government’s responsibility for citizens and the meaning of becoming American.

³⁵⁰ In the early twentieth century, insane deportees were also dumped in European ports to be taken care of at nearby hospitals or wander about aimlessly. See Wulf and Schmiedebach, “„Die sprachliche.“”

Chapter Three

Questions of “Reception and Care”: Insanity, Mobility, and Ideals of American Citizenship

In 1914, in his article “Comedies and Tragedies at Ellis Island,” John F. Mann, an employee at the immigration station, narrated in detail a case of an American citizen named Jones. Jones was an inmate of a public hospital for the insane in America and there he learned that insane aliens were deported to the countries where they came from. Hoping to take a sea voyage, he convinced the hospital staff that he was in fact an Irish immigrant, not an American citizen. As an insane alien, he was deported to Ireland with an attendant named Brown, who was in charge of Jones and a few other deportees. Once in Ireland, Jones no longer desired to stay there; after working odd jobs for a while, he was arrested as a vagrant. Realizing that the ship record put him as an Irishman and the attendant Brown as an American citizen, he took a chance and claimed to the Irish authorities that his name was Brown. After his record was verified, he was deported to the United States. At Ellis Island, Jones, though deported under the name of Brown, revealed his real identity, but he was detained as an Irish vagrant because the ship record showed that Jones was an Irish, and therefore a British citizen; after investigations, he was finally proven to be an American and regained his freedom.³⁵¹

As the title suggests, Mann’s story could have been a comedy at Ellis Island to illustrate many contingencies at America’s largest immigration station, but this amusing vignette also opens up broader discussions of immigration and insanity at the turn of the

³⁵¹ John F. Mann, “Comedies and Tragedies at Ellis Island,” enclosed in letter dated December 5, 1914 to the Commissioner-General of Immigration by Acting Commissioner of Immigration, Ellis Island. File 55224/371A, Entry 9, RG 85, NARA, DC. It is not clear why Jones was allowed to roam about and work in Ireland when he was deported for being insane. The deportation and delivery system had not been fully established by the time the article was written, so it is possible that Jones was let go as soon as he reached Ireland; or his condition might not have been considered serious enough for institutionalization.

twentieth century: the “alien insane” subject to deportation, the importance of immigration files and papers, boundaries between the citizen and the alien, responsibility for care and protection, and international relations that governed the movements of people. Jones was able to manipulate the American institutional system and utilize his knowledge of the immigration laws to navigate the two worlds; having been a mental hospital inmate, he knew the danger of being insane and alien, but he also realized that it could facilitate his “sea voyage.” Through deportation, Jones became part of the immigration filing system, which in turn constructed his identity: his ship manifest from America listed him as an Irishman named Jones and his deportation order from Ireland was in the name of Brown, an American citizen. In both the United States and Ireland, government officials made their decisions of admission and deportation following Jones’s paper trail, which challenged his claim of who he really was.³⁵² Jones’s case also reveals blurry boundaries between the citizen and the alien. As an American citizen, Jones had a right to enter the United States even when he had been arrested and deported as a vagrant; at the same time, his American citizenship status was easily questioned when it did not match evidence from the government files and documents. Jones’s story could have been intriguing enough even if he had not been an insane inmate; however, it was his alleged insanity and institutional commitment that caused the unexpected turn of events. His interactions with immigrant inmates at the mental hospital also show, though not explicitly, that the “alien insane” did receive protection and care in America despite their immigrant status and deportability and had knowledge of the American immigration system. In this way, insane individuals, whether American citizens like Jones or immigrants in general, can lead us to larger political and social issues beyond the national boundaries.

³⁵² Adam McKeown, *Melancholy Order: Asian Migration and the Globalization of Borders* (New York: Columbia University Press, 2008). See Chapter 10, Files and Frauds. Also see Also see Craig Robertson, *The Passport in America: The History of a Document* (New York: Oxford University Press, 2010), 164-171, for a discussion on visual surveillance and documentation of immigrants at Ellis Island.

Situated in the Progressive era, this particular history of the “alien insane” sheds light on the multiple conditions which immigrants of varying civic status—a man without a country, a naturalized citizen, a derivative citizen, and a domiciled alien (or resident)—experienced and on the ways in which insanity, mobility, and other contingencies attending immigration constructed or challenged their positions. This chapter also examines the deportation or repatriation of insane American citizens at Canadian mental institutions, whose cases situate immigration and insanity in both the national and international contexts and reveal the continuing federal and state struggles over hegemony.

A Man without a Country

Successful in proving his citizenship status, Jones was released from his detention at Ellis Island. However, many immigrants suffering from insanity were not as fortunate as Jones in finding freedom or securing a place to return. They could not readily produce evidence of their legal and political status, and unlike Jones, who was let go despite his previous insanity record, they often required costly institutionalization or care wherever they went so that they would neither harm themselves nor others. In 1915, Russian-born Nathan Cohen enjoyed a brief moment of fame when his seafaring story was reported throughout the United States. Cohen, “a man without a country,” “a wanderer of the sea,” “a sea wandering Jew,” arrived at Ellis Island in May 1912 from Brazil.³⁵³ After passing through the immigration station, he went to Virginia and opened a little store with a relative. About a year

³⁵³ Cases like Nathan Cohen’s were not uncommon. See for example, “Man Without Country Raises Knotty Problem,” *San Francisco Call*, March 24, 1912. The American authorities refused to land a Russian seaman, who became insane on his way to America; the Russian government insisted that his nationality be proven first before it took him in. Another case concerned a Filipino named Thomas Sonega, who was committed to the State Asylum for the Insane in Kansas. His case was not about proving his nationality but more about whether he as a Filipino should be naturalized first to be committed to an American insane hospital. Instead of waiting for the federal advice on the matter, the Kansas Board of Control sent him to the asylum. In this case, the Government Hospital for the Insane (later named St. Elizabeths Hospital) seems to have refused to receive him into the hospital, although its rationale for refusal was not clearly stated. “Trouble Over Custody of Insane Filipino Boy,” *San Francisco Call*, July 29, 1905.

or so later, he began to show symptoms of insanity—some stated that Cohen’s friend ran off with his money and wife, whom Cohen had married in the United States, and that after weeks and months of frantic search for them, he became insane—and was committed to a Virginia mental hospital. There, Cohen was ordered deported to Brazil for becoming a public charge within less than three years after his arrival in America. The Virginia authorities returned him to New York, where the Bureau of Immigration confirmed his insanity and ordered the steamship company which had brought Cohen to America to return him to Brazil.

In March 1914, Cohen was carried back to Rio de Janeiro, but the Brazilian government refused his landing, claiming that he was a Russian subject despite his lengthy stay in Brazil. The liner captain, not knowing what to do, continued his journey to Argentina with Cohen on board and attempted to land him in Buenos Aires to no avail. Cohen came back to New York in May 1914 on the same steamship but was barred from entering the country because of his insanity. For six months afterward, he had been a boarder at Ellis Island with the steamship company paying for his keep. The company considered sending Cohen to Russia, but the war in Europe made his return difficult.³⁵⁴ On January 9, 1915, Cohen resumed his old journey. Brazil again was unwilling to admit him, and when he came back about two months later, “invigorated by the sea air and normal in his mentality,” the immigration authorities in New York refused even to land him.³⁵⁵ Cohen was locked in a cabin on the liner with his few belongings. His mental health improved and he was now sane,

³⁵⁴ Several newspapers reported that he was sent to Russia before the war but was not allowed to land because he could not prove his birth in Russia. It was not known how long he had been in Brazil before he left for America.

³⁵⁵ James F. Taylor, “Nathan Cohen, Now Thirty-Five Years Old, Left Russia in Early Youth, Went to Brazil and Thence to New York and Virginia as Emigrant—Expelled as Mentally Unsound, He Becomes Compulsory Ward of Steamship Company and Homeless Wanderer,” *The Pittsburgh Press*, April 18, 1915. Cohen returned to New York in March 1915. His passenger record stated his last place of residence as “Ellis Island, N. America.” See the Ellis Island Ship Database, The Statue of Liberty-Ellis Island Foundation, Inc. at http://www.ellisland.org/search/passrecord.asp?PID=100345020190&fromShip=y&letter=v&half=1&sname=Vasari&year=1915&sdate=03/14/1915&port=Buenos*Aires&page=>

according to the steamship doctor, but he still had no place to go. Finally, the Hebrew Sheltering and Immigration Aid Society (HIAS) came to his rescue. The Society found that Cohen “had really been sane when he landed in this country, and that his mental aberration had developed while here,” thereby justifying his entry to the United States. When these facts were presented to the Secretary of Labor, he approved Cohen’s entry and accepted a bond of five hundred dollars from the Society guaranteeing that he would not become a public charge.³⁵⁶ On March 27, 1915, fifteen minutes before the liner left for Chile with Cohen on board, the immigration authorities allowed his landing.³⁵⁷ He was sent to Dr. MacFarland’s Sanitarium in Connecticut, where he was supported by the HIAS until he died in 1916 at the age of thirty-five. It should be noted that his stay in the United States was supposed to be temporary until he would recover and could be transported to Russia, his birthplace. However, as the *New York Tribune* reported, “[h]e could not outlast the war, and now he will stay permanently in the land of his choice.”³⁵⁸

Nathan Cohen’s case was complicated by his mobility, war in Europe, and insanity. The fact that he arrived in the United States from Brazil, not from his Russian birthplace, made it difficult for the American authorities to determine where to return him. Cohen had been in the United States for less than three years, the time required to declare his intention to naturalize and therefore protect himself from deportation. As a result, Cohen became a man without a country and, given his insanity, unable to assert his rightful place or his

³⁵⁶ Taylor, “Nathan Cohen.”

³⁵⁷ “No Country Wants Cohen: Insane Immigrant May Stay on Ellis Island Till He Dies,” *New York Times*, June 9, 1914; “Again Bars Sea Exile,” *Washington Post*, March 24, 1915; “Sea Wanderer Ends 33,740-Mile Journey,” *New York Times*, March 28, 1915; “Real Case of a Man without a Country: Sea Wandering Jew is unable to get off of ship on which he came to New York,” *Prescott Journal Miner*, April 4, 1915; Taylor, “Nathan Cohen”; “The Man without A Country,” *The Survey* 34, no. 2 (1915): 39-40; “Outcast Finds Home in Death,” *New York Tribune*, March 6, 1916; “Insane Wanderer Dies: For Years Brazil and United States Shipped Cohen Back and Forth,” *New York Times*, March 6, 1916. The cause for his death was unknown, but these articles mentioned how frail he became during his frequent travels and detention at Ellis Island.

³⁵⁸ “Outcast Finds Home in Death,” *New York Tribune*, March 6, 1916.

competence as a potential citizen. As a reporter for the *Pittsburgh Press* wrote, Cohen, with the eyes more like those of “an affectionate dog or timid deer,” was forced to remain silent because of the language difficulties (he understood only Yiddish and Portuguese—in the *Survey* magazine, he was said to speak Spanish, Yiddish, German and a little English) and because of his mental condition.³⁵⁹ His story raised humanitarian concerns about his suffering, but the fact is that as an insane in constant need of protection and care, he became a victim of the competing claims by immigration officials, nation-states, and steamship companies, none of which wanted to take responsibility for him. Cohen was not welcomed in any countries because he lacked an ability to support himself and fulfill duties and obligations of a citizen. Ironically, Cohen’s deportation, complicated by his movements from Russia to Brazil to the U.S., resulted in a greater degree of mobility that covered nearly 34,000 miles between the United States and South America, endangering his physical and mental health and his claims to belonging. This story of the man without a country embodied the perils of mobility and hinted at the precarious position of many immigrants who became a burden upon the public.

Citizenship, Domicile, and Residence

Nathan Cohen earned a momentary relief only through the immigrant society—the HIAS (Cohen was described as a Russian Jew)—as he was unable to establish his claims to any of the countries in which he had been.³⁶⁰ Lacking his own government to offer him protection and guarantee, Cohen ended up becoming stateless.³⁶¹ He had neither proof that he was a Russian citizen nor document to confirm his domicile in Brazil. The only tangible evidence was the record of his public charge status from the Virginia mental hospital and his

³⁵⁹ Taylor, “Nathan Cohen.”

³⁶⁰ Some newspaper reports claimed that Cohen had joined the Knights of Pythias and was take care of by the organization as well as the HIAS.

³⁶¹ Hannah Arendt, “The Perplexities of the Rights of Man,” in *The Portable Hannah Arendt*, ed. Peter Baehr (New York: Penguin Classics, 2000), 31-45, 32. From “The Origins of Totalitarianism.”

ship manifest to show when and where he entered the United States, which in turn served for his deportation. However, the situation might have been different if Cohen had established residence or domicile, if not naturalization, in any one country and had proof for his claims; he could have had a place to return in spite of his insanity and public charge status. As sociologist Rogers Brubaker reminds us, citizenship is not necessary to assure many civil and socioeconomic rights.³⁶² In fact, residents can have most rights that citizens have, including “the right to enter, work, reside, and above all, remain in a prosperous and peaceful country” as well as the right for protection and care.³⁶³ Historically, immigrants in the United States received protection and care from the federal and state authorities; declaring their intention to naturalize (declarant alien) or establishing domicile or residence in the country or in a state protected the immigrants who were not yet citizens.³⁶⁴ At the turn of the twentieth century,

³⁶² In “Citizenship and Social Class,” T. H. Marshall argues that citizenship consists in the enjoyment of civil, political, and social rights of capitalist societies. This rights-based universal citizenship model provided a framework through which the scholarship of citizenship has developed, but it has also met criticisms. Sociologist Bryan S. Turner asserts that the Marshallian framework is regarded as “evolutionary, analytically vague and ethnocentric,” and unable to explain multiple forms of citizenship and citizens’ duties and obligations. In the American context, Evelyn Nakano Glenn challenges the Marshallian framework by arguing that American citizenship, which has been defined as universal and inclusive, has in fact been “highly exclusionary in practice,” leaving out the poor, women, slaves, and Native Americans. She adds that in the late nineteenth and early twentieth centuries, race-based barriers to immigration designed a new category of “aliens ineligible for citizenship” (Asian immigrants); gender-based concepts of independence and dependence also organized the principles of American citizenship. That is, as sociologists Will Kymlicka and Wayne Norman argue, citizenship did not confer full equality. See T. H. Marshall, *Citizenship and Social Class and Other Essays* (Cambridge: University of Cambridge Press, 1950); Bryan S. Turner, “Outline of a Theory of Citizenship,” *Sociology* 24 (1990): 189-217, 212; Evelyn Nakano Glenn, *Unequal Freedom: How Race and Gender Shaped American Citizenship and Labor* (Cambridge, MA: Harvard University Press, 2002), 24, 29; Will Kymlicka and Wayne Norman, “Return of the Citizen: A Survey of Recent Work on Citizenship Theory,” *Ethics* 104 (January 1994): 352-381.

³⁶³ William Rogers Brubaker, “Membership without Citizenship: The Economic and Social Rights of Noncitizens,” in Brubaker, ed. *Immigration and the Politics of Citizenship in Europe and North America* (Lanham: University Press of America, 1989), 145-162, 147.

³⁶⁴ A five-year continuous residence in the United States was required for naturalization. One could declare his intention to naturalize, initially three years in advance, and from 1824, two years in advance. In nineteenth-century America, these “declarant aliens” enjoyed most privileges of citizens, including enfranchisement. However, in the early twentieth century, concerns with voting machines and fake certificates called for stricter regulations of the naturalization process. Andreas Fahrmeir, *Citizenship: The Rise and Fall of a Modern Concept* (New Haven: Yale University Press, 2007), 69-71. In the American context, even aliens could have rights and benefits undistinguishable from those for citizens after the 1886 *Yick Wo v. Hopkins* decision in which the Supreme Court held that aliens are “persons” for purposes of protection under the fourteenth amendment. However, based on the plenary power doctrine, the

these protean categories of citizenship, domicile, and residence classified both Americans and immigrants, and though subject to debates and contestations, they all guaranteed certain rights for those who belonged to each category.

Citizenship and domicile carried similar meanings in a way that both required residence and intention to permanently reside in the United States. Yet, they were not the same and the courts have commented upon the matter. In *State v. Jackson*, the Vermont Court observed in 1907:

Citizenship is a matter of public concern, over which the government assumes, in some degree, control. It is in its nature continuous, and once established, is presumed to continue until the contrary is shown. A change of domicile, merely, does not effect a change of allegiance. To overcome the presumption of the continuance of the allegiance once established, evidence of an actual removal or a continued residence abroad, with a fixed purpose to throw off and terminate the former allegiance, must be produced.³⁶⁵

Residence in the early twentieth century did not carry the same legal meaning as we have now: residence simply indicated “a place of abode, whether permanent or temporary” and it did not require the manifestation of the “intention” to permanently remain there, unlike domicile or citizenship.³⁶⁶ However, residence and domicile were also used interchangeably; as we shall see in debates concerning insane American citizens at Canadian mental institutions, state authorities and courts used either term to discuss states’ responsibility for insane American public charges.³⁶⁷ At the same time, these varying statuses for the citizen and the alien suggest that without concrete evidence—i.e. certificates, papers, or testimonies—it would be difficult to define and clarify an individual’s legal, political, and

government could control and regulate matters of immigration without judicial constraints. Linda S. Bosniak, “Membership, Equality and the Difference that Alienage Makes,” *New York University Law Review* 69 (1994): 1047, 1060-1061.

³⁶⁵ *State v. Jackson*, 65 A. 657, 660, 79, Vt. 504, 8 L. R. A. (N. S.) 1245 (1907), *Judicial and Statutory Definitions of Words and Phrases*, 1914, 702.

³⁶⁶ *Harding v. Standard Oil Co.*, 182, Fed. 421, 423, 424 (1910), *Ibid.*, 702.

³⁶⁷ Helen I. Clarke, *Social Legislation* (New York: Appleton-Century-Crofts, 1957), 505.

social positions. Nathan Cohen and others like him suffered because they were, of course, unable to produce this evidence.

Despite the many benefits domiciled immigrants and declarant aliens received, becoming a burden upon the public could render them targets of “social closure.”³⁶⁸ Brubaker explains citizenship as a mechanism of social closure through which the territorial state can control the flow of people across its borders. His analysis of the territorial state and closure demonstrates that “expulsion” was “a zero-sum game,” in which “a state could expel into the territory of another state only a person belonging to that state; and a state was obliged to admit to its territory its own members.”³⁶⁹ Nevertheless, historically, this exchange was dictated by the plenary power doctrine, which allowed the government to regulate the “admission, expulsion, and naturalization of aliens,” and required each nation-state to assume a responsibility for its citizens, domiciles, and residents.³⁷⁰ In addition to entry or exit, those who were in need of care and protection became subjects not only of the national territorial states but also of their local state governments in charge of local institutions and facilities for reception and care. Within the context of expanding federal powers, the problems presented by immigrants, in particular those who were insane, offered a fertile ground for discussions and debates. In 1918, the New York State Hospital Commission emphasized the unique challenges of dealing with insane persons by distinguishing them from other public charges:

This [that New York had borne unfair amount of burden to provide care for the insane] is the situation which exists and there is no relief from it, as the patients are insane and cannot be sent out of the state because they are unable to care for themselves and would in some cases be a menace to the community. It is right here that we see the contrast between the ordinary public charge and the insane charge. In

³⁶⁸ Bosniak argues: “Although aliens’ fundamental personhood is recognized as a constitutional matter, and although alienage is deemed an irrelevant basis of distinction for a host of statutory and common law rights, alienage is still very often treated as an entirely legitimate basis for the denial of rights and benefits in our society in both constitutional and subconstitutional law.” Bosniak, “Membership, Equality,” 1064.

³⁶⁹ Rogers Brubaker, *Citizenship and Nationhood in France and Germany* (Cambridge, MA: Harvard University Press, 1992), 23-25.

³⁷⁰ Bosniak, “Membership, Equality,” 1059.

the case of the latter it is imperative that arrangements be made for their *reception and care*, not only for the protection of the patients themselves, but also that of the community into which they go.³⁷¹

Humanitarian ideals across the national boundaries were closely tied to the discussions of the “alien insane” or the insane in general; yet, during the Progressive era, these ideals were structured and conditioned by the financial interests and the national and political atmosphere of each nation-state. In America, it was not only the federal government but also state authorities that shouldered the responsibility for care of alien immigrants. The “alien insane” were in constant need of medical attention and costly institutionalization before, during, and after their deportation arrangement, and it was crucial for the national and local authorities to locate the responsible party who could provide the often indigent insane aliens with appropriate care. Therefore, the New York Hospital Commission pointed out another task that insane public charges commanded: fixing residence. It was never easy “especially when the party in question is one who has moved about from county to county, even though he has remained continuously within the one state.”³⁷² As Nathan Cohen’s example well illustrates, determining residence of an insane immigrant was even more burdensome as it involved foreign authorities as well as the federal and state governments.

Defining and clarifying an immigrant’s status required considerable efforts even when he needed no protection and care. In particular, the process of deportation demanded careful investigations so that the countries involved would not overstep their boundaries and bear unfair burdens. In America, upon receiving information regarding deportable immigrants, immigration offices looked for arrival information and other documents of the immigrants in question to determine their ports of entry, contacted state authorities and foreign consuls, and applied relevant provisions of the immigration laws to the process.

³⁷¹ New York, State Commission, 29th *Annual Report* (1918), 170-171. Emphasis added.

³⁷² *Ibid.*

However, as the cases of Jones and Cohen show, demographic information recorded upon the entry of the immigrants did not always tell who they were and where they should be sent, which was also determined by the changing international boundaries. For example, social workers, not to mention immigration officials, had difficulty classifying Russian-speaking immigrants from Germany; were they Russian or German?³⁷³ The Swiss government also complained that due to the absence of a “Swiss” category on the immigration service form, immigrants from Switzerland were categorized by languages they spoke.³⁷⁴ Greeks in Turkey puzzled both immigrants and immigration officials. In 1921, Fred Rindge Jr., reporting for the Young Men’s Christian Association, explained: “Emigration from Turkey is perhaps as complicated as that from any other country. Comparatively few of the emigrants are really Turks. A large proportion of them are Armenians, Greeks, Russians, etc., who are Turkish subjects.”³⁷⁵ Under these circumstances, where should these immigrants be sent in case of deportation and who should take responsibility for them?

Moreover, the immigration authorities were ill equipped, primarily due to the lack of resources, to deal with the task of locating information of potential deportees. In 1923, Dr. Spencer Dawes of the New York State Hospital Commission complained that state hospital staff bore the brunt of the government incompetency: “We pick up, say, an insane alien, and the first thing we do is to go to Ellis Island and ask the immigration officers to verify the entry date of the alien. Many times it is extremely difficulty [sic] and impossible to verify the entry dates, because the index of incoming aliens is, due to a shortage of employees, about 3

³⁷³ *Interpreter Releases*, July 1924, Box 18, Foreign Language Information Service, Immigration History Research Center, University of Minnesota (hereafter IHRC).

³⁷⁴ Deirdre Moloney, *National Insecurities: Immigrants and U.S. Deportation Policy Since 1882* (Chapel Hill: The University of North Carolina Press, 2012), 131. Also see Letter dated January 17, 1920 to Frank L. Polk from Hans Sulzer. File 52729/9, Entry 9, RG 85, NARA, DC. Immigrants from Switzerland were required to categorize themselves as German, French, or Italian.

³⁷⁵ YMCA records, Reel 2, Folder 8, IHRC.

years behind.”³⁷⁶ Foreign governments too were actively engaged in identifying and locating their own people. In 1922, the Polish government hoped that having a Polish official join representatives of the American agencies would help deal with problems concerning its immigrants, including “the wrong spelling of the name of persons or localities, the incorrect designation of place of origin (district, commune), the non-establishment of nationality, and other circumstances of importance to the Polish Government.”³⁷⁷ These concerns were not ungrounded. Social workers noticed that wrong spellings made it difficult to confirm an immigrant’s status in the United States. In July 1924, *Interpreter Releases*, the magazine of the Foreign Language Information Service, wrote: “Errors in spelling makes it, at some times, difficult or even impossible to find the records of legal admission to the United States.” The magazine published a story of an Italian immigrant Ralph Severino as an example. The Bureau of Immigration denied Severino’s reentry permit because it could not find any record of his previous legal entry to the United States. The Italian Bureau of the Foreign Language Information Service, in an attempt to assist him, “reread his letter and signature” and “remembered that the Italians write S like L and that this man’s name might be entered as Leverino instead of Severino.” In the end, his records were found under the name of Leverino and he was permitted to return to the United States.³⁷⁸ Locating an immigrant’s identity and history was a muddled task, requiring collaboration of multiple agencies both in the United States and abroad.

The very fact of their mobility from place to place further complicated the searches and efforts to identify immigrants and their histories. Foreign governments protected their

³⁷⁶ Statement of Spencer L. Dawes, M. D., of the New York State Hospital Commission, U.S. Congress, House, Committee on Immigration and Naturalization, *Alien Seamen – Insane Aliens- Statement on Various Immigration Problems*, Hearings, 67th Congress, 4th Session, on H.R. 14273 (January 30 and February 6, 1923), 609.

³⁷⁷ Letter dated October 28, 1922 (translated) from Hugh Gibson, Envoy Extraordinary and Minister Plenipotentiary of the United States of America. File 54933/351A, Entry 9, RG 85, NARA, Washington, DC.

³⁷⁸ *Interpreter Releases*, Box 35, IHRC.

citizens abroad, and a long stay in America shielded immigrants from deportation to a degree (except in the cases of criminals or prostitutes, who were deported regardless of the statute of limitations); however, being away from one's country of origin without getting naturalized in his place of residence could cost him dearly. As historian Linda Kerber asserts, "It is the leaving that makes the individual or community vulnerable, whether or not the leaving was itself voluntary."³⁷⁹ In the early twentieth century, German, Roumanian, and Swedish policy stipulated that "any aliens who have been out of their countries for a period of 10 years lose their nationality, and are no longer citizens of those countries."³⁸⁰ Other countries followed suit. Witnessing many hardships that immigrants without domicile or naturalization underwent, social workers encouraged both immigrant men and women to become citizens.³⁸¹ In 1930, social worker Edith Terry Bremer, discussing deportation at the International Institute of San Francisco board of directors meeting, emphasized the importance of citizenship for foreign-born women: "It is not her [a foreign-born woman's] fault, nor is it ours, that the ruthless combination of immigration, deportation, and naturalization laws, have turned the possession of citizenship into a new kind of social insurance... It should be pointed out to them that if they plan to make their home in America, it is a matter of self protection to proceed to acquire citizenship."³⁸² Despite many contingencies of immigrant life, becoming American, declaring intention to naturalize, or establishing domicile offered insurance for many immigrants, even the insane; these measures allowed them to receive protection from the American government and to pass their

³⁷⁹ Linda K. Kerber, "The Statelessness as the Citizen's Other: A View from the United States," *American Historical Review* 112, no. 1 (February 2007): 1-34, 31.

³⁸⁰ U.S. Department of Labor, *Annual Report of the Commissioner-General of Immigration to the Secretary of Labor*, 1920 (hereafter *Annual Report of Immigration*), 309.

³⁸¹ With passage of the Cable Act in 1922, immigrant women married to American citizens no longer received derivative citizenship.

³⁸² "A Forward Look for International Institute," Box 1: IISF-board of Directors Minutes, 1930, Folder 9, International Institute of San Francisco, IHRC.

status or transfer property to their spouses and minor children so that they too could enjoy the rights and benefits of citizens.

Insanity, Naturalization, and Derivative Citizenship

In 1911, Representative William Stiles Bennet (R-NY) submitted a report titled “Naturalization of Wives of Insane Aliens” to accompany a House bill, originated on the recommendation of U.S. District Court Judge Page Morris of Minnesota.³⁸³ In the report, Bennet cited Morris’s explanation about the regulations of naturalization in relation to homestead entries:

If an entryman becomes insane after making his entry and establishing residence, patent [to the land] will issue to the entryman on proof by his guardian or legal representative that the entryman had complied with the law up to the time that his insanity began. In such a case, if the entryman is an alien and has not been fully naturalized, evidence of his declaration of intention to become a citizen is sufficient.

As long as the alien declared his intention to become an American citizen by taking out his first paper (declaration of intention), he could enjoy the rights of other male citizens and possess land. It is likely that once declared insane, his voting rights would be suspended and his guardian or representative would take over his rights to property control, but he still had the rights of a citizen and pass his status to his family members, like other entrymen who declared their intention but died before naturalization.

What motivated Morris to recommend amendments of the existing law was the status of the alien entryman’s wife and minor children. The extant naturalization law and homestead provisions conferred a husband’s intent to naturalize upon a “widow” (in case of both his death *and* insanity) and minor children, but not upon a “wife,” even though the husband’s insanity did not turn the wife into a widow. According to Judge Morris, “The purpose of the

³⁸³ The Act of Feb. 24, 1911 (36 Stat. 929) was repealed by the Act of May 24, 1934 (48 Stat. 798). Under this Equal Nationality Act of 1934, an immigrant mother was allowed to pass her citizenship status to her children, both legitimate and illegitimate.

[amendment] bill is to permit the *wife* of an alien who has become insane after having declared his intention, but before the final order of naturalization, to take out a homestead and be naturalized without making any declaration of intention.”³⁸⁴ Morris was reacting to “a peculiar oversight” in the existing law, which provided for a “widow” but not a “wife” in the case of the husband’s insanity. Morris discussed one case in which a man declared his intention to become a citizen but became insane afterwards. The man’s wife, now the head of the household and main supporter of the family, qualified to make a homestead entry; she filed on a homestead and had been living on it with her children for six years.³⁸⁵ However, under the existing law, she could not obtain a patent for the land because she was not naturalized, and Morris doubted whether she could ever be now that her husband had gone insane.³⁸⁶ Therefore, he suggested an amendment to read: “when any alien, who has declared his intention to become a citizen of the United States, dies or becomes insane before he is actually naturalized, the widow and minor children of such aliens, or *in case of his insanity his wife and minor children*, may, by complying with the other provisions of this act, be

³⁸⁴ The existing provision in case of death of an alien after declaring his intention of naturalization was made by the Act of June 29, 1906.

³⁸⁵ The homesteader had to live on the homestead for five years to qualify for a land patent. Single women qualified for the homestead, but married women, dependent on their husbands, could not unless they were heads of households. In the above mentioned case, the wife’s nationality became an obstacle to obtaining a land patent. See Teresa L. Amott and Julie A. Matthaei, *Race, Gender, and Work: A Multi-Cultural Economic History of Women in the United States* (Boston: South End Press, 1996), 106.

³⁸⁶ Under the act of March 2, 1907 (34 stat. 1228), all women who married after that date acquired their husband’s nationality; the alien wife could not herself naturalize unless her alien husband did so. Some courts did naturalize the alien wife, but her citizenship was subject to cancellation. Before 1907, immigrant women could naturalize, but they had few incentives to naturalize because all women had no voting rights, they already had most benefits of citizen women, and they had to pay fees for naturalization. After passage of the 1922 Cable Act, immigrant women were required to naturalize, independent of their husband’s citizenship status. American women married to alien husbands could keep their U.S. citizenship, but those who married “aliens ineligible to citizenship”—that is, Asians—continued to assume their husbands’ racial and citizenship status. See Marian L. Smith, “Women and Naturalization, ca. 1802-1940,” *Prologue Magazine* 30, no. 2 (Summer 1998) <http://www.archives.gov/publications/prologue/1998/summer/women-and-naturalization-2.html>; Candice Bredbenner, *A Nationality of Her Own: Women, Marriage, and the Law of Citizenship* (Berkeley: University of California Press, 1998); Martha Gardner, *The Qualities of a Citizen: Women, Immigration, and Citizenship, 1870-1965* (Princeton: Princeton University Press, 2005).

naturalized without making any declaration of intention.”³⁸⁷ Passed in February 1911, the benefits of the Bennet bill, which incorporated the amendment proposed by Judge Morris, applied only to wives and minor children of the insane aliens making homestead entries. Nevertheless, the bill highlighted several aspects of American citizenship and naturalization in relation to immigration and insanity. So long as an alien declared intention to naturalize, he would be granted citizenship even when he became insane between his declaration and naturalization; and under this law, his wife and minor children would derive their citizenship from him. Perhaps this expansiveness might have led the lawmakers, like Bennet, to grant the provision only to homestead entry cases, not to all immigrants in America.

Another interesting feature of the Bennet bill was its attention, or lack thereof, to insanity. Judge Page Morris noticed that the initial omission of a “wife” from the provision, although it could have been a mere “oversight,” prevented the wife of a living insane husband from enjoying and deriving citizenship rights from her spouse. However, this omission also implied that a living insane husband suffered a kind of “civil death,” and therefore his wife became a fictive “widow.” The bill ignored the possibility that the husband, once cured and released from a mental institution, could assume full citizenship rights nor did it cover the rights of his guardian wife, or for that matter, rights of insane alien women. While the Bennet bill clarified certain issues regarding derivative citizenship and property transfer for wives and children, problems pertaining to those of an insane male’s naturalization and property remained unclear. In reality, a large number of hospital inmates were discharged only several months or years after their admission, and many immigrant patients, once discharged, returned to their communities and resumed their lives. Their legal rights might have been

³⁸⁷ Emphasis added. U.S. Congress, House Committee on Immigration and Naturalization, *Naturalization of Wives of Insane Aliens*, 61st Cong., 3d sess., H. Rpt. 2149 (February 11, 1911).

temporarily compromised due to their dependent condition, but as long as they had family and land, even insane immigrants could become integrated into American society.

The Bennet bill was primarily about property rights, but it adhered to the contemporary gender norms that the alien wife and her status were dependent upon her husband and his status. Derivative citizenship allowed the wife and minor children to function as independent citizens without becoming a potential burden upon the public in the absence of a male breadwinner. Through a patent for the homestead land, they would be able to manage the insane husband as well as themselves. Moreover, since the insane husband fulfilled the residence requirements, the state of his residence would assume his care when he became a public charge. Unlike Nathan Cohen, these fortunate immigrants duly documented in the homestead entries and declaration papers could in spite of their insanity receive protection, medical care, the benefit of property ownership and a home for their families.

In addition to naturalization, derivative citizenship through marriage to a citizen (for female immigrants) and through naturalization of a father³⁸⁸ (for minor children) endowed the rights for settlement and reentry in the United States. As the previous section mentioned, even without naturalization, immigrants still had certain rights. Yet, in order to fully protect themselves from many contingencies of immigrant life, including deportation, immigrants, whether naturalized or domiciled, were required to arm themselves with documentary evidence to prove their status. Male immigrants in general succeeded in verifying their legal status by producing naturalization papers or first papers of declaration of intention. However, female immigrants who became citizens by virtue of marriage to American citizens or naturalization of their immigrant husband, or those who came to the United States as minors and became citizens when their parents naturalized often found it difficult to establish their

³⁸⁸ A mother could pass her citizenship onto her children under the 1934 Equal Nationality Act. See Bredbenner, *Nationality of Her Own*; Gardner, *Qualities of a Citizen*.

legal and political status. The lack of proof compromised not only their experiences within America (threat of deportation) but also their movements in and out of the country (right to (re)enter).

Before passage of the Cable Act in 1922, derivative citizenship, first codified in 1802 and strengthened in 1855 and 1878, provided another way to enter America for those who were otherwise excluded, including those who had been insane before their entry or were certified of insanity at the immigration borders.³⁸⁹ Florence Bishop's case illustrates certain advantages of derivative citizenship. In 1907, thirty-six-year-old English-born Bishop, who arrived in America at the invitation of her parents-in-law after a ten-year stay in England, was certified insane and detained at the Ellis Island Immigration Station. Bishop claimed that she had lived in the United States for ten years and been married to a Californian-born citizen. A special inquiry was held to determine her case. Initially, immigrant inspectors unanimously agreed to deport her because of her mental condition and the lack of evidence regarding her citizenship claim; however, at the special inquiry, Bishop stated that she went back to England shortly after her marriage to settle property matters, and while there, received letters that her husband was dead. She explained that she was not sure what really happened to him but she had never established residence in England and always considered herself an American citizen. She had the letters from her parents-in-law and a marriage certificate, but inspectors were not satisfied. While her case was deferred for further evidence of her citizenship, immigration officials contacted the authorities in California, where she claimed her husband was born, and several weeks later, she was allowed to enter despite her insanity as she was finally proven to be a citizen by marriage.³⁹⁰

³⁸⁹ Xiaojian Zhao, *Remaking Chinese America: Immigration, Family, and Community, 1940-1965* (New Brunswick: Rutgers University Press, 2002), 38.

³⁹⁰ File 51740/18, Entry 9, RG 85, NARA, DC. The circumstances under which she was certified of insanity are not clear. There was no medical certificate in her file other than a brief statement from an

Even with the letters and marriage certificate, Florence Bishop had trouble proving her citizenship status. Female immigrants found it particularly difficult, if not impossible, to obtain documentary evidence of their naturalization status. Only in 1929 and after could a woman who gained citizenship through her husband's naturalization obtain a "Certificate of Derivative Citizenship" from the U.S. Immigration and Naturalization Service. An immigrant woman who became American by marrying an American citizen had to wait until 1940 to get a certificate of citizenship.³⁹¹ Thus, when a female immigrant's citizenship was in question, the authorities turned to the legal status of her husband because more often than not marriage determined who she was.³⁹² In a number of cases, not only the lack of documentation but also death of a husband, remarriage, or divorce jeopardized the status of female immigrants. As Bishop's case shows, claims of immigrants who became American through derivative citizenship were not always accepted; for the "alien insane," their mental condition posed another challenge because the governments did not want to take responsibility for their reception and much-needed medical care.

The case of Elizabeth Abeldt-Fricker tells another side of the story. Swiss-born Elizabeth married an American citizen in 1892 after immigrating to the United States. Thirteen years later, she divorced him and returned to her native Switzerland, where she became an inmate at an insane asylum within a year. The Swiss government, unwilling to pay for her keep, relegated the financial and medical responsibility to the American government, arguing that she was an American citizen by marriage and therefore should be cared for by the American government. The U.S. State Department refused to accept the claim and

immigration inspector that doctors certified her insane (another document shows that she was LPC, but probably from being insane). Her interview at a special inquiry focused on establishing her citizenship status and did not discuss her mental condition.

³⁹¹ Smith, "Women and Naturalization."

³⁹² It changed after the Cable Act, but for those who got married before 1922, marriage to American citizens still gave foreign wives derivative citizenship. See Bredbenner, *Nationality of Her Own*; Gardner, *Qualities of a Citizen*.

insisted that despite her marriage, she was a Swiss citizen because when she left America to permanently resettle in Switzerland, she gave up the right to the U.S. citizenship and reassumed her former nationality. Moreover, she would not be allowed to reenter the United States for care because the immigration acts barred the entry of insane aliens.³⁹³ Historian Candice Bredbenner saw this case as an example of how frail the connection of marriage to American citizenship was for immigrant women and how transnational marriages generated legal confusions. At the same time, the case reveals the precarious status of derivative citizenship, or for that matter, citizenship in general when it came to insanity and institutional care. Bishop was admitted to America because she had maintained her marriage tie for the ten years she was in England and, though difficult to prove, demonstrated her intention to remain an American citizen; however, Abeldt-Fricker's status was compromised by her divorce, her mobility, and more importantly, by her institutionalization.

Naturalization as minors, combined with frequent movements, could also challenge an individual's citizenship status. For example, in 1918, Danish-born Charles Keller was arrested and detained at an immigration station in Texas for being a Likely to become a Public Charge (LPC)—he was an International Workers of the World (IWW) member when he reentered the country as a seaman in 1917 and his membership qualified him as an LPC—and coming into America without inspection. Keller stated that he first came to the United States at the age of ten or eleven and became an American citizen when his father naturalized;

³⁹³ Case cited in Bredbenner, *Nationality of Her Own*, 27-28. There were other similar cases. In 1887, the Zurich authorities applied to the American legation in Berne for a passport for Mrs. Weiss, an insane public charge. In 1873, she married a native of Baden in New York, who naturalized shortly after. The couple returned to Europe in 1878 and two years later, the husband deserted Mrs. Weiss. She remained in Zurich and became insane. The U.S. Department of State claimed that her stay in Zurich after the desertion restored her previous nationality and that the attempts of the Swiss authorities to track down her and her husband's citizenship status, even when Mrs. Weiss became insane and could not consent to their investigation, indicated their intention to send her back to the U.S., and therefore the application could not be granted. Letter dated March 19, 1886 from Mr. Bayard (Department of State) to Mr. Winchester (Legation of the United States, Berne, Switzerland). *Congressional Edition*, Vol. 2627, 1531. Also see, John Bassett Moore, ed. *A Digest of International Laws*, vol. 3 (Washington, DC: Government Printing Office, 1906), 460.

he testified that he had seen his father's papers, but he himself had no documents. To verify Keller's claim, immigration officials did so much as to visit his alleged hometown, asking people whether they knew Charles Keller, his parents, and their citizenship status, and going through local directories to confirm the information he volunteered; yet, they failed to find evidence that Keller was an American citizen. Moreover, this localized and communal form of verification could be rather incriminating: "some of these persons [who knew Keller] claim him to be very radical, some have gone so far as to say they believed him to be insane."³⁹⁴ Instead of proving his citizenship status, information such as this facilitated his deportation. Keller was detained in Philadelphia until he could be deported, but later committed to New Jersey State Hospital for the Insane for causing too much trouble. Soon he escaped from the hospital, and the immigration authorities cancelled his warrant of deportation after they lost track of him.

Race and Citizenship

As a legal status, citizenship was circumscribed on the basis of race. The most obvious example might be that Asian immigrants were ineligible for naturalization and were denied access to rights and privileges of citizenship. As the 1920s and 30s' expatriation scheme in California suggests, Mexican immigrants and even their American-born children too were not always protected from deportation.³⁹⁵ However, the seemingly scientific

³⁹⁴ File 54379/34, Part 6, Reel 16, Records of the Immigration and Naturalization Service (hereafter INS). After he was arrested for deportation and sent to Philadelphia for detention (due to the wartime instability), the Public Health Officer who examined him informed the Commissioner of Immigration: "I have to state that he is the character of man that would gladly welcome an opportunity to blow up an ammunition plant to kill people, even though he himself were killed in the catastrophe, so that he might be regarded as a martyr. The proper place for the detention of this man is in an institution for the criminally insane." See the letter dated August 31, 1918. It is noteworthy that a mental institution was considered to be a detention place for dangerous people.

³⁹⁵ Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History*

ideology of race at the turn of the twentieth century had a far-reaching influence on the everyday life of immigrants, including the process of admission, deportation, and integration. Whiteness studies have well illustrated that being “white” was not fully defined during the period; southern and eastern Europeans—not quite white—were believed to be inferior to Anglo-Saxon or Nordic old stock immigrants in their physical and mental capacities. Racial stereotypes put the allegedly “inferior” and “undesirable” new immigrants under greater scrutiny and risk of deportation. According to historian Amy Fairchild, instead of relying on the scientific racial categories, the Immigration Service used a broader definition of “race,” which allowed it to throw a wider net of exclusion and deportation, and the lack of more fixed and clearer concept of “race” destabilized the status of many immigrants.³⁹⁶ Still, whiteness benefited many European immigrants who hoped to become American. First of all, they were not barred from naturalization, unlike Asian immigrants. Moreover, despite the scientific and biological understanding of “race,” there were no “physical traits” or “racial uniform,” in sociologist Robert E. Park’s words, that distinguished these immigrants from white Americans upon ocular examinations.³⁹⁷ How can you tell an Englishman from an Italian? An Irishman from a Russian? What determined who this individual was and where he belonged, particularly in the absence of concrete documentary evidence? Such confusions were most common at Ellis Island, the country’s largest immigration station. In 1921, Fred H. Rindge of YMCA shared an interesting anecdote from his work at Ellis Island:

One day nearly all the interpreters on the island tried to communicate with a swarthy immigrant bombarding him with every language available in that Babel of tongue. Teutonic, Slavic, Semetic, the languages of Europe, Asia and Africa were tried in

of Public Health and Migration to Los Angeles (New Brunswick: Rutgers University Press, 2007); Natalia Molina, *Fit to Be Citizens?* (Berkeley: University of California Press, 2006).

³⁹⁶ Amy Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: The Johns Hopkins University Press, 2003), 203.

³⁹⁷ Robert E. Park, “Human Migration and the Marginal Man,” *American Journal of Sociologist* 33, no. 6 (May 1928): 881-893, 890.

vain. “Alas” said one in English, “I wonder that in --- he can speak.” Immediately the man’s face lighted up, “I understand that” he said. “I can speak English.”³⁹⁸

Perhaps because he was “swarthy,” these interpreters saw him differently from an American or an Anglo-Saxon, and did not even attempt use English. Regardless of who they were and where they came from, in the eyes of Americans, these immigrants became outsiders and strangers—thus, *aliens*—but at the same time they were barely distinguishable from one another, or from Americans themselves. The story of Jones, which opened this chapter, might be one example of how immigrants could exploit these confusions.

Asian immigrants had somewhat different experiences. Despite exclusionary policies that barred their entry and made them ineligible for naturalization, Chinese and Japanese still had certain rights and privileges as long as they were able to prove their birth in America, exempt status (i.e. merchant), or domicile. Under the immigration acts of 1903 and 1907, immigrants who established domicile in the United States and its territories had the rights to reenter the country even when they were afflicted with “dangerous contagious” diseases, such as trachoma, an eye disease that left uncured could lead to blindness. In 1910, Representative E. A. Hayes (R-CA), supporter of the Chinese Exclusion Acts, claimed that between 1908 and 1910, 293 aliens, mostly Chinese and Japanese, were admitted to the United States despite suffering from trachoma, and mistakenly criticized the immigration authorities for failing to implement the immigration policy. Against his accusation, the immigration office explained that these Chinese and Japanese were “domiciled” (“natives”—Chinese born in America, merchants and their families, or those with reentry permits) and exempt from the operation of the exclusion statutes.³⁹⁹ However, this guarantee of protection also led to complaints against immigration officials:

³⁹⁸ Fred H. Rindge, Jr., YMCA, Reel 28, IHRC.

³⁹⁹ E. A. Hayes, “Diseased Orientals Being Admitted to This Country in Violation of Laws,” Speech in the House of Representatives, 1910. Contrary to what Hayes argued, a large number of trachoma-afflicted

[I]t was a common practice at this Port [San Francisco] to land aliens who were certified as suffering from a dangerous and contagious disease, yet who claimed to be returning to a former domicile in the United States; that such action was taken without any investigation as to the truth of the domicile claims, and, in fact, with practically no examination whatever, either by an inspector or before a board.⁴⁰⁰

The alleged lack of examinations came about not because immigration officials neglected their duties but because having claims to residence, domicile, or citizenship granted these Asian immigrants protection under the law. Files and documents that they carried and helped compile certainly enabled them to gain entry to and settle in the country, but these Asian immigrants and “natives” encountered additional difficulties in proving their status even with legal documents.

The American authorities also paid attention to these immigrants’ testimonies in determining their rights to (re)enter the United States. In 1909, Chinese Li Dick was arrested for entering the United States from Canada without inspection. He claimed that he had established a domicile in the United States as a brother of a merchant and had left the country with intention to return. He smuggled himself in, instead of going through the legal route, because “several of his friends had been refused readmission, and he feared the same result.” The immigration authorities were full of doubts: they were sure that Li Dick had established a domicile “apparently by unlawful means” and intended to resume it “although quite evidently preferring to accomplish such resumption by unlawful rather than lawful means.” Even though Li Dick lacked papers to verify his claim, the immigration authorities did not issue him a warrant of deportation because until proven otherwise, Li Dick, a person of an exempt class—merchant, student, native son (born in the U.S)—could not be deported; nevertheless, they directed an immigration official to give him a chance to establish his claim

Chinese were excluded at the American border even when they were born in the United States and had a right to reenter the country. See “Bar Chinese American Born,” *Oakland Tribune*, October 20, 1908; Shah, *Contagious Divides*.

⁴⁰⁰ U.S. Department of Justice, *Investigation of the Immigration Service, San Francisco* (1910). File 53108/24, Entry 9, RG 85, NARA, DC, 180-181.

and to “conduct an investigation with regard to the manner in which he secured entry to the United States in the first place.” The ways in which he gained his original entry were suspected because of the surreptitious reentry and, perhaps more importantly, of his race.

Hon Chee, another Chinese, was arrested with Li Dick for entering without inspection. Chee explained that he was born in San Francisco but sent to China when young; after twenty years in China, he went to Canada in 1899 and naturalized in 1908 to become a British subject. Establishing his citizenship status was relatively easy because he presented “a naturalization certificate in his name” and “a head tax receipt” to prove his initial entry to Canada. As “an alien, of the Chinese race, but of Canadian nationality,” he was ordered to be deported to Canada, not to China.⁴⁰¹ A British subject, he could have been returned to Canada without any problem, but given that the Canadian government was also concerned with unwanted Chinese immigrants and often refused their readmission, it is possible that Chee was sent to China against his will, or worse, ended up as a man without a country. That is, Chinese immigrants were more likely to suffer from stricter investigations and examinations; their “Chineseness” was hard to shake off as their race, regardless of their nationality or domicile, became the most obvious marker of who they were and where they belonged.

The Chinese insane in America suffered more. The political and legal safeguard, which protected many immigrants, did not always help them; even those who had been domiciled and lived in the United States for several decades were not safe from the possibility of deportation, and they found it difficult to defend their rights to stay due to their mental condition. In 1912, immigration inspectors in California interviewed a number of Chinese mental patients at Napa State Hospital, California, to determine their eligibility for

⁴⁰¹ Letter dated November 17, 1909 from Charles Earl, Acting Secretary to the United States Commissioner of Immigration, Montreal, Canada. File 52541/27, Part 1, Reel 15, INS. They left Montreal by car and crossed the Canada-U.S. border without an inspection. Then they took a train at a station in New York, but were later apprehended in Utica by the Immigration Inspector of Malone, New York. Canada imposed a heavy head tax to discourage immigration from China.

deportation; these Chinese insane were a burden upon the public, the Commissioner of Immigration at San Francisco claimed, and immigration officials were anxious to get rid of them. The problem was that none of these Chinese could be deported under the general immigration act with a three-year statute of limitations because they had been in the U.S. for more than a decade at the time of their hospital commitment. Therefore, the San Francisco Commissioner of Immigration decided to investigate not their mental condition or public charge status but their initial entry status. One of the interview questions for them concerned when they came to the United States and another, their registration certificate (*chock chee*), which would prove whether they had entered the United States legally or surreptitiously. When asked about the certificate, these Chinese patients gave an address or a location where the paper was stored, answered they had never had it, or refused to respond (or could not answer due to their mental deterioration).⁴⁰² Some patients like Quong Ah Fook claimed that they no longer remembered what happened to the paper—"I forget what became of it [paper]"—or lost it—"Chock chee lost."⁴⁰³ Thus, it was not easy to determine their eligibility for deportation. The deportation scheme eventually reached the State Department; however, the Secretary of State, though concerned with all Chinese, not just the insane, without a registration certificate, urged not to proceed with the investigation for he was worried that deporting these insane Chinese would lead to anti-American boycott by the Chinese and bring about economic losses for the residents of California greater than the cost of the patient

⁴⁰² File 52516/10, Part 1, Reel 14, INS. The Geary Act of 1892 required all Chinese residents in the United States to register with the federal government and carry a registration certificate which included age, residence, photograph of the bearer, and the official seal. Grant Carpenter, a newspaper man, wrote an amusing account of a chock chee forger in *Sunset*, the monthly magazine of Southern Pacific Company. See Carpenter, "The Claws of the Dragon," *Sunset* 30, part 1 (1913): 165-174.

⁴⁰³ File 52516/10, Part 1, Reel 14, INS. Wong Ah Fook (Quong Ah Fook, in the hospital register). He was admitted to Napa State Hospital in November 1901. Hearing conducted on October 19, 1912 with Inspector W. H. Clendenin and Reporter Albert Betz. In the supplementary hearing, Fook answered that he lost his chock chee.

care.⁴⁰⁴ If this plan had received approval, those without a registration certificate would have been the most likely candidates for deportation.

Especially for Chinese immigrants, who were often suspected of gaining illegal entry to the United States, keeping their documents was crucial; however, in turn, relying on files and documents to identify immigrants created a loophole in the system. Some realized how dependent the Bureau of Immigration was on papers and files and manipulated the system, getting rid of paper trail of their “alien” status and claiming their rights to American citizenship. The San Francisco earthquake and fire of 1906, which destroyed all birth records of the city, proved to be a boon for many Chinese; without the papers, the immigration service had no choice but to accept the testimony of Chinese immigrants and witnesses that they were born in San Francisco.⁴⁰⁵ It might have benefited some European immigrants as well, although they would not have been required to present their papers as frequently as the Chinese. According to historian Adam McKeown, many Chinese also resorted to the immigration authorities and the courts to create a new identity for themselves. Immigration officials received an anonymous letter giving the name and address of a Chinese who allegedly gained illegal entry. They arrested, tried, and sentenced him to deportation; then, the Chinese appealed, had witnesses testify for him, and got discharged as a citizen. Through the process and the files created, he would be able to prove and confirm his undeniable citizenship status, which would continue to protect him from deportation and allow him to bring over his family members.⁴⁰⁶

⁴⁰⁴ Letter dated January 8, 1913 from the Secretary of State to the Secretary of Commerce and Labor. Ibid.

⁴⁰⁵ Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003), 106. At least one patient interviewed at Napa State Hospital claimed that he was born in San Francisco and therefore he had no registration paper. Also see McKeown, *Melancholy Order*.

⁴⁰⁶ McKeown, *Melancholy Order*, 275. See also Lee, *At America's Gates*; Torrie Hester, “Deportation: Origins of a National and International Power” (Ph.D. Dissertation, University of Oregon, 2008).

Redefining Citizenship in the International Setting

The cases of the “alien insane” suggest that an American or a potential citizen was defined as independent, competent, and settled, whose civic duty and individual responsibility at the turn of the twentieth century included “the development and regulation of body and mind.”⁴⁰⁷ Therefore, when immigrants who failed to meet these definitions and qualifications could not become real American, even as they entered and settled in the country. In 1916, Dr. Henry M. Hurd condemned these unworthy immigrants who reaped the benefit of care through the incompetent and ineffective federal immigration acts:

Although it takes five years for an alien to become a citizen, nevertheless an alien by being three years within a state, neither desiring nor intending to become a citizen, at no time contributing by the payment of direct taxes to the support of the commonwealth and being unavailable for the military or civil duties of a citizen, may, if he becomes insane, by operation of the Immigration Act, acquire such rights as against the state that it is powerless to expel him from its boundaries or to compel his return to the country of which he is a citizen, but, for its public safety and welfare or from humanitarian motives, must care for and maintain him so long as he chooses to remain.⁴⁰⁸

He saw the immigrant insane particularly problematic; after the expiration of a three-year (in 1917 and after, five-year) statute of limitations, they could enjoy their rights and privileges of a citizen without fear of deportation, even when they had no intention or ability to fulfill their duties and obligations. However, becoming an American citizen was not without problems. There was a criticism against foreigners who naturalized in the United States and either returned to their home countries or stayed in a third country, enjoying the privileges that their American citizenship endowed without performing their duties and obligations to the country.

⁴⁰⁷ In the British context, Peter Barham and Marian Barnes, “The Citizen Mental Patient,” in *Law without Enforcement: Integrating Mental Health and Justice*, eds. Nigel Eastman and Jill Peay (Oxford: Hart Publishing, 1999), 133-146, 145; Fairchild, *Science at the Borders*; Robert Menzies, “Governing Mentalities: The Deportation of ‘Insane’ and ‘Feeble-minded’ Immigrants out of British Columbia from Confederation to World War II,” *Canadian Journal of Law and Society* 13, no. 2 (1998): 135-73; and Ian Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 1997).

⁴⁰⁸ Henry M. Hurd, ed. *The Institutional Care of the Insane in the United States and Canada*, Vol. 1 (Baltimore: Hopkins, 1916), 366. The three-year statute of limitations increased to five under the 1917 Immigration Act.

This abuse of citizenship status, though amended in 1907 through the residence requirement (two years' residence in one's country of origin, or five years' residence in any other country led to renunciation of American citizenship) continued to be contested, especially when it came to questions of reception and care.⁴⁰⁹ American citizens abroad were no exception to this concern.

The American authorities, both the federal and state, had long complained about the lack of cooperation from foreign governments in the matter of undesirable immigrants and the resulting unfair burden. In 1911, the New York State Board of Alienists complained that foreign countries deliberately sent out their diseased and defective people to America and refused to take them back:

In the case of those returning, however, the conditions are reversed. The passengers are carefully scrutinized by ships' surgeons at the gangway as they embark at the port of New York, and those who do not satisfy the steamship officials or the representatives of foreign Governments stationed on such ships are peremptorily refused passage, even although they have been only a short time away from the countries to which they owe their allegiance. Cases are not decided individually upon their merits, but as soon as it is learned that an applicant for passage has been in an institution for the insane he is at once rejected. It can be seen that with an unimpeded flow of inferior immigrants to the country, and with an outflow which is so carefully regulated that only the prosperous and sound can return, we must ultimately become the asylum for an increasing number of those unable to sustain themselves.⁴¹⁰

In fact, the American authorities were not much different from these foreign governments in the matter of undesirable Americans abroad. At the turn of the twentieth century, anti-immigration publications and statistical studies publicized the menace of immigrants—crime, juvenile delinquency, illiteracy, and mental defects. However, they did not show that many American citizens abroad also ended up becoming criminals, juvenile delinquents, or insane and were returned to the United States. Following the American immigration model, other countries established similar immigration control systems in the early twentieth century, and

⁴⁰⁹ Elihu Root, "The Basis of Protection to Citizens Residing Abroad," *American Society of International Law* 4, no. 3 (July 1910): 517-28.

⁴¹⁰ Cited in "Immigration of Aliens into the United States," 64th Cong., 1 sess., Rpt. No. 95, 2.

ironically, American citizens abroad bore the brunt of the new policies. At the turn of the twentieth century, Britain passed a series of immigration acts to exclude undesirable immigrants, including the insane.⁴¹¹ Similarly, Australia was concerned with insane immigrant populations, both British and non-British subjects, and devised various means to facilitate their repatriation from the country.⁴¹² In the 1920s, France pursued exclusionary immigration policy comparable to that of the United States; one reason for it was that “hospitals and charitable institutions are filled with aliens.”⁴¹³ Canada also banned and banished insane and feeble-minded immigrants not fit for citizenship.⁴¹⁴ Indeed, quite a few American citizens were returned home from these countries; yet, the American authorities and the public neglected the possibility and reality that American citizens, once they settled in other countries, could have become the “undesirable” themselves and faced removal.

The United States was and has been a major immigrant receiving country, but some of its citizens, though small in number, elected to move to countries around the world. Between 1918 and 1930, 4,788,960 immigrants arrived in the United States, and 455,872 native-born Americans (about 9.5 percent of the new arrivals) permanently departed the country.⁴¹⁵ These Americans abroad required legal and political protection as well as various

⁴¹¹ Krista Maglen, “Importing Trachoma: The Instruction into Britain of American Ideas of an ‘Immigrant Diseases’, 1892-1906,” *Immigrants & Minorities* 23, no. 2 (2005): 80-99. She focuses on trachoma but deals briefly with other “undesirable” conditions associated with immigrants.

⁴¹² Philippa Martyr, “Having a Clean Up? Deporting Lunatic Migrants from Western Australia, 1924-1939,” *History Compass* 9, no. 3 (2011): 171-199. Martyr’s data did not show how many Americans had been committed to and deported from Western Australia hospitals.

⁴¹³ “Immigration conditions abroad,” Minutes of Meeting of Board of Trustees, February 3, 1926, American Council for Nationalities Service, Box 1, FLIS, IHRC.

⁴¹⁴ According to Menzies, between 1921-1922 and 1935-36, U.S. citizens constituted 11.5 percent of the foreign-born admissions to Canadian mental institutions (third largest behind only England and Scotland) and 10.7 percent of deportations (second largest after England). Menzies, “Governing Mentalities,” 148-149.

⁴¹⁵ The data was first collected in 1918. For the number of immigrants into the U.S., see U.S. Immigration and Naturalization Services, *Statistical Yearbook of the Immigration and Naturalization Service*, 1996 (Washington, DC: U.S. Government Printing Office, 1997), Table 1. Immigration to the United States: Fiscal Years 1820-1996. For the number of native-born citizens, see *Annual Reports of Immigration*, 1918-1930, Table on native-born citizens permanently departed. This number does not include naturalized citizens permanently departed. For the number of U.S. citizens (both naturalized and native-born citizens)

consular services.⁴¹⁶ However, the U.S. government lacked provisions for the relief and care of “indigent citizens” abroad, including as we shall see, the indigent insane. The *Instructions to the Diplomatic Offices of the United States* in 1897 read that except in the case of destitute seamen, “there is no appropriation or authority for the relief by a diplomatic representative of a distressed citizen of the United States or for furnishing him transportation home.”⁴¹⁷ The U.S. legations in foreign countries often declined to send home destitute American public charges, including the insane, abroad at the expense of the American government.

As part of the international order, what went on in the United States influenced and was influenced by the ways in which foreign governments dealt with American citizens in their countries. In 1897, the Austrian minister Mr. Hengelmiller complained: “in all cases where American citizens had become insane in Austria they had been removed to the public asylums where they had been treated and cared for, and that application for compensation or for the removal of such persons to their homes had not been made until sometime afterwards, and then through the diplomatic channel.”⁴¹⁸ He stated that despite the efforts of the Austrian government, the American authorities failed to reciprocate and did not provide for Austrian immigrants in the United States. Exclusion and deportation of immigrants were also mired with international expectations for reciprocity by civilized nation-states. For example, in 1903, when the United States excluded diseased Italian immigrants from entering the country, the Italian government retaliated by banning the departure of naturalized American

permanently departed—519,626 (about 11 percent of the new arrivals)—see Bredbenner, *Nationality of Her Own*, 224-225. According to Bredbenner, the State Department was concerned with Americans permanently leaving the country during the interwar years because a large number of them were children, who would grow up to marry foreign citizens.

⁴¹⁶ For American citizens in Paris and their use of the Paris consulate, see Nancy L. Green, “Americans Abroad and the Uses of Citizenship: Paris, 1914-1910,” *Journal of American Ethnic History* 31, no. 3 (Spring 2012): 5-32.

⁴¹⁷ Also cited by Borchard in his 1915 publication, which means that until that time, there still was no provision for destitute American citizens abroad. Edwin Borchard, *The Diplomatic Protection of Citizens Abroad: Or, the Law of International Claims* (New York: Banks Law Pub. Co., 1915).

⁴¹⁸ Moore, *Digest of International Laws*, 808.

citizens of Italian descent for the United States. These “tourists,” who were ready to leave for America after a visit to their relatives in Italy, were found to be afflicted with trachoma. The Italian government, upset about Italian immigrants being turned away from America for trachoma, stated: “if the disease is really contagious, as certified by the United States officials, they cannot risk the spread of contagion to the other passengers on the ship.”⁴¹⁹ Without the reciprocal cooperation from the American authorities, the Italian government would neither allow American citizens to leave its country nor assist the American effort to return undesirable Italian immigrants home. As the New York State Hospital Commission repeatedly complained, the Italian government was also reluctant to assist and cooperate in the matter of the “alien insane.”

Protection of citizens abroad and exclusion of undesirable immigrants at home went hand in hand. The care of the “alien insane” in America was not merely a humanitarian endeavor; it served the practical purpose of guaranteeing the protection of Americans abroad. On the one hand, since the American authorities took care of insane immigrants in their midst, they expected foreign countries to do the same for American citizens who became public charges abroad. On the other hand, the American government did not have a federal appropriation to take back destitute American citizens abroad, and therefore, it did not force foreign governments to pay for institutionalization and deportation of their immigrant public charges in America. Thus, the American government neither repatriated its destitute citizens residing in foreign countries nor paid expenses for their keep; instead, it focused on regulating steamship companies by fining them for bringing in defective immigrants and requiring them to ship deportees back at their own cost, and when a need arose, appropriated

⁴¹⁹ “Italy Turns the Tables: Refuses to Allow American Citizens with “Trachoma” to Take Ship for Home,” *New York Times*, March 18, 1903. The New York State Hospital Commission often complained about the lack of cooperation from the Italian government in its deportation efforts.

the Immigration Fund (raised from immigrants' head taxes) to process deportation.⁴²⁰ At the turn of the twentieth century, however, with growing mobility and global immigration control setting in throughout the world, it became no longer possible to ignore demands for cooperation from foreign governments and protection from American citizens abroad. Thus, in 1910, Elihu Root, President of the American Society of International Law and former Secretary of State, assured that American citizens abroad would receive protection and justice from the U.S. government in time of need. However, Root also advised them to be mindful of their own situation as foreigners, who would be at a disadvantage against citizens in the countries where they were living for their unfamiliarity with the foreign lands and customs, and urged them to obey the laws of a foreign country and "submit to the inconvenience of proceedings" when they committed any offenses.⁴²¹ The same principle, though Root did not state it explicitly, would be applied to foreigners in America, which justified Root's advice for American citizens abroad. The presence of immigrants and their treatment in America were closely tied to those of American citizens abroad. Whether naturalized or native-born, American citizens in foreign countries also encountered the threat of deportation or exclusion, just like immigrants in America, and their rights were frequently compromised despite the promise of protection, especially when they became a burden upon the public.

Becoming a public charge, especially for insanity, in a foreign country raised a number of issues for an American citizen. Unless the person established domicile in the foreign nation where he was residing, he was likely to be deported to America for institutional care. In this case, the American authorities needed to verify whether or not he

⁴²⁰ Moore, *Digest of International Laws*, 411.

⁴²¹ Elihu Root asserted: "It is very desirable that people who go into other countries shall realize that they are not entitled to have the laws and police regulations and methods of judicial procedure and customs of business made over to suit them, or to have any other or different treatment than that which is accorded to the citizens of the country into which they have gone." Root, "Basis of Protection," 527.

was an American citizen and if a citizen, to which state he should be sent. Like many other countries, the United States was reluctant to receive undesirable burdens, and it negotiated with various agencies to address the problems posed by insane American citizens abroad. In particular, their reception and care necessitated close interactions between the federal and state authorities. The United States had a federal institution for the insane, St. Elizabeths Hospital in Washington, DC, but it served only DC residents, enlistees and veterans; moreover, there was no Congressional provision to commit deported American citizens to the federal hospital.⁴²² Therefore, the U.S. government had to persuade and negotiate with states to take back the destitute Americans who were either born or had lived in these states; long concerned with overcrowded hospital conditions, state governments learned to tread carefully not to waste any more of taxpayers' money by adding to the already large insane populations at their mental institutions. State authorities paid particular attention to the number of years these insane Americans spent in each and every place so that they could relegate the responsibility for care to the right party. As in the case of the "alien insane," moving frequently without settling down in one place long enough to establish residence endangered the Americans' claim to national citizenship and state residence; in many cases, they had neither documents nor mental capacity to prove their residence. Nevertheless, these insane American citizens challenged the process by which the American government struggled to establish its immigration policy, international principle of reciprocity, and hegemony over state governments.

Insane American Citizens at Canadian State Hospitals

⁴²² St. Elizabeths Hospital was founded in 1855 as the Government Hospital for the Insane. The Act of June 12, 1917 (40 Stat. 179) provided for the transfer to the hospital of insane American citizens in the Panama Canal Zone but not in other areas. For details on the Act, see letter dated January 18, 1929 from Secretary of State Kellogg to Representative Hiram W. Johnson. File 55203/177, Entry 9, RG 85, NARA, DC.

As Elihu Root assured in 1911, American citizens abroad received protection from the United States and regardless of mental or physical defects were admitted to the country upon proving their American citizenship. However, unlike voluntary entry or departure, repatriation or deportation of American citizen public charges in foreign countries presented different problems. In addition to ascertaining their citizenship status, there came the question of which state they belonged to once they were admitted to the United States. Insane American citizens at Canadian mental hospitals offered an example that revealed the complexity behind this question. Even though they were American citizens, their dependent status as insane and frequent moves across the state and national borders complicated their legal and social position. While physical defects, in addition to being visible, might have restrained the mobility of the affected,⁴²³ suffering from mental illness did not necessarily prevent one from wandering about and moving from one place to another. As Chapter 1 shows, mobility was associated with unstable mental conditions of those who moved. As if to support this claim, American patients in Canadian hospitals had frequently relocated themselves—although we cannot say for certain whether it was because of their mental instability or because of their vitality—and their mobility made it difficult for the authorities to determine legitimacy of their claims to American citizenship.

The problem with insane American citizens at Canadian institutions was grounded in the international principle of reciprocity involving deportation between the United States and Canada. Since the late nineteenth century, the two countries had worked together to control their borders and prevent the entry of undesirable immigrants. They discussed deportation, or rather, exchange of individuals across the borders, international principle of reciprocity,

⁴²³ Douglas Baynton, "Defectives in the Land: Disability and American Immigration Policy, 1882-1924," *Journal of American Ethnic History* 24, no. 3 (Spring 2005): 31-44.

identification of their citizens, and responsibility for protection and care.⁴²⁴ Two years after the Canadian government passed its first deportation law in 1906, both countries made a reciprocal agreement to simplify deportation of immigrants with illegal entry.⁴²⁵ However, this bi-national relation was not suited to the task of public charge-related deportation. In 1910, the Commissioner of Immigration at Montreal complained that the Dominion immigration authorities recognized only native-born, not naturalized, Canadians, and refused to take back the naturalized Canadian citizens who had become public charges and deportable in America.⁴²⁶ In response, the Canadian Superintendent of Immigration pointed out that the American government did not allow the return of Americans in Canada, either, unless it received clear evidence that they were indeed American citizens. Both nations agreed that there should be a reciprocal arrangement to deal with this matter, and the Canadian government conceded that it would allow the return to Canada of all naturalized Canadians deportable under the American law. In 1915, Canada and the U.S. came to an agreement concerning “the return to either country of an alien once excluded” (from either state), but it was “never filed in written form.”⁴²⁷ Another problem with the agreement was that the return could be implemented only when the case was reported for deportation “within one year from the date of original exclusion,” which limited the number of eligible cases. This stalemate frustrated and embarrassed the immigration officials who had to deal with demands for prompter action. Commissioner John H. Clark of Montreal complained: “Living

⁴²⁴ For the U.S.-Canada and U.S.-Mexico border control, see Lee, *At America's Gates*. Also see, Ngai, *Impossible Subjects*, 66-67. According to Ngai, the U.S. immigration service was more concerned with legal immigration traffic crossing the U.S.-Canada border than with control of illegal and surreptitious entry.

⁴²⁵ For turn of the twentieth-century deportation cases involving American and Canadian citizen public charges, see Hester, “Deportation,” 195.

⁴²⁶ Memorandum for the Secretary, dated June 27, 1910; letter dated June 22, 1910 from the Commissioner of Immigration, Montreal, Canada, to the Commissioner-General of Immigration, Washington, DC. File 52600/2, Part 1, Reel 16, INS.

⁴²⁷ Letter dated July 17, 1923 from the Commissioner of Immigration at Montreal to the Commissioner-General of Immigration. Ibid.

in a glass house as we are concerning this matter of deportations, I think the Bureau [of Immigration] will concede that we are not in the best position in the world from which to insist that the Dominion Government hasten its investigation with regard to Canadians to be deported from the United States, in order that the period of detention may be lessened and [American] economy subserved.”⁴²⁸ To make matters worse, the 1920 conference between the two authorities regarding the extension of the one-year period did not materialize at the protest of the Canadian government.⁴²⁹ The list of potential deportees grew longer.

This problem resurfaced in 1924 as the question of insane American citizens in Canada again drew attention of the American government; they were the most problematic group because wherever they went, they would continue to need costly institutional care by state or local authorities. As in the United States, immigration officials and medical practitioners in Canada, aided and abetted by the contemporary racial thinking and public fear of new immigrants, resorted to deportation to get rid of insane and feeble-minded immigrant patients.⁴³⁰ American citizen patients at Canadian mental institutions became a convenient target of deportation, despite their relatively small number (as of 1929, there were about forty deportable insane American citizens at Canadian institutions). Mindful of the reciprocal agreement, the American government had acknowledged the advantage of the Canadian scheme to send back American public charges at the Canadian mental institutions: “Since the United States is the greater beneficiary, owing to the fact that there are more Canadian residents in this country than there are American residents in Canada, it would be highly desirable to make it possible for the federal officials to authorize return, in order that

⁴²⁸ Letter dated March 16, 1917 to the Commissioner-General of Immigration, Washington, DC. File 52600/2C, Entry 9, RG 85, NARA, DC.

⁴²⁹ Letter dated September 14, 1923 from the Commissioner-General to Inspector in Charge, Immigration Service, Los Angeles, California. File 55225/367, Part 1, Reel 16, INS. The one-year limit was amended in 1924 to deal with convicted criminals. Hester, “Deportation,” 195.

⁴³⁰ Menzies, “Governing Mentalities”; Dowbiggin, *Keeping America Sane*.

Canada may at all times be encouraged to receive back its comparatively many public charge and insane inmates from our institutions.”⁴³¹ Reluctantly, the American government consented to admit insane American citizens from Canada. However, investigations to prove potential deportees’ legal status were time-consuming, and delays in proceedings were frequent. Some deportable immigrants suffered a long period of detention as a result, which incurred not only humanitarian concerns but also financial troubles for both countries. Above all, the federal government failed to realize the magnitude of the problem until it started negotiating with state governments and their mental institutions.

Insanity among repatriated citizens, who still required institutional care, reminded the federal and state governments of their responsibility to citizens; the tension over these immigrants functioned as a stand-in or cover beneath which these authorities struggled to establish hegemony in the matter of deportation and repatriation. Although the federal government had assumed the power over all matters of immigration since 1876, the federal and state power struggles continued well into the 1920s. As the cases of New York and California in the previous chapter demonstrate, state authorities had long complained that the federal government did not alleviate their financial burden and employed various means to rid themselves of insane immigrant patients and send back “non-resident” inmates to their home states. To return aliens and non-residents alike to the responsible states, state authorities first needed to figure out where these patients came from. The same principle was adopted for the insane American citizens from Canada. In admitting these American citizens, state authorities demanded they prove their national citizenship *and* state residence (also called “state citizenship” during the period) before they were returned. State governments also hoped to clarify the definition of citizenship; on this occasion, their interest lay in “state

⁴³¹ Memorandum dated March 24, 1925 for Mr. White, Assistant Secretary of Labor, from G. E. Tolman, Assistant Commissioner General of Immigration. File 55203/177, Entry 9, RG 85, NARA, DC.

citizenship,” that is residence or domicile. In the case of Inga Ostjard, who had become an inmate at a Canadian mental hospital in British Columbia, it was her state residence, not national citizenship, that puzzled the American authorities.

Born in Joice, Iowa in 1901, Ostjard had “satisfactorily established” her claim to American citizenship based on the immigration office’s communication with the City Clerk at Joice and the information her father volunteered; however, the question was to which state she should be sent, once deported from Canada. She had moved from Iowa (between 1901 and 1903) to North Dakota (1903-1905) to Colorado (1905-1906), back to North Dakota (1907-1923) to Washington (1923-1924) and finally to Canada (come in 1924 and institutionalized in 1926)⁴³²; and the states of Iowa, North Dakota, and Washington all refused to take her back, arguing that she had lost her claim due to her long absence from these states. In his communications with the Commissioner of Immigration at Montreal regarding her case, the Attorney General of North Dakota offered a clarification of residence: “Our statute and the general law is the same, that residence can be changed only by the union of act and intent; but, that where one removes from one state to another with the intention of permanently changing his domicile, that immediately upon establishing a domicile in another state he become a resident of the State in which he is last domiciled.”⁴³³ Therefore, he claimed that Ostjard should be sent to the state of Washington, where she had lived for eleven months right before moving to Canada. However, the Washington Assistant Attorney General explained that under the Fourteenth Amendment, “a naturalized citizen of the United States is a citizen of the state wherein he resides”; according to him, “resides” meant “domiciled” and included not only physical presence but also the intent of choosing that

⁴³² Letter dated May 12, 1927 from Commissioner H.R. Landis to the Commissioner General of Immigration, Washington, DC. File 55203/177 Exhibit, Entry 9, RG 85, NARA, DC.

⁴³³ Letter dated March 11, 1927 from Mr. Chas W. Seaman, District Director of the Immigration Service to K. E. Leighton, Office of Attorney General, State of North Dakota. Ibid.

place as a permanent residence. He added that if this person were insane at the time he entered the state, thus unable to express his intent, his domicile lay in the last state he was in; even were he sane, if he expressed no intent of making this state his permanent abode, his domicile would continue to be the last state in which he was.⁴³⁴ Thus, the state of Washington refused to admit Ostjard. One important problem was that “intent” was not easily documented (with an exception of a first paper for naturalization) and was difficult to verify; under the circumstances, it was the “act” of moving that would be more likely to define one’s residence claim. In the case of Ostjard, her frequent movement exacerbated the federal and state efforts to determine her rightful place, and her mental instability prevented Ostjard from claiming her belonging. Without evidence to show her state residence, she could not find a place to return. Her undeniable legal status as an American citizen did not help when no states were willing to receive her. Ostjard’s case was put aside until Congress made a provision to care for Americans like her at a federal institution.⁴³⁵

Despite the detailed discussions among multiple agencies, it was still difficult to reach a clear definition of residence or citizenship when it came to insane American citizens in Canada. In 1929, S. D. McKenny, State Deportation Agent of Chicago, asked the opinion of the Assistant Secretary of Labor when his lengthy communications with the Commissioner at Montreal yielded no result: “The only question that concerns our [Deportation] Department is whether the Federal Government considers the birth-place citizenship or the last established residence.”⁴³⁶ Assistant Secretary White replied: “it is the view of this Department that the last place of permanent residence determines the State citizenship

⁴³⁴ Letter dated April 16, 1927 from the Assistant Attorney General of Washington to the Assistant Commissioner, U.S. Immigration Service, Seattle, Washington. Ibid.

⁴³⁵ Letter dated May 12, 1927 from Commissioner H. R. Landis to Commissioner General of Immigration, Washington, DC. Ibid.

⁴³⁶ Letter dated January 29, 1929 from S. D. McKenny, State Deportation Agent of the Chicago State Hospital to Assistant Secretary of Labor Robt Carl White. File 55203/177A, Entry 9, RG 85, NARA, DC.

[residence] of such individuals.” He acknowledged that “the domicile of origin, that is, that of place of birth, is presumed to continue unless there is proof to the contrary.” However, the “union of act and intent” should be taken into account because, according to White, “[t]he place of one’s permanent residence is determined not only by acts but by his intentions and the surrounding circumstances.”⁴³⁷ Despite his explanation, demonstrating a mental patient’s proper residence continued to pose problems.

Even after the union of “act and intent” of the insane American citizens at Canadian institutions was confirmed, state governments were unwilling to take these Americans back. They asserted that these individuals should be taken to a federal institution for the insane since the states had no reason to take care of those who had lost their residence. Thus, while trying to reach a compromise, the federal government began to seek a Congressional solution. William A. White, Superintendent of St. Elizabeths Hospital, Washington, DC, was worried that these Americans would end up becoming charges upon the District of Columbia unless their residence was determined; he advised that legislation regarding the insane American citizens at Canadian hospitals should be enacted before they were officially committed to the federal institution.⁴³⁸ The Assistant Commissioner General of Immigration agreed with him, but he had another solution in mind: “Superintendent White, of St. Elizabeths suggests either legislation by Congress, or the course which I suggested in the first place—that is of taking them to the locality in which they were born, notifying the state authorities, and leaving them—Supt. White agrees this would be crude, and we acknowledge that it is somewhat inhumane, but what else can we do?”⁴³⁹ The immigration authorities insisted that what mattered most in the case of the American insane at Canadian hospitals were “the attitudes of

⁴³⁷ Letter dated February 18, 1929. Ibid.

⁴³⁸ Letter dated March 3, 1925 from White to the Secretary of the Interior, Washington, DC. File 55203/177, Entry 9, RG 85, NARA, DC.

⁴³⁹ Letter from Assistant Commissioner General to Husband, no date (ca. 1925). Ibid.

the responsible State officials, in most cases based upon State statutes.”⁴⁴⁰ The Canadian government had a similar problem with Provincial institutions, which refused to cooperate, just like the American state authorities; however, the Canadian immigration official was confident that as soon as the U.S. made a provision for American citizens deported from Canada, the Provincial institutions would “fall in line” and receive Canadian citizens deported from America. Thus, the Commissioner of Immigration at Montreal asserted: “In fact, most of the deadlocks now are due to the refusal of institutions in the United States to receive public charges from institutions in Canada.”⁴⁴¹ These statements demonstrate that the federal government, despite its elaborate immigration and deportation policy, was not adequately equipped to deal with a task of repatriating American citizens in foreign countries. The state governments’ refusal to cooperate exacerbated its already strained efforts.

The involvement of multiple agencies, including branches of the federal government, Congress, and foreign countries further complicated the dynamics of deportation or repatriation. Senator Johnson, Chairman of the Committee on Immigration, lamented this perplexing situation in which even American citizens could not find a place to return. In the 69th Congress (1925-26), he called for a legislation to resolve the issue: “To permit these unfortunate people to be thrust across the border and enlarged upon the public would not only be an act of inhumanity but constitute a serious menace to the communities in which they might be released. Some of them are helpless and would probably perish without assistance while the vicious among them would endanger the public safety, and besides the Canadian government refuses to adopt such a vicious and inhuman course.” The apparent helplessness as well as the political and economic threat they embodied could not negate the fact that they

⁴⁴⁰ Letter dated January 27, 1928 from H. R. Landis, Commissioner of immigration, Montreal, Canada, to the Commissioner General of Immigration, Washington, DC. Ibid.

⁴⁴¹ Letter dated February 1, 1929 from H.R. Landis to Commissioner General of Immigration, Washington, DC. Ibid.

were still “American citizens” and “proper charges either upon the States or the federal government.” Johnson understood the principle of reciprocity in international affairs and criticized the current American immigration policy for its lack of adequate provisions for American citizens abroad:

We are vigorously enforcing the immigration law which provides for the deportation of alien people of this character to the respective countries from which they came and the countries of which they are citizens are receiving them back, and yet the United States is unable to provide for the proper return of our own insane citizens who are confined in the public institutions of Canada. Not only is it highly important for us to maintain with scrupulous fidelity our reciprocal arrangement with the Canadian government in this matter but the dictates of common humanity demand that we make adequate provision for the institutional care of our helpless and distracted citizens who have become public charges in other countries.⁴⁴²

As Johnson stated, American immigration officials had been diligently sending immigrant patients back to their home countries, oftentimes risking the safe delivery of the deportees. However, they found it difficult to do the same for American citizens because they failed to prevail upon state governments and institutions. To make matters worse, the problem of insane American citizens abroad did not stop at the American-Canadian borders. Other countries brought up the same issue with the American government. In early 1929, Secretary of State Frank B. Kellogg referred to the international dimension of the problem in his letter to Representative George S. Graham (R-PA), the Chairman of the Committee on the Judiciary, and explained that foreign diplomatic officers in Washington, DC, informed the government of additional cases of insane American public charges in their countries.⁴⁴³ Calling for speedy passage of the Congressional provision for these citizens, the Secretary of Labor too hoped to find a prompt solution to “the embarrassing and troublous situation,

⁴⁴² Letter dated March 28, 1925 to Hiram W. Johnson from James J. Davis, Secretary of Labor. Assistant Commissioner General G. E. Tolman was also of the same opinion. Ibid.

⁴⁴³ Letter dated January 31, 1929. File 55203/177A, Entry 9, RG 85, NARA, DC.

which is becoming more troublous and embarrassing continuously.”⁴⁴⁴ In addition to working together with states and their institutions, this matter called for close cooperation within the federal government. Since it concerned American citizens, the Department of State assumed responsibility; however, the Department of Labor in charge of the Bureau of Immigration was not indifferent because American citizens “are aliens in foreign lands and we [Department of Labor] are asking foreign governments to accept aliens in our country who are not citizens in theirs.”⁴⁴⁵ These Americans abroad were indeed a mirror image of immigrants in America. Additionally, the Department of Interior, which took charge of St. Elizabeths Hospital, came together with the other departments to push for legislation.

In the meanwhile, some of the Canadian provinces declared that they would not accept any more insane Canadians from the United States until American citizen patients were removed from their institutions.⁴⁴⁶ Negotiations between the federal and state authorities were nearing the limit. On March 2, 1929, Congress passed an act “to provide for the repatriation of certain insane American citizens” and designated St. Elizabeths Hospital for the care of “all American citizens legally adjudged insane in the Dominion of Canada.”

The legislation read:

That upon the application of the Secretary of State, the Secretary of the Interior is authorized to transfer to St. Elizabeths Hospital, in the District of Columbia, for treatment, all American citizens legally adjudged insane in the Dominion of Canada, whose legal residence in one of the States, Territories, or the District of Columbia, it has been impossible to establish. Upon the ascertainment of the legal residence of persons so transferred to the hospital, the superintendent of the hospital shall thereupon transfer such persons to their respective places of residence, and the expenses attendant thereon shall be paid from the appropriation for the support of the hospital. Upon the request of any such patient, his relatives or friends, he shall have a

⁴⁴⁴ Letter dated February 5, 1929. Ibid. Urging George S. Graham, Chairman of the Committee on the Judiciary to secure the passage of H.R. 16436, Secretary of Labor emphasized direness of the situation.

⁴⁴⁵ Memorandum dated February 2, 1928 for Mr. Husband. Ibid.

⁴⁴⁶ Letter dated July 10, 1928 from H.R. Landis, Commissioner to the Commissioner General of Immigration, Washington, DC. Ibid.

hearing in the Supreme Court of District of Columbia upon his mental condition and the right of the superintendent of St. Elizabeths Hospital to hold him for treatment.⁴⁴⁷

The American authorities hoped that in addition to providing the insane American citizens with a place to stay, this bill would “undoubtedly facilitate the return to Canada of a considerable number of aliens [Canadian citizens] who are inmates of insane institutions in this country.”⁴⁴⁸ The Canadian authorities agreed to cover the expenses for transporting the American citizens to the United States as long as they were removed from their institutions. At last, the American citizen patients found their home, no matter how temporary, at St. Elizabeths. However, the provision of the legislation was limited in a way that it did not include insane American citizens in foreign countries other than Canada. Moreover, there was still a chance that as soon as their state residence was determined, these Americans might experience yet another round of mobility, transferred from St. Elizabeths to various state institutions and again rendered vulnerable to the possibility of statelessness.

Conclusion

Deportation of the insane aliens from America exposed the difficulties and contradictions involved in the repatriation of the insane, and the United States’ negotiations with Canada regarding insane citizens raised questions of state and federal conflicts and the international principle of reciprocity. Constant care and protection required for the insane turned insanity into a site of cooperation and contention and necessitated the federal government to establish the privilege of citizenship and its obligation to protect them. That is, as mobile subjects in need of public attention, the “alien insane” helped, albeit unintentionally and unwillingly, the American government negotiate its national and

⁴⁴⁷ 45 Stat. 1495, Public—No. 935—70th Congress H.R. 16436. Ibid. Also see *Congressional Record*, 70th Cong., 2d sess. (March 1, 1929): 4048. It was passed in the House on February 25, 1929.

⁴⁴⁸ Letter dated February 5, 1929 from the Secretary of Labor to George S. Graham, Committee on the Judiciary. Ibid.

international authority and reexamine ideals of American citizenship. In this case, they functioned as a proxy, through whom the meaning of citizenship was constructed and solidified and the national boundaries were drawn. Insane immigrants, along with their American counterparts abroad, occupied a precarious position in American society; becoming insane compromised their rights and rendered them dependent, unfit and in need of governing by various agencies. Moreover, they were exposed to the possibility of removal and even statelessness as no country or state wanted to keep these insane public charges in its midst without undeniable evidence of citizenship. As the correspondence between the American and Canadian authorities showed, the main interest of the parties involved was in defining and determining citizenship claims and discussing the responsibility for reception and care, an endeavor the growing federal bureaucratic network demanded to exercise its power and justify its continuing influence.

Hearings transcripts and investigation reports by immigration officials offer excellent materials to study international law and legal status and rights of an immigrant; however, the stories of insanity, varying statuses of citizenship and alienage, and federal-state conflicts over hegemony do not reveal what happened inside state institutions, where both insane immigrants and American citizens encountered medical treatment and a form of detention, waiting for deportation or repatriation, and in many cases, for death. Moreover, they could not explain social, economic, or cultural circumstances that led to the immigrants' confinement to and eventual removal from a state mental hospital. How and why did these immigrants become mental patients? What kind of experience did they have at state mental institutions? In the next chapter, I turn to state mental hospitals in New York and California to examine who these insane aliens were, how they were distinguished from native-born Americans, and what it was like to be alien and insane at American public institutions.

Chapter Four

The Racialized “Alien Insane” and the Reality of Confinement:

New York and California State Hospitals, 1890-1930

In 1908, the Board of Alienists of New York examined the histories of patients deported from New York hospitals and reported that eighty percent of the deportees had either been insane before entering the United States or were suffering from symptoms of mental illness at the time of landing. The rest were mentally defective and described by their friends as follows:

“Always queer.” “Unstable.” “Dopy.” “Peculiar and nervous.” “Silly and forgetful.” “Had a bad mind.” “Always acted funny.” “Utterly useless.” “Stupid and ‘thought too much.’” “Dull, nervous and sickly.” “Eccentric and excitable.” “Quiet, seclusive, not bright, and nervous.” “Always had severe headaches and depressed spells.” “Sickly and queer for years.”⁴⁴⁹

These lay persons’ descriptions, the Board suggested, implied that the deported immigrants had been “defective and psychopathic” for a long time and that they would have developed mental troubles wherever they went. It was not the hardships of immigration but inherited mental defects that explained their pathology and commitment to state mental institutions. The report lamented that many defective immigrants passed the mental examination at Ellis Island because examiners attributed their defects to “racial traits” rather than existing mental illness, thus overlooking their apparently abnormal conditions.⁴⁵⁰ Any person described as “queer,” “unstable,” or “nervous,” the report suggested, should be a potential candidate for commitment to a mental hospital, regardless of his or her skin color, nationality, or language. Given this critique, it is possible to assume that immigrants’ racial or cultural backgrounds did not have much significance when it came to commitment, examination, and diagnosis of

⁴⁴⁹ New York, State Commission, 20th *Annual Report* (1909), 36.

⁴⁵⁰ *Ibid.*, 37.

immigrant patients at New York mental hospitals. However, there existed various ideas concerning immigrant patients and their differences, and these ideas influenced the patients' experience with the American institution.

While the discourses of civilization and mobility distinguished immigrants from native born Americans, and Asians from European immigrants, there was neither consensus nor consistent and coherent argument supporting the racial foundations of their differences. For the most part, existing scholarly studies of psychiatry and mental institutions that discuss race and insanity confine their study to southern institutions that treated African-American patients in a largely segregated institutional setting.⁴⁵¹ Racialization of the immigrant insane has not been a topic of discussion in the historiography of insanity because many scholars saw that psychiatrists did not diagnose patients strictly along racial or ethnic lines. According to scholars like Joel Braslow, race (unlike gender) had “scant institutional import” and “no therapeutic significance.”⁴⁵² In fact, with the exception of southern hospitals, patients in American institutions were not racially segregated; some states such as California had no “race” section on a patient register until the 1940s.⁴⁵³ Even when race was noted on hospital

⁴⁵¹ For a brief discussion of race at mental institutions, see Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton: Princeton University Press, 1995); Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1999). For African-American insane in the South, see Peter McCandless, *Moonlight, Magnolias and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: University of North Carolina Press, 1996); John Hughes, “The Madness of Separate Spheres: Insanity and Masculinity in Victorian Alabama,” in *Meanings for Manhood: Constructions of Masculinity in Victorian America*, eds. Carnes, Mark C. and Clyde Griffen (Chicago: The University of Chicago Press, 1990), 53-66; Hughes, “Labeling and Treating Black Mental Illness in Alabama, 1861-1910,” *Journal of Southern History* 58 (August 1992): 435-60. For mid-western institutions and African-American patients, see Jonathan M. Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009); Sean Harris, “Found Insane in the Holy Land: Psychiatry and the African American Experience in Illinois, 1870-1910” (Ph.D. diss., University of Illinois, Chicago, 2007). Call for more attention to race in the history of psychiatry, see Ellen Dwyer, “Psychiatry and Race during World War II,” *Journal of the History of Medicine and Allied Sciences* 61, no. 2 (2006): 117-43; Andrew Fearnley, “Primitive Madness: Re-Writing the History of Mental Illness and Race,” *Journal of the History of Medicine and Allied Sciences* 63, no. 2 (2008): 245-257.

⁴⁵² Braslow, *Mental Ills and Bodily Cures*, 23.

⁴⁵³ Recently, historians of mental hospitals in Australia and New Zealand have begun to examine patient case files for the patterns of commitment, mobility, and ethnic or racial differences among Europeans,

admissions or commitment court forms, it was often haphazardly and inconsistently recorded, suggesting that it does not merit great significance. However, the absence of a race section and unfixed notions of what “race” meant do not indicate that there was no concern for racial differences among the hospital population.

My study of administrative forms and state hospital reports is based on the contemporary definition of “race” as it was applied to the institutional and clinical setting, which was not necessarily about a black-white binary in today’s sense but rather a conflation of many elements that included skin color, nativity, nationality, religion, and language. For example, during the period, immigration stations determined “race” by “the stock from which aliens sprang and the language they speak. The original stock or blood shall be the basis of the classification, the mother tongue to be used only to assist in determining the original stock.”⁴⁵⁴ Of course, the “color” scheme that distinguished white Europeans from non-white or “colored” peoples (in this chapter, Asians) had been operating in legal and political institutions.⁴⁵⁵ However, the contemporary racial ideology ordered and categorized various

Chinese, and indigenous Maoris. See Angela McCarthy, “Ethnicity, Migration and the Lunatic Asylum in Early Twentieth-Century Auckland, New Zealand” *Social History of Medicine*, 21 (2008): 47-65; Catharine Coleborne, “Making ‘Mad’ Populations in Settler Colonies: The Work of Law and Medicine in the Creation of the Colonial Asylum,” in *Law, History, Colonialism: The Reach of Empire*, eds. Diane Kikby and Catharine Coleborne (Manchester: Manchester University Press, 2001), 106-22. For Maori patients, see Lorelle J. Burke, “‘The Voices Caused Him to Become Porangi’: Maori Patients in the Auckland Lunatic Asylum, 1860-1900” (M.A. diss., Waikato: The University of Waikato, 2006); Lorelle Barry and Catharine Coleborne, “Insanity and Ethnicity in New Zealand: Maori Encounters with the Auckland Mental Hospital, 1860-1900,” *History of Psychiatry* 22, no. 3 (September 2011): 285-301.

⁴⁵⁴ Ellis Island, list of races or people, no date. Box 48, FLIS, Immigration History Research Center, University of Minnesota (hereafter IHRC).

⁴⁵⁵ In the contemporary records, “colored” generally referred to African Americans, but it also included Native Americans, Chinese, and Japanese. The U.S. Census data reflected uncertain categorizations. The 1890 Census included “black, Chinese, Japanese, and Indians among the “colored.” The 1900 Census confirmed that “black” designated negro or of negro descent, but “colored” still included “persons of negro descent, Chinese, Japanese, and [American] Indians.” Even without the explicit reference to “race,” the “colored” category drew a line between whites and non-whites. According to historian Martha Hodes, the color scheme of the 1890 U.S. Census reflected the American conviction that “those outside the category of “white” were not really Americans at all and thus undeserving of citizenship.” Hodes, “Fractions and Fictions in the United States Census of 1890,” in *Haunted by Empire: Geographies of Intimacy in North American History*, ed. Ann Laura Stoler (Durham: Duke University Press, 2006), 240-70, 260-61; Jennifer L. Hochschild and Brenna Marea Powell, “Racial Reorganization and the United States Census 1850-1930:

groups, which we now see mostly as ethnic groups, on the basis of physical and behavioral characteristics.⁴⁵⁶ Thus, African, Hebrew, Irish, Italian, Slavonic, Chinese, and many other groups were believed to be distinct “races,” while the aggregations of skin color, nativity, nationality, language, and religion, though peculiar to modern eyes, were understood as a surrogate or place holder for observable differences between the foreign and native born and among the foreign born themselves. The contemporary racial thinking also intersected with the notions of gender and sexuality of immigrants. They were all expected to conform to American gender norms and sexual mores, but different “races” received different levels of surveillance and control for their gender and sexual behavior.

The inconsistencies within administrative and statistical records and acted upon conceptions of difference were decades in the making and they were subject to adjustment and legislative interpretation. According to historian Mae M. Ngai, while nationality and race had long been conflated, by the early twentieth century the two were disaggregated and realigned. The new immigration acts of the 1920s distinguished European immigrants by nationality, but they also constructed them as a white race, separate and distinct from those who were deemed not white.⁴⁵⁷ In legal, political, and even medical contexts, European immigrants were seldom denied “white” status; at state hospitals, for example, doctors, despite their recognition of differences, still considered most European immigrant patients “white.” As many scholars have well demonstrated, however, the racial stratification of the period under the influence of Social Darwinism and scientific racism created a varying

Mulattoes, Half-Breeds, Mixed Parentage, Hindoos, and the Mexican Race,” *Studies in American Political Development* 22 (Spring 2008): 59-96, 93.

⁴⁵⁶ For discussions of the 1911 Dillingham Report, *Dictionary of Races and Peoples*, see Matthew Frye Jacobson, *Whiteness of a Different Color: European Immigrants and the Alchemy of Race* (Cambridge, MA: Harvard University Press, 1998); Samuel B. Thielman, “Psychiatry and Social Values: The American Psychiatric Association and Immigration Restriction, 1880-1930,” *Psychiatry* 48, no. 4 (November 1985): 299-310, 301.

⁴⁵⁷ Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (Princeton: Princeton University Press, 2004), 24.

degree of whiteness within the European populations in America.⁴⁵⁸ Southern and eastern Europeans were considered to be inferior and undesirable despite their eventual integration into American society. Asian immigrants were more clearly and visibly racialized than their European counterparts. Public protest and the force of law aided and abetted the process: Anti-Asian immigration agitations, the Chinese Exclusion Acts of 1882, and the Gentlemen's Agreement of 1907 threatened Asian immigrants' rights to enter the United States. A series of the Alien Land Acts of the 1910s, the 1917 and 1924 Immigration Acts, and several court cases, such as *Takao Ozawa v. U.S.* (1922) and *U.S. v. Baghat Singh Thind* (1923), marked their ineligibility for American citizenship. These decisions were soon applied to other peoples of Asian countries and constructed them as a racial category.⁴⁵⁹ In the U.S. Census, Asian immigrants continued to be enumerated by their nationalities (for example, "Chinese" referred to both race and nationality) no matter how long they had been in America, and they were coded as foreign and ineligible for assimilation. That is, despite the absence of a racial term for Asian immigrants, a clear racial ideology was in practice.⁴⁶⁰ Political and legal measures and medical examinations at the immigration borders separated Asians from European immigrants; according to historian Amy Fairchild, the immigrant medical examination during the period, which disproportionately excluded and deported non-European immigrants, reflected "a significant national endeavor that set European immigrants apart from Asians and from Mexicans and other Latin American people."⁴⁶¹

State hospital doctors were equipped to diagnose and treat patients as individuals, not part of a racial group, and were wary of involvement with the fierce debates and anxieties

⁴⁵⁸ See Jacobson, *Whiteness of a Different Color*; Ian Haney López, *White by Law: The Legal Construction of Race* (New York: New York University Press, 1996). In court documents for hospital commitment and patient care records, they were more often than not classified as "white," at least in terms of their skin "color."

⁴⁵⁹ Ngai, *Impossible Subjects*; Jacobson, *Whiteness of a Different Color*.

⁴⁶⁰ Hochschild and Powell, "Racial Reorganization," 73.

⁴⁶¹ Amy Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force* (Baltimore: The Johns Hopkins University Press, 2003), 220.

about racial differences among new immigrants. In 1903, looking for causes of insanity, John Robertson, a superintendant of a private sanitarium in California, claimed: “Race does not form so important an element in the development of insanity as does the simple fact of being foreign-born.” However, this seemingly benign and even progressive remark by a man of science belied more complicated attitudes toward race. He explained that the “fiery Irishman,” “erratic Frenchman,” and “cold-blooded German” naturally formed a large proportion of the insane while “the Chinamen, subjected to all the stress and more dissipation” was the least susceptible to insanity. Without a good explanation for the differences among these “races,” he resorted to the foreign-born category and blamed foreign birth for insanity.⁴⁶² When examining immigrant patients, medical practitioners could use nativity as a viable category of analysis by grouping them as “foreign-born” as opposed to “native-born,” without referring to the patients’ “race.” As our story unfolds, however, it becomes clear that these doctors and hospital staff engaged with treating and evaluating the “alien insane” were not always free from the claims of scientific racism and its implied racial hierarchy. They could not ignore the cluster of characteristics among immigrant patients when they examined, communicated with, diagnosed, and discharged the patients. The presence of many indigent immigrant patients at state mental institutions also encouraged doctors and staff to consider not only medical aspects but also policy implications of the “alien insane.” In particular, the process of deporting the “alien insane” from mental institutions suggests that doctors collaborated with the racial ideology embedded in the federal bureaucratic apparatus that sorted out and rejected the undesirable, those designated unsuitable candidates for citizenship and those already signified as a possible threat to the established American system. Doctors understood the aim of the mental hospital was to treat these immigrant patients so that they could be

⁴⁶² John W. Robertson, “Prevalence of Insanity in California,” *American Journal of Insanity* 60 (1903): 75-88, 84.

removed from the hospitals and continue their lives; at the same time, they identified and prepared deportable immigrants through proper record keeping, which was part of their scientific and progressive agenda, but also compatible with the demands of new restrictive immigration laws.

*Filing Immigrants at State Hospitals for the Insane in New York and California*⁴⁶³

This chapter, which explores state mental hospitals of New York and California between 1890 and 1930, allows further examination of what it meant to be both alien and insane. Comparing New York (a large European immigrant population) and California (more diverse immigrant groups) helps examine the ways in which race was understood and acted upon during the period and sheds light on the experience of the “alien insane” within the American institutional system.⁴⁶⁴ Both states established a centralized state hospital commission, whose reports offered detailed statistical records compiled from mental state hospitals, including demographic information, diagnoses, and movements of patients, and larger pictures of the institutions, the states, and the work of medical professionals.⁴⁶⁵

⁴⁶³ For New York state hospitals, see Ellen Dwyer’s *Homes for the Mad: Life inside Two Nineteenth-Century Asylums* (New Brunswick: Rutgers University Press, 1987) and Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1973); *The Mad Among Us: A History of the Care of America’s Mentally Ill* (New York: The Free Press, 1994). For the architectural history of Buffalo State Hospital, see Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007). The construction of Buffalo State Hospital began in 1871, and when it opened in 1888, it was one of the largest hospitals of the time period. The hospital building was completed in 1895. Several state institutions were formed in California in the second half of the nineteenth century. Stockton State Hospital, first open in 1851, invited more immigrants than other state institutions due to its geographical proximity to large cities of California. Mendocino State Hospital was founded by statutes of 1889 and opened in 1893. For the history of the California state hospitals for the insane, see Margaret H. Smyth, M.D. “Psychiatric History and Development in California,” *American Journal of Psychiatry*, March 1938; Richard Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978).

⁴⁶⁴ Fox, *So Far Disordered*, 17. Northeastern hospitals shifted from therapy to custody at the turn of the twentieth century, but California institutions played custodial roles from the start.

⁴⁶⁵ The first New York State report was published in 1890 (the commission was created in 1889) and the first biennial report for the California State Commission in Lunacy came out in 1898. At least in New York, commissioners were themselves psychiatrists, and the Commission reports included hospital

However, these records described by hospital doctors and staff do not reveal the complex interactions between hospital staff and patients, or subtle prejudices or stereotypes, that could have influenced decisions concerning diagnosis, commitment, discharge, or deportation. Hospital patient records reveal day-to-day experiences of immigrant patients at state hospitals, but the immigrant patients rarely left records of their own. A few letters they wrote to their family members or doctors remain, and most were silenced by their mental condition, illiteracy, or inability to speak intelligently. Yet, hospital case files sometimes included interviews of immigrant patients and their acquaintances; albeit filtered and intermediated by American authorities, these records allow us to examine not only doctors' viewpoints but also immigrants' experiences of insanity and encounters with American psychiatric institutions.

For New York, I have used records from Buffalo State Hospital now housed at the New York State Archives.⁴⁶⁶ I sampled 76 case files of immigrant patients, who were “foreign-born” and not naturalized at the time of their commitment between 1898 and 1920. For California, I examined 26 available Mendocino State Hospital immigrant patient case files (also foreign-born and non-citizen), which included both European and Asian patient records.⁴⁶⁷ In order to complement the records from California, I examined 405 registers of Chinese, Japanese, and Korean patients from Stockton State Hospital, who were committed between 1900 and 1920. In addition, I consulted state hospital and commission reports, government publications, and newspaper articles on the “alien insane” in America (For more details on the sources and statistical data, see Appendix C).

To commit an allegedly insane person to a state mental hospital, a petition or an affidavit needed to be filed. Then, the person was brought to court, examined by two certified

superintendents' reports. Whether the interests of the Commission corresponded to those of state hospital doctors needs further investigation.

⁴⁶⁶ 14231-93, Patient Case Files, New York State Archives.

⁴⁶⁷ Several boxes of Mendocino State Hospital patient files are available at California State Archives. Series 6 Patient Case Files 1892-1972, California State Archives.

doctors, and committed to an institution if his insanity was confirmed. Many patients were picked up by the police for wandering about or threatening peace of the community and sent to prisons or jails; when they showed peculiar or strange behavior, they were brought to state hospitals for the insane. Some came directly from their residence as emergency cases without court proceedings; after a brief period of observation, they were admitted to a mental institution. Upon commitment, state hospitals filled in patient information gathered from patients themselves and informants (usually petitioners requesting commitment), which included demographic data, family history, and symptoms of insanity. As Chapter 1 shows, this information offered invaluable statistical data for medical, legal, and political purposes. In particular, state hospital admissions blanks had provide a vehicle for understanding the contemporary racial thinking of medical practitioners as they reflected changes in the social and political atmosphere of the period. These blank forms recorded age, gender, occupation, education, religion, and nativity of patients, but at the turn of the twentieth century, they began to incorporate new categories of “color” or “race,” though not consistently used, to classify their inmate populations.

In New York, there were numerous ways to distinguish immigrant patients from their native-born American counterparts. For instance, Buffalo State Hospital, New York, had recorded since the 1900s “Years in U.S. _____,” a means to mark immigrant patients and detect their eligibility for deportation. Other details varied from time to time: the forms from the 1900s included birthplaces of both patients and their parents but no reference to the patients’ color or race. In 1911, the hospital blanks added a section for “color”—white, black, yellow, and red. Americans and European immigrants were invariably categorized as white, because at least in legal terms (commitment being a legal process), they were white, eligible for naturalization and land purchase; however, other characteristics still mattered in filing

patients.⁴⁶⁸ In 1914, the form removed the “color” section and introduced two new sections of “race” and “citizen, U.S.” The entries in the “race” section revealed the development of a complex classification scheme: “race” was conflated with nationality, religion, or language of both a patient and his parents, and hospital inmates were classified into several “racial” groups of African (black), English, German, Hebrew, Irish, Italian, Magyar, Scandinavian, Slavonic, unascertained, and mixed (“most of the native Americans”).⁴⁶⁹ This section had not been consistently recorded because in order to determine one’s “race,” his skin color, nationality, language, or religion also needed to be taken into account. For Joseph T., his “race”—“Italian”—designated his nationality.⁴⁷⁰ Norwegian-born George’s “race” section initially read “white,” but it was later crossed out and replaced by “Scandinavian” in a different handwriting, suggesting that “race” as a category was still undefined.⁴⁷¹ Parentage also mattered: the “race” section for one patient read “mixed” because she had an English father and an Irish mother, while she herself was born in Ireland and grew up in England.⁴⁷² With few non-white patients at the hospital, differences among European immigrants continued to draw attention.

⁴⁶⁸ Fairchild, *Science at the Borders*, 219-220.

⁴⁶⁹ The 26th *Annual Report* explained: “This is the first time that a general table of the race of first admissions has been possible, as the new statistical card on which data respecting race was first called for did not come into general use until 1914.” See New York, State Commission, 26th *Annual Report* (1915), 597. “Race” table was available for deported immigrants as early as 1911, reflecting the classification scheme adopted by the Immigration Service, but it soon fell out of favor because what really mattered for deportation was to which countries these immigrants were and should be sent, which “race” could not tell.

⁴⁷⁰ 14231-93 Patient case files, Buffalo State Hospital, New York State Archives (hereafter Buffalo), admitted in August 1920, discharged in October 1921. Diagnosis: epileptic.

⁴⁷¹ Buffalo, admitted in July 1918, discharged in June 1919, undiagnosed. Brought from Memorial Hospital, Niagara Falls, New York. About a month and a half after his admission, a Medical Inspector of the State Hospital Commission visited him for deportation. However, he was released from the hospital on trial in November 1918 with the help from his friend and was discharged recovered in June 1919. He might have been saved from deportation because of wartime instability, which continued to disrupt transportation to Europe; or because of his relatively quick recovery—no mental symptoms by November—made him a good candidate for discharge. His “race” might also have rendered him more desirable than other immigrant patients from southern or eastern Europe.

⁴⁷² Buffalo, admitted in August 1920, discharged in December 1920 to the custody of her husband. Diagnosis: manic depressive psychosis, depressed phase.

The California State Commission in Lunacy and state hospitals did not have a section for “race” on the hospital forms until the 1940s; however, “color” had become a viable category for classifying hospital inmates. Admissions abstracts at Mendocino State Hospital in the 1910s and 20s included “nativity, date of birth, occupation, religion, civil state, and financial status” without a reference to race or color of a patient, but the certificate of medical examination blanks required the patient’s “color” to be entered.⁴⁷³ As early as 1905, Stockton also began to use ocular reports of perceived “color,” but not “race,” on its commitment registers. As in the categorization at Buffalo State Hospital, both European immigrants and Americans, unless marked as “colored” or “Negro,” were more often than not classified as “white.” However, as if to reflect the racial or national diversity of the patient population in California, there were many shades of “color”—white, yellow, brown, copper, dark, and in some cases, Chinese, Japanese, or Mongolian—entered in the color section.⁴⁷⁴ The fact that Chinese or Japanese was used synonymously with “color” signified that the “color” section of the Stockton Hospital registers referred not only to skin color but also to nationality, or race, in a broad sense. For example, the Stockton State Hospital register for Kageyama had “Japan” in all three sections for nativity, color, and religion, which indicated that being Japanese was the only necessary identification for him and for the hospital.⁴⁷⁵ In some cases, “Chinaman” or “Jap” was hand-written next to patients’ names on registers, unsolicited identifiers signifying their difference from native-born patients. Like the Buffalo State Hospital forms, the Stockton registers included a section for “years in U.S.” and “years in California” for patients, which again marked immigrant inmates from native-born patients.

⁴⁷³ Mendocino State Hospital (hereafter Mendocino), Ida was admitted in January 1907 but the available records of her file were from the late 1910s. Long-term patient, born in Finland. Diagnosis: dementia praecox, hebephrenic.

⁴⁷⁴ Several Chinese and Japanese cases from Stockton had “white” for the color section. It is not clear from the records whether it was a reflection of actual skin color, a mixed-race origin, or merely a mistake.

⁴⁷⁵ Stockton State Hospital (hereafter Stockton), admitted in October 1919 and died of tuberculosis in November 1922. Diagnosis: dementia praecox.

African-American patients were almost always referred to as “colored” or “Negro” even when their race was recorded as “American”; however, in the case of mixed bloods or races, it was difficult to figure out who these patients were, and there was a possibility of a mistaken identity. The blank forms themselves shaped the understanding of the patient classification as well. For example, in the early twentieth century, Native Americans were required to prove their tribal membership to gain admissions to the Indian Hospital in Canton, South Dakota, the mental institution established only for Native Americans. The problem was that the commitment application form, which had been used for Americans living in the Indian Territory, gave only two options for “race”: white or colored. To commit Native American patients, applicants were instructed to add “Indian” in the race section, crossing out “white” and “colored.” In 1907, this form caused confusion among the officials of the Oklahoma Indian Territory when they received a request for the whereabouts of one William Green or Greenfeather. He was recorded as “white” by the City Marshal who filled out his hospital admission form (See Figure 4.1). However, he had been known as a Cherokee Indian and if he had been “white,” he could not have been committed to the hospital for the Indian insane.

Figure 4.1. Application for William Green/Greenfeather

2. Give name and following information in reference to insane person?

Name *William Green* Age *40*

Race, white or colored *white* Sex *male*

Previous occupation *Painter*

How long insane *1 week or 10 days*

Source: File of William Green/Greenfeather, Entry 19, Records of the Bureau of Indian Affairs, Record Group 75, National Archives, Fort Worth, Texas.

It is possible that Green or Greenfeather was a person of a mixed race, thus looking “white,” or that the City Marshal, noticing no option for “Indian,” made a choice between white and

colored for Green/Greenfeather.⁴⁷⁶ This case shows that different parts of the United States used different notions of race. New York and California with their large immigrant populations did not always resort to the binary scheme of racial categorization, which also proved to be a problem in the Indian Territory.

The arbitrary approach to “race” was not uncommon at either New York or California hospitals. Frequent changes in the admissions form classifications and the inconsistent use of a racial category could be a result of a haphazard record keeping at state hospitals for the insane.⁴⁷⁷ Or, as historian Elizabeth Lunbeck shows, doctors’ endeavor to classify “race” was a reflection of the contemporary trends in racial thinking and of progressive attempts to scientifically catalog the patients. Thus, Lubeck argues that race had “little diagnostic significance” and did not much influence “the day-to-day practice of psychiatry.”⁴⁷⁸ However, doctors did regard the “alien insane” as a unique population. The conflation of nationality and race as well as “mixed” parentage (father and mother with different nationalities or races) puzzled doctors and hospital staff; changes in nationalities or races following the reordering of the international world, in particular during and after World War I, also complicated the classification scheme. Perhaps to deal with this problem, state hospital doctors and social scientists preferred the convenient and less controversial distinction between “foreign-born” and “native-born” to a racial classification. However, contemporary psychiatrists and social scientists criticized that the category of “foreign-born” did not consider the diversity of the

⁴⁷⁶ William Green/Greenfeather’s file stated that he was “[e]xcitable but not violent as yet, simply insane.” Entry 19, Records of the Bureau of Indian Affairs, Record Group 75, National Archives, Fort Worth, Texas.

⁴⁷⁷ Herbert Goldhamer and Andrew W. Marshall, *Psychosis and Civilization: Two Studies in the Frequency of Mental Disease* (Glencoe, Ill.: Free Press, 1953), 15. Against those who might think that examining the nineteenth century records could be “a rather hazardous scientific venture,” the authors argued: “We have today become so professionalized in the procedures of institutional and scientific bookkeeping that we sometimes forget that recording and counting admissions to a hospital, noting dates of entrance, county of residence and such like matters are intellectual operations which even in the 19th century had already been conquered.” Still, it should be noted that arbitrary bookkeeping did exist even well into the twentieth century as some of the case files illustrate.

⁴⁷⁸ Lunbeck, 126. Doctors succeeded in making a diagnosis of their patients even without communication.

immigrant population, as they indiscriminately included long-term residents and naturalized citizens in that group.⁴⁷⁹ In addition, the foreign-born and native-born distinction did not hide the fact that doctors still took into account skin color, nationality, or language differences in examining and observing patients. As psychiatrist S. P. Rosenthal argued in his 1935 study, alleged “racial” differences—here, among European immigrant patients—in the mental diseases were derived from and influenced by “a preconceived notion (conscious or unconscious), that some races are inferior to others, and hence that this inferiority will manifest itself in the racial disease rates.”⁴⁸⁰

The classification scheme at state hospitals served political and social purposes by filing and categorizing immigrant patients, especially those who were removable and deportable. That is, even if race had “little diagnostic significance” as Lunbeck argues, the contemporary racial ideology built discussions and debates around deportation of immigrant patients and marked them more problematic and burdensome.⁴⁸¹ It also categorized the immigrant patients themselves, reflecting alleged racial differences between the old stock and new immigrants, and justified their removal. The 1907 New York Hospital Commission report admitted that “new immigrants” were not to blame for overcrowded hospital conditions: “Russia, Austria-Hungary and Italy show a smaller proportion of insane than of the foreign-born population [in general].” However, it continued: “it should be remembered that more than one-half the natives of these countries residing in the State have been here less than six years—too short a time for them to be fully represented in the insane population.”⁴⁸²

⁴⁷⁹ Morris D. Waldman, “The Alien as a Public Charge, with Particular Reference to the Insane,” *Proceedings of the New York State Conference of Charities and Correction*, 13th conference (1913), 82-117. Age distribution of the immigrant patients and mixed parentage (i.e. native-born father, foreign-born mother) should be noted as well.

⁴⁸⁰ He understood the difficulties in defining “race” and was cautious in his use of statistics. S. P. Rosenthal, “Racial Differences in the Mental Diseases,” *Journal of Abnormal and Social Psychology* 28, no. 3 (October 1933): 301-318, 303.

⁴⁸¹ New York, State Commission, 31st *Annual Report* (1920), 151.

⁴⁸² New York, State Commission, 18th *Annual Report* (1907), 241.

Their shorter residence in America (the statute of limitations for insanity-related cases was three years at the time) also made them more vulnerable to deportation, and in fact, the New York Hospital Commission statistics showed that they were deported in greater proportion than those from western or northern Europe. Still, their overrepresentation among deported immigrants suggests, that they were also more likely to be targeted for deportation than patients from other parts of Europe: between 1908 and 1909, immigrant patients from Russia, Poland, Austria-Hungary, and Italy constituted about 60 percent of the “aliens” deported from New York state hospitals, while only 30 percent of the foreign-born first hospital admissions were from these countries.⁴⁸³ Until World War I, the percentage of the first admissions for those born in Austria, Hungary, Italy, and Russia (and Poland) remained at 39 percent of the foreign-born, but they continued to represent more than half of the deported aliens.⁴⁸⁴ The State Commission classified these “new immigrants” as a threat to the financial stability of the state and removed them in greater numbers, whether to their home countries or to other states, than the old stock patients. Their whiteness was rarely contested, but the conflation of nationality, religion, or language in defining the contemporary view of race facilitated exclusion and deportation of certain groups from the United States and enlisted the cooperation of mental hospital doctors.

At California state hospitals, a patient’s identity was, as in New York, shaped by various elements of skin color, nationality, and language; however, Chinese and Japanese patients with their relatively visible presence were more clearly marked and defined than

⁴⁸³ Ibid., 240. The number here is based on the Board of Alienists table of “Nativity of those deported.”

⁴⁸⁴ War time instability made it difficult to compare deportation and first admissions statistics. However, the outbreak of war in Europe did not change the admission pattern: “The changes in the race of admissions due to the war are not so great as was anticipated.” New York, State Commission, 30th *Annual report* (1919), 304. There was a slight increase in the number of first-admissions from Austria, Hungary, Russia, and Italy; between 1917 and 1919, they constituted over 40 percent of the foreign-born first admissions. During the wartime, New York, unable to deport southern and eastern European immigrants to their home countries, removed them to other states. Those who were born in Austria, Hungary, Italy, Poland, and Russia were more likely to be removed from the State of New York, constituting 56 percent of the foreign-born removal to other states. New York, State Commission, 25th *Annual Report* (1914), 154.

their European counterparts were in New York. As addressed in Chapter 1, government reports from the early twentieth century claimed that despite their numerous vices of crime, prostitution, and opium abuse, Chinese and Japanese were less likely to go insane than other immigrants and native-born Americans.⁴⁸⁵ However, California state mental hospitals, directly engaged with foreign inmates, offered different views of the Asian insane.⁴⁸⁶ In 1898, the First Biennial Report of the State Commission in Lunacy, California, pointed the finger at Chinese and southern European immigrants as main burdens of the state, who did not naturalize but continued to drain the state's resources. The report, adopting the rhetoric of humanitarianism, urged removal of these patients:

This [not taking out naturalization papers and acknowledging allegiance to foreign governments] is notably true of the Chinese, and a number of other patients who comes from the southern part of Europe. A large number of these foreign born patients have expressed a desire to return to their native countries, and in many cases it is the opinion of the medical authorities having them in charge that if it were possible to send them home, where they would be environed by the surroundings of their youth and the mode and manner of life to which they were accustomed before coming to this country, they would undoubtedly, if not entirely recover, at least be very much improved.⁴⁸⁷

Chinese were not eligible for naturalization, a fact the report ignored, and China lacked institutions to provide adequate care for the insane; what mattered most was to get rid the state of this insane and presumably inassimilable group. Japanese did not garner as much attention as Chinese at California state hospitals, but their special legal status under the 1907 Gentlemen's Agreement and subsequent immigration acts subjected them to intense surveillance and potential deportation. The California State Commission in Lunacy deportation statistics demonstrate that while a large number of southern and eastern European

⁴⁸⁵ Congress, House. Committee on Immigration and Naturalization, *Analysis of America's Modern Melting Pot: Hearings* (Report of Dr. Harry H. Laughlin.) 67th Cong., 3d sess., 21 November 1922.

⁴⁸⁶ California, Stockton State Hospital, 33rd and 34th *Annual Report* (1885/1886), 14. The Stockton superintendent complained about 70 Chinese (67 males and 3 females) under its care and declared: "[i]n proportion to the number of Chinese in the State, I consider mental disease particularly rife amongst them."

⁴⁸⁷ California, State Commission, 1st *Biennial Report* (1897-1898), 30.

patients were deported from the state, Chinese and Japanese patients stood out among the deportees. Between 1908 and 1914, a total of 380 alien insane were deported from California; Chinese constituted 27 percent (103) and Japanese 13 percent (49) of the 380 cases. Yet, during the same period, Chinese and Japanese together consisted of less than three percent of the general patient and less than five percent of the foreign-born patient population in California.⁴⁸⁸ In 1920, Chas. F. Waymire, Deportation Agent of the California State Commission in Lunacy, boasted about his work for the Commission with a table that showed “results obtained” since the organization of the Bureau of Deportation in 1915:

Nonresidents returned to their homes [other states]	789
Aliens deported by Federal authorities	518
Chinese returned to China	165
Japanese returned to Japan	71
Total	1,543 ⁴⁸⁹

This table illustrates that Chinese and Japanese patients were specifically targeted for deportation in the State of California.⁴⁹⁰ My Stockton State Hospital data show that between 1900 and 1920, about 30 percent (78) of 258 Chinese and Japanese inmates—compared to about seven percent for foreign-born patients—discharged were sent to their home

⁴⁸⁸ During the fiscal year ending June 30, 1914, the population at five California hospitals was 9,176 of whom 4,197 were of foreign birth, or 48 percent. Among 4,197 foreign-born patients, the largest groups were Irish (730), Germans (710), French (363), Italians (302), English (300), Austria-Hungarians (235), Chinese (128), and Japanese (64). By 1910, Chinese consisted of 1.5 percent and Japanese 1.74 percent of the general population of California. Given the age distribution of Chinese and Japanese in California, these groups were underrepresented among the hospital population. The number of Italian deportees was quite high; it might have been due to the precarious racial position of Italians in the West during the time period.

⁴⁸⁹ California, State Commission, 12th *Biennial Report* (1919-1920), 22. During the same period, the federal government deported only five Chinese and six Japanese; the rest were removed by the State or by the patients’ friends or relatives. After 1920, the number of Chinese and Japanese deportees became quite small, fewer than 10 biennially, but they continued to be singled out. The State Commission, which became the Department of the Institution in 1920, marked Chinese and Japanese in the table “results obtained” and added Filipinos (not excluded by the National Origins Act of 1924, but still undesirable) in 1932. They also began to pay more attention to Mexicans, which reflects social, economic, and political concerns of the time period.

⁴⁹⁰ U.S. Department of Labor, *Annual Reports of the Commissioner-General of Immigration to the Secretary of Labor*, 1915-1920.

countries.⁴⁹¹ That is, Chinese and Japanese were more likely to be returned home than general inmates and other foreign-born patients. Lengthy stay or residence in the state did not protect them from deportation.⁴⁹² Shimizu, a thirty-three-year-old Japanese inmate at Stockton, had been in America for ten years at the time of his commitment in 1908, but he was “deported” to Japan as “improved” when he was discharged in September 1910.⁴⁹³ Forty-eight-year-old Chinese Yee, who had been in the United States for his entire life (forty-eight years) and in California for thirty-five years, was discharged “improved to China” in 1919, two years after his commitment to Stockton.⁴⁹⁴ These insane Asian inmates became easy targets of deportation because their family, friends, and governments were often willing to cooperate with the State Commission and also because their racial differences—skin color, nationality, religion, and language—combined with the discriminatory immigration acts rendered them vulnerable to removal.⁴⁹⁵

Deportation cases of the “alien insane” from New York and California state institutions allude to the racialization and marginalization of the immigrant patients as different, financially burdensome, and undesirable. That certain “racial” or “national” groups were disproportionately represented in the deported cases indicates that racial or national identity, no matter how arbitrarily defined, influenced the lives of the “alien insane,” and the

⁴⁹¹ Out of 405 Stockton Chinese, Japanese, and Korean patients, 258 were discharged and 133 died. At California state hospitals between 1910 and 1914, deportation by government warrants and by friends and relatives accounted for about 7 percent of all discharges and 7.7 percent of foreign admissions. California, State Commission, *Biennial Reports*, 1909-1914.

⁴⁹² My Stockton data show that more than 60 percent of these deported/sent-back patients had been in the U.S. or California for over six years (about 44 percent had been more than 10 years) before they got committed to Stockton State Hospital. They contrast with the Buffalo State Hospital statistics, in which the majority of deported or sent-back patients (20 out of 22) had been in the United States for five years or less at the time of their commitment, thus eligible for federal deportation. For Chinese deportation under the general immigration laws, see Lucy E. Salyer, *Laws Harsh as Tigers: Chinese Immigrants and the Shaping of Modern Immigration Law* (Chapel Hill: The University of North Carolina Press, 1995).

⁴⁹³ Stockton, Admitted in November 1908 and discharged in September 1910. Deported to Japan.

⁴⁹⁴ Given the years he had been in the United States, it is likely that he was born in America. However, his “nativity” was recorded as China.

⁴⁹⁵ For the Japanese attitudes toward Japanese immigrants in America, see Eiichiro Azuma, *Between Two Empires: Race, History, and Transnationalism in Japanese America* (New York: Oxford University Press, 2005).

hospital authorities, who selected and reported those deported and returned home, determined their fate.

*Languages in Patient Case Files*⁴⁹⁶

Despite the inconsistent use of references to “race” as a category, the hospital case files show that race was an important part of a diagnostic process for those who escaped deportation and stayed at state mental institutions. For instance, examining doctors needed to take into account immigrant patients’ cultural background and beliefs as well as their racial, national, or linguistic traits.⁴⁹⁷ According to Gerald N. Grob, psychiatrists at the turn of the twentieth century were in large part motivated by humanitarian interests and struggled to come up with accurate diagnoses for their patients; however, even for experienced doctors, diagnosing patients, particularly those who could not provide enough information, posed a challenge.⁴⁹⁸ The two most common diagnoses at state hospitals during the period were manic-depressive psychosis and dementia praecox, known today as schizophrenia. Psychiatrists themselves admitted the difficulty of distinguishing the two, and their attempt to scientifically classify diagnoses was not always successful. When “a satisfactory history” was not available, doctors often had no choice but to place such patients in an “unclassified

⁴⁹⁶ For immigrants’ language problems, translation, and mental illness detection at Ellis Island, see Nancy Carnevale, *A New Language, A New World: Italian Immigrants in the United States, 1890-1945* (Urbana: University of Illinois Press, 2009). For psychological studies of immigrants, see Stanley Sue and James K. Morishima, *The Mental Health of Asian Americans: Contemporary Issues in Identifying and Treating Mental Problems* (San Francisco: Jossey-Bass Publishers 1982). Problems with communication were not limited to American institutions; Wulf and Schmiedebach show in their examination of the Friedrichsberg Asylum in Hamburg, Germany that doctors at German institutions, especially in port cities, had difficulties communicating with foreign patients, who had been deported from the United States. A majority of these patients were from Eastern Europe. Wulf and Schmiedebach, “„Die sprachliche.“”

⁴⁹⁷ Anne Fadiman’s study on epilepsy among Hmong immigrants, although of much later period, well illustrates that in order to understand an illness both patients and doctors needed to recognize each other’s cultural references and beliefs. *Spirit Catches You The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus and Giroux, 1998).

⁴⁹⁸ Grob, *Mental Institutions*.

group.”⁴⁹⁹ Medical practitioners took several steps to reach a diagnosis. They examined a patient mentally and physically upon hospital admission and made a tentative diagnosis; through several interviews with the patient they thereafter confirmed or changed the diagnosis. Doctors also had conferences with each other (mostly three doctors present, sometimes four) and on occasion settled upon a tentative result until they gathered more information about the patient’s mental condition. In many cases, the tentative diagnosis became definite upon approval of the superintendent and was subsequently entered into the patient’s case file. State hospital doctors used physical examinations, photographs, and later, the Wasserman test for syphilis, as scientific diagnostic means⁵⁰⁰; still, they needed to collaborate with petitioners, informants, and patients themselves to reach a diagnosis.

Languages used by immigrant patients became an important tool to categorize and file them as the patients were involved in the process of mental examinations and interviews; however, this tool often failed to define who these immigrant patients were and was limited in usage for the difficulty of communication.⁵⁰¹ Given the contemporary understanding of race that conflated nationality, language, skin color, and religion, it may be possible that patients’ languages functioned as a kind of racializing marker for state hospital doctors. As early as 1898, the first *Biennial Report* of the State Commission in Lunacy, California, explained: “It is also a notable fact that the percentage of insane is larger among those of foreign birth who do not talk English, than among those who do; which may probably be

⁴⁹⁹ New York, State Commission, 19th *Annual Report* (1908), 1055. It discussed the “unclassified group.” The majority of the 23 patients who belonged to the group were immigrant patients.

⁵⁰⁰ At Buffalo, the admissions page included patients’ photos—one front, the other profile—and in some cases, a before-and-after type of photos, perhaps to show the successful work of the hospital. However, it is not clear how these photographs were used at Buffalo, other than to identify its patients in case they escaped from the hospital.

⁵⁰¹ For ritual aspects of border encounters through the creation of Chinese immigrant files, see Adam McKeown, *Melancholy Order: Asian Migration and the Globalization of Borders* (New York: Columbia University Press, 2008). Patient case files were similar to immigrants’ entry files in a way that they were not necessarily about medical care but about classifying and putting the patients and their records in right places.

accounted for on the ground that their ignorance of the English tongue tends to isolate those who do not speak it, and therefore makes their struggle for life harder and their mental depression greater.”⁵⁰² This statement might be considered a humanitarian reference to the hardships of immigrants; however, that this came right after the discussion of Russian patients and their overrepresentation among the hospital inmates suggests that it targeted certain immigrant groups and questioned their mental state. In 1912, the New York Board of Alienist reported similar ideas but saw immigrant patients without sufficient knowledge of English as more troublesome and problematic. It complained that the non-English speaking “alien insane” were “less able to appreciate the intentions of doctors and nurses,” and that “the cost of their care is considerably greater than the average for all patients.”⁵⁰³ A recommendation for New York hospitals even stated that “the alien insane, who are not able to speak the English language, should be segregated in some special institution in which their native language would be spoken,” although it was deemed impracticable.⁵⁰⁴ While not so visible as skin color, language differences could mark immigrant patients, and their inability to speak English rendered them ignorant and troublesome and even warranted physical segregation from native-born American patients.

The language barrier was noted with interest but not always addressed. State hospital doctors often made notes on the case files of immigrant patients that they could not obtain information due to language difficulties and that they would be able to learn more once an interpreter became available. One case file from Buffalo State Hospital included a note from an attending doctor: “It is not possible to communicate with him [the patient] except through

⁵⁰² California, State Commission, 1st *Biennial Report* (1897-1898), 32.

⁵⁰³ New York, State Commission, 25th *Annual Report* (1914), 78. The Board of Alienists had allocations for interpreters, which added to the cost of care for immigrant patients.

⁵⁰⁴ *Ibid.*, 56.

an interpreter, and none is at present available.”⁵⁰⁵ Another file read: “No interpreter is available that can speak the native tongue of the patient, and as he does not understand English it is impossible to make a thorough mental examination.”⁵⁰⁶ State hospital doctors, like immigration officials and Public Health Service officers at Ellis Island, hired interpreters to better understand the mental condition of the immigrant patients. However, the help of interpreters was not always reliable and the limited resources of state institutions restricted their use. In some cases, social workers, including those who worked for the International Institute under the auspices of the YWCA, were called in to state institutions or private hospitals to act as interpreters for immigrant patients. They were warmly welcomed by nurses and doctors.⁵⁰⁷ On other occasions, hospital staff turned to former employers, relatives, or friends of the immigrant patients to act as interpreters, who were themselves not fluent in English. When the hospitals failed to secure even their help, doctors, ward attendants, or other patients from the same language backgrounds helped with communication. The New York State Hospital Commission acknowledged the contribution of attendants: “it has been shown that attendants speaking the language of the alien insane patient are of great assistance in the diagnosis of the patient’s affliction and in the treatment thereof.”⁵⁰⁸ However, the number of foreign-language speaking attendants was “quite inadequate,” and doctors often solicited other immigrant patients’ help. In 1908, Polish-born Julius, committed to Buffalo State Hospital in February of the same year as an emergency case, “acted as interpreter for

⁵⁰⁵ Buffalo, Likola, admitted in November 1912 and deported in October 1913 to his home country, Austria. Diagnosis: “unclassified.”

⁵⁰⁶ Buffalo, Antony from Greece, admitted in October 1912 and deported in January 1913. Diagnosis: not given. He had been in the U.S. for 15 days when he was admitted to Buffalo State Hospital. Interpreter was hired to give more information in November 1912.

⁵⁰⁷ March 1923 report, International Institute of Niagara Falls, New York, IHRC. According to Stefan Wulf and Heinz-Peter Schmiedebach, steamship company employees and guards also acted as interpreters for mental patients. See Wulf and Schmiedebach, “„Die sprachliche Verständigung ist selbstverständlich recht schwierig.“ Die „geisteskranken Rückwanderer“ aus Amerika in der Hamburger Irrenanstalt Friedrichsberg 1909,” *Medizinhistorisches Journal* 43 (2008): 231-263.

⁵⁰⁸ New York, State Commission, 26th *Annual Report* (1915), 184.

another Polish patient and has done it very intelligently.”⁵⁰⁹ Mendocino State Hospital too utilized its own patient-interpreters. In the case of Tanaka, a Japanese woman committed in 1924, doctors, unable to communicate with her “due to language difficulty,” secured an interpreter for her. However, he was, according to the file, “unreliable due to his mental deterioration, so examination was unsatisfactory through him.” His identity was unknown, but he could have been another Japanese patient at the same hospital who was brought in to help doctors talk with Tanaka.⁵¹⁰ A patient-interpreter was also an informant for doctors.⁵¹¹ According to German scholars Stefan Wulf and Heinz-Peter Schmiedebach, immigrant patients at a German hospital often acted as interpreters for doctors and in some cases, even wrote case files of other patients, translating from the interviews they conducted and imbuing their own mental perspectives.⁵¹² No matter how unreliable or inefficient it might have been, without the help of interpreters—relatives, friends, employers, attendants, or fellow inmates—immigrant patients, unable to articulate their condition in English, became vulnerable to misunderstanding and misdiagnosis.

Medical practitioners also depended on the limited knowledge of English of their patients and tried to glean from their “broken” English speaking family relations, personal histories, hallucinations, and delusions. Joseph L.’s case demonstrates how much doctors relied upon patients’ own statements in determining their mental condition. This young man from Hungary was brought to Buffalo State Hospital in 1908 when he became restless and required restraint. Joseph L. told the doctors that he heard no imaginary voices, but in the second interview, the doctors learn that he “constantly hears voices calling him a thief, saying

⁵⁰⁹ Buffalo, admitted in February, 1908 and discharged for deportation in August 1908. Diagnosis: traumatic insanity.

⁵¹⁰ Mendocino, admitted on April 8, 1924, in California for 9 years.

⁵¹¹ Buffalo, admitted in September 1908 and discharged in May 1911. In U.S. for 28 years. Diagnosis: alcoholic psychosis.

⁵¹² Wulf and Schmiedebach, “Ver/rückte Anamnesen a la Friedrichsberg. Explorationen ausländischer Patienten durch mehrsprachige Mitpatienten in einer deutschen.” *Medizinhistorisches Journal* 45 (2010): 341-367.

he is no good, that he should be hung up, cut to pieces, etc.” One of the attending doctors, Dr. Frost, explained that this initial failure to detect his condition was “probably a mistake due to his [Joseph L.’s] imperfect English.”⁵¹³ Hallucinations or delusions were crucial to reaching a diagnosis, and in many cases, were visible to observant doctors; however, their reliance on the patient’s limited knowledge of English prevented them from making a correct diagnosis.

The language difficulty was not merely a practical concern for doctors because the inability to speak English was noted as one of the symptoms of mental troubles.⁵¹⁴ For recent immigrants, the language “handicap” was a hurdle to overcome, not a symptom of mental illness, but doctors underscored its possible medical implications, such as speech disorder or “word salad.” Patient case files from both New York and California fastidiously noted immigrant patients’ tendency to use foreign languages (for them, their mother tongues) in addition to their behavior, hallucinations, and delusions: “Two weeks ago began to talk Polish,” “Speaks Italian,” “Speaks only in German,” were some of the notes from the case files of the immigrant patients, including those who had been in the United States only for a brief period.⁵¹⁵ The language issue became more apparent during mental examinations at state hospitals, which required patients to have a considerable grasp of the English language and American society. At Buffalo, the mental examination for patients asked: attitude and manner, stream mental activity, general mental attitude, orientation, recent past, personal identification, retention, education and general experience, current events, counting and

⁵¹³ Buffalo, Joseph L., admitted in August 1908, and discharged in April 1919. Diagnosis: toxic exhaustive. He had been in the U.S. for one year, but instead of being deported, the case file recorded that he went to Hungary with a friend.

⁵¹⁴ For instance, in 1926, social scientist Marvin L. Darsie, in his examination of the mental capacity of American-born Japanese children, admitted that language barriers should be taken into account in examining immigrants and their children. He added: “It must not be overlooked, however, that the existence of pronounced language handicap may itself be indicative of lack of capacity to master the language adequately.” Darsie, *The Mental Capacity of American-born Japanese Children* (Baltimore: The Williams & Wilkins Company, 1926), 84.

⁵¹⁵ Dwyer, *Homes for the Mad*.

calculation, and writing, with a writing sample of the patient attached.⁵¹⁶ At Mendocino, doctors examined orientation; insight; hallucination & delusion; general memory; special memory; Masselon test; Ziehen test; association; stories; Finckh test; ethical test; holidays; general information; and sleep & dream⁵¹⁷ (For samples of the mental examinations, see Appendix D). These examinations aimed to test patients' mental acumen and fitness as future citizens and asked even immigrant patients to demonstrate their knowledge of American history, politics, and society as well as American norms and ideals set by doctors, and broadly, by American society. Doctors administering mental examinations made room for modifications, taking into account language barriers and educational backgrounds, so that they could test individual patients based on their capacities and conditions. For example, when a Polish woman who had been in the United States for almost two decades was unable to answer the questions for education and general experiences, the Buffalo State Hospital doctor in charge of her concluded: "this is most probably due to the fact that she does not read or write, is always taking care of her home, rarely goes out."⁵¹⁸ Her inadequacies were excused because she had done her duty as a wife and mother and nothing more than a maternal responsibility was expected of her. However, these examinations could confirm the undesirability of immigrant patients as ignorant and illiterate and distinguish them from other inmates. Doctors also expressed a doubt whether immigrant patients could ever make "good" citizens at the state hospital and outside the institutional confine.⁵¹⁹

⁵¹⁶ See Braslow, *Mental Ills and Bodily Cures*.

⁵¹⁷ Mendocino, Sally. Born in Ireland, indigent widow. By 1921, she had been admitted to state hospitals five times. Admitted July 1905, discharged October 1905. Readmitted April 1908 and paroled on January 1909. Admitted again in December 1910. The examination was conducted in February 1913.

⁵¹⁸ Buffalo, Josephine, admitted in May 1911 and discharged in Jan 1913 (she was paroled in June 1912 to the custody of her husband). Diagnosis: depressive hallucinations.

⁵¹⁹ The New York State Commission was aware of the possibility that the "alien insane" could become citizens; this posed another challenge to the State because once they became citizens, there was nothing to prevent them from enjoying the benefits the country or the state offered. See New York, State Commission, 26th *Annual Report* (1915), 188. As for immigrants' literacy, social work scholar Yoosun Park argues: "As a measure testing the fitness of aliens for the practice of American democracy the literacy test was, in any

Even when the “alien insane” had successfully proved intelligence, their language use put their mental condition in doubt. For example, insisting upon using English, when their language skill was limited, suggested a lack of insight. In an interesting reversal, Alice, a Hungarian-born female patient at Buffalo, earned distinction for her persistence in using English:

[She] Gave the impression of being decidedly childish. She refused to speak German or Polish although her English was very broken. Said smilingly, “I can talk English.” As a rule questions had to be asked in German because she could not grasp the English but after she had grasped the meaning she would insist that the question be repeated in English before she would answer.⁵²⁰

Maybe she really was inferior in her mental makeup, being childish, resistive, and delusional. However, Alice’s case suggests that patients’ attempt to convey themselves in ways they chose was often perceived by the doctors as a symptom of their unstable mental condition. Mendocino State Hospital, which kept more detailed records of interviews as well as transcripts of clinical conferences, had similar examples. Talking too much, especially in an incomprehensible language, invited scathing remarks from doctors. Consider the mental examination of Greek patient Adrian:

Doctor: The trouble is, you are crazy now?

Patient: No.

Doctor: Yes; you talk too much.

Patient: I can’t help it.

One of the doctors present at his examination concluded: “I think the great difficulty is the language question and it is very hard to value the situation.” Nevertheless, the doctors

case, a proxy measure for the imbricated categories of race, culture, and class hazards contained in the immigrant body.” Park, “Constructing Immigrants: A Historical Discourse Analysis of the Representations of Immigrants in U.S. Social Work, 1882-1952,” *Journal of Social Work* 6, no. 2 (2006): 169-203, 191. See also Carnevale, *New Language*; Jeanne D. Petit, *The Men and Women We Want: Gender, Race, and the Progressive Era Literacy Test Debate* (Rochester, NY: University of Rochester Press, 2010).

⁵²⁰ Buffalo, admitted in July 1920, and discharged in August 1920, in the U.S. for seventeen years. Diagnosis: dementia praecox, simple type-seclusive. It is not clear why she was interviewed in German when her patient case file noted that she spoke Hungarian.

diagnosed Adrian with dementia praecox, paranoid type.⁵²¹ The case of Tanaka, the Japanese female patient at Mendocino, is also revealing. Her clinical conference note read: “Patient does not seem to comprehend questions, or will not answer them. Repeats, “I like to go home, open door please,” over and over again.” One of the Mendocino doctors expressed his frustration: “I do not think she is fit to go home if she is that persistent, unless it is a language difficulty.” For him, Tanaka’s deteriorated mental condition—here, unreasonable persistence—was indiscernible from her problematic language use.⁵²² Given the contents of the questions and patients’ inability to understand them, these examinations were not a scientific means to measure the mental state of the inmates but rather a procedure to classify and categorize them. Even when doctors were unable to conduct mental examinations due to language barriers or incompetence of the patients, they almost always came up with a diagnosis.

In addition to hampering the interactions between doctors and patients, immigrant inmates’ languages were closely linked to the notion of “race.” State hospital medical practitioners did not express explicitly racial or racist attitudes toward immigrant patients, but they saw how different these patients were through the language barriers and through their own muddled contemporary view of “race.” For example, at Buffalo State Hospital, doctors often noted that they could not communicate due to the patients’ limited knowledge of English and “German”; as the case of Alice previously mentioned shows, not only German patients but also those from Russia or Hungary were expected to understand German. It could be that at that time, German was a lingua franca of American state institutions as many

⁵²¹ Mendocino, born in Constantinople, Turkey but his nativity was recorded as Greece. Admitted in October 1920. Long-term patient. Diagnosis: dementia praecox.

⁵²² Mendocino, admitted in April 1924, in California for 9 years. Hospital did not keep a good track of paroled patients. In 1927, Tanaka left the hospital in the care of her cousin, who also acted as an interpreter and promised to bring her back at the end of the six-month parole; in 1934, she was discharged as “recovered in as much as we have not received word from her for the last seven years.”

doctors had been familiar with German medical training; that many European immigrant patients might have worked or lived in Germany prior to their immigration to the United States, German ports being popular embarkation points; or, that the hospital record keeping, despite its attention to details involving patients' personal histories, was merely for statistical purposes to manage and file patients and not to provide proper medical understanding and care for the patient population. At Mendocino State Hospital, doctors noted that one of their patients, Austrian-born Sophie, a thirty-seven-year-old housewife, "frequently expressed her difficulty in comprehending English." However, the doctors too had difficulty (or did not pay attention to) matching her background with her language use. They noted in several occasions: "[she] Talks in foreign language"; "when I ask her questions she talks to the attendant in Italian"; "[she] talks to self in Russian; "Her talk was incoherent and silly, mutters to self a great deal in Austrian"; "Replies to questions in a foreign language."⁵²³ She might have been a multilingual, but it is doubtful whether the doctors or attendants understood which languages she was using on each occasion. Despite the information that her commitment papers and hospital admissions form provided, identifying her challenged the doctors.

The conflation of language, nationality, and color became pronounced with the Asian inmate population. The elaborate racial stratification system of the early twentieth century as well as the changing international politics distinguished Chinese and Japanese; nevertheless, Americans, both professional and lay, rarely separated the two.⁵²⁴ Hospital staff was not

⁵²³ Mendocino, committed in July 1916. Long-term patient. In California 16 years. Diagnosis: dementia praecox, catatonic. Her husband was Italian, so she could have spoken and understood Italian.

⁵²⁴ Mary Ting Yi Liu, *Chinatown Trunk Mystery: Murder, Miscegenation, and Other Dangerous Encounters in Turn-of-the-Century New York City* (Princeton: Princeton University Press, 2005); Peggy Pascoe, *What Comes Naturally: Miscegenation Law and the Making of Race in America* (New York: Oxford University Press, 2009). Pascoe discusses sexualization and racialization of Asian Americans in the West by examining miscegenation laws. Also see Nayan Shah, *Stranger Intimacy: Contesting Race, Sexuality, and the Law in the North American West* (Berkeley: University of California Press, 2011) for homosocial and homosexual intimacies among immigrants.

much different when it came to determining Asian immigrant patients' identity. For example, the Mendocino State hospital files recorded only the nativity of patients, but the ways in which the hospital authorities interacted with their inmates reveal complexities that demographic information or physical appearance alone could not tell. In 1914, Wong, whose nativity had been left unrecorded at the time of her commitment, was brought to Mendocino State Hospital from the Oriental Home where she had stayed since the San Francisco fire of 1906. Doctors had trouble figuring out who she was. Her commitment paper stated that she was deaf and dumb; however, they soon found out that she would answer their questions but rarely cooperate. Interpreters were hired to obtain information from her; yet, they failed to determine who she was. First, a Chinese interpreter was brought in, but he thought she was Japanese "from the way she dressed her hair, the way she looked, her mannerisms, etc." Then, a Japanese interpreter was hired to no avail; he could not understand her at all. Later, Wong volunteered information to the Chinese interpreter, though not enough to satisfy the hospital doctors, and gave them her real name. Despite the lack of information, there was no doubt that Wong was an "Oriental" after all.⁵²⁵ Even without fully communicating with her, the Mendocino doctors went on to diagnose Wong with dementia praecox.⁵²⁶

This attention, or lack thereof, to languages, in addition to clothes, looks, and mannerisms examined in Wong's case, is also explained by doctors' identification of native-born patients with the use of English; they negated claims of native birth or belonging by the patients who were unable to speak proper English. Thus, those who were born in the U.S. but could not be classified as "American" (that is, white) were subjected to greater scrutiny in

⁵²⁵ The general observation section described her as "Slender, poorly developed, and poorly nourished Oriental woman."

⁵²⁶ Mendocino, Wong, admitted in April 1914 and died of tuberculosis in October 1926. In California for 7 or 8 years. Diagnosis: dementia praecox (tentative). Similar language problems also existed for American doctors in China due to many dialects of Chinese patients. See Charles C. Selden, *Work among the Chinese Insane and Some of Its Results* (Canton, China: The China Baptist Publication Society, 1903).

terms of their language use. At Mendocino State Hospital, twenty-one-year-old Chinese laborer Hong, born in San Francisco, was not fluent in English and his “speech” was recorded to have “Chinese accent and dialect.” During his mental examination, one of the conferring doctors asked: “Why can’t you talk English? Weren’t you born here?” Hong answered, “I go China,” suggesting that he recently came back from China. His inability to speak English despite his birth in the U.S. frequently appeared on his ward notes. One of the notes read: “[he] says he is not a Chinaman but an American.”⁵²⁷ The absurd notion of a Chinese man claiming to be an American confirmed his lack of insight and his insanity; however, the actual value of the statement—he was born in the U.S., and by birthright he was an American—was buried under his inability to speak fluent English as well as his physical appearance.

In spite of these language difficulties, some immigrant patients were able to express their distress during their examinations and interviews. Italian-born Agostina’s frustration was noticeable enough to earn a short sentence in his Buffalo case file: he “tries to make us understand him and looks disgusted when we do not comprehend his language.” He used “pantomimes” to make the doctors understand his personal history and succeeded in conveying his ideas, to some degree.⁵²⁸ Others refused to answer any questions without an interpreter, or talked only to patients from the same language background. Despite the Norwegian psychiatrist Ø. Ødegaard’s assertion that difficulties of immigration experiences did not have much impact on patients’ mental condition, the language barriers indeed shaped patients’ lives. Pablo from Italy “has suffered from dizzy spells and thinks it was due to lack of association, not having anyone to talk to as he lived with English people, and

⁵²⁷ Mendocino, Hong, committed in June 1916. Long-term patient. Diagnosis: dementia praecox, hebephrenic. Hong seems to have been following a Chinese girl, about whom he made obscene remarks.

⁵²⁸ Buffalo, Agostina, admitted in May 1903 and discharged recovered in June 1903. In the U.S. for one year. Diagnosis: acute mania.

lonesome.”⁵²⁹ Another patient at Buffalo, John N., was “very pleased when he finds someone to talk Polish with him.”⁵³⁰ Patients also complained about living conditions, especially food, at state institutions. Hong, the Chinese patient, when asked about food at Mendocino, replied that he wanted Chinese rice and didn’t like the food there.⁵³¹ Doctors and hospital staff carefully noted the difficulties in communicating with immigrant patients and their seemingly unreasonable demands. However, they were neither equipped nor willing to deal with these issues, which they saw as an indication that immigrant patients were costly, incomprehensible, and unmanageable. State hospitals and Commissions were scrupulous in recording nationality, language, and when available, “color” or “race” of their patients, but they could always resort to a convenient label of “foreign-born” to diagnose and treat and define the “alien insane” and define these immigrant patients.

Gender and Sexuality at State Institutions

At state mental hospitals, immigrant patients’ race was intersected with their gender and sexuality, which were closely tied to the contemporary concerns and anxieties about immigrants to the United States. Immigrants were expected to adhere to gender norms and sexual mores of American society, and by doing so, demonstrate their fitness as potential citizens.⁵³² Medical professionals conformed to and participated in the contemporary discourse of gender and sexuality, and mental institutions offered a site where proper gender norms were constructed and tested. Historians of psychiatry have described gender

⁵²⁹ Buffalo, Pablo, admitted in July 1920 and deported in March 1921. In the U.S. for about a month at the time of commitment. Diagnosis: dementia praecox.

⁵³⁰ Buffalo, John N., born in Poland, committed in September 1908 and discharge about a month later. Diagnosis: toxic exhaustive. He had been in the U.S. for 2 years by the time of his commitment, but it is not clear from the file why he was not reported for deportation.

⁵³¹ Mendocino, Hong, His case files read: “he demanded breakfast and tomatoes. He complained about the food at the state hospital and demanded Chinese rice.”

⁵³² Donna Gabaccia, *From the Other Side: Women, Gender, and Immigrant Life in the U.S., 1820-1990* (Bloomington: Indiana University Press, 1994); Moloney, *National Securities*.

differences among hospital patients in terms of their behavior, causes and symptoms of insanity, diagnoses, and treatments. Both men and women suffered from distress and depression, but female patients were more readily associated with emotional suffering and troubles related to reproduction—“she is more troublesome and more violent when menstruating, and each time when pregnant”⁵³³—while male insanity was linked to violent, homicidal, or destructive behavior. Contrary to the popular belief in higher rates of insanity among females, commitment rates at state hospitals did not vary by sex. The sex ratio at New York and California institutions was relatively balanced. The ratio for Asian patients in California was severely skewed but it reflected that of the general Asian population in early twentieth-century America.⁵³⁴ Women, both American and immigrant, were more strictly governed by the conventional gender norms, deviation from which led to greater doubts about their mental condition.⁵³⁵ For example, in 1903, an Italian-born woman was committed to Buffalo by her husband’s petition because “[she] wanted her husband to change clothing with her; that she would go to work at the Steel Plant [in Buffalo] and he would do the housework.”⁵³⁶ As a result of overstepping the proper gender boundaries, she was committed to the mental institution. Hospitals also played a disciplinary role for their patients: when English-born Mary W., six months after being paroled to her husband, applied to Buffalo

⁵³³ Buffalo, Ida, admitted on April 11, 1903, and died in 1941. Diagnosis: dementia praecox, paranoid. This statement came from her husband.

⁵³⁴ My records from Buffalo State Hospital have 29 female and 47 male immigrant patients, but the sex ratio of the general inmates at Buffalo during the early twentieth century was relatively balanced with slightly more male patients. At Stockton, out of 405 Asian patients, only 21 were women (19 to 1 male to female). During the period, the Chinese male to female ratio was around 15 to 1. While a number of Asian men were committed from penitentiaries or jails, Asian women had less contact with the American penal institutions.

⁵³⁵ See Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (New York: Virago Press, 1987); Gregg Andrews, *Insane Sisters: Or, the Price Paid for Challenging a Company Town* (Columbia: University of Missouri Press, 1999).

⁵³⁶ Buffalo, Lucy, admitted in April 1903, and died six days later of acute delusional mania. Years in the U.S. unknown. Diagnosis: acute mania.

State Hospital “for protection [from her abusive husband],” she was admonished to “better give up her foolish notions and do as her husband told her.”⁵³⁷

While immigrant women were evaluated by their conformity to the American gender norms, both men and women were expected to display an ability and willingness to work as a test of their mental stability and their desirability as potential citizens; after parole or discharge, their work habits were taken as evidence of recovery.⁵³⁸ Hospital doctors acknowledged that a large number of patients, both native- and foreign-born, were discharged as recovered or improved and continued to live their lives in American society.⁵³⁹ For example, Buffalo had a reeducation school for female patients (10 to 20 attended), and it taught female immigrant inmates the English language and American ways so that they could better adjust to the outside world once discharged.⁵⁴⁰ In addition to having a therapeutic value, work was particularly important for male patients as supporters and breadwinners of their family. Doctors looked approvingly at immigrant patients who were good ward workers and carefully noted patients’ ability or willingness to work before and after their discharge from state mental institutions. For example, Austrian-born Walter’s ward note at Buffalo read: “He shows good insight, has a natural feeling for his family and is anxious to go out and support them.” For doctors, this evidenced his mental improvement, and he was paroled to go home with his wife. Sometime later, Walter reported to the hospital that he had been regularly employed and “gets sufficient wages to support his family.” After six-month parole, he was discharged as recovered.⁵⁴¹ In the 1910s, social workers in New York began to visit

⁵³⁷ Buffalo, admitted in April 1911 and discharged in November 1911. In U.S. for 2 years. Diagnosis: paranoiac condition.

⁵³⁸ For African American patients at St. Elizabeths Hospital, see Matthew Gambino, “‘These Strangers within Our Gates’: Race, Psychiatry and Mental Illness among Black Americans at St Elizabeths Hospital in Washington, DC, 1900-40,” *History of Psychiatry* 19, no. 4 (2008): 387-408.

⁵³⁹ For doctors’ effort to reintegrate patients, see Gambino, “These Strangers.”

⁵⁴⁰ New York, State Commission, 25th *Annual Report* (1914), 370.

⁵⁴¹ Buffalo, admitted in August 1913, and discharged as recovered in April 1914, in the U.S. for 6 years. Diagnosis: allied to infection-exhaustive.

paroled patients and report to the hospital about their progress; most reports were concerned with the patients' occupation, noting whether or not they worked during parole. As former inmates, many of them found it difficult to get hold of a suitable position. In the case of Mike, a Russian immigrant, "It was then learned that patient applied for work to his former employer but was refused until he could show a note from the doctor stating that he was well."⁵⁴² However, immigrant patients were not as clueless as doctors often thought them to be. Some realized that mental hospitals exploited and benefited from their ward work and demanded to be paid. Greek-born Dennis, a former patient at St. Elizabeths, complained to the hospital superintendent that he lost his "practice" as a pastry cook because of his institutionalization and he now had "to be a dish-washer to make my living." Having difficulty in earning a decent living and believing that his commitment had been unjust, Dennis demanded compensation for his work at St. Elizabeths during his thirteen-year commitment. To the doctors, however, this demand reflected the former patient's unstable mental condition because, as they wrote to Dennis, his work was to help him recover and therefore could not be remunerated.⁵⁴³ Whether as a form of therapy or as proof of recovery, working and becoming industrious members of society assured doctors of the immigrant patients' sanity.

⁵⁴² Buffalo, admitted in August 1916, and discharged in January 1917 (allowed to leave the hospital with a friend in September 1916). Born in Russia Poland, in the U.S. for 3 years. Diagnosis: alcoholic. A social worker who visited him reported: "[I] was informed by the boarding house keeper that patient went back to the old country a month ago. As the informant could speak very little English, it was impossible to learn anything further regarding patient." Not only the doctors but also social workers had to deal with the language barrier.

⁵⁴³ Case files of patients, 1855-1981 (bulk 1855-1950), St. Elizabeths Hospital, RG 418, National Archives, DC. He was admitted to the hospital in 1910 and sometime in 1921 he began to contact his "relatives" (fellow Greeks, according to the doctors) and the Greek consulate to secure his release from the hospital and to go back to Greece. He had taken out his naturalization paper and anglicized his name. The doctors at St. Elizabeths did not allow his release because they believed that he would not be able to make adjustment to society; however, as his condition improved, Dennis was paroled to the care of his friends and discharged later. He began writing letters demanding payment after his discharge in 1923 until 1925: one of the letter states, "Since I had been discharged of this Hospital, it's one year and eleven months in which I am waiting day by day to pay me for my work service in this Hospital's sick ward for thirteen years in which I suffered heavily in cleaning the dirty of the sick people and scrubbing the floor and the toilet of the ward." His file did not have a record of what happened to him afterward.

State mental institutions took careful note of patients' history of sexual intercourses and habits such as masturbation, for example, more commonly reported for male patients. Joel Braslow argues that doctors were more lenient toward the display of male sexuality than that of female sexuality.⁵⁴⁴ That is, while female sexuality—immoral behavior, including prostitution, masturbation, and pregnancy out of wedlock—was looked down upon and blatantly criticized, male patients' sexual appetites and urges were considered natural. However, when these desires came from immigrant, especially non-European, non-white men, they caused anxieties that often resulted in heightened regulation and surveillance of their behavior. Gender and sexual propriety set by American society governed interracial intimacies, associating protection of native-born white women with that of the nation.⁵⁴⁵ As racist ideas were firmly ingrained in everyday American life, nativists feared that growing social interactions and sexual intimacies between native-born Americans and new immigrants (Jews, for example) would pollute the nation.⁵⁴⁶ Anti-miscegenation sentiments were particularly ripe in the West, where many states passed laws in the late nineteenth and early twentieth centuries to condemn, if not completely eliminate, interracial unions between Asian men and white American women. Asian women were blamed for corrupting American men (Chinese prostitutes) and for challenging racial stability of the nation (high fecundity of Japanese women), but the skewed sex ratio among Asian immigrants exempted these women from the contemporary anxiety about interracial unions.⁵⁴⁷ It was Asian "bachelors" without

⁵⁴⁴ Braslow, *Mental Ills and Bodily Cures*, 164.

⁵⁴⁵ Shah, *Contagious Divides*; Nicola Kay Beisel, *Imperiled Innocents: Anthony Comstock and Family Reproduction in Victorian America* (Princeton: Princeton University Press, 1998); Brian Donovan, *White Slave Crusaders: Race, Gender, and Anti-Vice Activism, 1887-1917* (Urbana: University of Illinois Press, 2006).

⁵⁴⁶ Walter Benn Michaels, *Our America: Nativism, Modernism, and Pluralism* (Durham: Duke University Press, 1995).

⁵⁴⁷ For Chinese prostitutes, see Lucie Cheng Hirata, "Free, Indentured, Enslaved: Chinese Prostitutes in Nineteenth-Century America," *Signs* 5, no. 1 (Autumn 1979): 3-29. For Japanese women and their reproduction, see Nancy F. Cott, "Marriage and Women's Citizenship in the United States, 1830-1934,"

any possibility of domestic life that posed more danger; as an embodiment of the Yellow Peril, they were believed to threaten racial purity and sanctity of white womanhood, despite the popular stereotype of Asian men as effeminate or emasculated. Sexuality of immigrant men did not garner as much interest or attention as that of African-American men, which often led to lynching in the South; however, their sexual behavior could brand them as insane and result in their commitment to a mental hospital for deviating from American sexual mores.⁵⁴⁸

At state hospitals, some of the common symptoms of insanity among male immigrant inmates included: fear of being poisoned, fear of persecution, delusions of great wealth, religious fervor, and being filthy, noisy, incoherent, incendiary, homicidal, or suicidal.⁵⁴⁹ In addition, they suffered from hallucinations or delusions of having intimate relationships with white, presumably native-born American, women. At state institutions, immigrant sexual fantasies were rarely reported for white males, but the media exploited them. On December 3, 1907, the *New York Times* published an article on a Swedish man, who had been deported twice for insanity but was back again in New York City, singing in the chorus of “Tom Jones.” He was recognized by one of the attendants from Central Islip State Hospital, New York, where he had been committed before his second deportation. According to the article, he did not mind being deported again, but “he is in love with an American girl and would like to make this country his home.” Interestingly, one of the sub-headlines of the article was “American Girl the Magnet,” which rendered his attachment to an American woman problematic and sensationalized the appeal of an “American girl” to a foreign man.

American Historical Review 103, no. 5 (1988): 1440-1474. See also for interracial intimacies, Shah, *Contagious Divides*; Pascoe, *What Comes Naturally*; Lui, *Chinatown Trunk Mystery*.

⁵⁴⁸ Lui, *Chinatown Trunk Mystery*; Pascoe, *What Comes Naturally*; Shah, *Stranger Intimacy*; William F. Wu, *The Yellow Peril: Chinese Americans in American Fiction, 1850-1940* (Hamden, CT: Archon Books, 1982).

⁵⁴⁹ For patterns of diagnoses for Chinese inmates between the 1850s and the 1950s, see Bernard Berk and Lucie Cheng Hirata, “Mental Illness among the Chinese: Myth or Reality?” *Journal of Social Issues* 29 (1979): 149-166.

Another case concerned August Probst, a young Swiss butler, who claimed that he would be deported for insanity because of “a romance with a young woman of wealthy family” in Pittsburg, Pennsylvania. Probst stated that in 1922, he met two young ladies at a club where he worked as a butler, and one of them expressed her love for him. When her family found out, he was fired from the club, was brought to New York City in the middle of the night by private detectives, held at one of the detectives’ home for two days, arrested for deserting from the steamer *Olympic* where he had been a steward, and taken to the Ellis Island Immigration Station for deportation. There, he was examined by two doctors and pronounced insane. One of the doctors claimed that Probst was suffering from “a form of paranoia” and explained that “the stories he told might be based on facts” but “the conclusions drawn from his own premises were distorted.” The second mental examination concluded that he was suffering from a type of pseudo-paranoia, and his was “the imagined case of love-sickness.” Immigration officials were not sure whether to deport him for his desertion from the steamer or for his insanity. Eventually, Probst was deported as a Likely to Become a Public Charge case because his mental condition would render him unable to support himself.⁵⁵⁰ One of the newspapers summed up his mental condition: “In plain English it would mean that this Swiss boy fell violently in love with a young woman above his social station, which naturally upset him.”⁵⁵¹ Probst himself explained that his misunderstanding of the American norms caused the trouble: “He said he had mistaken the attitude of American

⁵⁵⁰ See “Butler’s Lawyer Quotes Love Tale,” *New York Times*, March 21, 1922; “Probst Put Back Into Insane Ward,” *New York Times*, March 31, 1922; “Probst Loses Fight Here: Deportation of Swiss Waiter Asked of Washington,” *New York Time*, April 20, 1922; “Probst Ordered Deported: Labor Department Rules He Is Illegally in the United States,” *New York Times*, April 27, 1922; “Kidnapping Charge of Probst Is Aired,” *New York Times*, May 7, 1922; “Halts Probst Deportation: District Attorney to Use Waiter as Witness in Kidnapping Charge,” *New York Times*, May 16, 1922; “Probst Ready to Go Back: Butler, Held for Deportation, Cured of His Infatuation,” *New York Times*, May 21, 1922; “Sleuths Indicted on Probst Charges,” *New York Times*, May 27, 1922.

⁵⁵¹ “Waiter Is Love-Sick, Alienist Believes,” *New York Times*, April 11, 1922.

girls when he thought they made love to him.”⁵⁵² This case might have been more about class differences than about a male immigrant’s sexual aggression, insanity, or race. However, Probst’s case emphasized his otherness as a poor immigrant and revealed the contemporary anxiety about male immigrants’ alleged sexual threat to American women.

California had a few cases of immigrant men chasing women, and it became more dangerous because of their race. In March 1931, the Commissioner of Immigration at the Angel Island Station instituted deportation proceedings on a Chinese man named Wong Jow, a public charge at Napa State (mental) Hospital, California. First entering the United States in 1921 as a Chinese merchant’s son, Wong Jow had made a visit to China in 1927 and returned to America one year later as a laborer. On July 12, 1930, he was committed to Napa State Hospital and diagnosed with “Dementia Praecox, Hebephrenic type.” His mental status was characterized by “auditory and visual hallucinations, and delusions of grandeur, and ideas about a white girl named Evelyn, whom he has seen in the moving pictures, is constantly importuning him to marry her.”⁵⁵³ It is not clear from the record whether he really had an affair with a white woman or whether everything was derived from his delusional mental state. However, the attention to his affair reveals how the contemporary ideas of race and sexuality pathologized Chinese male bodies at mental institutions specifically, and in American society generally.

At California state hospitals, several male inmates were believed to become insane due to “disappointed affections.” The question here was whether they pined for an imaginary or a real-life woman, and if the latter, who she was. In 1905, a Chinese clerk and cook, Wang, was committed to Stockton State Hospital. Among the facts indicating insanity—

⁵⁵² “Probst Sent Back to His Swiss Home,” *New York Times*, June 7, 1922.

⁵⁵³ Wong Jow, Case Files of Investigations resulting in warrant proceedings, 1912-1950, File 12020/17698, Box 4, RG 85, National Archives, San Bruno. He was deported for reasons that “he was a person likely to become a public charge at the time of his entry; and that he became a public charge within five years after his entry into the United States from causes not affirmatively shown to have arisen subsequent thereto.”

acting irrationally, singing constantly, noisy, destructive, not eating—was a brief statement: “Talks about marrying a white woman that he is in love with.”⁵⁵⁴ The register did not offer more information, but given that he was brought to the mental hospital, doctors might have concluded that this woman was a product of his mad imagination. Others were more active in their pursuit. Lock, a Chinese cook, who was committed to Stockton in July 1902, explained that “a woman had been stolen from him and [he] was searching for her—that he had had sexual intercourse with a woman but could not say whether she was a white woman or a Chinese.”⁵⁵⁵ Hiroichi from Japan, admitted to Stockton in June 1917, “writes annoying letters to employer’s daughter” and “[r]emarks about different strangers (ladies) trying to pay attention to him.” His register added that he “[c]laims to have peeked through bath-room key-holes, while young ladies were bathing.” He was discharged as unimproved from the hospital less than a month after his admission.⁵⁵⁶ The patient registers seemed to imply that these men invented imaginary women as a desperate attempt to deal with the problems of their “bachelor” community, although it is also possible that they had real relationships with these women. The reference to the racial identity of the women also suggests that male immigrants’ sexual relationships, especially with white American women, were perceived as an act of deviance verging on insanity. Other than tidbits from the commitment registers, detailed case files on such immigrants are hard to find, and it is challenging to medically label them; nevertheless, this particular indication of insanity reveals the kind of American society in which they lived and its desire to control alleged immoral and sexual behavior that

⁵⁵⁴ Stockton, admitted in April 1905. Discharged in June 1909 as recovered. Years in California unknown. Diagnosis: not given.

⁵⁵⁵ Stockton, admitted in July 1902 and discharged in October 1903 as improved. In California for 20 years. Diagnosis: dementia

⁵⁵⁶ Stockton, admitted in June 1917 and discharged in July 1917 as unimproved. In California for 12 years. Diagnosis: paranoia (manic depressive insanity).

crossed a racial line.⁵⁵⁷ Their forcible commitment and incarceration could have been justified as a means to bring peace and order to American society as well as to protect white womanhood; these immigrants, in addition to robbing American men of their jobs, were threatening to take their women away.

Interracial sexual intimacies mostly concerned male immigrants, and yet they could also produce disastrous outcomes for white women who willingly participated in such unions. Although I was unable to find any hospital files of white women going insane as a result of their marriage to Asians, newspapers from the period noted that interracial intimacies could be viewed as evidence of insanity. In 1912, the *San Francisco Call* reported that “[f]ive white women who married Japanese in Los Angeles have been sent to an insane asylum within the last year.” According to the article, “[i]t is a fair presumption that a white woman who deliberately accepts conjugal relations with an Asiatic is not mentally sound, and it is nowise surprising that she should in the outcome find her way into an insane asylum. Any marriage of this kind is a tragedy.”⁵⁵⁸ The newspaper showed that crossing the racial line proved to be dangerous not only for Asian men but also for white women. In March 1915, San Francisco-born sculptress Gertrude Boyle was taken to the Detention Hospital for mental observation; her sister took out a warrant charging her with insanity because Boyle fell in love with a Japanese artist, E. Ishigaki. Boyle had already been married to Japanese nobleman Takeshi Kanno, and her involvement with another Japanese convinced her family that “the non-conformist member was crazy.” Boyle herself acknowledged that it was her

⁵⁵⁷ Robert Menzies also argues that Canadian authorities took a strong measure against Chinese immigrants when they were believed to threaten “the security and sensibilities of ‘women and children’.” Menzies, “Race, Reason, and Regulation: British Columbia’s Mass Exile of Chinese ‘Lunatics’ aboard the *Empress of Russia*, 9 February 1935,” in *Regulating Lives: Historical Essays on the State, Society, the Individual, and the Law*, eds. Dorothy E. Chunn, John McLaren, and Robert J. Menzies (Vancouver: UBC Press, 2002), 196-230, 210.

⁵⁵⁸ Edward F. Cahill, “The Candid Friend,” *San Francisco Call*, August 4, 1912.

“unconventionality” that brought about the trouble she was in now.⁵⁵⁹ She neither conformed to the gender norms nor respected the racial boundaries. The two Japanese men involved with Boyle were depicted as effeminate and powerless, waiting to be chosen by her; nevertheless, the emphasis on their racial identity conveyed the threat they posed to the stability of the American family and American womanhood. By forming interracial relationships with Asian men who were ineligible for naturalization, white American women lost their citizenship and even worse, went insane; their immigrant partners were subject to greater losses, including the possibility of commitment and deportation.

Committing Immigrants at State Mental Hospitals

While the previous sections showed the ways in which medical practitioners and American society viewed insane immigrants, this section turns to immigrants themselves, who adhered to the rules of the American system but also used them to their advantage. Patient case files from New York and California were more than medical records; they shed light on daily activities and encounters among immigrant patients, their families and friends, hospital staff, and the American authorities. Scholars of immigration history have shown that newcomers were initially suspicious of American medical institutions and relied on their own communities for protection and care. According to historian Alan M. Kraut: “For the foreign-born, the hospital remained a frightening place... The foreign-born’s distrust of hospitals was an obstacle both to their own well-being and to the broader public health.”⁵⁶⁰ Immigrants

⁵⁵⁹ Soon released from the Detention Hospital, Gertrude struggled to win a divorce from her husband; four years later, Kanno finally agreed to divorce her. Gertrude and Ishigaki moved to New York after the divorce. See “Girl Artist Prefers Japs,” *Los Angeles Times*, March 13, 1915; “Second Japanese Wins the Love of Miss Boyle,” *San Francisco Chronicle*, March 13, 1915; “Her Family Has Artist Arrested on Insanity Charge and Placed in Hospital,” *San Francisco Chronicle*, March 13, 1915; “Seeking a Divorce from Japanese, Sculptress Must Prove Sanity,” *Washington Post*, March 18, 1915; “Again in Love with Japanese,” *Boston Daily Globe*, March 28, 1915.

⁵⁶⁰ Kraut, *Silent Travelers*, 199. He discusses both European and Asian (Chinese in particular) immigrant experiences with the American medical system. In his autobiography, F. Michele Daniele, an Italian-

avoided contact with American medical professionals for fear of separation from family and friends; they were also afraid that their reliance on the American medical system would stigmatize and even penalize them. Immigrant patients were aware of the “profoundly alienating cultural experience” of institutional committal as they were removed from the familiar environment and thrown into a strange community, often against their will.⁵⁶¹ However, as Chapter 1 shows, many immigrants had already been exposed to medical institutions both in home countries and in America; some had experiences with insanity themselves, knew it among their kin, and had seen mental institutions first-hand. For example, twenty-four-year-old Dominick at Buffalo had been at an insane hospital in Messina, Italy, for six months before he came to America in 1915. He reported that “St. Peter appeared to him and predicted the war” when he served in the army in Italy:

The vision impressed him greatly; he tried to tell the people and the officer of his regiment what he had seen and heard and that war would come upon the world unless the people were treated better. They, however, wouldn't believe him, wouldn't let him talk about it, and when he persisted sent him to a hospital for the insane, “La Croce Rossa Mandalare” in Messina where he was confined for six months.⁵⁶²

Immigrants like Dominick with previous attacks of insanity were excluded by the immigration acts, but he somehow managed to gain entry and ended up becoming a public charge at Buffalo State Hospital.

American doctor, also stated that Italian immigrants in early twentieth-century America showed a general fear of all hospitals. See Daniele, *Signor Dottore: The Autobiography of F. Michele Daniele, Italian Immigrant Doctor (1879-1957)*, ed. Victor Rosen (New York: Exposition Press, 1959). 69.

⁵⁶¹ Robert Menzies and Ted Palys, “Turbulent Spirits: Aboriginal Patients in the British Columbia Psychiatric System, 1879-1950,” in *Mental Health and Canadian Society: Historical Perspectives*, eds. James E. Moran and David Wright (Montreal: McGill-Queen's University Press, 2006), 149-175, 162. They discuss cultural alienation in their study of Maori patients in New Zealand. Lorelle Barry and Catharine Coleborne, “Insanity and Ethnicity in New Zealand: Maori Encounters with the Auckland Mental Hospital, 1860-1900,” *History of Psychiatry* 22, no. 3 (September 2011): 285-301.

⁵⁶² Buffalo, Dominick. He first came to the U.S. in 1907, returned to Italy in 1911, served two years in the army, and came back to America in 1915. He was committed in July 1916 and killed himself in September of the same year. Diagnosis: dementia praecox, hebephrenic.

Contacts with doctors, whether at American or immigrant hospitals, often produced adverse outcomes for immigrants; in some cases, doctors sent their immigrant clients to state mental institutions, perhaps because they lacked resources to care for the insane or because they wanted to get rid of troublesome patients. According to German scholars Wulf and Schmiedebach, whose study examines immigrant patients deported from the United States and committed at Friedrichsberg Asylum in Hamburg, Germany, doctors in America referred their immigrant patients to mental hospitals without informing them of the true nature of the institutions, and unsuspecting immigrants became subject to deportation for their insanity or for public charge status.⁵⁶³ One case they discuss is that of Janos S., a Hungarian patient committed at Friedrichsberg in 1909. While in America, he had trouble finding work and was distressed that he was unable to send money to his family in Hungary. One day, suffering from a headache, Janos S. visited a doctor, who referred him to a hospital without much explanation. Only after he went there did he realize that it was a mental hospital, and a few weeks later Janos S. was deported from the U.S. for insanity.⁵⁶⁴ In New York and California, too, a number of patients were transferred from general hospitals to mental institutions after they allegedly developed symptoms of insanity. The Buffalo State Hospital records I examined show that six out of 76 immigrant patients (eight percent) were committed from other hospitals; at Stockton, at least 24 Chinese and Japanese patients out of 405 (six percent) were brought from the Clark's Sanitarium in Stockton, California.⁵⁶⁵

Understandably, some immigrants lacked sufficient knowledge of the American system. For example, the petitioner and informant of Joseph T., his cousin, stated that the

⁵⁶³ Wulf and Schmiedebach, „Die sprachliche,” *Medizinhistorisches Journal* 43 (2008): 231-263, 253-55. Most patients who returned from America and got committed to the German institution were Eastern Europeans.

⁵⁶⁴ *Ibid.*, 254-55.

⁵⁶⁵ The Clark's Sanitarium was a private hospital under the supervision of the California State Commission in Lunacy. It probably functioned as a detention or observation hospital and temporarily housed these patients. Or, the patients' families could no longer support them at the private institution and decided to transfer them to a public mental hospital.

“patient was sent to the City Hospital and shortly afterwards he [the cousin] was asked to sign some papers which he did; did not know they were for patient commitment to this hospital [Buffalo State].”⁵⁶⁶ The cousin, who “understands English poorly,” ended up becoming an inadvertent accomplice in committing Joseph T. to the mental hospital. Insane immigrants were also committed to state institutions due to meager resources and unfavorable social circumstances of immigrant communities, which had no other option but to send their fellow immigrants to state hospitals. However, this choice often brought about unexpected outcomes. In 1906, newly married Russian-born Kelly Korliner committed his wife, Fannie, also from Russia, to a New York state mental hospital when she became ill. Kelly gave a detailed explanation for his decision:

A few days before we were married I had noticed that she acted queerly in some respects. I inquired if she felt ill, and she replied that ever since she left Warsaw, Russia, her mind seemed to be clouded. A few days after we had been married I noticed that my wife was not as she should be, she appeared to be in a stupor, gradually she refused to speak, and later refused to eat. As I am employed during the day and had no one to take care of my wife, I sent her to the hospital.⁵⁶⁷

Despite his good intention to provide care for the wife in his absence, he unwittingly contributed to her deportation by making her a public charge at the state hospital. Without money to hire a lawyer or pay for her hospital expenses, Kelly could not prevent Fannie’s deportation. These examples reveal why immigrants feared the American medical system; they did not always know what to expect once they were at the American hospital.

In addition to medical practitioners, police and prison officers frequently appeared on commitment registers as petitioners: they arrested and took to state hospitals those who

⁵⁶⁶ Buffalo, Joseph T. Diagnosis: epileptic. During this period, epileptics were also sent to state mental institutions.

⁵⁶⁷ File 51466/81, Entry 9, RG 85, NARA, Washington, DC.

scared people on the street or wandered aimlessly.⁵⁶⁸ The Italian Dominick was arrested and then sent to Buffalo when he “was found walking rapidly up and down foot bridge over canal talking to himself and waving his hands. His actions scared people off the bridge.”⁵⁶⁹ An eighty-eight-year-old Chinese man, Ong Waugh, was sent to Stockton State Hospital and diagnosed with senile dementia because he “absolutely refuses to keep his place or self clean, and refuses to obey any requests or demands of the City or County authorities.”⁵⁷⁰ Occasionally, social workers took action on behalf of immigrants. In 1907, Donaldina Cameron, the well-known social reformer in San Francisco, petitioned for the commitment of Ah Kum, “Chinawoman,” to Stockton; her case file read that Ah Kum, rescued from a Chinese home of prostitutes, had been “mentally deficient since birth” and unable to care for herself.⁵⁷¹

Many cases, however, suggest that immigrants were savvy participants in hospital commitment processes. The Buffalo State Hospital patient records I examined show that more than 50 percent of the petitioners were close family members (parent, child, spouse, or sibling) or relatives (uncle or cousin).⁵⁷² Immigrant parents sent their children to state hospitals, children their parents; husbands petitioned for the commitment of wives, and wives had husbands arrested, only several days or even hours after they witnessed alleged symptoms of insanity. Immigrants used mental hospitals not only to provide care for their friends and relatives but also to manage those who disrupted their communities and maintain

⁵⁶⁸ At Buffalo, 7 patients out of 76 (9 percent) were committed from a penitentiary and by the police. No statistics available for Stockton or Mendocino because case files were not complete and petitioners' occupations/positions often remained unrecorded.

⁵⁶⁹ Buffalo, Dominick. His cousin stated: “He does not now consider patient insane.”

⁵⁷⁰ Stockton, admitted June 1916 and discharged in July 1916 as “not insane.” The color section read “Mongolian.”

⁵⁷¹ Stockton, committed in March 1907 and discharged in June 1909 as recovered.

⁵⁷² Of 67 petitioners, 36 were relatives (husband 14, wife 9, father 2, mother 1, brother 3, son 3, daughter 1, cousin 1, and uncle 2); 3 were friends; 9 were Superintendent (Overseer) of Poor (in charge of the Poor House); 3 Police; 4 Hospital associates; 4 Commissioner of Charities; and 3 Penitentiary officers. This did not include 1 voluntary, 2 emergency, and 2 cases of unknown petitioners.

immigrant respectability. The sixty-three-year-old Italian woman Giuseppina's example illustrates this point. In September 1913, she was brought to Buffalo as an emergency case; the petitioner was her son, and her son-in-law provided information necessary to her commitment. By that time, Giuseppina had been in the United States only for twenty-three days, having arrived from Italy at the invitation of her son-in-law. Shortly after arrival, she "began to show symptoms of activity and expressed exaggerated ideas, such as that the people and houses all about belonged to her"; she destroyed household goods and even "wanted to throw the informant[son-in-law]'s baby away." Her patient record included a letter from the Immigration Inspector regarding her warrant of arrest: "As the alien herself is unable to comprehend the nature of the warrant proceedings, the warrant will be served upon her relatives at Niagara Falls and they will be given an opportunity to show cause why she should not be deported." There was no indication that Giuseppina's family tried to prevent her deportation. Less than three months after her commitment, she left the hospital with the Immigration Inspector to be deported. Her family, afraid for their own safety, became willing participants in her commitment and deportation, even when the "etiological factors" of her insanity were "[c]hange of surrounding and stress of immigrating."⁵⁷³ Not only family members but also friends and neighbors from the immigrant communities were involved in committing insane immigrants to mental hospitals; they filed petitions for commitment, visited hospitals, or in some cases asked for deportation of their friends. For example, in 1908, a Polish man was taken to the Poor's Office (Poor House) of Erie County by his friends "who wished to have him deported" because he had acted "irrationally for some time." He was

⁵⁷³ Buffalo, committed in September 1913 and discharged unimproved in December 1913. Diagnosis: manic depressive-excitement. Her deportation file stated that she would be sent to the care of "(Mother) Maria DiNeggio" in Italy, who was "still living at the age of 86." Her deportation was processed without any question of whether or not her mother was indeed capable of taking care of her.

committed to Buffalo State Hospital and deported soon after as his friends had wished.⁵⁷⁴

Branded annoying and troublesome, these immigrants were no longer protected even by their own people. Employers often participated in the commitment process as well, making a petition or appealing to the local authorities. In 1912, Polish-born Russian Piotr was sent to a police station by his employer, Mr. P. whom Piotr had asked for four thousand dollars to take care of his wife. From the police station he was sent to Buffalo State Hospital, and after being discharged, Piotr returned to his employer.⁵⁷⁵

Discussing the image of Chinese immigrants as a public health threat in San Francisco at the turn of the twentieth century, historian Nayan Shah states: “Their [Chinese] reluctance to notify health officials did reveal the distrust of Chinese men and women for the public health procedures, as well as their doubts about the ability of Western doctors to cure the ill, but the problem may also have been that they did not approve of measures to segregate those afflicted with disease from their friends and family.”⁵⁷⁶ Asian communities in America provided their members with certain degrees of medical protection; the Chinese Six Company offered medical care and service, and Chinese and Japanese herbalists and traditional healers helped immigrants cope with their bodily and mental ills.⁵⁷⁷ Friends and family put up with and tolerated disturbing behavior of the insane for a long time, and in many cases, they sought state hospitals only as a last resort. One case from the Stockton State

⁵⁷⁴ Buffalo, admitted in February 1908, born in Poland, in the U.S. for 6 months. Deported in April 1908. Diagnosis: traumatic insanity due to a fall.

⁵⁷⁵ Buffalo, admitted in September 1912 and discharged in April 1913. Diagnosis: alcoholic psychosis. He claimed that his wife came to the United States and he needed the money to take care of her. However, it turned out that his wife had been in Poland all along.

⁵⁷⁶ Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), 60. This reluctance might be due to the particular nature of the diseases, such as small pox, which Chinese asserted were unfairly associated with them.

⁵⁷⁷ See Charles C. Jew and Stuart A. Brody, “Mental Illness among the Chinese I. Hospitalization Rates over the Past Century,” *Comprehensive Psychiatry* 8, no. 2 (April, 1967): 129-134. They attributed the low hospital admission rates among the Chinese in California between 1854 and 1903 to protection from commitment by friends and relatives, placement in a “pest house” by the Chinese six Company to avoid detection, and removal to China. They explained the later increase in the admission rates as a result of Chinese acculturation to Western ideals or a genuine increase in mental illness.

Hospital is particularly revealing: Chun King, committed in 1909 through the petition of Wong Shee (relationship unknown), was recorded to have “fired three shots at a countryman about a year ago” and afterwards imagined that people were attempting to injure him. That he was committed more than a year after his first violent, even homicidal, fit suggests that the community had tolerated him until it could no longer do so.⁵⁷⁸

Still, Asian immigrants in California, despite the popular belief in their isolation from American society, were exposed to American mental institutions, and their commitment stories resembled those of European immigrants in New York. According to historian Richard W. Fox, “the male, the unskilled, the foreign-born, the most recent immigrants, and those with no relatives in the city [San Francisco] were significantly more likely to be judged in a disapproving way.”⁵⁷⁹ However, it is noteworthy that many of the witnesses and petitioners for Chinese and Japanese patients at Stockton came from the patients’ own racial or ethnic communities. Between January 1900 and June 1920, the Stockton State Hospital data I gathered show that out of 405 Chinese, Japanese, and Koreans committed to the hospital, 151 (about 40 percent) of them were petitioned by people from the same ethnic backgrounds, among whom were friends, parents, husbands, employers, and immigrant society members.⁵⁸⁰ Mrs. Aitto, listed as “Female Jap” in the register, was committed in 1908 upon the petition of her husband about a month after her “present attack” of “insane and irrational behavior” began.⁵⁸¹ Chinese Lee Chung’s petitioner was his cousin.⁵⁸² In 1920,

⁵⁷⁸ Chinese in Canada also took similar measures to deal with the insane. Lisa R. Mar’s article on a Chinese woman, Lin Tee, sheds light on the Chinese care of the insane in early twentieth-century Canada and discusses the ways in which notions of gender and race intersected in small communities. Mar, “The Tale of Lin Tee.”

⁵⁷⁹ Fox, *So Far Disordered*, 153.

⁵⁸⁰ I deduced the petitioners’ ethnic backgrounds from their names. The Stockton State Hospital registers recorded full names of the petitioners but did not specify their titles or positions. Available information suggests that some of the patients had been prisoners or convicts, committed to the hospital through the petition of a jailor or a sheriff. Some came from a private sanitarium or a general hospital.

⁵⁸¹ The register of Mrs. Kimmi Aitto noted that her husband was “financially able to pay \$10.00 per mo.” She was committed in August 1912 and discharged in December 1916 as improved. Diagnosis: puerperal

Kaoru, an eighteen-year-old Japanese, was sent to Stockton by his father for being a danger to himself; the father was also frustrated because Kaoru denied he had a father and a brother. Since Kaoru had been in California only for ten months at the time of commitment, he was issued a warrant of deportation and discharged unimproved.⁵⁸³ It is possible that these petitioners were pressured by American society to act upon the unwieldy and disruptive members of their communities, or that they were mere bystanders, stepping in as petitioners at the request of others less familiar with the commitment process. It is also possible that immigrant communities received assistance from American officials and authorities to commit their own; thus, the actual involvement of Asian immigrants with the commitment process could have been greater than the number alone suggests.

While these examples demonstrate the extent to which immigrant families and communities became part of the commitment process, voluntary commitment cases show that suffering immigrants also embraced the American institution. Though not common,⁵⁸⁴ voluntary commitment sheds light on both the immigrant communities and the functions of the mental institution. In 1916, John M. from Russia Poland called at the police station in Niagara Falls and asked to be sent “[t]o a place where they doctor the head.” He admitted that he had been an inmate at a Pennsylvania mental institution but not a committed patient, and

melancholia. The tie between patients and their petitioners was not always clear; however, the correspondent section of the registers and the last name of the petitioner suggest that about eight of the 21 female patients (11 Chinese and 10 Japanese) were committed by their husband.

⁵⁸² Lee Chung was committed in May 1909 and died in August 1909 of maniacal exhaustion. Diagnosis: mania. He had been in the US for 40 years by the time of commitment.

⁵⁸³ Stockton, admitted in April 1920 and discharged in July 1920. Diagnosis: deferred. A warrant of deportation was issued in the same month. It is hard to tell from the brief register whether or not Kaoru’s father was aware of the deportation provision. Still, it is possible that he deliberately used the American system to send away a disobedient son with a free passage home.

⁵⁸⁴ State hospitals began to receive voluntary cases in the early twentieth century. In 1908, the State of New York allowed voluntary admission to thirteen civil State Hospitals “without commitment and on their own application.” For discharge, voluntary commitment cases were required to follow the same court proceedings as regular inmates. By 1925, 29 states allowed voluntary commitment, while in 15 states, temporary care was available upon the adjudication of a case. See Walter L. Treadway, *Mental Hygiene with Special Reference to the Migration of People* (Washington, DC: Government Printing Office, 1925), 44.

explained in broken English that people were bothering him and calling him names. John had promised to sign a voluntary commitment application but when he arrived at the hospital, he refused to sign his name and gave no personal information. The Buffalo hospital staff managed, however, to identify who he was and discovered that he had escaped from the Pennsylvania hospital. In 1917, a warrant was issued for John's deportation for becoming a public charge within three years of landing in America. Because of the war time instability, he had to stay at the institution for four more years until 1921 when he was finally deported to his home country.⁵⁸⁵ John M. voluntarily sought out commitment to a mental institution as a way to protect himself from those who bothered him, and he managed to escape from the first hospital before getting reported for deportation.⁵⁸⁶ His second commitment resulted in his removal from the country, and yet, the four years at Buffalo could have helped him regain his health or at least offered him a relief from the difficulties of everyday life.⁵⁸⁷ The Stockton State Hospital registers also included several voluntary commitment cases of Chinese and Japanese male patients. Like John, they illustrate divergent approaches to insanity and institutional life adopted by immigrants. The circumstances that drove these people to voluntary commitment are unclear: pressure from the community, different understandings of mental illness, or class or educational backgrounds might have been at work. For example, in 1917, a Chinese student, Fong Wong Gee, who had suffered from drug habits, committed himself to Stockton with a statement that his father would be able to pay fifteen dollars a month for his treatment.⁵⁸⁸ Committing oneself for drug habits would have

⁵⁸⁵ By 1921, deporting insane immigrants to European countries became possible, excepting for Russia.

⁵⁸⁶ Ellen Dwyer also discusses positive influences of nineteenth-century mental institutions where tired and sick people could get rest and receive actual treatment. Dwyer, *Homes for the Mad*.

⁵⁸⁷ Buffalo, John M., admitted in August 1916, deported in April 1921. In the U.S. 3 years. Diagnosis: dementia praecox, hebephrenic. He had been at Warren State Hospital, Pennsylvania between 1914 and 1915, and after escaping from the hospital went to Niagara Falls. He had been suspicious of other people for several weeks and went to the police station to ask for admission to a mental hospital.

⁵⁸⁸ Stockton, admitted in June 1917 and discharged a year later, in California for 4 years. Diagnosis: not given.

been less ignominious than being committed for a nervous breakdown, suicidal tendency, or hallucinations. Moreover, as a student with a financially reliable father, Gee could have opted for voluntary commitment, unlike others who had been forced to a life of incarceration. Masaru, a Japanese patient, was in fear of “tough-looking white men” following him, and he opted to commit himself voluntarily to Stockton. For him, the hospital was a place for protection and safety.⁵⁸⁹ Immigrants knew, probably from their experience with mental institutions in the Old World or exposure to the American system, that state hospitals allowed patients medical treatment, food and a place to live, as well as a temporary respite from the hardships of immigrant life.

Integration and Movement of Immigrant Patients at State Institutions

Investigating mental illness and travel in eighteenth and nineteenth-century England, Jonathan Andrews argues that confinement itself was a form of “travel” for patients; despite the eventual incarceration, they needed to be removed from their home first so that they could be committed at mental institutions often situated in a faraway countryside.⁵⁹⁰ Likewise, immigrant patients experienced many forms of mobility before, during, and after their commitment to state hospitals. State hospital buildings were designed to facilitate the mobility and surveillance of doctors over attendants and patients while preventing hospital inmates from wandering from ward to ward.⁵⁹¹ However, the institutional system allowed patients certain degrees of mobility despite its supposed role of confinement and custody. Mobility was not uncommon within the “ward system,” in which patients were transferred

⁵⁸⁹ Stockton, Masaru, admitted in November 1919 and discharged “unimproved” in less than a month. In the U.S. for 16 years and in California for 4 years. Diagnosis: manic depressive.

⁵⁹⁰ Jonathan Andrews, “Letting Madness Range: Travel and Mental Disorder, c1700-1900,” in *Pathologies of Travel*, eds. Richard Wrigley and George Revill (Amsterdam: Rodopi, 2000), 25-88.

⁵⁹¹ Yanni, *Architecture of Madness*, 136-137. Doctors saw attendants as little better than patients and tried to control their movements.

from one ward to another to make room for incoming patients, to prevent them from disturbing others, and to ensure proper treatment for their conditions. Not only physical changes of wards, but also changes in patients' standing were observed. As sociologist Erving Goffman argues, "[c]ontrary to popular opinion, the "ward system" insures a great amount of internal social mobility in mental hospitals, especially during the inmate's first year."⁵⁹² In spite of the cultural and linguistic differences, immigrant patients too coped with their conditions and gradually began to conceive themselves as part of the institutional life, receiving treatment and following ward routines.

Moreover, as Gerald N. Grob states, "there was considerable interaction among patients, often with positive results for all concerned."⁵⁹³ Despite the conventional understanding of isolation and lack of interaction between native-born Americans and immigrants, the "alien insane," through their commitment and confinement, were exposed to patients of various races and classes, although how much they actually benefited from such exposure needs further examination. The New York and California hospital records showed that the immigrant inmates often fought with each other, perhaps motivated by racial differences and antagonism, recognized their racially and ethnically diverse environment, and some even picked up English as a result of their lengthy stays; others remained in their own racial or immigrant enclaves even at the state hospitals, conversing only with those who shared their linguistic or cultural backgrounds.⁵⁹⁴ Nevertheless, "the striking lack of contact" between immigrants and English-speaking Americans met challenges at the state institution.⁵⁹⁵

⁵⁹² Goffman, *Asylums*, 162-3.

⁵⁹³ Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York: Free Press, 1973), 229.

⁵⁹⁴ Mendocino Hospital patient case files for Hong, Marie, Ida, and others.

⁵⁹⁵ Carnevale, *New Language*, 112.

Patients were also allowed to move beyond the hospital walls through “transfer.” State hospitals were monotonous places, and doctors suggested transfer within and between hospitals as a way to deal with the problem. However, it was also to relieve overcrowded hospital conditions by sending undesirable patients away to other places. Doctors in New York, in particular, tried to disguise their ultimate goal in the language of therapeutic intervention. In 1908, the New York State Commission asserted: “Under the circumstances, why not make a virtue of necessity, and transform the plan of transfer into a valuable therapeutic agency?”⁵⁹⁶ The report continued to explain the benefits of transfer for hospital patients; transfer would provide distraction to monotonous institutional life and offer new environments where patients might find themselves improved. It even proposed to pay for the transportation for friends without means who wanted to visit the transfer patients. However, the Commission report also admitted: “in fact the selection [of transfer patients] is likely to be made on the basis of what patients the hospital is most anxious to get rid of, rather than what patients will be most benefited by a change of life and scene.”⁵⁹⁷ Immigrant patients, especially those without friends or family, would have become the most likely candidates for transfer. In California, transfers between hospitals were quite common, and when new hospitals were built, patients were moved to the new facilities to lighten the burden of the overcrowded institutions. For example, when Mendocino State Hospital opened in 1893, many Chinese and Japanese patients were transferred from Agnews (also from Stockton and Napa State Hospitals) to make room for new admissions. The two hundred-mile distance between Mendocino and Agnews must have made it even more difficult for their friends and relatives, if any, to visit them. In California, transfer of hospital patients was banned after the 1920s so that it would not disturb the patients’ mental condition and treatment processes;

⁵⁹⁶ New York, State Commission, “State Charities Aid and Association Annual Report,” 17th *Annual Report* (1906), 1106-1107; 19th *Annual Report* (1908), 1253.

⁵⁹⁷ New York, State Commission, 17th *Annual Report* (1906), 1107.

nevertheless, another form of transfer—deportation—for immigrant patients continued well into the 1930s.

Commitment at mental hospitals was often associated with life-long confinement; however, these institutions saw a lot of movements among their patients. Some escaped and earned freedom, and some died of tuberculosis, pneumonia, or exhaustion without ever getting out. Many patients were discharged, transferred, paroled, or deported or sent back home not long after their commitment. Immigrant patients and their family and friends soon learned how the institutional system worked; in particular, when it came to deportation, they often manipulated the loopholes of the American system to their advantage to care for themselves, get rid of their troublesome friends, place them in proper facilities where they could receive better care, or assist in returning them to home countries. As Chapter 2 shows, many immigrants were familiar with the provisions of the American immigration laws and able to protect their kin from deportation by keeping them at home or inexpensive private sanitariums until the statute of limitations expired. After that, they could resort to public mental hospitals without fear of deportation.⁵⁹⁸

By promising to take good care of the patients, medically as well as financially, family and friends removed the insane patients from state hospitals before deportation proceedings took place,⁵⁹⁹ paid for hospital expenses so that the patients would not become public charges, or willingly accepted the decision to deport the suffering members as the costly passage home, which they could not afford, would be covered by the federal

⁵⁹⁸ New York, State Commission, 23rd *Annual Report* (1912), 112-113. The New York Board of Alienist report.

⁵⁹⁹ When patients showed signs of improvement and became quiet and stable, hospitals doctors allowed their friends or family to take them home. The doctors “paroled” the patients and asked them to report to the hospital, but in most cases, they discharged those who had been paroled but did not report as recovered or improved.

Immigration Fund or state appropriations. In the case of forty-year-old Italian Agostina, committed at Buffalo in 1903 after a year in the United States:

He was visited to-day by several of his countrymen who managed to make us understand that they all knew the patient at his home in Italy and worked with him at the Steel Plant [in Buffalo]. They state that his derangement was due to too much drink and that he is perfectly coherent and rational now in all that he says. Although he is not yet in good physical condition he is allowed to go with his friends on trial, they promised to see that he does not resume heavy work immediately. They say that they will aid him to return home to his family in Italy.⁶⁰⁰

Despite their language handicap, Agostina's friends were able to help him receive treatment and prevent his deportation. In 1913, when Buffalo patient Likola, who had been in the U.S. for six years, "expressed a desire to return to his native country," the New York State Bureau of Deportation arranged his "deportation" through the state appropriations without the federal aid.⁶⁰¹ Although Likola's three-year statute of limitations had already expired at the time of his commitment, thus making him ineligible for deportation by the federal government, his wish to return home was granted through the cooperation of the state hospital and the State Commission's Deportation Bureau, without any extra cost upon Likola's family and friends.⁶⁰² A considerable number of Chinese and Japanese patients in California were discharged from state institutions to return to their home countries with friends or family members, who contacted home countries, made transportation arrangements, or raised funds to take the insane patients home. For example, in 1916, Japanese patient Ono was discharged from Stockton as "improved (to Japan)" when his friends succeeded in raising enough money

⁶⁰⁰ Buffalo, admitted in May 1903 and discharged in June 1903. Diagnosis: acute mania. Even though he had been in the U.S. only for a year, he did not receive a warrant of deportation. Friends' willingness to assist him might have alleviated the fear that he could end up a burden upon the state and prevented the hospital from reporting his case to the immigration authorities. One month later, the hospital discharged him as recovered, with a statement: "We have had no report from patient since he went home but we are sure that he was recovered."

⁶⁰¹ Not an immigrant inspector (for federal deportation cases) but a doctor (presumably of Buffalo State Hospital) took him to New York for a sail to Austria. This shows that the deportation process was initiated and presided over by the New York State Bureau of Deportation, not the immigration authorities.

⁶⁰² Buffalo, Likola.

to send him home.⁶⁰³ Through the efforts of the friends, Ono secured freedom and passage home. Since cooperation and coordination between state institutions and government agencies took time, some of the deportable patients could avoid getting arrested and deported from the country simply by disappearing after parole. In the case of Harris, by the time a warrant of deportation was issued for him, he had already left Buffalo State Hospital with his friend. Harris promised to report his progress to the hospital, but he soon “reverted to his former self” and left the country on his own accord.⁶⁰⁴ As former insane patients, their life choices would have been limited outside the institutional walls; nevertheless, these cases show that immigrants, Agostina and Harris among them, took active part in their movements in and out of mental hospitals.

Conclusion

Examining patients’ personal belongings left at Willard State Hospital, New York, Darby Penney and Peter Stastny state: “Psychiatry in those days (and still today) was largely in the business of stripping patients of their quotidian identities. Diagnostic categories serve mainly to pitch people into a few pigeonholes that help psychiatrists talk about them among themselves.”⁶⁰⁵ They also claim that the psychiatric labels to which these patients were assigned did not speak to the narratives of their lives. Indeed, it is not easy to obtain a complete history of an individual patient through patient case records and state hospital reports because these narratives were in the voices of the authorities; however, this limited range of sources still illuminates the ways in which immigrants’ “quotidian identities”

⁶⁰³ Stockton, admitted January 1916, and discharged in May 1916, in the US/California for 25 years. Diagnosis: melancholia dementia.

⁶⁰⁴ Buffalo, Harris, admitted in September 1918 and discharged in July 1919. Diagnosis: general paralysis.

⁶⁰⁵ Darby Penney and Peter Stastny, *The Lives They Left Behind: Suitcase from a State Hospital Attic* (New York: Bellevue Literary Press, 2009), 19-20. Most patients they examined were committed to Willard in the first half of the twentieth century.

influenced doctors' understanding of immigrant patients, how immigrants became inmates at state hospitals, what kind of examinations they received, and what difficulties, other than their mental troubles, these "alien insane" experienced during their confinement. It might even be true that immigrant patients, just like "native-born" inmates, were stripped of their identities other than being insane, and their racial, national, or linguistic traits were rendered invisible by the designation of "foreign-born," a convenient label widely used in the early twentieth century. Still, the experience of the immigrant patients sheds light on their individual travails as well as the larger environments of which they were an integral part. The "alien insane" were not a historical phenomenon that popped up at the turn of the twentieth century and disappeared thereafter. As we shall see later, Stanley Sue and James K. Morishima's study, though limited to Asian-Pacific/Asian immigrants, illustrates that despite medical and technological developments that can help improve the logistics of detecting and treating the insane, the marginalization of mentally ill immigrants continues to this day.⁶⁰⁶

⁶⁰⁶ Sue and Morishima, *Mental Health*.

Chapter Five

Going Mad in America: Narratives of Insane Immigrants in Modern America

“Going mad was a specialty of the family,” begins William Saroyan’s short story, “Madness in the Family” (1967).⁶⁰⁷ Himself an Armenian immigrant, Saroyan offers a fictionalized account of how a family experienced insanity and mobility. At home in Armenia, everyone needed to undergo madness in one way or another to become a full family member; those who went through madness early and frequently throughout their lives garnered respect. This specialty persisted even after the family moved to the United States. The New World presented new challenges: “When the tribe packed up and came to America ... the family madness continued, but the form changed. Of course, this was to be expected, since America was another kind of place entirely.”⁶⁰⁸ “[C]ompelled by the New World,” Uncle Vorotan was the first to manifest a new type of madness.⁶⁰⁹ Mindful of the health of the family, Vorotan visited the ill in hopes that they would soon die and save the family. At last, when a tribe member died, he was instantly healed of madness. At the gravesite, he proclaimed: “Now, at last, we are here.”⁶¹⁰

William Saroyan’s story suggests that immigrants formed their own understandings of madness and American life. Vorotan’s novel form of madness was derived from the immigrant experience, which decades ago Oscar Handlin famously portrayed as uprooted and restless.⁶¹¹ Vorotan asked his wife and mother, “Has anybody died yet, to heal this fearful

⁶⁰⁷ William Saroyan, “Madness in the Family” (1967) in *Madness in the Family* (New York: New Directions, 1988), 1-4, 1.

⁶⁰⁸ *Ibid.*, 2.

⁶⁰⁹ *Ibid.*, 3.

⁶¹⁰ *Ibid.*, 4.

⁶¹¹ Oscar Handlin, *The Uprooted* (Philadelphia: University of Pennsylvania Press, 2002). Also see John Bodnar, *The Transplanted: A History of Immigrants in Urban America* (Bloomington: Indiana University Press, 1985).

loneliness, this aimless walking about, the emptiness and disconnection?”⁶¹² While this search for rootedness might indicate a legitimate desire for assimilation or Americanization, Uncle Vorotan’s madness was another matter. Without the protection of his family, he might have ended up at a California mental hospital. For his family, however, being mad was not something strange or remarkable; rather, it was a way of life, not to be shunned or resented but to be embraced and accepted. In Saroyan’s story, madness was, in fact, a reasonable response for the family who experienced transplantation from Armenia to America. As Americans at the turn of the twentieth century formed their own ideas of sanity and insanity, immigrants also contemplated what it meant to be insane and created own ways of negotiating their new place in America.

This chapter uses three sets of narratives: American authors’ exposés or memoirs of asylum experiences, official files and public documents that incorporated allegedly insane immigrants’ voices, and immigrant authors’ fictional or autobiographical accounts of insanity. The chapter interprets these documents as narratives of insanity, immigration, and assimilation. The American writers used insane immigrants, to whom they rarely gave a voice, as a backdrop for their own successful struggles to reclaim their value as Americans. Still, asylum memoirs offer a rare public acknowledgement of the alien insane residing in asylums and release them from neglect and invisibility. Public files and documents—clemency letters, naturalization stories, and insanity pleas, supervised and directed by state bureaucrats, officials and legal advisors—allow us to observe the “alien insane” participating as co-authors of the documents but speaking with their own voices. Finally, the fictional or autobiographical narratives, the works of immigrant writers like Saroyan, offer insider perspectives of insane immigrants living outside mental hospitals in the safety of their own communities. These writers portray immigrants who faced emotional difficulties, possible

⁶¹² Saroyan, “Madness in the Family,” 3.

deportation, and sometimes legal action but still managed to negotiate their new lives and construct their own paths to assimilation.

Assimilation and Adaptation: The American Perspectives

Despite substantial criticisms over the years, assimilation theory still offers a useful framework for understanding immigration to the United States.⁶¹³ Torn between the two worlds, immigrants needed to find a way to resolve tensions inherent in their immigrant experiences and adapt to the new environment. In his classic 1928 study, “Human Migration and the Marginal Man,” sociologist Robert E. Park saw the immigrant as a personality type: a marginal man who earned emancipation and enlightenment through migration but also suffered inner turmoil, instability, restlessness, and malaise, living on the margin of the two worlds.⁶¹⁴ Immigrants reacted to this marginality in various ways, and their assimilation and adaptation could, as sociologists Alejandro Portes and Ruben G. Rumbaut remind us, “lead to widely different outcomes.”⁶¹⁵ In 1933, social scientist Lawrence Guy Brown argued that immigrants to America made pathological adjustments, involving pauperism, dependency, criminality, and insanity. Some, he claimed, exhibited these pathologies before they left

⁶¹³ Sociologists Richard Alba and Victor Nee define assimilation as “the decline, and at its endpoint the disappearance, of an ethnic/racial distinction and the cultural and social differences that express it.” At an individual level, assimilation is “changes that make the individuals in one ethnic group more like, and more socially integrated with, the members of another.” They explain that socioeconomic assimilation has two different usages: assimilation as social mobility and assimilation into similar native groups. According to them, this view of assimilation has been criticized for being inapplicable for non-European immigrants and historically contingent. Richard Alba and Victor Nee, “Rethinking Assimilation Theory for a New Era of Immigration,” *International Migration Review* 31, no. 4 (Winter 1997): 826-74, 863-864, 835-836. For historical studies of assimilation, see Russell Kazal, “Revisiting Assimilation: The Rise, Fall, and Reappraisal of a Concept in American Ethnic History,” *American Historical Review* 100, no. 2 (April 1995): 437-471; Ewa Morawsk, “In Defense of the Assimilation Model,” *Journal of American Ethnic History* 13, no. 2 (1994): 76-87.

⁶¹⁴ Robert E. Park, “Human Migration and the Marginal Man,” *American Journal of Sociologist* 33, no. 6 (May 1928): 881-893. Also see Portes and Rumbaut, *Immigrant America*, 158-159.

⁶¹⁵ Portes and Rumbaut argue that there is a positive correlation between the level of acculturation and the prevalence of mental disorders. The more acculturated immigrants were, the more exposed they were to risky behaviors (i.e. drug abuse), which would result in mental disorders. Portes and Rumbaut, *Immigrant America: A Portrait* (Berkeley: University of California Press, 1990), 187.

Europe. In other cases, the long journey to the United States and their experiences after settlement produced the pathologies. Since the immigration acts excluded paupers (and those likely to become paupers), criminals, and the insane at the American borders, Brown claimed that pauperism, criminality, or insanity in America most often indicated “an adjustment to the social situation in the United States.”⁶¹⁶ That is, he argued that immigrants’ insanity was the product of their adjustment to social situations in the New World and brought attention to the social conditions that created mental instability.⁶¹⁷ Without dismissing heredity as a cause for insanity, Brown insisted: “If the social factor is as important as recent opinion would make it, then one would predict a high rate of insanity among immigrants who face a great problem of adjustment and who have their habitual means of control greatly disturbed.”⁶¹⁸ For Brown, insanity could be understood as a natural and anticipated outcome of immigrant life. The pathological adjustments that led to insanity and criminality were not failures to be blamed upon the immigrants; rather, they revealed problems of American society into which the immigrants moved.

Looking backwards, today’s scholars raise a different critique of the American perception and analysis of immigrant adjustment. The move into the New World has been closely linked to the process of assimilation and adaptation, which viewed settlement as an endpoint of immigrants’ journey.⁶¹⁹ Literary critic Sau-ling Cynthia Wong expresses a similar view: “a number of mainstream texts using motifs of mobility imply an endpoint of immobility, but immobility of a desirable kind: that of having created a permanent home and

⁶¹⁶ Lawrence Guy Brown, *Immigration: Cultural Conflicts and Social Adjustments* (New York: Longmans, Green and Co., 1933), 248.

⁶¹⁷ *Ibid.*, 249.

⁶¹⁸ *Ibid.*, 249-50.

⁶¹⁹ Alba and Nee, “Rethinking Assimilation,” 836. They see that social mobility is “inexplicitly linked to” assimilation. However, immigrants’ social mobility did not come naturally as the long-standing myth of their success seems to imply; therefore, Marc Fried calls for the reinterpretation of this convention. Fried, “Deprivation and Migration: Dilemmas of Causal Interpretation,” in *Behavior in New Environments: Adaptation of Migrant Populations*, ed. Eugene B. Brody (New York: Sage Publications, 1970), 23-71.

cast down roots.”⁶²⁰ Immigrant authors, especially the early writers’ accounts of immigrant experiences often internalized the American mythos of geographic and upward economic mobility. Their characters were like pioneers of the American frontier, who resolved their individual and familial pain and suffering by taming and farming a piece of land, or settling and establishing a permanent home. In an effort to salve their discontent, these characters shared with Saroyan’s Uncle Vorotan a search for a permanent connection to American soil. As the previous chapters show, however, the dominant American narrative of mobility, the movement toward settlement, excluded certain immigrants. Thus, Wong argues: “it is the group’s exclusion (often rendered invisible) from “general” patterns of American mobility” that encouraged some immigrant writers to offer different narrative visions that included coerced geographic mobility and exclusion from settlement upon the land, property ownership, and economic improvement.⁶²¹ From an outside perspective, insane immigrants were incapable of self-improvement and settling. Yet, some immigrant writers created characters who, through their insanity, found ways to live and affirm their own views of the world and their own strategies of becoming American. They did so not solely through a straight path to assimilation, such as settlement and social mobility, but through other means often involving mental suffering and pain. The story of insane immigrants, then, is one example of Wong’s “divergent representations” of immigrant life.⁶²²

Scholars like Mark Wyman and Susan Matt demonstrate that the history of immigration is also a history of emotions.⁶²³ Immigration was not only about economic and social journeys but also about mental pursuits, in which immigrants faced the unique

⁶²⁰ Sau-ling Cynthia Wong, *Reading Asian American Literature: From Necessity to Extravagance* (Princeton: Princeton University Press, 1993), 122.

⁶²¹ *Ibid.*, 123.

⁶²² *Ibid.*

⁶²³ Mark Wyman, *Round-Trip to America: The Immigrants Return to Europe, 1880-1930* (Ithaca: Cornell University Press, 1993); Susan J. Matt, *Homesickness: An American History* (New York: Oxford University Press, 2011).

difficulties of the immigration process. Many immigrants, even those who successfully established a “home,” the ultimate symbol of assimilation and adaptation, suffered these difficulties and settled with grievances and complaints. At the turn of the twentieth century, thousands of immigrants made frequent return journeys home despite the physical, mental, and financial cost of transatlantic and transpacific trips.⁶²⁴ Like Park’s marginal man, they often found themselves lost in between the two worlds and feeling “placeless,” homesick for their mother country in America and missing America when they were in their hometowns.⁶²⁵ Stories of immigrants experiencing insanity or considered to be insane by their fellow countrymen, psychiatrists and physicians, and other Americans reveal many of the tensions and conflicts inherent in the process of finding a new home and becoming part of the New World. As the immigrants’ return to overseas homes exposed their ambivalence about America, their mental illness, whether success or failure of adjustment, suggests an alternative response to the assumed, taken for granted movement toward assimilation and becoming American.

Stories from Insane Asylums

Sources that shed light on immigrant suffering and pain, especially insanity, are rare, and existing materials—hospital reports, patient case files, for example—are not always useful. Literary critic Madelaine Hron, discussing mental illness among immigrants, admitted limitations of the available sources, including hospital records: “In most cases, the hospital was more likely the horrific pinnacle of a long journey of alienation from family, friends, co-workers and perhaps self. Finding evidence of patients’ feelings, however, is difficult since

⁶²⁴ Wyman explains that between 1908 and 1923, 9,949,740 immigrants entered and 3,498,185 left the United States. The return rate among all immigrant groups was around 35 percent for the period, but it varied considerably from one country to another. For examples, the return rate for south Italians was 60 percent while the rate for north Italians was 11 percent. Wyman, *Round-Trip to America*, 9-12.

⁶²⁵ Matt, *Homesickness*.

psychiatrists, social reformers, and journalists wrote the majority of the available sources.”⁶²⁶

Still, one collection of writings offers some insight into how the “alien insane” were perceived by others familiar with mental asylums, their fellow American-born inmates. These writers, presenting themselves as sane people, produced a then popular and sensational genre—asylum narrative or exposé—and used their experiences at the asylums to demonstrate their own triumph over potential madness (they feared they might “catch” insanity) and adversity. American authors’ exposés and memoirs offer rare, if not entirely objective, eye witness accounts of mental institutions and immigrant patients. They also suggest how immigrants, especially the insane, were perceived as “Others,” through whom the authors could reaffirm their own claim to American identity.

In *Madness*, historian Mary de Young reads asylum memoirs to discuss the moral career of their authors at insane hospitals:

The experiences of these memoirists vary widely, even *wildly* if only because of their differing personal circumstances, historical contexts, geographical locations and institutional altercations, but those experiences can be distilled into a common element—a “moral career,” i.e., a sense of self and of identity that is slowly and steadily shaped as much as [sic] by the experiences of institutionalization itself as by any real or imputed madness.⁶²⁷

This trajectory of a “moral career” was limited to the privileged few, as de Young acknowledges in her study, who maintained a certain level of social influence and managed to articulate their experiences. These memoirists were not “mental patients” in sociologist Erving Goffman’s sense, as they did not consider themselves insane; they were observers of the institutional system, who nevertheless were transformed through their everyday

⁶²⁶ Madelaine Hron, *Translating Pain: Immigrant Suffering in Literature and Culture* (Toronto: University of Toronto Press, 2009), 188.

⁶²⁷ Mary de Young, *Madness: An American History of Mental Illness and Its Treatment* (Jefferson: McFarland & Co., 2010), 125. De Young references Erving Goffman’s discussion of the moral career of a mental patient from *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 127-131. In the “Asylum Patients” chapter, de Young offers diverse categories of asylum narratives based on the sources published between the mid-nineteenth and the late twentieth centuries. She argues that the “process” of institutionalization and contingencies of asylum life influenced the ways in which memoirists viewed their madness experience.

interactions with patients, doctors, attendants, and the mental institution itself. In addition to the “moral career,” these asylum memoirists revealed the ways in which the immigrant insane became entangled in the American institutional system and what role, if any, they played in imagining madness of American society.

Novelists and non-fiction writers had since the early nineteenth century catered to popular curiosity about the insane and the asylum, and the memoirists who included insane immigrants in their works represented a continuation and elaboration of this tradition.⁶²⁸ By the late nineteenth century, insanity was no longer a novelty, but readers continued to take great interest in insanity, insane hospitals, and the legal and medical practices of commitment, treatment, and discharge. Historian Karen Halttunen’s study of nineteenth-century insanity pleas demonstrates that fearful Americans objectified or “othered” the insane, particularly the mad murderer, who, they believed, should be separated and quarantined from ordinary Americans. At the same time, individuals who might be considered different, even if innocent of criminal activity, were regarded with suspicion and constructed as the American citizen’s Other.⁶²⁹ The foreign or immigrant insane fell into these categories, at once derided and reassuring objects, who reaffirmed Americans of their own health, sanity, and suitability as citizens. The public familiarity with the genre and the novelty of particular stories, along with American fears of insanity and concerns about the conditions of mental institutions, explained the popularity of the asylum memoirs and exposés. Stories from insane asylums and hospitals, therefore, were about the writers themselves who acted as interlocutors for the

⁶²⁸ In the early nineteenth century, insanity was one of the most popular themes explored by American writers and novelists. For earlier first-hand accounts by asylums patients, see Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Cornell Studies in the History of Psychiatry) (Ithaca: Cornell University Press, 1995); Benjamin Reiss, *Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture* (Chicago: The University of Chicago Press, 2008); E. Fuller Torrey and Judy Miller, *Invisible Plagues: The Rise of Mental Illness from 1750 to the Present* (New Brunswick: Rutgers University Press, 2001).

⁶²⁹ Karen Halttunen, *Murder Most Foul: The Killer and the American Gothic Imagination* (Cambridge, MA: Harvard University Press, 2000), Chapter 7.

anxieties and concerns of their American readers; other inmates, including immigrant patients, became backdrops upon which they could inscribe their agendas. Many first-person narratives of asylum experiences emerged in the late nineteenth and early twentieth centuries, boosted by the contemporary reform movement leaders like Dorothea Dix and Elizabeth Packard. However, only a privileged few—in many cases, educated white middle-class women—were able to explain or reveal the conditions of mental institutions and challenge legal obstacles that barred committed individuals from enjoying their freedom.⁶³⁰ These memoirists revealed the atrocious treatment of the insane at mental institutions, challenged the conventional understandings of insanity, and exposed unfair legal and medical provisions that took advantage of the powerless—married women committed by their husbands, marginalized colored people, or immigrants unable to comprehend their new lives.⁶³¹ Their stories of travail and eventual success—release from the asylum and publication of the narrative—as well as the emphasis on the writers’ apparent “sanity” revealed these writers’ potential as keen observers, through whose eyes readers could look inside the asylum. Still, asylum exposés by former patients, invariably native-born Americans, rarely discussed the “alien insane” in depth; immigrant patients’ separation from family and friends, inability to communicate, and ignorance of what might happen to them appeared in their writings in one way or another, but foreign inmates functioned in these texts as foils to emphasize how different these writers really were from other hospital inmates. The undoubted foreignness of the immigrant inmates set the tone of the narratives; not only did they speak in foreign

⁶³⁰ In his examination of insanity among African Americans, Sean Harris contrasts the absence of their writings with white women’s narratives and argues that these white women expressed feelings echoed by Roland Johnson and Malcolm X. Harris, “Found Insane in the Holy Land: Psychiatry and the African American Experience in Illinois, 1870-1910” (Ph.D. diss., University of Illinois, Chicago, 2007), 188. See also Jeffrey L. Geller and Maxine Harris, *Women of the Asylum: Voices from Behind the Walls, 1840-1945* (New York: Anchor Books, 1994); John S. Hughes, ed. *The Letters of a Victorian Madwoman* (Columbia: University of South Carolina Press, 1993); Dale Peterson, *A Mad People’s History of Madness* (Pittsburgh: University of Pittsburgh Press, 1982); James Sterling King, “Black Madness: Insanity, Resistance and Revision in African American Literature” (Ph.D. diss., City University of New York, 2007).

⁶³¹ Margaret Starr, *Sane or Insane? Or How I Regained Liberty* (Baltimore: Fosnot, 1904).

languages, but to American eyes, they also had obviously foreign appearances. Yet, in the absence of immigrant inmates' own writings, these narratives help us gain knowledge of the "alien insane." Even though not the memoirists' original intent, their writings give a glimpse into the life at the asylum and reveal the diversity and heterogeneity within the American mental institution.

One of the best known exposés of a mental institution is Nellie Bly's 1887 piece of investigative journalism, *Ten Days in A Mad House*, originally published in the *New York World*. In the late nineteenth century, newspaper and magazine articles often reported corruption and violence at state institutions for the insane; the State of New York, for example, had been mindful of reforms at its mental hospitals long before the publication of Bly's exposé and had dealt with frequent charges of patient abuses.⁶³² In 1880, the New York Senate Committee investigated asylum management and abuse charges at the City Asylum for the Insane of New York on Ward's Island. In the committee meeting, Charles Partuban, a nurse at Ward's Island, testified "with a strong German accent" that he had no knowledge of abuses or restraints at the asylum. He claimed that he did now know the Cuban patient who was allegedly punished by a doctor with a shower bath (there were many Cuban patients, according to the accused doctor), and when asked whether he remembered "the cases of John Henry Wesley Wells, a negro, or a man named O'Reilly," he answered, "[t]here were a good many O'Reillys there." Laughter ensued.⁶³³ Although Ward's Asylum did not blame foreign-born patients for overcrowded hospital conditions and financial strains,⁶³⁴ the committee

⁶³² Booke Kroeger, *Nellie Bly: Daredevil, Reporter, Feminist* (New York: Times Books, 1994).

⁶³³ "Ward's Island Asylum," *New York Times*, December 5, 1880, 2.

⁶³⁴ The 1887 State Board of Charities report claimed that unlike state hospitals, which received a large number of immigrants who had already been insane when they arrived, the city asylum admitted immigrants who became insane after arriving in the United States and only two-ninths of the entire patient population had been in America less than five years. "Ward's Island Abuses," *New York Times*, August 23, 1887, 3. According to Gerald N. Grob, "the New York City Lunatic Asylum on Blackwell's Island in 1850 held 534 foreign-born patients as compared with only 121 native Americans," Grob, *The Mad among Us*, 87.

members and the American public had no difficulty imagining the asylum full of foreigners with interesting accents and distinctive last names. Even after this exposure, the conditions of the asylum did not change much. On August 23, 1887, the *New York Times* again reported abuses of patients by attendants at Ward's Island.⁶³⁵ The investigation of the "grievous evil" was, however, quickly turned into a discussion on the financial difficulties that the State of New York and the institution had endured for many years and on the new legislative measures to lift the state of its burden. In this context came Bly's exposé.

Invigorated by her previous successes as a stunt girl, Nellie Bly posed as an insane woman and secured a commitment to Blackwell's Island, New York, as a mental patient. Aware of the proceedings for commitment, Bly chose the Temporary Home for the Women as a place to display her insanity so that she could be speedily sent to an insane asylum; when the Home's women suspected her of showing signs of insanity, they alerted police officers, who took Bly to court. Bly was adjudged insane, sent to Bellevue Hospital for medical examination, and then committed to Blackwell's Island. In the exposé of the miserable conditions of the insane asylum, Bly did not hesitate to criticize the court system, which failed to question her sanity or to use proper channels of communication for foreigners. She also mentioned doctors, who were incapable of determining real insanity, nurses, who cared more about themselves than patients, and inhumane hospital conditions. At the same time, her story shed light on the diversity of the inmate population and spoke to the contemporary awareness of racial or ethnic differences among these people.

Nellie Bly assumed a pseudonym of Nellie Brown to disguise herself and to help her editor at the *New York World* to follow her journey. She created a different persona for her piece by shedding her American self and taking on a foreign character. She spoke with "a little accent" (one said she had a southern accent, another a western accent) and her

⁶³⁵ "Ward's Island Abuses," *New York Times*, August 23, 1887, 3.

difference was duly noted.⁶³⁶ When Judge Duffy, who presided over her commitment proceeding, asked Bly whether she came from Cuba, she seized the opportunity and passed for a Cuban in the name of Nellie Moreno. No one suspected the validity of her identity, and with a bit of Spanish, she became known as the Cuban girl.⁶³⁷ Bly presented herself as a helpless but respectable Cuban woman, undistinguishable from a white, native-born American but nevertheless designated as foreign.⁶³⁸ From her first display of insanity to her journey inside Blackwell's Island, she offered a look at other insane women, who included both native-born Americans and immigrants from the other side. In her study of Nellie Bly and *Ten Days in A Mad House*, literary critic Jean Marie Lutes states that the inmates at Blackwell's Island were "the mentally ill immigrants"; it is true that state institutions in 1880s' New York had a large immigrant population (about a third of the hospital inmates at the New York city asylum were foreign-born), but they certainly had a greater number of American-born patients. Lutes's assumption is justifiable because Bly indeed devoted a large part of her writing to the subject of foreign women; Bly might have been familiar with the

⁶³⁶ Nellie Bly, *Ten Days in A Mad House*, Kindle edition, 2011, 288.

⁶³⁷ "Who Is This Insane Girl?" *New York Sun*, September 25, 1887, 1:7; "In and about the City: A Mysterious Waif," *New York Times*, September 26, 1887, 8:3; "Nelly Marina or Brown," *New York Sun*, October 5, 1887, 1:6; "Still A Mystery: Nellie Mareno's Friends as Silent as She Was Herself," *New York Times*, October 7, 1887, 8:2; "Friends Claim Nelly Moreno," *New York Sun*, October 07, 1887; "Playing Mad Woman," *New York Sun*, October 14, 1887, pg. 1, 2. There might have been many Cubans at New York mental hospitals during the time period. Or, it might have had something to do with the contemporary political environment, or the popular understanding of Cuba under the Spanish occupation. For example, Kristin L. Hoganson argues that in the nineteenth century, Cuba was often visualized as a damsel in distress. See Hoganson, *Fighting for American Manhood: How Gender Politics Provoked the Spanish-American and Philippine-American Wars* (New Haven: Yale University Press, 1998).

⁶³⁸ In 1904, Broughton Brandenburg published an account of his "immigrant" experience. He and his wife, disguised themselves as Italian immigrants, traveled from Italy to the United States and reported their findings in *Imported Americans: The Story of the Experiences of a Disguised American and His Wife Studying the Immigration Question* (New York: Frederick A. Stokes Company, 1904). Brandenburg presented himself and his wife as authentic Italians by exploiting the prevalent "racial" stereotypes for the group; however, Brandenburg depended on his Americanness and moral judgment as an American to complete his journey. Bly's stunt produced other followers who disguised themselves and pursued dangerous and scandalous scoops. For other stunt girls and "down-and-outers" in the late nineteenth century, see Jennifer Fronec, *New York Undercover: Private Surveillance in the Progressive Era* (Chicago: The University of Chicago Press, 2009); Brooke Kroeger, *Undercover Reporting: The Truth about Deception* (Evanston, IL: Northwestern University Press, 2012).

contemporary debate that immigrants overcrowded state mental hospitals and realized that they were the most abused group of people. This context also made it possible for Bly to present herself as a Cuban; she was able to navigate the boundary between her own sanity and her feigned insanity because of her awareness of various assumptions attached to being foreign. According to Lutes, “In the process of making her first and most crucial move, the transformation from free woman assumed to be sane to incarcerated woman assumed to be *insane*, she revealed the liability of claiming an ethnic identity in a legal system that purportedly saw beyond such distinctions.”⁶³⁹ Moreover, “she took advantage of the ease with which cultural difference could be encoded as pathological difference.”⁶⁴⁰ Sensitive to national or ethnic backgrounds of the women around her, Bly acknowledged that language barriers often prevented legal and medical experts from making accurate judgments and resulted in unfair and unjust hospital commitments. As doctors did at state mental institutions, she often used language differences to recognize immigrant patients’ personal circumstances. She was surprised that despite the ease of securing the service of an interpreter, judges and doctors committed patients without attempting to have full communication with them in their native tongue. Bly was particularly interested in a young German woman: Louise Schanz “did not look insane, but as she was German I [Bly] could not learn her story.”⁶⁴¹

Nevertheless, Bly explained how Mrs. Schanz was denied the help of an interpreter at the hospital, and continued:

Thus was Mrs. Louise Schanz consigned to the asylum without a chance of making herself understood. Can such carelessness be excused, I wonder, when it is so easy to get an interpreter? If the confinement was but for a few days one might question the necessity. But here was a woman taken without her own consent from the free world

⁶³⁹ Jean Marie Lutes, “Into the Madhouse with Nellie Bly: Girl Stunt Reporting in Late Nineteenth-Century America,” *American Quarterly* 54, no. 2 (June 2002): 217-253, 226.

⁶⁴⁰ *Ibid.*, 226-227. Lutes argues that authorities could have interpreted her adoption of a foreign name as a sign of insanity. However, Bly’s writing does not refer to any such suspicions from the authorities who judged her to be insane.

⁶⁴¹ Bly, *Ten Days*, 659.

to an asylum and there given no chance to prove her sanity. Confined most probably for life behind asylum bars, without even being told in her language to why and wherefore. Compare this with a criminal, who is given every chance to prove his innocence. Who would not rather be a murderer and take the chance for life than be declared insane, without hope of escape? Mrs. Schanz begged in German to know where she was, and pleaded for liberty. Her voice broken by sobs, she was led unheard out to us.⁶⁴²

Bly noticed another patient who found herself in a similar situation: “A pretty young Hebrew woman spoke so little English I could not get her story except as told by the nurses.”⁶⁴³ Bly also wrote about an old Irish woman, a German girl, a French woman, a Polish girl, and a Mexican woman. She was conscious of the hardship and suffering of these immigrant patients but more interested in preserving her identity as a respectable middle-class white woman by highlighting her observational and writing skills, rather than the tribulations of those she observed. Even when she was not able to communicate with them, she managed to detect their ethnic backgrounds without much difficulty. In addition to language differences, her stint as a journalist might have helped her distinguish these women from native-born Americans, or she might have internalized the contemporary stereotypes of different nationalities.⁶⁴⁴ Bly’s passing for a Cuban illustrates that ethnic or racial visibility was easily changeable; nevertheless, as Matthew Frye Jacobson argues, the ineluctable circle of racial ascription—in Jacobson’s example, “looking Jewish, seeing Jews”—existed here as well.⁶⁴⁵ Often, one’s facial features, whether imagined or real, revealed her origin: Bly referred to eye or hair colors of the female inmates (a blue-eyed German, a blue-eyed Irish, a red-haired Irish girl) and noted that a nurse at Blackwell’s, Miss Grupe, had “a nice German face.” The nurse

⁶⁴² Ibid., 706-708.

⁶⁴³ Ibid., 1116.

⁶⁴⁴ See Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Baltimore: The Johns Hopkins University Press, 1997), 186. She argues that in the 1920s and 30s the America public still resorted to racial or ethnic stereotypes evoked by the race science of the nineteenth century. Both women and men wanted to achieve ethnic anonymity through plastic surgery and claim their “whiteness,” that is, Anglo Saxon identity. See also Sander Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (Ithaca: Cornell University Press, 1988).

⁶⁴⁵ Matthew Frye Jacobson, *Whiteness of Different Color: European Immigrants and the Alchemy of Race* (Cambridge: Harvard University Press, 1998), Chapter 5.

stood out as an interesting case for Nellie Bly. Despite her allegedly German features, “Miss Grupe proved to be one of those people who are ashamed of their nationality, and she refused [to interpret], saying she could understand but few words of her mother tongue.”⁶⁴⁶ Although she acknowledged the alienation and discrimination that immigrants experienced, Bly was still disappointed with those who did not want to admit their immigrant past. Initially in Bly’s account, the immigrant patients did not lose their distinctiveness as individuals even in the face of insanity; yet, they ended up becoming representatives of their own national or racial backgrounds, unable to hide their differences from ordinary Americans. Such differences helped Bly distance herself from other patients and keep her respectability as an observer and member of “sane” society. She initially sacrificed her “whiteness” by pretending to be a Cuban woman, but her careful representation of herself and the asylum and her act of writing distinguished Bly from other inmates throughout her journey.⁶⁴⁷ Upon her release from Blackwell’s Island, she regained her American self. On her last day at the asylum, it was reported that her friends hired a lawyer to secure her release and paid a bond promising proper care for her. Still oblivious to Bly’s true intentions, the *New York Sun*, the rival newspaper of the *New York World*, concluded: “The girl is an American, and did not give her true name.”⁶⁴⁸ The immigrant insane Bly showed to be the “Other” further affirmed her identity as a white, American woman. Her sympathetic views of the inmates and willingness to give them a voice did not prevent Bly from using their stories as an effective ploy to serve her own narrative and, more generally, to expose the cruelty of the American legal and medical system.

⁶⁴⁶ Bly, *Ten Days*, 699.

⁶⁴⁷ Lutes, “Into the Madhouse,” 227, 229. Lutes focuses on Bly’s successful presentation of herself as a respectable middle-class white woman throughout her stunt.

⁶⁴⁸ “Friends Claim Nellie Marena,” *New York Sun*, October 7, 1887, 5:6.

Another interesting discussion of life at an insane asylum is *A Year at Elgin Insane Asylum* (1902). In 1899, “Kate Lee,” a pseudonym, was taken to Elgin Insane Asylum in Illinois by a sheriff under the ruse that she would receive an examination there and would then be cleared of her insanity charge. The background behind her commitment is murky: it is possible that her family decided to commit her to get rid of her, or that Lee, despite her protests, might have shown disturbing symptoms that alerted her community. In spite of the forced commitment and questionable circumstances under which she became an inmate, Lee had a relatively positive attitude toward her experience. In her introduction, Lee claimed she won approval from both the insane inmates and the asylum superintendent for her narrative; that is, her account would not be an exposé but rather a memoir of her stay at Elgin. She refrained from expressing her opinions directly and instead employed the voices of other inmates—for example, by quoting their complaints—to expose Elgin’s shortcomings. Still, she was critical of the institutional system and made it clear that “I may never be returned to the Asylum.”⁶⁴⁹ Lee claimed that asylum inmates lost their freedom for no apparent reason and received no proper treatment. Contrary to the widespread belief, Lee argued “[w]hatever treatment is given at the Asylum seems to consist of regular hours, long nights of sleep, low diet, and a daily walk and discipline . . . If regular hours and low diet with plenty of sleep and outdoor exercise, are desirable, they can be had anywhere, at least in the country.”⁶⁵⁰ Even this “moral” treatment was not strictly carried out at Elgin. Like Nellie Bly, Lee questioned the medical expertise of doctors, who deemed perfectly normal women insane and failed to treat their patients.

Admitting grudgingly that she had not much to complain about the hospital life other than her loss of freedom, Lee claimed: “I do not regret the one year spent at the Asylum,

⁶⁴⁹ Kate Lee, *A Year at Elgin Insane Asylum* (New York: Irving Company, 1902), 14.

⁶⁵⁰ *Ibid.*, 74. Despite the moral treatment, strait-jackets were used to restrain violent patients.

during which it was possible to mingle with the world, meet pleasant acquaintances, and gain new ideas.”⁶⁵¹ Indeed, she mingled with the world. The ethnic and racial composition at Elgin Asylum was different from that of more diverse New York institutions like Blackwell’s Island, but Elgin did admit inmates from various class, ethnic, and racial backgrounds—a Southern woman, a mulatto singer, a lady born in India (the daughter of missionaries), a young lady from a California ranch, a working girl who thought Elgin “a lovely place,” an African-American woman “Nig,” a Swedish woman, a Chicago German girl, a Jewess, and a Canadian.⁶⁵² When she described these patients, Lee saw them not as a group of insane persons but as individuals with histories and names (often assumed, to be sure), who shared their life stories and experiences with her. However, she distinguished herself from them not only through her alleged sanity but also through her power of observation. Female inmates at Elgin were committed for many different reasons, including physical sickness, overwork or overstudy, grief over lost ones, trauma, religious delusions, or family troubles. Immigrant women became insane for the same reasons; however, they also suffered from homesickness, which Lee did not fail to notice. Upon observing Mrs. Golden, a German Jewess, Lee explained: “The trees pleased her, for they reminded her of forests near her old home in Germany, where she went berrying when a girl.”⁶⁵³ In Lee’s account, immigrant patients were rarely distinguishable from native-born patients in terms of daily asylum life and medical treatment; most of them, rather surprisingly, seem to have spoken English well enough for Lee to communicate with them. Nevertheless, her efforts to maintain their individuality and demonstrate the diversity of the asylum population, in the end, could not hide the fact that they all suffered the same fate, confined at a mental hospital without an easy way out. Lee herself was discharged a year after her commitment; however, she was deemed

⁶⁵¹ Ibid., 14.

⁶⁵² Ibid., 118.

⁶⁵³ Ibid., 63.

merely improved rather than cured, and therefore she was not yet restored to her full rights and liberty and remained vulnerable to the possibility of readmission to the asylum. Lee insisted that there was an error in her case and claimed that many inmates, doctors, and nurses over the year had seen her as a sane person; “You don’t seem to be insane,” they frequently commented. Unlike other inmates, she was also able to publish her views of the institution, treatment, and its patients. She managed to present herself as a voice of reason, through which she introduced and challenged the workings of the institutional system. It was more than what any foreign-born inmates could ever do.

Margaret Starr in *Sane or Insane? Or How I Regained Liberty* (1904) went a step farther than Lee. Starr presented a critique of the damage done when committing “sane” people to insane asylums without due process and of harsh treatments of patients by doctors and attendants at mental institutions. One day, Starr visited the office of her lawyer upon receiving his letter, and from there she was sent to an insane asylum without any hearings or court proceedings. Despite her distress at this sudden turn, she managed to describe an asylum life and the ways in which patients interacted with each other within the hospital setting. Starr wrote about several foreign patients she met during her stay: “a tall, good-looking German woman,” who made Starr’s bed on her first day at the asylum, and several Irish women, one of whom, according to Starr, “was one among the many who were born on Erin’s soil, under England’s Flag, and who now lives—no, exists—under the flag of the States.”⁶⁵⁴ Soon, such distinctions disappeared because Starr, as a *sane* woman, began to feel the injustice of having to associate with insane inmates: she eventually dropped ethnic or racial references altogether and focused on her own situation. Her sympathy for other inmates waned as time went by; unable to secure her release from the asylum and abused by the head nurse Madam Pike, Starr herself became the patient. Initially, she drew a clear line between

⁶⁵⁴ Starr, *Sane or Insane?* 13.

sanity and insanity, but she found it increasingly difficult to separate herself from other patients at the asylum as she stopped observing others and began looking into herself. Starr later realized that her friends could not visit her because of the interference of Madam Pike; however, she also wondered, “Do my friends believe that I have gone crazy if only from the mere fact of my being detained here?”⁶⁵⁵ Institutions produced insane people, not the other way around; she concluded that staying with the insane made one walk the same path.⁶⁵⁶ Starr questioned the role of the asylum in treating or curing patients, but as Susan J. Hubert argues, she justified its validity in the case of treating the truly insane as opposed to sane people like herself. Starr did not protest beyond what was allowed to her as a middle-class white woman, and even in her narrative, she managed to present herself as a respectable woman unfazed by the unjust medical and legal systems. Her narrative stood only through the presence of the insane who marked her sanity and reaffirmed her virtue; though small in number, immigrant inmates certainly played a role in this.⁶⁵⁷ Like Kate Lee, who feared the repercussions of her commitment even after being discharged from the asylum, Starr realized that her rights as a woman, that is an allegedly insane woman, were greatly limited in overcoming the legal and medical systems. However, Starr eventually succeeded in bringing her case to court to redeem herself as a sane and valuable member of American society and managed to avoid going insane in the process.

These female writers, while exposing faults of the institutional system, ultimately wrote their narratives from the perspective of privileged American women. Bly’s Cuban disguise did not undermine her position as an all-American white woman; Lee used the voices of other inmates to challenge the authorities not to compromise her position; and Starr,

⁶⁵⁵ Ibid., 89.

⁶⁵⁶ Ibid., 89-90. Starr began to see insanity as something contagious. She cited an article by a German doctor, who declared that insanity was “infectious.”

⁶⁵⁷ Susan J. Hubert, *Questions of Power: The Politics of Women’s Madness Narratives* (Newark: University of Delaware Press, 2002).

who attacked the American system, was nevertheless influential enough to have her voice heard and despite her protest maintained the propriety of a middle-class white woman. They called for reform, not revolution, and their narratives reaffirmed the demarcation between their sanity and others' insanity in spite of their fear that they too might become really insane. In addition, they all managed to navigate the medical and legal institutions, which was not always possible for immigrant inmates.

Experiencing and escaping insanity also allowed men to redeem themselves as true Americans; however, male writers of mental hospital experiences encountered greater obstacles and challenges than their female counterparts. As Benjamin Reiss explains, "male patients in some sense had more to lose than did women in becoming mental patients (the rights to vote, to hold property, and so on)."⁶⁵⁸ Certainly, their madness was an affront against their manliness and masculinity, and their protests against the institutional structure posed even more danger because by protesting, they exposed themselves as insane: "In a culture that lionized male self-possession, then, to speak out as a victim was to court ruinous associations."⁶⁵⁹ This attitude explains the small number of asylum exposés or memoirs by male authors at the turn of the twentieth century. Nevertheless, Clifford W. Beers' influential autobiography, *A Mind That Found Itself* (1908), shows that the main goal of these narratives was the redemption of their authors and affirmation of their American selves.⁶⁶⁰ Beers' writing differed from the narratives of madness penned by the aforementioned female authors; instead of rebelling against or challenging the psychiatric label imposed upon him, he

⁶⁵⁸ Reiss, *Theaters of Madness*, 20. See also John Starrett Hughes, "The Madness of Separate Spheres: Insanity and Masculinity in Victorian Alabama," in *Meanings for Manhood: Constructions of Masculinity in Victorian America*, eds. Mark C. Carnes and Clyde Griffen (Chicago: The University of Chicago Press, 1990), 53-66.

⁶⁵⁹ Reiss, *Theaters of Madness*, 189.

⁶⁶⁰ Clifford W. Beers, *A Mind That Found Itself: An Autobiography* (New York: Longmans, Green, and Co., 1908). Beers explained why he was sent to these institutions: "Choice of a sanitarium by people of limited means is, unfortunately, very restricted. Though my relatives believed the one in which I was placed was at least fairly well conducted, events proved otherwise." Beers, 41.

admitted his mental problems and eventually became part of the system by helping the foundation of the National Committee for Mental Hygiene.⁶⁶¹ Beers, born in 1876 in New Haven, Connecticut, was from a privileged background and seemed to have a promising future as a Yale graduate with a career on Wall Street. However, in 1900, he attempted to kill himself by jumping from the window of his home in New Haven. He was taken to a hospital, where he experienced delusions; Beers began to imagine that he was at the center of all evil and crime and became suspicious of the world. He was later committed to two private asylums and one state mental hospital, and his experiences there resulted in his life-long commitment to reforming the American institutional system.⁶⁶² Beers' autobiography gave detailed descriptions of his delusions and state of mind, from which he suffered until 1903, while situating them in his social milieu and time; his conviction that he no longer belonged to the upper echelon of society contributed to his worsening condition at the asylum. This sense of alienation might not have been much different from what immigrant patients, though of different social standing, felt during their confinement. Yet, Beers maintained his "Americanness"—his bloodline was truly American—and gentleman-like behavior in his narrative despite the illness that compromised his position in the world.⁶⁶³ Initially, Beers interacted only with his attendants and doctors because he was suspicious of everyone around him and refused to speak during two years of his confinement. Once he began to write about other patients in his autobiography, they, including a couple of Irishmen and a foreigner from an unidentified country, became pawns in his effort to expose the cruelty and violence of attendants and doctors who bullied the decent or who were bullied into treating the patients in inhumane ways.

⁶⁶¹ Hubert, *Questions of Power*, 67.

⁶⁶² Peterson, *Mad People's History of Madness*, 161-63; Grob, *Mad among Us*, 152-56; Roy Porter, *A Social History of Madness: The World through the Eyes of the Insane* (New York: Weidenfeld and Nicolson, 1988).

⁶⁶³ Beers, *Mind That Found Itself*, 6.

These narratives relied heavily on the authors' identity as respectable American citizens. Even when they were confined and admitted their mental suffering or blurred vision of insanity and sanity (they were conscious of the possibility that they themselves might go insane in the company of insane people) these writers never denied their right to belong to American society. Their release from the hospitals and subsequent writing experiences also demonstrated their worth as true Americans. Through the hospital commitment, these writers were able to interact with the indigent patient population, of which immigrants constituted a large and visible part; however, they could never fully identify with the unfortunate beings as they remained observers (even Beers) of, rather than participants in the human suffering around them. While the American authors eventually moved beyond the institutional confines, immigrant patients would not have enjoyed such mobility, or at least so it seemed; the writers led readers to believe that immigrant patients were stock figures, whose individuality and personality was overshadowed by their racial or national markers, and eventually by their insanity.⁶⁶⁴ The task of claiming their place in American society fell to immigrants themselves.

Files and Documents: Stories of Naturalization, Citizenship, and Insanity

While these privileged American authors focused on reclaiming their Americanness, they neglected the agency of immigrants in the institutional setting. As previously mentioned, immigrants' own narratives of insanity were rare; however, immigrants encountered other American institutions, which allowed them to refashion their identities, challenge American norms, and construct their own narratives. One example is *The Autobiography of A Thief*

⁶⁶⁴ See Lois A. Cuddy and Claire M. Roche, eds. *Evolution and Eugenics in American Literature and Culture, 1880-1940: Essays on Ideological Conflict and Complicity* (Lewisburg, PA: Buckness University Press, 2003).

edited by Hutchinson Hapgood, first published in *Frank Leslie's Popular Monthly* in 1902.⁶⁶⁵

A sensational but realistic account of a thief's life at Sing Sing Prison and Matteawan Hospital for the criminally insane in New York, it shed light on the American reality experienced by immigrants and their descendants.⁶⁶⁶ The Thief, whose story was reconstructed by the editor Hapgood, occupied an in-between status. He was neither a privileged middle-class man like Clifford Beers nor a new immigrant, but he grew up with Germans and Irish in the lower eastside of New York City and described himself: "I was half Irish, and about that race there is naturally something roguish: and that was part of my wickedness."⁶⁶⁷ Through his encounters with the American penal and medical institutions, the Thief revealed the lay person's view of insanity. He showed that at prison, insanity was part of prisoners' lives. He introduced to readers various terms used by inmates to describe conditions of insanity: "shoot a bug" (sham insanity), "pipes" (crazy), "buggy" (crazy), or "pipe house" (insane hospital). Prisoners learned from other inmates how to fake insanity and which disorder to mimic so that they could be transferred to a hospital, where they expected to receive better treatment and care. For example, one of the inmates at Sing Sing, Billy, with his black eyes and "cadaverous face," was advised to "shoot the melancholy bug." With his faked illness, he was pronounced insane by two doctors and soon transferred to the mad-house.⁶⁶⁸ The Thief himself was sent to Matteawan State Hospital for the insane, according to him, without any apparent reason. As a sane man in an insane place, he developed various

⁶⁶⁵ Hutchins Hapgood, ed., *The Autobiography of a Thief* (New York: Fox, Duffield & Company, 1903).

⁶⁶⁶ Along with Josiah Flynt's *The World of Graft* (1901), Hapgood's *Autobiography* belonged to the genre of literary realism. See also Gilfoyle's discussion of George Appo, and Tchen's discussion of Quimbo Appo, Chinese immigrants in New York, who shared similar experiences with the Thief. Timothy J. Gilfoyle, *A Pickpocket's Tale: The Underworld of Nineteenth-Century New York* (New York: W.W. Norton, 2006), 311; John Kuo Wei Tchen, *New York Before Chinatown: Orientalism and the Shaping of American Culture, 1776-1883* (Baltimore: The Johns Hopkins University Press, 1999). For the study of a psychiatric hospital at Sing Sing between 1916 and 1917, see Bernard Glueck, "A Study of 608 Admissions to Sing Sing Prison," *Mental Hygiene* 2 (1918): 85-151.

⁶⁶⁷ Hapgood, *Autobiography of a Thief*, 197.

⁶⁶⁸ *Ibid.*, 167.

theories of insanity in his own terms. He was afraid that he might catch insanity as if it were contagious: “My three years in the Pipe House convinced me that beyond a doubt a man contracts a mental disease just as he contracts a physical ailment on the outside. I believe in mental as well as physical contagion, for I have seen men, a short time after arriving at the hospital, become raving maniacs.”⁶⁶⁹ While the fear of contagion did not dissipate easily, the Thief continued to test and develop new theories. Once he got committed to the insane hospital, the Thief claimed:

In one way I have been insane all my life, until recently. There is a disease called astigmatism of the conscience, and I have been sorely afflicted with that. I have always had the delusion, until the last few months, that it is well to “do” others. In that way I certainly was pipes, and in another way, too, I was insane. After a man has served many years in stir and has contracted all the vices, he is not normal, even if he does not go violently insane. His brain loses its equilibrium no matter how strong-minded he may be, and he acquires astigmatism of the mind as well as of the conscience.⁶⁷⁰

This condition he explained as “moral insanity,” which the autobiography suggests was well known even to the lay public. It displayed no obvious somatic symptoms but induced those who were allegedly afflicted with it to cheat and steal from others. Prisons, the Thief claimed, aimed to correct inmates’ “perverted conscience,” but prison conditions worsened their symptoms until they became completely mad. Insane hospitals did not attempt to make any corrections; rather, they were disciplinary institutions where the unruly and unmanageable were merely confined without proper treatment or care. This view enabled the Thief to question the boundaries between sanity and insanity; after an interview with an asylum doctor, he was convinced, though “perhaps without reason,” that not only patients and attendants but doctors too were insane.⁶⁷¹ In addition to questioning the medical authorities and experts, the Thief showed that ordinary Americans, even not so ordinary persons such as

⁶⁶⁹ Ibid., 313.

⁶⁷⁰ Ibid., 309.

⁶⁷¹ Ibid., 324.

himself, knew and understood insanity though their knowledge was couched in lay terms as opposed to medical jargon. After his prison and hospital stays and eventual reclamation of freedom, the Thief became a “man and good citizen” free from all vices that once rendered him unfit and undesirable, including his opium habit.⁶⁷² He made a contribution to society by revealing the terrible conditions at mental hospitals; also, by maintaining his position as an observer, he was able to distance himself from other criminals and insane people. His encounters with insanity as well as his prison and hospital life recreated him as a true, moral American, which in turn demonstrated the redeeming qualities of his experience.

An astute observer, the Thief was aware of his environment and diverse people that populated American urban areas. Living among Germans and Irish, he had often targeted Italians for his criminal activity; at the institutions, he noticed African American prisoners, who received worse treatment and were more likely to die than white men. Indeed, American penal and mental institutions during the period had heterogeneous inmate populations with a considerable number of immigrants.⁶⁷³ Perhaps through their involvement with such institutional structures, immigrants became aware of their differences from institutionalized and imprisoned American citizens and learned the value of the rights that Americans enjoyed. Some, like undocumented Chinese immigrants insisting upon their citizenship status before judges, attempted to create new identities through their encounters with the American authorities; others produced various stories of assimilation and adjustment, which at least on the surface confirmed their ability to settle. In *Melancholy Order*, historian Adam McKeown explains:

Truth resided in the cross-reference files rather than in the individual bodies that each inspector purported to examine... In short, migration procedures were less an investigation into how things actually were than an assertion of how things *should* be. To create and fix a new identity was much more important than to discover or

⁶⁷² Ibid., 348.

⁶⁷³ Some sources claimed that almost a half of the New York mental hospital patients were foreign born.

confirm a preexisting one. In all subsequent interactions with the government, migrants had to reproduce themselves in the terms of the files, thus gradually investing their new identities with political reality.⁶⁷⁴

One of the best ways for immigrants to achieve this new American identity was to naturalize and become Americans. Clemency letters at the New York State Archives show that immigrants, especially those who experienced the justice system of their adopted country, became savvy participants in claiming their rights and creating new identities.⁶⁷⁵ They hired lawyers and contacted the American authorities to process “restoration” of their citizenship even when they were not citizens. In March 1901, Secretary to the Governor, James G. Graham, explained in his reply to Mr. Ferrari of New York that the New York Governor “does not think it would be proper to grant restoration to citizenship to a person who is not a citizen at all.” His client “would not be a proper candidate for restoration under the present circumstances.”⁶⁷⁶ In April of the same year, another letter asking for restoration to citizenship arrived from David King on behalf of Max H. Again, the Secretary explained that restoration would not be possible because there was no evidence that Max H. was a citizen: “It does not appear that he was ever naturalized and the fact that he came here under age does not make him a citizen. If he is not a citizen there would be no propriety in restoring to him the right to vote. The only way he can get the right to vote is by being naturalized the usual way.”⁶⁷⁷ In several letters, the Secretary explained that restoration to citizenship was “simply removing the disability to vote arising from conviction of a criminal offence” and recommended those who were not yet citizens “first to get naturalized and then apply for

⁶⁷⁴ Adam McKeown, *Melancholy Order: Asian Migration and the Globalization of Borders* (New York: Columbia University Press, 2008), 269.

⁶⁷⁵ A0629-78: Executive Clemency and Pardon Application Ledgers and Correspondence, 1849-1903, Box 14, New York State Archives (hereafter NYSA).

⁶⁷⁶ Ibid.

⁶⁷⁷ May 1901, Ibid.

restoration” because both should be done before they could vote.⁶⁷⁸ In the nineteenth and early twentieth centuries, non-citizens often voted without needing to prove their citizenship; it is possible that these immigrants, prior to their imprisonment, had cast a ballot in local or state elections and were eager to reclaim that privilege.⁶⁷⁹ Or, the immigrants who applied for pardon or restoration to citizenship might have, through their exposure to institutional life, realized the importance of citizenship rights. In 1918, forensic psychiatrist Bernard Glueck noticed the lower percentage of recidivism among the foreign born at Sing Sing Prison and explained that “contact with the law and penal and reformatory institutions accomplishes much better results in the foreign born than it does in the native born.”⁶⁸⁰ However, these statistical data belied the reality of immigrants entangled in the American institutional system. In fact, many prisoners, instead of rehabilitating themselves, built social networks for criminal activities they would use upon release; immigrants not yet familiar with American society might have learned that to further protect themselves they also should become American citizens.⁶⁸¹ Given the involvement of lawyers and representatives on their behalf, it seems that the immigrants who asked for restoration to citizenship attempted to manipulate loopholes in the immigration and naturalization laws so that they could obtain legal, social, and political rights as citizens. Indeed, depending on what the Governor wished to do,

⁶⁷⁸ August 1901. To Walter N. Thayer, Esq. on behalf of the German immigrant, Herman G., Ibid.

⁶⁷⁹ At the end of World War I, nine states still allowed non-citizens to participate in elections. Bredbenner, *Nationality of Her Own*, 49. See also Ronald Hayduk, “Democracy for All: Restoring Immigrant Voting Rights in the U.S.,” *New Political Science* 26, no. 4 (December 2004): 499-523; Jamin Raskin, “Legal Aliens, Local Citizens: The Historical, Constitutional, and Theoretical Meanings of Alien Suffrage,” *University of Pennsylvania Law Review* 141 (April 1993): 1391-1470. The increasing influx of immigrants threatened the interests of the political elites, who went on to promoting the disenfranchising measures in the early twentieth century. Although there was a similar concern about the crime level of the foreign-born, foreign-born inmates at Sing Sing were underrepresented: between 1916 and 1917, 35 percent of the admissions to Sing Sing were foreign born while the foreign-born male over 16 years of age consisted of more than half of the general population.

⁶⁸⁰ Glueck, “Study of Admissions to Sing Sing,” 95. Also see 125. He argued that adverse social and economic conditions created the so-called “accidental offender” among the foreign born, who had acted in an antisocial manner as they were yet unfamiliar with the American legal and penal system.

⁶⁸¹ Gilfoyle, *Pickpocket’s Tale*; also see Daniel Bell, “Crime as an American Way of Life,” *The Antioch Review* 13, no. 2 (Summer 1953): 131-154.

restoration for “aliens” could have been processed. In August 1901, the Secretary, who had received a note from Mr. McKnight saying the Governor wished restoration papers made for Joseph W., replied that the petition for Polish-born Joseph could not be processed because he was an “alien.” However, the Secretary added: “It is quite probable that the Governor did not notice the statement [of Joseph being an alien] in the petition. If he still desires to grant the restoration, I will forward the papers.”⁶⁸² This suggests the ways in which immigrants and lawyers manipulated the petition process; they could have been granted the restoration of citizenship, and even if not, the petition was worth trying because many immigrants understood the difficulties attending the legitimate naturalization process.

Insanity cases are different from these examples; the insane, regardless of their citizenship status, were deprived of citizens’ rights. In the eighteenth and nineteenth centuries, the insane lost their rights to manage property and therefore were practically disenfranchised. Even after the property test for voters was gone in the mid-nineteenth century, they continued to be excluded as states began to include explicit provisions that barred insane people from voting.⁶⁸³ The insane were also distinguished from immigrant criminals. The clemency letters showed that a governor could grant commutation of sentence to those who were imprisoned at state prisons or penitentiaries, but his authority was limited. In 1901, responding to a woman’s letter who wished the Governor of New York to grant a release for her son, currently at Matteawan State Hospital after being adjudged insane while in jail, the Secretary clarified that the Governor’s jurisdiction extended “only to persons who have been tried and

⁶⁸² August 1901, A0629-78, Box 14, NYSA.

⁶⁸³ Kirk Harold Porter, *A History of Suffrage in the United States* (Chicago: The University of Chicago Press, 1918), 20-21. In 1860, fourteen states in the United States disenfranchised “insane people” or “idiots,” and by 1880, eleven additional states added this language to their constitutions. After 1880, as twelve more states entered the Union, they included a prohibition against the voting of such people in their constitutions. Today, 44 states have either statutes or constitutional provisions that prevent some persons with disabilities from voting. See Kay Schriener and Lisa Ochs, “No Right is More Precious: Voting Rights and People with Intellectual and Development Disabilities,” *Policy Research Brief* 11, no. 1 (May 2000).

convicted and not to those who are simply awaiting trial.”⁶⁸⁴ Moreover, he had no authority to release a patient from a mental hospital. The Secretary stated on several occasions that “[t]he courts have full jurisdiction to order the release of persons illegally detained.”⁶⁸⁵ As *The Autobiography of A Thief* showed, the insane asylum was a total institution, whose hold over the inmates was greater than that of prisons or jails; patients and observers of the system often contrasted it with the penal institution and decried its greater evil. Moreover, the insane were viewed as innocent victims, who needed constant care and attention, unlike criminals who must, according to the rules of justice, pay for their sins.

Still, the insane did have a legal means to reclaim their rights. In New Jersey, for example, the Court of Chancery supervised property matters of the insane.⁶⁸⁶ When family or relatives of an insane patient filed a petition for *writ de lunatico inquirendo*, the Court issued an order to examine her mental status, the exact value of her property, and her nearest heirs. If the individual’s insanity was confirmed and her property was believed to be in danger, the Court appointed a guardian to manage the assets. Not only family members but also neighbors, in the absence of relatives, could be legally appointed a guardian and have control over the property of their charge, whether to use it for hospital expenses or to squander it away.⁶⁸⁷ The insane person, as long as she was released from the hospital as recovered, could make a petition to the Court to restore her right to property. A number of former mental patients, including immigrants, made a petition, and the Court, upon receiving satisfactory evidence of their sanity, granted the restoration of their property rights. Indigent immigrants

⁶⁸⁴ March 1901, addressed to Mrs. Margaret B., A0629-78, Box 14, NYSA.

⁶⁸⁵ April 1901, addressed to Mr. Edward M., Matteawan State Hospital; March 1901, addressed to Mr. James D., Buffalo State Hospital, dealing with the same topic; December 1902 on John S. at Dannemora State Hospital, New York. Ibid.

⁶⁸⁶ Chancery Court, Lunacy Case Files, 1796-1912, New Jersey State Archives.

⁶⁸⁷ Chancery Court (1906), the lunacy case file of Annie, a German widow, currently at Trenton Asylum. The petitioner in Annie’s case was her landlord. He insisted that he was not Annie’s creditor and that he filed the petition for *writ de lunatico inquirendo* to protect her own interests and rights as she was unable to manage her property and had no relatives in the United States to care for her. He was also responsible for Annie’s commitment to the Insane Asylum at Trenton, New Jersey.

might not have had this legal option, but the “alien insane” could still resort to it to claim their rights, if not to citizenship or enfranchisement, but at least to their property.

The clemency letters and appeals to the state authorities reflected the contemporary concerns with American citizenship. As historian Dorothee Schneider explains, late nineteenth and early twentieth-century efforts to increase the value of citizenship, which was allegedly tarnished by inassimilable and un-American “new” arrivals, made it difficult for immigrants to naturalize on their own without the involvement of party machines.⁶⁸⁸ The lack of information and complicated application procedures also proved to be major obstacles.⁶⁸⁹ During this period, citizenship tests raised a bar for immigrants, requiring them to become familiar with various aspects of American life before their naturalization.⁶⁹⁰ In March 1913, the *Christian Science Monitor* shared a sampling of “strange answers” immigrants gave in response to citizenship test questions. According to the article, obtaining one’s naturalization papers was not “the simple matter.” It delineated the cases of Francesco, Josephus, and Ricardo to show some of the questions from the naturalization court. What is the capital of New York State? (Francesco looked blank and shook his head); Who elects the senators? (“the people”); How old is the government of the United States? (he hurried mental

⁶⁸⁸ Dorothee Schneider, *Crossing Borders: Migration and Citizenship in the Twentieth-Century United States* (Cambridge, MA: Harvard University Press, 2011), Chapter 5.

⁶⁸⁹ A 1906 *New York Times* article, “Our Deteriorating Citizenship” (March 10) pointed the finger at southern and eastern European immigrants: “The largest proportions of aliens among males of voting age are Greeks, Italians, Hungarians, Austrians, Poles. The thought of naturalizing them as Tammany naturalizes the Irish is revolting, and it is known that the volume of fraudulent naturalization is great.” According to another article published in 1910, immigrants were forced to naturalize by political machines. “One obvious feature of the situation is that the applicants for citizenship are largely considered only as so much raw material for elections and their naturalization is taken up largely by the lower type of politicians who expect to make use of their votes in the market awaiting them.” Continuing the criticism that American citizenship had been deteriorating due to naturalization of undesirable immigrants, this article called for “the radical revision” of the naturalization system. See “The Abuses in Naturalization,” *The New York Times*, July 9, 1910.

⁶⁹⁰ See Joren Lyons, “Mentally Disabled Citizenship Applicants and the Meaningful Oath Requirement for Naturalization,” *California Law Review* 87, no. 4 (1999): 1017-1049, 1024. Throughout the 1910s, discussions of literacy requirement for immigrants abounded, culminating in passage of the 1917 Immigration Act. However, the requirements of literacy and American civics knowledge were often waved for immediate family members of American citizens who were otherwise excludable.

calculation and answered “Five hundred years, mebbe”) After this question, the judge told him, “You are not quite ready yet to become a citizen,” and to try again in six months. Have you read the constitution? (Josephus said, “Oh, yes”); Tell me what you know about George Washington (he confused Washington with Lincoln); whom did Washington fight? (“He fought the American people”) Josephus did not pass the test, either, and had to “wait a little longer.”⁶⁹¹ Asked to explain what happened at Bunker hill, Ricardo answered with a big smile: “they put a pile of stones there; I have seen the pile of stones.” Never having learned to read English despite his fifteen-year stay in America, Ricardo did not pass the test.

Underlying the contemporary concerns with “new immigrants,” the article described Italians and Russian Jews as failures, even as it admitted that some of them had passed the test and taken the oath of citizenship, and contrasted them with other nationalities: “The other applicants on this particular morning were a German, a Swede, a Canadian, and a Dane. They were all successful, although some of them had considerable difficulty in explaining the difference between Congress and the Legislature.”⁶⁹² It neither questioned the effectiveness of the citizenship test nor made explicit remarks on the applicants’ differences, but it was suggestive enough: “new immigrants” from eastern and southern Europe were not as desirable as those from western and northern European countries, and their ability to adapt and Americanize was put in doubt.

Becoming an American through naturalization continued to pose a challenge. Not all immigrants actively pursued naturalization, and they were criticized for not conforming to American life.⁶⁹³ In a 1926 Congressional hearing, Professor Ernst Freund at the University of Chicago claimed that some immigrants, especially women married to American citizens,

⁶⁹¹ “Citizenship Test Questions often Draw Strange Answers,” *The Christian Science Monitor*, March 6, 1913.

⁶⁹² *Ibid.*

⁶⁹³ Dorothee Schneider shows that Mexican immigrants were not particularly keen to naturalize; some explicitly stated that they would never give up their Mexican citizenship. See *Crossing Borders*, Chapter 5.

might not have been politically minded enough to become naturalized even when their marriage status no longer earned them automatic citizenship. At the same time, he argued that the naturalization law demanded too much from ordinary immigrants; five years' continuous residence in the United States, for example, was hard to prove, so "it was hardly possible for a person to become naturalized without subornation of perjury."⁶⁹⁴ The naturalization court judge's discretion also determined whether or not one could become a citizen, making the process difficult for many willing candidates. In the late 1920s and early 1930s, critics of the citizenship tests drew attention to the problems of the administration. In the *Pennsylvania Bulletin*, the unnamed author, who was foreign born and married to a naturalized American citizen, expressed her frustration with the management of the citizenship administration in a scathing criticism of the naturalization process.⁶⁹⁵ Her first advice to applicants was: "learn the great art of waiting, waiting patiently for days, weeks and months." She was also critical of the officials, who had no consideration for immigrants unfamiliar with the English language: "Mumbling, by the way, is not a habit with the naturalization officials, it is an Art."⁶⁹⁶ Moreover, the citizenship questions were too tricky to answer, not only for immigrants but even for educated Americans. She resented that just to become an American, a poorly educated immigrant laborer was required to know what even teachers and college professors did not.

Passing the citizenship test and becoming an American citizen would have been a great advantage to insane immigrants, discharged from hospitals and resuming their lives in America. There are no available sources on the difficulties they might have had in passing the

⁶⁹⁴ "Deportation of Alien Criminals, Gunmen, Narcotic Dealers, Defectives, etc.," Hearings before the Committee on Immigration and Naturalization, House of Representatives, 69th Cong., 1st sess. (March 25, 26, April 13, 1926): 15-6.

⁶⁹⁵ "How to Become an American: By One Who Knows and Did," *The Pennsylvania Bulletin*, date unknown (ca. 1928), 3, 10-11, Folder 12: Naturalization, 1927-36, Immigration and Refugee Services of America, Foreign Language Information Service, IHRC.

⁶⁹⁶ *Ibid.*, 3.

naturalization tests; however, mental examinations at state hospitals give a glimpse into their potential troubles. For example, at Buffalo State Hospital, New York, some of the questions to test patients' "education and general experience" included: president of the U.S., how he was elected, capital of the U.S., governor and capital of New York, mayor of Buffalo, and the first president of the U.S. (See Appendix D for samples of the mental examinations at Buffalo State Hospital, New York, and Mendocino State Hospital, California). After World War I, doctors also asked patients when the war began, when the U.S. got involved, and which side won. Some immigrant patients showed a limited or fair grasp of these questions in keeping with their "education and advantages."⁶⁹⁷ Others were "unable" or refused to answer, or responded only with, "I don't know"⁶⁹⁸; oftentimes, doctors just wrote "no cooperation" in the examination section of the patient file. Still others had stories to tell to justify their inability to answer these questions. In 1908, after the mental examination with Polish-born Gustav, the examining doctor wrote, "scarcely any," in the education section, and added: "He can read a little in Polish and can write his name, or at least he says he can when he has glasses."⁶⁹⁹ Like the immigrants who failed the citizenship test, insane immigrants not yet familiar with American society, whether due to the language barrier, lack of education, or mental instability, might have found it difficult, if not impossible, to achieve the legal and political status of an American citizen.⁷⁰⁰

⁶⁹⁷ Buffalo State Hospital, Mary W., admitted in April 1911 and discharged in December 1911. In U.S. for 2 years. Diagnosis: paranoiac condition. Her abstract read that "[h]er Store of General Knowledge is rather limited but evidently in keeping with her limited education and advantages."

⁶⁹⁸ Mendocino State Hospital. French-born Marie, admitted in November 1917. In U.S. for 17 years. Diagnosis: manic-depressive insanity. She died of pulmonary tuberculosis in November 1918.

⁶⁹⁹ Buffalo, admitted September 1908 and discharged May 1911. In U.S. for 3 years. Diagnosis: alcoholic psychosis.

⁷⁰⁰ In 1994 Congress exempted citizenship applicants with mental disabilities from the requirements of English fluency and knowledge of the United States history and civics. However, Joren Lyon argues that they are still barred from citizenship by the Immigration and Naturalization Service, whose rigid interpretation of the oath of allegiance requires the applicants, even mentally disabled, to successfully demonstrate their belief in the Constitution and intent to renounce all prior allegiance. See Lyon, "Mentally Disabled Citizenship Applicants," 1017-1020.

Despite these hardships, immigrants had their own stories of naturalization experiences, and the amusing vignettes somewhat ameliorated their troubles with the naturalization law. Ernesto Tummolillo, an Italian immigrant, arrived in the United States in 1901, looking for adventure. According to his granddaughter, “[h]e was such a brilliant scholar that three weeks after he arrived [in America] he received his United States citizenship.”⁷⁰¹ In 1908, Edward Wilhelm Lawrence, born Irish, became naturalized “[b]ecause he knew the positions of all the clubs of the two major baseball leagues.” The naturalization court judges considered him “sufficiently versed in American institutions to be worthy of full citizenship.” Of course, he had to take the naturalization tests and manifest his knowledge of general affairs of the country, but “the baseball situation was taken up, and Lawrence made a home run in proving that he was a good American.”⁷⁰² Not surprisingly, Asian immigrants were left out of the citizenship stories because of their ineligibility for naturalization.⁷⁰³ Still, these accounts suggest the ways in which immigrants and their descendants became participants in constructing naturalization and citizenship as a symbol of successful settlement and assimilation in America.

Insanity stigmatized the “alien insane” and deprived them of certain citizenship privileges; yet insane immigrants, with the help of professional psychiatrists and lawyers, were able to use American views of insanity to their advantage. Insanity pleas were common at the turn of the twentieth century, and they were embraced by native-born Americans and

⁷⁰¹ Tummolillo, Ernest (1879-1916) Papers, Box 3: “Italian Miscellaneous Manuscript Collections,” IHRC.

⁷⁰² “Baseball Naturalizes Him,” *The Washington Post*, May 31, 1908.

⁷⁰³ For Asian immigrants, see Erika Lee and Judy Yung, *Angel Island: Immigrant Gateway to America* (Oxford: Oxford University Press, 2010) and Connie Young Yu, “Rediscovered Voices: Chinese Immigrants and Angel Island,” *Amerasia* 4, no. 2 (1977): 123-139. Though not naturalization narratives, *Angel Island* and “Rediscovered Voices” offer many stories of Asian immigrants, including discussions of the Angel Island poems. For the Angel Island poems, see *Island: Poetry and History of Chinese Immigrants on Angel Island, 1910-1940*, eds. Him Mark Lai, Genny Lim, and Judy Yung (Seattle: University of Washington Press, 1991).

immigrants alike.⁷⁰⁴ Even new arrivals managed to exploit the American legal system to create a sympathetic narrative for themselves. Dr. Ishida's case, briefly mentioned in Chapter 1, offers a rare view of how the insanity of an immigrant was discussed and determined. In December 1918, Ishida, a Japanese psychiatrist at the Sheppard and Enoch Pratt Hospital in Baltimore, Maryland, shot and killed his colleague, George B. Wolff. Upon trial, he insisted that the American doctor called him a spy and traitor and, in addition, violated the honor of a hospital nurse.⁷⁰⁵ The nurse, on the other hand, stated that Dr. Wolff did not attack her and it was in fact Dr. Ishida who made an improper proposition to her. Ishida claimed when he committed the murder, he was temporarily insane and could not remember what he did. He and his lawyers pleaded insanity at his murder trial and solicited the assistance of fellow psychiatrists to measure his mental state; however, Ishida himself was a psychiatrist with Japanese and American training, and the American public as well as the medical experts feared that he might "fake" insanity using his knowledge of the disease. His defense team, therefore, turned to Ishida's Japanese acquaintances for the real proof of his insanity:

All [of his Japanese friends] said Dr. Ishida was extremely boastful about himself after he returned from Chicago last fall, where he was made an honorary member of

⁷⁰⁴ Joseph Collins, "The Alienist in Court," *Harper's Monthly Magazine* 150 (February 1924): 280-286. He was concerned that an indiscriminate use of insanity pleas and complicity of dishonest psychiatrists compromised the profession of alienists. Insanity pleas were widely used, and new types of insanity were frequently invented. In 1908, a Korean man named In Whan Chang shot and killed Durham White Stevens, the American diplomat and representative of the Japanese government in Korean affairs, in San Francisco, California, and was tried for murder. Chang's fellow countrymen asserted that he was insane on the subject of relations between Japan and Korea, and his defense team pleaded "patriotic insanity"—a "novel defense" as one newspaper called it. Medical professionals who observed Chang in the courtroom claimed that he was sane at the present time but they were not certain what his mental condition must have been like when he shot Stevens. The plea was not accepted; Chang was convicted of second degree murder and sentenced to life imprisonment. Still, this case shows how both immigrant communities and American lawyers manipulated the court system through their familiarity with insanity. "Koreans Will Fight to Save Life of Slayer," *Los Angeles Herald*, April 11, 1908; "Novel Defense for Korean Assassin," *San Francisco Call*, December 8, 1908; "Korean Conditions Revealed at Trial of In Whan Chang," *Los Angeles Times*, December 23, 1908; "Diplomat's Slayer Guilty of Murder," *San Francisco Call*, December 24, 1908. One of the most famous trials to utilize an insanity plea was the Thaw trial of 1907. See Martha Merrill Umphrey, "Media Melodrama! Sensationalism and the 1907 Trial of Harry Thaw," *New York Law School Law Review* 43 (1999-2000): 715-739.

⁷⁰⁵ Newspapers added a touch of sensationalism to this murder story by focusing on the love triangle of Dr. Ishida, his victim, and the nurse.

the American Psychiatric Association. They said no Japanese gentleman ever exalts himself unless his mind is unbalanced. Dr. Mutsuji Kosaki said he thought Dr. Ishida was of unsound mind because he assisted the wife of another Japanese to remove her coat at a dinner party given by the Japanese residents of this city in October and then talked to her most of the time they were at the dinner table. He caused laughter in the courtroom when he explained that a Japanese gentleman whose mind is sound would allow the lady to remove her own coat, hang it on the rack, and would allow her husband to do most of the talking to her. Dr. T. Matsumoto [sent by the Japanese government to the Phipps Clinic at the Johns Hopkins University] said Dr. Ishida proved his insanity on the trip from Japan to this country a little over a year ago, when he wore his coat inside out at a masquerade dance on the boat. He admitted that practically every man on the boat wore his coat inside out at the dance, but he said it showed insanity for a man of Dr. Ishida's standing to do it.⁷⁰⁶

In addition, several Japanese psychiatrists who had known Dr. Ishida testified that he had given evidence of "self-exaltation" or that in plain American language, he was "swell-headed." The defense tried to prove that this "swell-headedness" was a sign of insanity. They also claimed that Dr. Ishida was a "paranoiac," whose symptoms included becoming suspicious and writing plays, poetry, and books.⁷⁰⁷ The insanity plea did not work: Ishida was convicted of murder in the first degree and was sentenced to life imprisonment at the Maryland Penitentiary. Ironically, Ishida became insane while serving his term and was sent to a mental hospital; since his mental condition did not improve and the expenses for his keep became burdensome, Ishida was returned to Japan in 1925 for medical care on condition that upon recovery he should come back to the U.S. to serve the rest of his sentence.⁷⁰⁸

Like Americans, Ishida's Japanese acquaintances were quick to judge others through their own cultural norms, deeming those who deviated as insane. Ishida's insanity became apparent to them when he crossed the boundaries of social class and gender conventions. At

⁷⁰⁶ "Nurse Accuses Ishida: Miss Jacobs Says Japanese Tried to Lure Her to His Room," *The Sun*, March 19, 1919, pg. 7.

⁷⁰⁷ "Fate Up to Alienists," *The Sun*, March 20, 1919, pg. 6.

⁷⁰⁸ His condition was so serious that it was doubted whether he could ever recover and return. "Dr. Ishida Found Guilty: Sentence to life imprisonment for first-degree murder," *The Sun*, March 21, 1919, pg. 16; "Move for Japanese Slayer: Governor asked to have Ishida released and returned to his home," *The Sun*, Sep. 14, 1919, pg. 13; "Dr. Ishida Hearing Set for Tuesday: Japanese Embassy Seeks Parole for Slayer of Dr. G. B. Wolff," *The Sun*, October 15, 1925, pg. 3; "Governor Grants Parole to Ishida," *The Sun*, October 21, 1925, pg. 5.

the same time, these acquaintances, mostly doctors, played with the idea of assimilation. The reason one of the friends could draw laughter in the courtroom was because he provided a contrast between Japanese and American norms: what was natural to Americans, such as helping a woman take off her coat, was inconceivable to Japanese, or so it seemed. Americans saw assimilation and settlement in America as a virtue for new immigrants, and insanity was a result of their failure at true assimilation or surrender to superior American civilization. However, from the perspective of the Japanese witnesses, too much knowledge of and familiarity with American life invited suspicion. Ishida's too-Americanized behavior, including "self-exaltation," or his eagerness to shed Japanese conventions breached the norms of their community and therefore translated into symptoms of insanity. Ishida's Japanese friends might have volunteered the information to save him from being sentenced to death for murder: after all, an insanity judgment was better than death as many legal cases with an insanity plea testified. Or, as upper class, educated psychiatrists familiar with American views of insanity, they could have manipulated the American understanding in their descriptions of Ishida's "insane" behavior. Their participation in the construction of the defense narrative suggests that through the legal proceedings, immigrants were able to work the system and articulate their own version of reality even as they failed in their attempt.

Narratives of Insanity by Immigrant Writers

Some immigrants were aware of the peril of insanity before their departure for the United States. Many European countries had already established state institutions for the insane, and some immigrants had experienced hospital commitment before they settled in America. In Asian countries, such as China and Japan, institutions for the insane, whether run by American medical professionals or founded by national governments, began to emerge,

attracting both the indigent and paying patients.⁷⁰⁹ Ethnic songs and skits at the turn of the twentieth century also imparted immigrants' familiarity with mental troubles; though casually, they talked about being crazy, having mental conditions, or being at a "bughouse"—"Ah, I think you are crazy and you need the bughouse"⁷¹⁰—which suggests that insanity was part of their everyday life.⁷¹¹ Many did suffer from mental disturbances and were stigmatized by their experiences. This section does not intend to negate their suffering and pain; rather, it aims to show that instead of merely internalizing American conceptions of insanity, immigrants constructed their own narratives of illness, assimilation, and American life.

Unlike the accounts of a life at an asylum or the official files and documents of naturalization and citizenship, the fictional or autobiographical accounts of insanity by immigrant authors rarely discussed institutional experiences or encounters with the American medical system, which would have ended in lengthy hospital confinement, even for a lifetime, or deportation. Nevertheless, these narratives expand our understanding by concretizing abstract notions of insanity and assimilation within their stories and characters and by showing that insanity was a reasonable response to the tensions of living between the two worlds. As historian Jonathan Metzl puts it in the case of African Americans and their 1960s civil rights protests, their mental trouble was an adaptation "necessary for survival" in societies where African Americans felt alienated and not accepted; immigrants too might

⁷⁰⁹ For China, see Guangqiu Xu, *American Doctors in Canton: Modernization in China, 1835-1935* (New Brunswick, NJ: Transaction Publishers, 2011); for Japan, see Akihito Suzuki, "The State, Family, and the Insane in Japan, 1900-1945," in *The Confinement of the Insane: International Perspectives, 1800-1965*, eds. Roy Porter and David Wright (Cambridge: Cambridge University Press, 2003), 193-225.

⁷¹⁰ From the 1922 recording of "Der Doktor's Operation Room." Ellis Island Discography Project at the Ellis Island Immigration Museum, the National Park Service.

⁷¹¹ For the bughouse reference, see the recording of Cal Stewart, "Uncle Josh at the Bughouse" (1919). The narrator was told he could not serve on the jury because a lawyer heard that he was "just let out of the bughouse." In fact, he was coming from a friend's whose name was Bug. While this recording does not concern a specific immigrant group, it suggests that insanity and its repercussions were well known in America. Early recordings of Swedish, Jewish, and Italian songs also had casual references to being "crazy." Ellis Island Discography Project.

have adopted insanity as an adaptation strategy to cope with their realities.⁷¹² This section examines, along with other immigrant accounts, O. E. Rølvaag's fictional work *Giants in the Earth* published in 1927, and Sui Sin Far's novella, "The Wisdom of the New" in *Mrs. Spring Fragrance*, from 1912.⁷¹³ Norwegian-born Rølvaag immigrated to the United States in 1896 and became a professor at St. Olaf's College in Minnesota. In 1924 and 1925, he published *Giants in the Earth* in Norwegian and two years later in his own English translation. An epic saga of a Norwegian family who settled in the Dakota Territory in the 1870s, *Giants in the Earth* narrates the story of Per Hansa and his wife Beret, whose deterioration into insanity paralleled the successful settlement of the family in America. Edith Maude Eaton, born in England to a westernized Chinese mother and an English father, adopted Sui Sin Far as her nom de plume and chose Chinese immigrants in North America as her main subject. In Canada, where her family moved from England, she began her career writing for newspapers in Montreal. She later worked as a secretary in the United States while continuing to write short stories and essays. "The Wisdom of the New" tells the story of a Chinese woman named Pau Lin, who followed her husband to Seattle. Jealous of her husband's white female friend and uneasy about her son's future, she ended up poisoning the child and leaving the country with the husband.

According to literary critic Madelaine Hron, popular narratives by immigrant authors at the turn of the twentieth century followed the literary tradition of the American success story, in which immigrants' suffering and pain became a necessary evil to achieve the status of real "Americans."⁷¹⁴ In this context, it is possible to see O. E. Rølvaag's and Sui Sin Far's

⁷¹² Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009), 119-20.

⁷¹³ O. E. Rølvaag, *Giants in the Earth: A Saga of the Prairie* (New York: Harper, 1929); Sui Sin Far, Amy Ling, and Annette White Parks, *Mrs. Spring Fragrance and Other Writings* (Urbana: University of Illinois Press, 1995).

⁷¹⁴ Hron, *Translating Pain*.

narratives as typical immigrant stories and consider their characters' suffering an essential step to their settlement and assimilation. However, they also suggest that insanity was not necessarily an illness which could be controlled or possibly cured; the characters' madness was often invisible to outsiders, and the boundaries between sanity and insanity were blurry. That is, these writings demonstrate, as Saroyan's short story does, that insanity was not something strange or unfamiliar for many immigrants but part of their everyday life, inseparable from their experiences as immigrants. The immigrant writers like Rølvaag and Sui Sin Far internalized many American notions, but they also provided a critique of American society by redefining what it meant for immigrants to come and settle in America. These fictionalized accounts reveal a highly charged emotional vision of assimilation or Americanization, which perhaps demanded much more from newcomers than legal or political integration (i.e. naturalization) did.⁷¹⁵

In 1932, the Norwegian psychiatrist Ø. Ø degaard explained why the American public took interest in insane immigrants. Naturally, American immigration officials were concerned with this particular group and:

[t]he [American] taxpayers were also interested, because most of the insane foreigners become public charges, which means that the public expenses increase by millions of dollars. Europeans on the other hand are somewhat alarmed by the frequent rumours of insanity caused by the hardships of immigrant life in America. Statements to this effect are very common in letters, newspapers, etc., and in Norway the widely read immigrant novels by Bojer and Rølvaag have in recent years brought the problem into the limelight of public interest.⁷¹⁶

⁷¹⁵ To the American government, insanity was a form of failure on the immigrant's part, but for the immigrant himself, it could have different meanings. Eugene B. Brody explains that not only migrants and their families but also the host country can define adaptation; that is, what the immigrants saw as proper adaptation might not be such for the host country, and vice versa. "Migration and Adaptation: The Nature of Problem," in *Behavior in New Environments: Adaptation of Migrant Populations*, ed. Eugene B. Brody (New York: Sage Publications, 1970), 13-22.

⁷¹⁶ Ø. Ø degaard, "Emigration and Insanity." *Acta Psychiatrica Scandinavica Supplement* 4 (1932): 1-206, 9-10. Johan Bojer, *The Emigrants* (New York: The Century Company, 1925); O. E. Rølvaag, *Giants in the Earth*.

Ø degaard claimed that these interests were not based on scientific or medical attitudes, which he adopted in his study “Emigration and Insanity” where he attempted an ideal balance of “the attitude of absolute and impartial authority and the spirit of service.”⁷¹⁷ Though not a scientific study, Rølvaag’s novel reflected the public attention to immigration and insanity and offered rich details on the difficulties immigrants experienced and the ways in which they coped with insanity as a means to address the overwhelming daily realities of their new existence.

In the United States, Asian immigrants afflicted with insanity did not receive as much attention or sympathy as European newcomers did. However, the public was aware of many forms of prejudices against Asians in America and the hardships they encountered. Sui Sin Far’s stint as a journalist in Canada suggests that she too knew of the suffering of Chinese immigrants in North America and used her writings to address racism against the Chinese. Tracing her early stage of writing in Canada, Sui Sin Far’s biographer Annette White-Parks found a newspaper article, which she believes Sui Sin Far wrote while working for the *Montreal Daily Witness* in 1890.⁷¹⁸ The piece titled “The Ching Song Episode: The Crazy Chinaman Regains His Senses and Stays in Canada” introduces readers to Ching Song, a Chinese laundryman, who had been kept in jail for the troubles he caused. He was “just on the eve of being declared insane,” but he “suddenly ceased to talk about desiring to go to “China or heaven,” and expressed his intention of becoming a good Canadian citizen and engaging prosaically in “washee-washee.””⁷¹⁹ The article does not go into detail about what happened; however, it hints that Ching Song challenged the authority of Customs officials by

⁷¹⁷ Ø degaard, “Emigration and Insanity,” 10.

⁷¹⁸ Most newspaper articles of the period did not have bylines, so White-Parks analyzed newspaper articles based on the writing styles and subject matters.

⁷¹⁹ Annette White-Parks, *Sui Sin Far/ Edith Maude Eaton: A Literary Biography* (Urbana: University of Illinois Press, 1995), 79. Even if Sui Sin Far had not written this piece, it would still have had its value as a historical account of Chinese immigrants and for its reference to the notion of insanity.

refusing to pay fifty dollars, a fee they charged before letting him begin his laundry business in Canada. His disobedience explained why he was in jail and why he was about to be declared insane. White-Parks argues that “[t]he controlling irony in this piece ... is in its oppositions of “craziness” and “sanity,” the former equated with a desire “to go to ‘China or heaven,’” the latter with ‘becoming a good Canadian citizen.’”⁷²⁰ Sui Sin Far left readers to wonder which was indeed a saner, better option for the Chinese man. She adopted a similar approach to her novella, “The Wisdom of the New,” in which Pau Lin’s jealousy and infanticide,⁷²¹ which could have evidenced her insanity, took on a new meaning; for Pau Lin, the infanticide was a reasonable response to her conflicted realities, while the outside world judged it as an undeniable symptom of insanity. Moreover, this tragic novella dealt with the mental suffering of an Asian immigrant and her view of America, which rarely came to the literary fore until the second half of the twentieth century with the publications of Maxine Hong Kingston and Hisaye Yamamoto.⁷²²

The elusive nature of insanity and its resistance to clear definitions helped the fictional characters of O. E. Rølvaag and Sui Sin Far conceal their mental condition and escape detection by the American authorities. In *Giants in the Earth*, the characters’ pioneer status protected them from urban pressures and legal threats that could have resulted in hospital commitment, or even deportation, for other immigrants. In Sui Sin Far’s novella, the invisibility of insanity, manifest only through the poisoning of the son, shielded Pau Lin and her husband from American intervention and criminal judgment. Their voluntary departure from the United States—after the murder of the child, Pau Lin and her husband returned to

⁷²⁰ Ibid., 80.

⁷²¹ Pau Lin was afraid her son was too Americanized, so she poisoned him before it got too late. This fear might not have been uncommon. Kate Lee explained that one woman at Elgin became insane because “My boy learned so many things that I did not want him to.” Lee, *A Year at Elgin*, 114.

⁷²² Hisaye Yamamoto, *Seventeen Syllables and Other Stories* (Latham, NY: Kitchen Table-Women of Color Press, 1988); Maxine Hong Kingston, *The Woman Warrior: Memoirs of a Girlhood Among Ghosts* (New York: Knopf, 1976).

China, leaving a note explaining that the child died from an accident—also shielded them from the threat of trial and deportation. Furthermore, Rølvaag's and Sui Sin Far's characters were able to articulate their mental pain and suffering, which American journalists or memoirists seldom did for immigrant patients. Their insanity was not a form of resistance against the deprivations they experienced in America,⁷²³ but rather a way to cope with the new environment.

O. E. Rølvaag's and Sui Sin Far's stories included various references to insanity or madness, similar to those often found in contemporary patient case files of the immigrant insane.⁷²⁴ In *Giants in the Earth*, Beret, a Norwegian woman who moved to the prairie with her husband Per Hansa, was described as being nervous and sick, having "strange spells of sadness" with a "strange, unnatural look." She also became "shabby, unkempt," did not bother to "wash herself," and kept losing her possessions.⁷²⁵ Eventually, she began to see a "monster" whose face came closer to her in the dark, and she became constantly haunted by the specter.⁷²⁶ In Sui Sin Far's "The Wisdom of the New," Pau Lin, the Chinese woman who came to America to reunite with her Chinese husband, did not show strange, or "mad," behavior. However, she maintained her distance from everything American and kept to

⁷²³ Marta Caminero-Santangelo, challenging the feminist valorization of madness, emphasizes the importance of acknowledging realities and consequences of madness. *The Madwoman Can't Speak: Or Why Insanity Is Not Subversive* (Ithaca: Cornell University Press, 1998). It is also important to see how immigrant writers expressed their insanity as a real and tangible concern, not just as a symbol of their marginalized status or an attempt of resistance.

⁷²⁴ These narratives also shed light on racial and cultural heterogeneity of immigrants. In Rølvaag's story, the possibility of Norwegians becoming American, whether hyphenated or not, was rarely questioned. Their "whiteness" granted them certain rights and privileges: with hard work, they bought and cultivated land and created a new life for generations to come. The Chinese as the example of Pau Lin and her family suggests had a more difficult time as "foreigners" or "strangers" in the land and they were denied legal and political adjustment (naturalization, land ownership, or reproduction). Sara Eddy, however, explains that the racial or ethnic identities of European immigrants on the plains were not as easily settled as those in the northeast, partly due to the absence of visible non-white "Others." Eddy, "'Wheat and Potatoes: Reconstructing Whiteness in O. E. Rølvaag's Immigrant Trilogy,'" *MELUS* 26, no. 1 (Spring 2001): 129-149.

⁷²⁵ Patient case files from New York and California hospitals at the turn of the twentieth century included many cases of "filthy" women, who stopped taking care of themselves and neglected their families.

⁷²⁶ Rølvaag, *Giants in the Earth*, 378.

herself and her family. Her jealousy—Pau Lin’s husband Sankwei treated a white woman better than he treated her—and the fear of assimilation led Pau Lin to kill her son, who became more and more Americanized: “Sooner would I, O heart of my heart, that the light of thine eyes were also quenched, than that thou shouldst be contaminated with the wisdom of the new.”⁷²⁷

These stories were not free from the popular American belief that immigrants’ inherent weaknesses and inability to adapt explained their mental troubles. For example, it was mostly female characters, of a weaker and inferior sex, who experienced insanity in the immigrant narratives. In *Giants in the Earth*, Rølvaag blamed the arid, harsh environment of the Dakota Territory for causing Beret and other immigrant women to become “nervous.”⁷²⁸ Still, he hinted that Beret was predisposed to going insane: according to the husband Per Hansa, Beret “has never felt at home here in America... There are some people, I know now, who never should emigrate, because, you see, they can’t take pleasure in that which is to come—they simply can’t see it!”⁷²⁹ Similarly, Pau Lin in “The Wisdom of the New” “had shown no disposition to become Americanized” and avoided interacting with others.⁷³⁰ Some medical experts concurred with the gendered assumptions of insanity. In 1918, the *Manual of the Mental Examination of Aliens* of the U.S. Public Health Services stated: “The ability of an individual to adjust himself to new situations might perhaps be considered a very fair test

⁷²⁷ Sui Sin Far, “Wisdom of the New,” 52.

⁷²⁸ Ø degaard in “Emigration and Insanity” also explains immigrant women’s insanity along the similar vein.

⁷²⁹ Rølvaag, *Giants in the Earth*, 440. Many scholars have seen Beret as “a failure in terms of pioneer life,” who continued to rely on the old world norms and hindered the process of Americanization. However, Beret played an important role in assisting Per Hansa’s Americanization. John Muthyala argues that it was the still remaining forces of separate spheres that conditioned Beret and Per Hansa’s frontier life. See Muthyala, “Gendering the Frontier in O. E. Rølvaag’s *Giants in the Earth*,” *Great Plains Quarterly* (2005): 229-244.

⁷³⁰ Sui Sin Far, “Wisdom of the New,” 47.

of his mental stability.”⁷³¹ Immigrants with insanity would not be able to adjust or assimilate into American society; in turn, their inability to make proper adjustment might lead to mental illness. This circular view of insanity and adjustment explained why these women, who merely followed their husband to the New World, perhaps against their will, became more prone to insanity: their dependent status, susceptibility to control, and comfort in traditional ways left them vulnerable. Others disagreed. As early as 1895, the *Boston Medical and Surgical Journal* article attempted to unravel the belief in female susceptibility to insanity. Using the records of the Massachusetts state hospitals for the insane, the author concluded that women seemed to be overrepresented among the hospital population because they tended to remain hospitalized and to live longer than male patients, not because they were more prone to mental illness.⁷³²

Despite their choice to emphasize madness among women, the authors of the immigrant narratives looked sympathetically upon their entrapment. Saroyan’s “Madness in the Family” (1967), although written later than the other stories, acknowledged gender differences in insanity: “Their [women’s] madness was justified and reasonable, which may have made its concealment a relatively simple matter. The demands on women for diplomatic behavior were so severe and so taken for granted by the men that madness was upon the women practically all of the time.”⁷³³ Saroyan understood the burden upon women of the family and accepted madness as a natural reaction to their life situation. On the other hand, Saroyan observed, the madness of men was celebrated as a kind of pilgrimage, a trip after which “they were considered wise men, or perhaps even holy men”; contrary to women’s madness, men’s “journeying” could not be justified or reasoned with and therefore, posed a

⁷³¹ U.S. Public Health Service, *Manual of the Mental Examination of Aliens* (Washington: Government Printing Office, 1918), 41.

⁷³² *Boston Medical and Surgical Journal* 133, no. 7 (1895): 162-163. According to the article, men were discharged more quickly than women because as breadwinners, they needed to support their families.

⁷³³ Saroyan, “Madness in the Family,” 1.

greater threat to the family and the community.⁷³⁴ In all, however, Saroyan chose not to emphasize the essential differences between the sexes but rather the demands and expectations of the new environment as a cause for male and female versions of madness.

This approach explains other narratives of immigration and insanity. In *The Divided Heart*, historian Dorothy Burton Skardal argues that Beret's mental troubles reflected the seriousness or even moroseness of the Norwegians. Skardal cites Waldemar Ager, a Norwegian-born newspaperman in Wisconsin, who claimed that the Norwegians on the American prairie were marked by melancholy: "The Irish brought their irrepressible humor with them... and the Germans and Danes their geniality and sociability... We Norwegians (and perhaps the Swedes) often become introspective and despondent. It is possible that the prairie is partly to blame. We are basically a mountain people."⁷³⁵ Although Ager reified alleged differences among immigrant groups in his statement, he also suggested that in explaining insanity, difficulties of confronting and dealing with new realities were more significant than differences between the sexes. *The Emigrants*, the 1925 novel by another Norwegian author Johan Bojer, captures this suggestion through Per Føll, a well-built and strong Norwegian man on the American prairie, who succumbed to insanity. His madness was precipitated by his suspicion that his wife married and followed him to America only because she had been carrying another man's child and wanted to hide her shame. In the end, however, it was the "plain" and the loneliness of the prairie that drove him mad.⁷³⁶ After a brief period of struggle, Per Føll was swiftly transported to an asylum never to return:

A couple of days later, a prairie-schooner drove slowly over the plain toward the town. There were four men with it, and Per sat inside, bound hand and foot. Now and

⁷³⁴ Ibid., 1.

⁷³⁵ Quoted in Dorothy Skardal, *The Divided Heart: Scandinavian Immigrant Experience through Literary Sources* (Lincoln: University of Nebraska Press, 1974), 100.

⁷³⁶ Bojer, *Emigrants*, 119. Johan Bojer, a well-known Norwegian novelist, was not an immigrant, but he visited South Dakota in 1923 to conduct research for *The Emigrants*. He published the novel in 1925 to celebrate the centennial of the first immigration of Norwegians to America.

then he screamed, and implored them to tie something over his eyes. The plain, the plain, the plain! It was drawing him, drawing him. Everything was spinning round. Hi! Hi! he was on a merry-go-round—hold tight! Perhaps it was all a joke, after all. He sang and laughed; and presently burst into tears again.⁷³⁷

The insanity of Per Føll, the strongest of the lot, revealed the extreme difficulties of American life, and his death at the asylum would function as a necessary sacrifice for the settlers to be integrated into American society. The insane had to perish because only through death could they save the community to settle and assimilate. Thus, Bojer fully internalized the logic of assimilation or Americanization; as a signal of the end of the old life and the beginning of a new one, death and burial offered a final resolution.

The autobiography of F. Michele Daniele, an Italian American doctor, is another American success story that viewed immigrant's mental disturbance as a necessary evil to overcome. *Signor Dottore* (1959) detailed Daniele's immigration to the United States from Italy at the turn of the twentieth century.⁷³⁸ He was not a typical immigrant in terms of his social and educational backgrounds. Rather, Daniele was a rare specimen of "supposedly sane, intelligent, educated" men who sacrificed everything for an opportunity in America.⁷³⁹ He managed to continue his career as a medical practitioner in Youngstown, Ohio, and with its Italian community as his main clientele, he was able to empathize with the grievances of Italian immigrants. Daniele witnessed not only physical difficulties and diseases but also superstitions—"the fogs and chimeras of ignorance"—and mental hardships that plagued Italians in Youngstown.⁷⁴⁰ He realized that cultural differences drove a wedge between Americans and Italian immigrants and tried to bridge the two through his medical and cultural expertise. Like other writers, he embraced the gendered notion of insanity when his

⁷³⁷ Ibid., 251.

⁷³⁸ F. Michele Daniele, *Signor Dottore: The Autobiography of F. Michele Daniele, Italian Immigrant Doctor (1879-1957)*, ed. Victor Rosen (New York: Exposition Press, 1959).

⁷³⁹ Ibid., 33.

⁷⁴⁰ Ibid., 61.

wife Elvira began to suffer from mental illness in 1910: “She had always been frail and weak, with a marked tendency to low blood pressure and anemia... Moreover, she had never really become acclimated to North American weather, and the damp, foggy, smoke-laden atmosphere of Youngstown affected her not only physically but emotionally as well.”⁷⁴¹ While acknowledging the environmental conditions, he did not deny the possibility that Elvira’s hereditary traits might have contributed to her infirmities: “There had been, I remembered, a history of tuberculosis in her family, and while it is in no sense a hereditary disease, there was always the matter of susceptibility to be considered.”⁷⁴² In addition, he explained that his wife’s “deep-seated, intense nostalgia” resulted in mental illness and that the only way to cure it was to return her home. Elvira went back to Italy with their children, leaving Daniele behind. Soon after, Daniele got into a car accident and was hospitalized for a week. The accident left him with head trauma followed by the “nervous shock and the inevitable emotional letdown,” and he decided to go home to bring his “physical, mental, emotional, and spiritual “tone” back to normal.”⁷⁴³ Head trauma from an accident was one of the most commonly cited causes of insanity for men at the turn of the century; and here, Daniele used it to justify his mental condition and return home. According to Daniele, however, he decided to go home, not because he had an empty, bitter, and miserable life in America (which was so for him) but because he was stirred up by “boredom and restlessness” and his “gypsy love of adventure”: “The old urge to be on the move once more was boiling up within me; I sought new challenges to meet and conquer.”⁷⁴⁴ As a medical practitioner and educated man, he translated his mental trouble into something “justified and reasonable,” revealing a hint of American “restlessness” praised and celebrated for so long. Moreover, he

⁷⁴¹ Ibid., 132.

⁷⁴² Ibid., 133.

⁷⁴³ Ibid., 135.

⁷⁴⁴ Ibid., 134.

moved back to his hometown, Agnone, “not as an Italian, not even as an ex-Italian, but as an American. That to me was my proudest achievement.”⁷⁴⁵ Instead of being the symptom of insanity, his restlessness continued to be the driving force of his life, and he was soon back in the U.S. with his family, where he eventually became a real American in both legal and cultural senses. At the end of his autobiography, Daniele admitted that his life might not have been a success in terms of wealth and fame—“mine I am afraid could not be called a “success story””—but he looks back at the past years with “deep satisfaction” because he “lived through them.”⁷⁴⁶ Although he succumbed to the mental disturbances and anxieties attending a new life, Daniele, like the Thief in the previous section, refashioned his illness to fit the American success narrative. Daniele’s autobiography considered his suffering a badge of honor, and his medical expertise justified his version of reality.

O. E. Rølvaag, Sui Sin Far, and William Saroyan all looked to illness or death as a final resolution of the pressing demands of assimilation and Americanization.⁷⁴⁷ However, they were more critical than Bojer and Daniele in their assessment of life in America. They emphasized that it was not their characters that were insane: America itself was mad. For Beret, tormented by the intolerable amount of work and the harsh environment of the prairie, America was a place without any signs of civilization, where she and her family had to create from scratch “decency and civilizing living.”⁷⁴⁸ Pau Lin, shocked by Western civilization—immorality, to be exact—on Seattle’s bustling streets, learned that America was “a mad place

⁷⁴⁵ Ibid., 134-135.

⁷⁴⁶ Ibid., 235-236.

⁷⁴⁷ For discussions of Americanization and assimilation in “Wisdom of the New,” see Patricia P. Chu, *Assimilating Asians: Gendered Strategies of Authorship in Asian America* (Durham: Duke University Press, 2000), 114-116. Chu explains Americanization in terms of accepting or understanding the American norms of marriage and romance. She also acknowledges Pau Lin’s murder as “melodramatic madness,” comparing her with a mad woman in the attic.

⁷⁴⁸ Rølvaag, *Giants in the Earth*, 355. For women’s labor in the Midwest, see Mariolina Salvatori, “Women’s Work in Novels of Immigrant Life,” *MELUS* 9, no. 4 (Winter 1982): 39-58.

in which to bring up a child.”⁷⁴⁹ However, their trouble did not render them victims. Unlike Bojer’s Per Føll, most of the insane characters survived the ordeal of their new realities. In “Madness in the Family,” it was not the mad uncle Vorotan who died but a supposedly sane and ordinary member—old Varujan, the gunsmith—of the family; his death healed Vorotan’s madness and settled the family in America because immigrants felt “a heightened connection to the soil once their kin were buried within it.”⁷⁵⁰ Vorotan saw this burial as a way to claim rootedness in and belonging to the land and the earth, whether a grave or a farmstead. In *Giants in the Earth*, Beret, the insane, emerged triumphantly as a survivor while her husband Per Hansa, the strong and resourceful one, perished during a blizzard without seeing the result of his hard work and sacrifice. Yet, Beret and her children would become American, settling on the land he cleared and claimed. Sui Sin Far’s Pau Lin left the United States with her husband after the infanticide, never to settle in the New World. The child, born on American soil, was entitled to citizenship, an outcome that itself promised to continue the conflict between her ways and the “wisdom of the New.” Pau Lin ended her suffering by killing the child who embodied that conflict. Like Uncle Vorotan, death offered an end to her suffering, but instead of joining her and her family to the land, it required their departure. Did Pau Lin’s leaving prove her inassimilable nature and her limitation as a Chinese woman? Probably. The irony of the story was that it was Pau Lin who was most assimilated. Adah Charlton, the American woman whose friendship with Sankwei, the husband, fueled Pau Lin’s jealousy, saw the real Pau Lin: “Now, for all her ignorance, I can see that the poor little thing [Pau Lin] became more of an American in that one half hour on the steamer than Wou

⁷⁴⁹ Sui Sin Far, “Wisdom of the New,” 49. By a Chinese lady, Sien Tau, whom Pau Lin met on the street.

⁷⁵⁰ Marilyn Yalom, *The American Resting Place: Four Hundred Years of History through Our Cemeteries and Burial Grounds* (Boston: Houghton Mifflin Company, 2008), 8.

Sankwei... has become in seven years.”⁷⁵¹ While her husband was still torn between being Chinese and being American, Pau Lin, who resisted the assimilative forces, saw what America was really like.

The visions of immigrant writers were limited in a way that their assimilation process had to be completed through either death (Rølvaag and Saroyan), if not that of the insane, or departure from America (Sui Sin Far). Assimilation allowed their characters to climb up the social ladder, but it closed down the possibility of their physical mobility; now, they had to settle and be firmly rooted in American soil, taking immobility granted, or leave never to return.

Conclusion

In Maxine Hong Kingston’s *The Woman Warrior*, the narrator pondered: “I thought every house had to have its crazy woman or crazy girl, every village its idiot. Who would be It at our house? Probably me.”⁷⁵² Kingston’s first person narrative offers a clearly articulated version of the perspective that began to emerge in the earlier immigrant narratives: is it possible, as the early twentieth-century fictionalized accounts imply, that through insanity, immigrants were able to gain their voices? For Kingston, as well as for Saroyan, insanity was part of everyday American life, in which people like her narrator—both first and second-generation immigrants—could lose their voices, with tongues cut off.⁷⁵³ Unlike the male family members in Saroyan’s story, whose madness allowed them a higher status in their

⁷⁵¹ Ibid., 53. On the steamer, Pau Lin saw that her husband treated white women differently from her. Then and there, she realized her position in the New World. White-Parks argues: “Characters in her [Sui Sin Far’s] stories are not valued by how closely they adhere to a “white” standard, but by their assertion of individual and cultural integrity against the assimilative forces of North America.” Annette White-Parks, “A Reversal of American Concepts of ‘Other-Ness’ in the Fiction of Sui Sin Far.” *MELUS* 20, no. 1 (Spring 1995): 17-34.

⁷⁵² Kingston, *Woman Warrior*, 189.

⁷⁵³ For discussions of Kingston’s *Woman Warrior* and anxieties of assimilation in relation to hypochondria, see Anne Anlin Cheng, *The Melancholy of Race: Psychoanalysis, Assimilation, and Hidden Grief* (Oxford: Oxford University Press, 2001), Chapter 3.

own community, Kingston's and to some extent Saroyan's and Rølvaag's insane women might have been lost in the New World; however, for both the men and the women, madness showed a similar development as they struggled in the new country.⁷⁵⁴ As Vorotan's madness was derived from "fearful loneliness," "aimless walking about," and "the emptiness and disconnection," the aunt of the narrator in Kingston's book, *Moon Orchid*, underwent parallel experiences of insanity, which began soon after her arrival in America. Moon, the sister of Brave Orchid, came from China in hopes of finding her husband, who had settled in America and now, she learned, had a second wife. She was also surprised to find America a savage place without any civilization. Looking at Brave Orchid's American-born children, she thought: "They must have many interesting savage things to say, raised as they'd been in the wilderness," and "raised away from civilization."⁷⁵⁵ Goaded by Brave Orchid, Moon finally confronted her long-lost husband, who was now a successful doctor, a real American; however, when he refused to take her back—he said, "You can't belong. You don't have the hardness for this country"⁷⁵⁶—Moon began to slip away from reality. She became afraid that some Mexicans were spying on her and did not want to be left alone: "Moon Orchid had misplaced herself, her spirit (her "attention," Brave Orchid called it) scattered all over the world."⁷⁵⁷ Without being firmly rooted or grounded, Moon Orchid, like Saroyan's Uncle Vorotan, struggled to cope with her realities and create her own narrative. At last accepting that her sister had gone mad, Brave Orchid explained: "The difference between mad people and sane people" "is that sane people have variety when they talk-story. Mad people have

⁷⁵⁴ For differences between Asian Americans and Asian diaspora, see Ma, *Asian American Subjectivity*, in which he distinguishes Asian American literature and Asian diaspora literature. Moon Orchid's experience, although having a lot in common with that of Asian Americans (born in the U.S., familiar with American life but torn between the two worlds), is rather similar to what early immigrants in Rølvaag's and Sui Sin Far's narratives underwent.

⁷⁵⁵ Kingston, *Woman Warrior*, 133, 134.

⁷⁵⁶ *Ibid.*, 153.

⁷⁵⁷ *Ibid.*, 157.

only one story that they talk over and over.”⁷⁵⁸ She took care of her sister for a while, but she eventually called her niece to put Moon Orchid in a California state mental hospital.⁷⁵⁹ However, Moon Orchid was not lost. She found her place and voice through her insanity. Despite her confinement and lack of “hardness” for uncivilized America, she created a new life at the hospital, where no one left her behind, where she could form new familial relationships with other women, and where she was truly understood: “we understand one another here. We speak the same language, the very same.”⁷⁶⁰ Moon Orchid soon died at the institution, without recovering her former self; yet, as Brave Orchid admitted, Moon now had a new story, her own story, in which she could be someone with children and grandchildren. Even as an insane person, Moon Orchid was able to carve out her place and reconcile with her reality in the New World. Her abrupt death might suggest that she was a victim to the new environment, but at the same time, she, at least in Kingston’s narrative, was not a failure that America considered her to be.

Mental illness has become a popular subject of novels and novellas for modern-day ethnic authors who examine through the subject not only their own ethnic communities but also American society; they challenge and reinterpret the label of insanity or madness imposed from the outside. These recent narratives of insanity are more subversive and complicated, reflecting new ideas about assimilation and ethnic consciousness.⁷⁶¹ Still, it is

⁷⁵⁸ Ibid., 159.

⁷⁵⁹ Ibid., 159. Moon Orchid became insane primarily because her husband abandoned her; however, her encounters with the strange and uncivilized American customs, including those of American-born children of her sister, were as much responsible for her insanity.

⁷⁶⁰ Ibid., 160.

⁷⁶¹ There has been growing interest in exploring immigrants’ psychiatry in the second half of the twentieth century. For example, Hisaye Yamamoto in “The Legend of Miss Sasagawara,” *Seventeen Syllables*, revealed the blurred boundaries between sanity and insanity through her writing set in the post-Japanese Internment period. Janice Tanaka’s 1992 documentary, *Who’s Going to Pay for These Donuts Anyway?* reexamined the definition of mental illness. It centered on a daughter’s journey to find her father, a Japanese American man, who was committed to an insane hospital during World War II and lost touch with his family afterward. The film showed immigrants’ perspective of mental illness and its treatment in

worthy of attention that earlier writers struggled with the same issues and tried to convey their own views of mental illness and American life. Immigrant narratives of insanity at the turn of the twentieth century were limited in that they conceded to the hegemonic American version of assimilation; internalizing the American imagining of the “Other,” the immigrant writers did not necessarily subvert or resist classic narratives of Americanization.

Nevertheless, they gave meaning to immigrants’ mental illness, pain, and suffering, which for them were not merely a step to achieve American success but also a means to cope with immigrants’ alternative notions of madness, perhaps even their alternative sense of reality.

For immigrant narrators, insanity was neither a failure in itself nor a result of failed assimilation or adjustment. It was, as Saroyan observed, a “justified and reasonable” alternative to American civilization.

Conclusion

In May 2009, the *New York Times* published an article detailing the experience of Xiu Ping Jiang, a thirty-five year-old Chinese woman with mental illness, who was detained at a jail in South Florida without proper legal representation or medical treatment.⁷⁶² Jiang had been arrested in December 2007 at a Greyhound bus station in Florida on suspicion that she was in the country illegally. Unable to hold jobs long enough to settle in one place, Jiang moved from New York to Iowa to Alabama and finally to Florida, where she was about to start another new job. In January 2008, Jiang was ordered deported as an illegal immigrant; having smuggled herself into the United States after fleeing China in 1995, she had no immigration papers. However, she was unable to travel due to her mental condition—she had a history of attempted suicides—and instead of being deported, Jiang was sent to a jail for illegal immigrants, where her mental and physical health rapidly deteriorated. Her sisters in New York sought her release, but Jiang’s entanglement in the immigration system made it difficult for them to find a way out. Only after her case was reported in the media, Jiang was released under a bond and received treatment as a voluntary psychiatric inpatient at Bellevue Hospital Center in New York. In 2010, an immigrant judge in New York granted her asylum based on her forced sterilization while in China.

As a person with mental illness, Xiu Ping Jiang faced challenges in dealing with deportation proceedings, which denied undocumented immigrants like Jiang legal representation and proper medical attention; her inability to understand American legal institutions and the English language also made it difficult for her to navigate the

⁷⁶² Nina Bernstein, “Mentally Ill and in Immigration Limbo,” *The New York Times*, May 3, 2009. Soon after the publication of her article, Jiang was released on bail under the care of her sister. A follow-up article by Bernstein, “Immigrant Finds Path out of Maze of Detention,” was published on September 10, 2009. See also Bernstein, “Judge Grants Asylum to Chinese Immigrant,” *The New York Times*, May 17, 2010.

immigration system. Yet, her case alerted and brought together multiple agencies, including immigration officials, judges, lawyers, doctors, and immigrant rights advocates, who all played a role in building her case. Though mentioned only fleetingly, Jiang's frequent movements were also of importance because they cast a doubt upon her mental condition and resulted in her arrest, deportation order, and detention. Jiang was fortunate enough not to be deported or institutionalized, but her case shares striking similarities with the "alien insane" of the early twentieth century.

The case of a single person, Xiu Ping Jiang, stimulated debates on the nation's immigration policy and mental care for immigrants, just as the "alien insane," despite their small number, had once captured the public and professional medical practitioners' attention. They demonstrated the ways in which insanity among immigrants became a site of contention and revealed the larger process by which the federal government interacted with state governments and international authorities over the matter of immigration.

Since the 1930s, the immigration laws concerning the "alien insane" have undergone reform; they now reflect and incorporate persistent concerns for family reunification as well as changes in medical views and in the public understandings of mental illness. During the New Deal era, immigrants with mental illness continued to face exclusion, but those with an isolated episode could be reviewed by medical officers at the American immigration stations and, if proven mentally stable, were admitted.⁷⁶³ After World War II, to keep families intact, Congress allowed the admission of veterans' mentally and physically disabled spouses and children.⁷⁶⁴ While relaxing regulations for certain mentally ill immigrants, Congress also incorporated various exclusionary measures. The Immigration and Nationality Act of 1952

⁷⁶³ Deirdre Moloney, *National Insecurities: Immigrants and U.S. Deportation Policy Since 1882* (Chapel Hill: The University of North Carolina Press, 2012), 213; E. P. Hutchinson, *Legislative History of American Immigration Policy, 1798-1965* (Philadelphia: University of Pennsylvania Press, 1981).

⁷⁶⁴ Act of Dec. 28, 1945 (59 Stat. 659). Joren Lyons, "Mentally Disabled Citizenship Applicants and the Meaningful Oath Requirement for Naturalization," *California Law Review* 87, no. 4 (1999): 1017-1049.

had seven health-related grounds for exclusion, which included feeble-mindedness, insanity, previous insanity attacks, and mental defects. The McCarran-Walter Act also prohibited the entry of aliens afflicted with “psychopathic personality,” expressly to exclude or remove homosexual immigrants. The 1965 Immigration Act made minor but significant changes regarding health regulations. Attorney General Nicholas Katzenbach explained some goals of the proposed act. One of the changes, he reported,

would remove the absolute prohibition against the entry of epileptics. We all recognize the medical advances that have made epilepsy controllable and curable. Our immigration laws should recognize them also. The other change is one of utmost compassion—to allow close relatives of Americans to come here, subject to appropriate controls and restrictions, even though they might be mentally retarded or have been treated for mental illness—so long as their relatives can assure their care.⁷⁶⁵

Advances in medicine and science allowed epileptics, once regarded as insane and excludable, to gain entry to the United States. In addition, the 1965 Immigration Act substituted “mentally retarded” for “feeble-minded,” now an outdated and unscientific term. Emphasizing the “humane policy of favoring family unity,” politicians supported the admission of mentally afflicted children and immediate relatives, whose care would be assumed by their citizen families in America.⁷⁶⁶ Despite these changes, the 1965 Immigration Act maintained the exclusionary framework set by the 1952 McCarran-Walter Act.⁷⁶⁷ The

⁷⁶⁵ Statement by Attorney General Nicholas deB. Katzenbach before the Immigration and Nationality Subcommittee of the House Judiciary Committee on H.R. 2580, An Act to Amend the Immigration and Nationality Act (March 3, 1965); Hutchinson, *Legislative History*, 374.

⁷⁶⁶ Memorandum, April 5, 1965 (to Norbert A. Schlei, Assistant Attorney General, Office of Legal Counsel from Robert L. Saloschin, Letters opposing the Immigration Bill collected by Chairman Celler, Box 480, Folder: Immigration 89th Congress, H.R. 2580 – Amendments) Draft for “Common Misapprehensions about the Administration’s 1965 Immigration Bill, H.R. 2580,” Emanuel Celler Papers, Library of Congress.

⁷⁶⁷ Margot Canaday, *The Straight State: Sexuality and Citizenship in Twentieth-Century America* (Princeton: Princeton University Press, 2009). In 1974, the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) lifted homosexuality from the list. The Public Health Service reflected the change and stopped issuing Class A medical exclusion (related to mental defects) certificates to gays and lesbians entering the United States; however, the Immigration and Naturalization Service continued to exclude them without the certification process. See Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton: Princeton University Press, 1987); Eithne Luibhéid, *Entry Denied: Controlling Sexuality at the Border* (Minneapolis: University of Minnesota Press, 2002), 97-99.

Immigration Act of 1990 broadly modified the grounds for exclusion and eliminated the majority of the health-related exclusion categories; however, immigrants with mental disorders and associated behaviors that might pose or had posed a threat to themselves and others would be barred unless they were immediate family members of U.S. citizens or permanent residents.⁷⁶⁸ Thus, while these late twentieth-century acts reflected the convergence of progressive social concerns and medical developments, they continued to offer the American government various means to control and surveil incoming immigrants for their mental condition.

Protection from exclusion or deportation did not by itself guarantee proper care, either. Jiang failed to seek medical assistance for her mental condition, perhaps because she was an illegal immigrant or because like many immigrants, she did not know where to turn for help. Even after her arrest and detention, she could not receive proper care; as a detained immigrant, she had no right to legal representation or medical treatment. Many immigrants, both documented and undocumented, have found it difficult to get access to mental health services. Displaced people and refugees entering the United States after World War II raised concerns with their mental condition and the necessity for a better care system for immigrants and minorities, but psychiatrists and medical professionals remained ill equipped to provide adequate assistance for patients from diverse ethnic and cultural backgrounds.⁷⁶⁹ In 1979, the *Seattle Times* reported a troubling and stunning instance of negligence and abuse: a Chinese immigrant at an Illinois mental hospital had been institutionalized for twenty-seven years “mainly because the man could not speak English.” The hospital had not treated him for any mental disorders and only after twenty-five years identified a psychologist who could

⁷⁶⁸ Pub. L. 101-649, Immigration Act of 1990. <<http://www.justice.gov/eoir/IMMACT1990.pdf>>

⁷⁶⁹ Anne Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Farrar, Straus and Giroux, 1998); Alejandro Portes and Ruben G. Rumbaut, *Immigrant America: A Portrait* (Berkeley: University of California Press, 1990).

communicate with him in Chinese. Previously, the doctors were unable to give him a mental examination because of the language barrier, but they diagnosed him as psychotic anyway and recorded that when asked questions, the Chinese patient answered in an “incoherent and unintelligible manner.” He was occasionally put in restraints for wandering to another ward, where it later turned out he sought the companionship of the only other Chinese speaking patient.⁷⁷⁰ As this example illustrates, language and cultural differences that once plagued the turn-of-the-twentieth-century mental institutions still haunted America’s mental hospitals and clinics, and immigrant patients without families or advocates would have had hard time securing necessary care.⁷⁷¹

In spite of her troubles, Jiang was one of the fortunate few, who managed to draw the attention of journalists and later a large group of interested people, fighting for and giving voice to her. At the same time, Jiang’s case demonstrates how difficult it was for insane immigrants to have their voices heard. The “alien insane” at the turn of the twentieth century rarely had channels to share their experiences and alert the public; they were merely a set of files, documents, and statistics that created and affirmed the contemporary American view of

⁷⁷⁰ The article was cited in Stanley Sue and James K. Morishima, *The Mental Health of Asian Americans: Contemporary Issues in Identifying and Treating Mental Problems* (San Francisco: Jossey-Bass Publishers, 1982), 4.

⁷⁷¹ In the second half of the twentieth century, a combination of federal initiatives (Joint Commission in Mental Illness and Health), pharmaceutical intervention (psychotropic drugs), and anti-psychiatrist movement (scholarly and popular literature) pushed for and legitimated deinstitutionalization. The Commission recommended transferring chronically ill patients to community-based treatment programs. In 1963, Congress passed the Community Mental Health Centers Act, which accelerated the rate of deinstitutionalization. The aggressive marketing efforts for psychotropic drugs like Thorazine appealed to the medical institutions and the public and contributed to the trend in deinstitutionalization. Exposés of the conditions of mental hospitals and popular novels, including Mary Jane Ward’s *The Snake Pit* (1946), garnered the public attention, and anti-psychiatric literature, such as Thomas Szasz’s *The Myth of Mental Illness* (1974), supported the ongoing debates of deinstitutionalization. Mary de Young argues that deinstitutionalization left a legacy that is not easy to assess; as a policy, it was a success that brought to the fore the rights of the institutionalized, but as a practice, it did not always work. Communities were not equipped to deal with former patients, and mental health services lacked funds and staff to offer adequate medical care. See E. Fuller Torrey and Judy Miller, *The Invisible Plague: The Rise of Mental Illness from 1750 to the Present* (New Brunswick, NJ: Rutgers University Press, 2001), 295-299; Mary de Young, *Madness: An American History of Mental Illness and Its Treatment* (Jefferson: McFarland & Co., 2010), 117-122.

undesirable and diseased immigrants. Yet, looking back at the government files, hospital records, memoirs, and fiction, we caught a glimpse of their lived experiences.

Examining immigration and insanity, my dissertation attempted to bring out the multifaceted life experiences of allegedly insane immigrants and various authorities, agencies, and sites involved in constructing and controlling their insanity and mobility. Many of the “alien insane” suffered from serious mental troubles; others might have been deported or institutionalized for crossing, as Charles Rosenberg aptly put it, “the permanently contested if ever-shifting boundary dividing disease and deviance, feeling and symptom, the random and the determined, the stigmatized and the deserving of sympathy.”⁷⁷² Regardless of their mental status, what these immigrants underwent shed light on not only their own lives in the New World but also upon various sites of immigration stations, national borders, state hospitals, immigrant communities, and immigrants’ home countries, where their insanity and immigration experience were constructed and sometimes contested. This story of the “alien insane” also revealed the process by which the American government fought for hegemony over state governments and international authorities. What was to be done with these people, who were in need of constant care and possible institutionalization? How should the modern state deal with nationality, citizenship, and legal rights in a global theater where immigration even among the mentally ill would continue? These questions and the need to resolve them allowed the American government to reexamine and negotiate its place in the national and international arenas. The American system wherein states continually asserted their rights or attempted to assign financial and medical care to the federal government also appeared in this narrative.

⁷⁷² Charles Rosenberg, *Our Present Complaint: American Medicine, Then and Now* (Baltimore: The Johns Hopkins University Press, 2007), 56.

Behind the walls of state hospitals, which participated in the process of detecting and deporting the “alien insane,” the contemporary racial thinking of medical practitioners influenced immigrants’ encounters with American institutions; despite the objective and scientific façade of the science of medicine, “new immigrants” from southern and eastern Europe and Asia met the medical gaze of doctors infused with racial stereotypes and assumptions; even those with good intentions failed to understand immigrants’ language and cultural (thus, “racial”) differences. This story of the “alien insane” also opened a window into pain and suffering of immigrants and their struggle to carve out a place in America. Like Jiang, many of them were trapped in legal, social, and political limbo and exposed to myriad forms of surveillance and control over their lives. Yet, among these “mad travelers” were capable participants and savvy actors who learned to navigate American institutions and presented their own perspectives on American life and becoming American. Although dealing mostly with the American national context, this dissertation showed that the “alien insane” were global or transnational subjects, whose movements and illness brought together international governments and encouraged the global exchange of medical knowledge. The “alien insane” were on the move, and their mobility across the oceans, continents, and nations, whether through their own will or forcible removal, contributed to the construction of immigration policy, medical knowledge, and public attitudes, and of course, to the lives of immigrants who shared this mobility. Like Uncle Vorotan in Chapter 5, some immigrants and their descendants, though considered mad, evolved what William Saroyan characterized as “justified and reasonable” ways to cope with the tensions of living rootless in two different realities—the one they brought with them from home and the other they found once in America.

Appendices

Appendix A - “Alien insane”

In most cases, the terms, “alien insane” and “insane aliens,” simply referred to immigrants suffering from insanity and were used interchangeably by politicians, medical professionals, and immigration officials, who seldom clarified what they meant. However, these terms, especially “alien insane,” had interesting legal, political and social implications. In the 1916 hearings on the restriction of immigration, Judge Leon Saunders of New York challenged provisions of the impending new immigration act regarding the exclusion of the mentally ill or deficient and criticized that arbitrary interpretations of these provisions could lead to the exclusion of worthy immigrants. When the chairman explained that the laws would save New York the cost of maintaining the “alien insane,” Saunders, mindful of clear definitions of any legal terms, questioned its meaning:

I do not know what the amount [of the cost] is, and I do not know what you mean by “alien insane.” Those who come here insane are not allowed to enter, and those who become insane after they have come to this country and lived for sometime, under the conditions existing in this country, can not be called alien insane.⁷⁷³

The chairman interjected that the “alien insane” simply meant insane aliens, and no more questions were asked thereafter about its definition. Still, Saunders’s statement and the continued use of the term, “alien insane,” indicate that once insane, immigrants, no matter how long they had been in the country, were “aliens” and never to become real American. Their mental condition made it hard for them to shake off the burden of being “alien,” and it was especially true when they came from different racial backgrounds. Toward the mid-

⁷⁷³ U.S. Congress, House. Committee on Immigration and Naturalization, *Restriction of Immigration: Hearings before the Committee on Immigration and Naturalization*, 64th Cong., 1st sess. (January 20, 1916), 53. They were discussing “psychopathic [sic] inferiority,” a newly added provision for the exclusion of an immigrant, and its vague definition. Saunders was careful about the wording as he himself was deeply involved with the immigration issue.

twentieth century, the “alien insane” began to be replaced by “mentally defective” or “mentally ill” immigrants, but the term continued to have a meaning in the studies of immigration and mental health.

Appendix B - Official Test of the United States Government

DESIGNATE PERFECT ANSWER 'A'	IMPERFECT ANSWER 'I'	NO ANSWER, IGNORANCE, 'O'
NAME _____	RACE _____	
AGE _____	S. S. _____	
SEX _____	MANIFEST NO. _____	
NATIONALITY _____	DATE _____	

Names of father, mother, brothers and sisters? $5+4=$ $7+9=$ $2+3+4=$ $15+17=$ $5\times 3=$ $4\times 7=$
 Three horses have how many legs? $10-7=$ $18-7=$ $10-3=$ Count backward from 20 to 1. What is
 the color of this card? What is this color? (Red) What is this color? (Blue) What is the name
 of the ship upon which you arrived? Port of embarkation? Days en route? What is your present
 age? What was your age when married? Number of years married? Able to tell time? Number of
 months in the year? Name them. Number of days in the week? Name them. Present date? Present
 day of the week? How many days does it take to hatch an egg? Quantity of milk yielded by a cow
 per day? How many yards of cloth are required to make a dress? Name animals and birds you have
 seen. Capital of native country? Largest city? Ruler of native land? Distance one can walk
 in an hour? In one day? Where does the sun rise? Where set? Where does it go overnight?
 (Native coins.) How many units make the piece? How many commandments of God? Name two of them.
 What does Christmas signify? When does it occur? What is Easter? Test knowledge of simple
 geometrical figure.

Source: "Are You Daft? Would You Like to Find Out? Try Uncle Sam's Test," *The San Francisco Chronicle*, May 5, 1912, pg. 2.

On May 5, 1912, the *San Francisco Chronicle* published an article titled "Are You Daft? Would You Like to Find Out? Try Uncle Sam's Test," which included an official test of the United States government, prepared by government alienists "who know sanity and insanity when they see them." The article delineated problems associated with the immigrant insane: the foreign-born insane drained financial resources of state governments, medical inspectors lacked fund to detect undesirable immigrants, and the federal government neglected its duties to exclude the insane. It also challenged immigration officials, such as Commissioner-General Keefe, Commissioner of Immigration at Ellis Island William Williams, and Deputy Commissioner Byron Uhl, to answer these questions themselves, but it doubted the officials would be able to answer them. The article appealed to readers: "Try answering the questions yourself, and write Doctor Stoner [Surgeon-in-charge at Ellis Island] if you are not pleased with the result." Not only immigrants but also native-born Americans acknowledged that these questions did not always reveal immigrants' worth as potential citizens, not to mention their mental condition.

Appendix C - Data for Chapter 4

Chapter 4 is based on 104 immigrant patient files from Buffalo State Hospital (14231-93, Patient Case Files, New York State Archives, IRB approval, study #09-12) and Mendocino State Hospital (Series 6 Patient Case Files 1892-1972, California State Archives). To protect their privacy, I have used pseudonyms, initials, or first names only when referring to patients who appear in these files.

For Buffalo State Hospital, I randomly selected 10 boxes out of 77 (about 100 case files per box) between 1890 and 1920 (years patients were committed)—1898, 1903, 1907-8, 1911-2, 1913, 1916, 1918, and 1919-20—to examine changes in blank forms (they offer information on racial classification at the state hospital) and in medical examination and treatment. From these files, I gathered 76 immigrant cases (29 female and 47 male; the sex ratio of the general inmate population at Buffalo State Hospital was relatively balanced with slightly more male patients than female). I defined an “immigrant” patient as a foreign-born, not naturalized, and non-English speaker; however, I also examined nine patients from English-speaking countries (Canada, England, and Ireland) as a control group. Although fewer in numbers, I read some native-born American, both white and black, patient case files from the same sample boxes as I checked all the demographic information in the boxes to gather my data. In examining these files, I focused on the ways in which immigrant patients experienced the process of commitment, examination, and discharge/deportation/death at the hospital and what distinguished them from native-born American inmates.

For California, I examined all the accessible files (there is a 75-year limit) of the Mendocino State Hospital Records at the California State Archives and gathered 26 files of immigrant patients (foreign-born based on the nativity section; 15 female and 11 male), whose commitment dates ranged from 1905 to 1924. While Buffalo State Hospital had maintained relative consistency in record keeping over the years, Mendocino records were a

bit erratic. Some of the surviving patient case files were very detailed, mostly because they were for long-term patients (11 out of 26), who had stayed at the hospital for several decades. Others were sketchy, missing details on what eventually happened to the patients. I attempted to get access to Stockton and Napa State Hospital records, but without personal or familial ties to any of the patients there, I was unable to secure their files. To complement the available records from Mendocino and get more cases of Asian patients (Buffalo samples had no Asian patient records), I consulted the Stockton State Hospital Records, Series 2 Commitment Registers 1856-1920, Rolls 7-17 (between 1900 and 1920), reproduced in microfilm. The registers were brief, one-page records with demographic information of patients and several factors (drug habit, indication and duration of present insanity attack, diagnosis, contact information, etc.) responsible for patients' admission to Stockton Hospital. These files lacked in-depth look into individual patients. Nevertheless, they were helpful in drawing a general picture of hospital admission and discharge practices. I selected registers of Chinese and Japanese patients based on the nativity section and gathered 405 Chinese and Japanese files (including six Koreans, some of whom were identified as Chinese Korean; 21 female—marked as either “Chinawoman” or “female Jap”—and 384 male) to examine these two particular racial/ethnic groups. I also read a number of registers for Indian, Filipino, Mexican, and European immigrants, but they were not included in my data.

I used two complementary sources for this chapter. One is forty-seven immigrant patient case files from St. Elizabeths Hospital, the federal hospital for the mentally ill, at Washington, DC (Record Group 418). The NARA houses cases of patients committed in years ending with 0s and 5s, so I sampled patient case files based on the nativity section of the commitment registers from years 1900, 1905, 1910, 1915, 1920, 1925, and 1930. The other is a total of twenty-four cases (mostly correspondence) of Native American patients, compiled between 1905 and 1907 (Entry 19, Records of the Bureau of Indian Affairs, Record

Group 75), from the National Archives at Forth Worth, Texas. This record group included hospital application forms and letters exchanged among officers of the Indian Territory, doctors at the hospital for the Indian insane in Canton, South Dakota, and Native American patients' families and friends.

Buffalo State Hospital (76) Committed between 1898 and 1920

In the US at the time of commitment for

Less than 1 year	17
1-5	24
6-10	13
11-20	10
21-30	6
31+	4
Unknown	2
Total	76

Ages of Patients at the time of Commitment

11-20	5
21-30	28
31-40	23
41-50	12
51-60	2
61+	6
Total	76

Nativity of Patients

Austria	6
Canada	2
England	3
Germany ¹	12
Greece	1
Hungary	3
Ireland	6
Italy	16
Norway	2
Poland ²	19
Russia ³	5
Spain	1
Total	76

¹ Includes Prussia and Alsace

² Includes Russia Poland, German Poland, and Austria Poland

³ Includes Poland Russia

Petitioner

Husband/Wife	23
Father/Mother	5
Son/Daughter	4
Brother/Sister	3
Relative (cousin, uncle)	4
Friend ¹	3
Commissioner of Charities	5
Hospital	6
Penitentiary	3
Police	4
Superintendent of Poor	11
Voluntary	1
Emergency	2
Unknown	2
Total	76

¹ Includes one case in which a nun was admitted. Her petitioner was another nun.

Movements of Patients

Discharged	26
Deported/Sent back ¹	22
Died	25
Transferred	2
Eloped	1
Total	76

¹ Includes those who were deported by government orders or by the New York Hospital Commission, and patients who were sent back to home countries by friends or relatives.

Departed/sent-back Patients: at the time of commitment, in the US for

Less than a month	3
1-6 months	5
7-12 months	4
12 months-2 year	4
3-5	4
6+	2
Total	22

More than ninety percent of the cases fell in the five-year statute of limitations period, although it should be noted that the statute of limitations changed from two to three to five years in the early twentieth century. The data suggest that Buffalo State Hospital had a good reporting system and worked closely with the State of New York and the federal government to facilitate deportation or removal of immigrant patients.

*Mendocino State Hospital (26) Committed between 1905 and 1924*In the US/ California (whichever is the longer)

Less than 1 year	0
1-5	2
6-10	6
11-20	8
21-30	1
31+	1
Life (born in the US/CA ¹)	1
Unknown	7
Total	26

¹ Despite birth in the US/California, this patient (Chinese) was not considered an American.

Age at the time of commitment

11-20	0
21-30	7
31-40	11
41-50	2
51-60	2
61+	1
Unknown	3
Total	26

Nativity

Austria	2
California ¹	1
China ²	3
Denmark	1
Finland	4
France	2
Germany	2
Greece	1
Hungary	3
Ireland	1
Italy	3
Japan	2
Norway	1
Total	26

¹ Chinese born in San Francisco, but not fluent in English. His claim to American citizenship was denied by hospital doctors.

² Includes one case in which the patient's nativity was initially unknown.

Movement of patients

Long-term patients	11
Discharged	2
Deported	3
Died	7
Unknown	3
Total	26

*Stockton State Hospital (405) Committed between 1900 and 1920*Nativity

China	245
Japan	154
Korea	6
Total	405

Movements of Patients (Chinese, Japanese, and Korean¹)

Discharged ²	180
Discharged to home (including deportation)	78
Died (including suicide)	133
Transferred	2
Escaped	4
Unknown	8
Total	405

¹ Include 1 "Corean Chinese"² Include 3 "not insane"Deported/sent-back Patients: at the time of commitment, in the US/California for

Less than 1 year	4
1-5	9
6-10	13
11-20	12
21-30	12
31-40	8
41+	2
Unknown	18
Total	78

More than sixty percent of the deported/sent-back Chinese and Japanese patients (excluding "unknown") had been in the United States or California for six years or longer. The Stockton records show that even long-term residence did not guarantee protection for immigrant patients, especially those who were racially different.

Appendix D - Mental Examinations

Patient case files from New York and California included detailed transcripts of interviews and examinations with patients. For example, the case file of Mercy, who was born in Ireland and moved to Niagara Falls, New York, in 1919 with her husband, had one of the most detailed interview transcripts.⁷⁷⁴ The section for mental status consisted of several parts: attitude and manner, stream mental activity, general mental attitude, orientation, recent past, personal identification, retention, education and general experience, current events, counting and calculation, and writing, with a writing sample of the patient attached.⁷⁷⁵ In the case of Mercy, the questions were:

For Education and General Experience (Mercy's answers)

Counties form British Islands? (England, Ireland, Scotland and Whales)
 Name Oceans? (Atlantic and Pacific)
 Capital of England? (London)
 Capital of Scotland? (Edinburgh)
 Capital of Ireland? (Dublin)
 Form of Government had Great Britain? (King)
 How king determined? (The next heir – the son)
 Ruled before King George? (King Edward)
 Before him? (Queen Victoria)
 King have unlimited power? (Limited)
 How limited? (Parliament – the Sec'y of State)
 Where is Paris? (France)
 Where is Berlin? (Germany)
 Where is Rome? (Italy)
 Capital of U.S. (New York)
 Capital of Canada? (Toronto)

For Current Events:

President of U.S. (Wilson)
 How President elected? (By peoples votes)
 Largest City in the U.S. (New York)
 Largest City in Canada? (Ottawa)
 Who is Gov. General? (Duke of Devonshire)
 Recent war begin? (1914)
 Countries involved? (Germany, England, Belgium, Turkey, Russia, Serbia, Italy, U.S.)

⁷⁷⁴ Buffalo State Hospital, Admitted in August 1920 and discharged in December 1920 as “recovered.” In U.S. for one year. Diagnosis: manic depressive psychosis.

When U.S. enter? (The year before the war finished)
 Fighting over? (November 1919)
 When Peace Conference? (I don't know)

Mercy managed to show “fair grasp” of these issues as she received public education in Ireland before her immigration. The fact that she had no language trouble in communicating with the Buffalo doctors certainly eased her examination process.

Case files from Mendocino State Hospital in California had a section for “special memory,” which was similar to the education and experience section at Buffalo. The mental examination of Sally,⁷⁷⁶ conducted in February 1913, had the following sections:

Orientation
 Insight
 Hallucination & Delusion
 General Memory
 Special Memory (last 5 presidents of U.S.; Capitol of U.S.; Capitol of California)
 Masselon Test (several words were given and a patient pieced them together to create a sentence)
 Ziehen Test (differences between “mistake” and “lie,” or “cows” and “horses”)
 Association (days of the week and months of the year forward and backward; The alphabet backward and forward)
 Stories
 Finckh Test (mottos or aphorisms asked; at Mendocino State Hospital, doctors used, “The early bird catches the worm,” “Too many cooks spoil the broth”)
 Ethical Test (when found ten dollars, what should be done?)
 Holidays
 General Information (color and price of stamps)
 Sleep & Dreams

These questions required greater knowledge of American society and the English language. Mendocino State hospital doctors accommodated immigrant patients by modifying the questions or hiring interpreters who could translate and clarify some of the questions. The Masselon test and storytelling were often omitted since they necessitated a significant level of cooperation from patients.

⁷⁷⁶ Mendocino, Sally. Born in Ireland, indigent widow. Diagnosis: manic depressive insanity. By 1921, she had been admitted to state hospitals five times. The mental examination was conducted in 1913 after she was admitted for the third time.

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